Do you sense a crisis in the world?

Here are two views of this crisis:

GIBSON WINTER, Professor of Social Ethics sees....

INDUSTRIAL CIVILISATION

making itself in to

A MACHINE

CONSUMING OUR SPIRITUAL DEPTHS

MAKING PEOPLE INTO 'OBJECTS'

He also sees society as

A WORK OF ART

flowing from

THE CREATIVITY OF COMMUNITIES ROOTED IN SOLIDARITY WITH EACH OTHER

THE CRISIS is the STRUGGLE

between the two
ANOTHER VIEW

IN OUR CIVILISATION

FORCES OF DESTRUCTION

RAPID
- nuclear War
- death of unborn
- oppression of labour
- abandonment of poor
- collapse of family
- violation of human rights—especially torture
- misuse of earth’s resources

SLOWER

but also

NEW ENERGIES EMERGING

A CIVILISATION OF LOVE

based on

- human dignity
- cooperative solidarity leading to

NEW economic and political institutions

NEW cultural foundation

A COMMUNITARIAN SOCIETY
beginning with the poor,
discovering the world
is spirit filled

We NEED SOCIAL ANALYSIS, but the deeper

task of SPIRITUAL and CULTURAL ANALYSIS

lies before us —

This is the view of Pope John Paul II
In My Lack of Insight

I used to wonder at the 'untidiness' and refuse around the houses in some areas. Now I realise what it would be like if I had to fetch water, dispose of the rubbish personally, grow my own food, try and make some money as well as care for my family all in the same 24 hours!

Oh! I forgot - collect firewood too!

For a Full and Healthy Life

**IN SOME PLACES**

- We turn a tap
- Its all done for us
- Shops are full - Easily available
- The 'bin' man comes weekly
- Expert help not far
- Available if we want it
- Knowledge available

**we need**

- SAFE WATER
- SANITATION
- ADEQUATE FOOD AND KNOWLEDGE OF NUTRITION
- CLEAN ENVIRONMENT
- CARE ANTENATALLY and at DELIVERY
- HEALTH CARE FOR INFANTS AND CHILDREN
- FAMILY SPACING
- TREATMENT FOR THE SICK AND HANDICAPPED

**IN OTHER PLACES**

- Some carry it for miles
- Latrines must be built and maintained
- Land and farming could be improved
- Have to dig own pit
- TBA's good, with new skills better
- Millions die yearly
- A need not yet met
- Available to a small minority
**COMMUNITY BASED HEALTH CARE (CBHC)**

The VISION (Geraldine Huisimg says) is that people based in the community should learn about:

- health care
- about the activities necessary to ensure it
- and about what to do when they or their neighbours fall sick.

People chosen out of the community should be trained for this and they are the people who can change their community.

Our EXPERTISE is needed to help train these people, but we can’t do it unless we see, walk and talk in their community and become part and parcel of it.

Geraldine goes on "To do such work requires courage. We need to pull ourselves away from our busy dispensaries and hospitals, out of the vicious circle of disease - cure - disease - cure. We need to step out of our ivory towers because inside it is comfortable familiar work, exhausting but satisfying - Outside is the unknown, perhaps unfriendly - But if we want justice and health for the poor we need to go to the community, live with the community, learn from them, share our knowledge so that the community learns self-reliance in health.

**HEALTH IN A COMMUNITY**

**REQUIRES TWO ELEMENTS**

**ACTIVITIES IN THE COMMUNITY PROMOTING**

- Good nutrition
- Food supply
- Safe water
- Sanitation
- Safe environment
- Child care
- N.F.P.
- Basic Curative

**A MOBILE ELEMENT**

Involved in Immunisations
- Training C.B.H.W.s and TBA’s
- Being a LINK with the HEALTH UNIT
But what **motivates** the CEHN to do all these things?

Here are some **models** of CEHC.

**LARGE SCALE PROGRAMMES**

Government or Non Government Organisation (NGO) with generous overseas funding

**Motivation is livelihood**

for me and my family

I would feel as an employee to my employers -
I would also look for 'advancement'
away from my community

but if they decide to stop paying
CEHN's as the programme expands ...

**Programmes with an **INSPIRATIONAL LEADER**

Who trains
Salaried
Supervisors.

Each supervises a
number of C.B.H.Ws.

C.B.H.W's are part-timers
and hopefully supported by
the community.

**Motivation is the inspiration**

of working together with a
**splendid leader**

and some pay

but if the **inspirational leader** goes ----
COMMUNITY BASED MODELS

Aimed at community building

by — working WITH, not FOR the community!

- allowing an AWAKENING process
- letting people GROW
- building their SOLIDARITY and ORGANISATION

MOTIVATION IS COMMUNITY SOLIDARITY

They vary enormously —

- Some are founded on Farmer’s Clubs and Women’s Organisations - e.g. the Project started by the Aroles in India 2.

- Some are groups taking part in ‘Training for Transformation’ 3. described in the books of that name. Here the method combines Paulo Freire’s work, with human relations training, social analysis and the Christian concept of transformation.

- The Jinka Integrated Programme in Ethiopia, again working with local groups, and also linked with Government is a unique situation - Their Report June 83 - May 84 would encourage others - as here they are facing their problems. "In theory the concept of P.H.C. is simple - In reality there are many problems to be faced - problems in community participation, training of C.H.W.’s, supervision and support, of C.H.W.’s, training of supervisors of C.H.W.’s, and motivation at all levels." So they are about to study these problems closely in two areas.

PROBLEMS SHOULD NOT SURPRISE US!

C.P. MacCormack 4. writes, about Community Participation and this article should be a must for all of us.

About TYPES OF COMMUNITIES he notes with obvious experience

- We assume they are free from internal exploitation, many are not.

- villages may be divided by ethnic origin

- in some villages rivalry between political parties is played out locally.

- some are destabilised by migration

- some are so unstable, disorganised or badly governed that it is a waste of resources to try and achieve participation in health care.

- political organisation of villages may be

  * democratic - slow to take decisions - but with a genuine commitment to long term maintenance
  * authoritarian - where activities may take place swiftly at first - and then all stops.
in politically unstable countries genuine community initiatives may be viewed as threatening.

But on the asset side,

there are social groups - religious groups - men's and women's clubs - and traditional midwives and "they should certainly be part of a village health committee."

We can't just expect community participation to happen it "is a skill which must be taught to community health workers and backed with support services."

---

**SMALL CHRISTIAN COMMUNITIES**

*as the starting point -
when they are ALIVE
their life spills over
into SERVICE - INTO MINISTRIES.*

One of these is HEALTH another SERVICE to the POOR

*These are truly VOLUNTARY WORKERS*

Recently I visited Nangina parish in Kenya, where small Christian communities have grown and developed - I met the people and spent two days with them - It can and does happen

**THE MOTIVATION?**

*LOVE, SO THAT THEY MAY HAVE LIFE, AND HAVE IT TO THE FULL*

And this is where we began on page 1 and 2.

We can ask ourselves

Do our activities really bring com-union between people?
What growth is there in my community and in the people around me?
What is stopping growth in my community and in those around me?
REFERENCES
1. Holland J. and Henriot P.

Periodontal disease - commonest cause of tooth loss - how to prevent it.
Cost of 24 self mounting slides £1.80 including surface postage.

COURSES
1. Diploma Course for Trainers and Supervisors of Community Rehabilitation Workers in Developing Countries. Run by Institute of Child Health and AHRTAG - Designed for experienced doctors and therapists (OCT - JULY).
Write: The Secretary, Rehabilitation Trainees Course, AHRTAG, 85 Marylebone High Street. LONDON. W1M 3DE. U.K.

BOOKS
Two wonderful newly published books should soon be available here:
'Beyond the Dispensary' by Roy Shaffer - Community Health Worker Support Unit, AMREF, Kenya.

CONTENTS
Crisis in the World 1 - 2
What is needed for health 3
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Page 8 – Issue 21
This LINK will consider briefly three points:

- The state of 'RESPECT FOR HUMAN LIFE' in the world
- Some light on 'IN VITRO FERTILISATION'
- Can we stay on the side lines?
  What is my stand?

The theme of the International Congress of 'Doctors who Respect Human life' held at Ostend, October 1984, was "Science and Conscience"

Papers given at this Congress provide most of the material for this LINK.

Of Course, respect for human life concerns not only doctors but all health workers and all people.
RESPECT FOR HUMAN LIFE

The Declaration of Geneva, 1948 is a present day version of the Hippocratic Oath and demands of doctors the following commitment.

"I will maintain the utmost respect for human life from the time of conception."

In his study "In Search of the Hippocratic Tradition" Ratner writes:

"The late Margaret Mead, anthropologist, adds a profound observation: the fact that the Hippocratic Oath marked one of the turning points in the history of man. She states that:

for the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world the doctor and the sorcerer tended to be the same person. He with power to kill had the power to cure...He who had the power to cure would necessarily also be able to kill.

Dr. Mead continues:

With the Greeks, the distinction was made clear. One profession, the followers of Asclepius, were to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect - the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child.

This a priceless possession which we cannot afford to tarnish but society always is attempting to make the physician into a killer - to kill the defective child at birth, to leave the sleeping pills beside the bed of a cancer patient...

She is convinced that "it is the duty of society to protect the physician from such requests."

But as you know, the acceptance of killing as a function of doctors, aided by other health workers is becoming more widespread today. The ancient principle since the time of Hippocrates 'do not harm' is no longer sacred. An example: doctors and health workers have heavy pressure on them, in many countries, to staff a State abortion or else you 'don't get the job'.

RESPECT FOR HUMAN LIFE?

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<th>HUMAN LIFE BEGINS</th>
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<th>DEATH</th>
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<td>EXPERIMENTATION?</td>
<td>ABORTION</td>
<td>ALLOWING HANDICAPPED BABIES TO DIE</td>
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WHEN DOES
HUMAN LIFE
BEGIN?

Some say it is an 'open question'

Professor R.B. Zachary puts it clearly:
The right to life does not depend on SIZE. "The fundamental right of a child of ten is no less than a man of thirty, no less at 10 weeks of age, no less at 10 days, or ten seconds after birth - or 10 seconds before birth - or 10 weeks before birth - In fact this right exists as long as a separate individual has existed - And how long is that?"

WHEN DID I
BECOME ME?

Put very simply:- Fertilisation is the process by which the ovum (egg) and the sperm join together to become one single cell - and then a completely new individual has started life. Although oxygen and food are supplied from the mother, all the parts of the body are produced by cell division from this one cell.

So the INSTRUCTIONS as to how this is to happen, whether you are to be male or female, short or tall, that a human brain, heart, limbs and so on are to be formed, are all present in this one initial cell. The instructions are carried by structures called GENES.

Half have come from the sperm (and so from the father) and half from the ovum (and so from the mother).

When it is the sperm and egg of humans:-

TWO FACTS

- It is HUMAN LIFE - not a chimpanzee
- not a crocodile

- The PATTERN OF GENES of this separate individual
  is as DIFFERENT FROM THE MOTHER
  as it is DIFFERENT FROM THE FATHER

  It can no longer be considered as PART OF THE FATHER
  Nor can it be considered as PART OF THE MOTHER
  (she has her own special genes)

THIS NEW IDENTITY is unique and will remain unique through the life of the individual human being.

This is a new human being and so is deserving of respect.

Teresa Iglesias' writes "The certainty of our personal beginnings from conception is founded on evidence provided not only by biology and common sense - ...There is an unshakeable form of certainty...which becomes total because it is founded on the testimony of a truth that comes from God: it is God's own manifestation to us of the kind of beings we are, i.e. always to be treated as persons, always, from conception, to be deserving of absolute respect."
**IN VITRO FERTILISATION (IVF)**  
(fertilisation outside the body)

Since the 1950's scientists have been experimenting with the eggs and sperm of animals and also of humans.

Since 1968 medical people have been working with them to try and achieve human fertilisation outside the body, and also to 'culture' the human embryo (i.e. find the right conditions to enable the embryo to grow by having enough oxygen and suitable nutrition and protection).

**THE AIMS OF IVF** are to help infertile couples to have a baby and to carry out research. The steps are:-

1. Mature ova are sucked from the woman's ovary.
2. They are put with human sperm in the laboratory.
3. If and when fertilisation occurs an embryo, or several embryos are implanted in the woman's womb.
4. Hopefully one at least will become attached to the inner wall and pregnancy will continue.

These steps were completed successfully when Louise Brown was born in 1978. Now at least 15 countries as well as U.S.A. and Australia have 'in vitro' centres.

**PRACTICAL POSSIBILITIES?**

- **WIFE STERILE**
  - Common cause blocked tubes.
  - Ova cannot reach the uterus from the ovary in the natural way.
  - So ova from wife sucked from the ovary and united with husband's sperm in the laboratory.
  - Embryos are implanted in wife's womb.
2. HUSBAND STERILE

Donor sperm used instead. Embryos implanted in wife's uterus (womb).

3. Wife sterile because she cannot bear pregnancies in her uterus. Husband's sperm fertilises wife's ova 'in vitro'. Embryos implanted in another woman's uterus - (called a 'surrogate' mother)

'SURROGATE MOTHERHOOD'

WHAT ARE THE RESULTS?

- As a means to help infertility only limited results - e.g. 11% in very experienced hands.
- In number 2, there are legal problems. The baby does not belong to the father, and will not know his or her father when old enough to realise this fact.
- In number 3, the surrogate mother may not wish to continue the pregnancy, so have an abortion, or she may change her mind about handing the baby over and want to keep the baby. Agencies make these 'arrangements' for large sums of money. It is a money making racket. I wonder what the feelings of the real mother are?

- All these methods are carried out AT THE EXPENSE OF THOUSANDS OF EMBRYOS which are used and destroyed, or which die in the process.

How is this?

Because drugs are given to the women which cause several eggs from her ovary to mature at the same time (it is usually one at a time).

These are then removed, fertilised in the laboratory and about 2 - 5 embryos are placed in the womb, in the hope that at least one will implant (sometimes several do!) But there are other embryos over and these are frozen and stored, or used for study and experiments.
WHAT EXPERIMENTS?

- On new methods of contraception.
- On a new way to produce abortion in the first month.
- On the early diagnosis of abnormalities.
- On the possibility of growing human embryos in other species.
- On the effect of new drugs on the human embryo.

Animal embryos can be 'split' to produce artificial twins and then 'split' again and so on. Is this being done with human embryos?

HOW DO OFFICIAL BODIES RESPOND TO THIS?

THE JOINT EUROPEAN MEDICAL RESEARCH COUNCILS, on the whole representing their national medical bodies put out a document in June 1983. In everyday language the main points are:-

1. ...research on the process and re-implantation of the products of IVF can be supported.
2. ...when human ova have been obtained and fertilised in vitro and are no longer required to overcome fertility, they may be used for research.
3. Ova may be fertilised in the laboratory for research as long as there is no intent to transfer the embryo.
4. Studies on the interaction between species involving human gametes (ova and sperm) are valuable...the product should not be allowed to develop beyond the very early stages.

These recommendations have been accepted by most European countries. Ireland expressed strong reservations concerning number 1 and 3, and Norway proposed its own recommendations with more limitations. The Warnock Report, England recommends the 'storage' of embryos up to 10 years and experiments up to 14 days, but that surrogate motherhood should be illegal.

TERESA IGLESIAS in her paper goes on to stress-

THE AIM OF IVF

is to - produce a pregnancy for infertile couples.
- further scientific and medical knowledge

THE AIM OF IVF IS NOT in present practice
- to give an opportunity for each newly conceived human being to continue to live and to be helped to follow the normal course of development.

The Recommendations given above also do not have the aim of giving each new embryo the opportunity to live and develop.

TWO VITAL FACTS ARE TAKEN FOR GRANTED AND PRESUMED TO BE TRUE

1. That the early human embryo does not enjoy full human status.
2. That the value and interests of science and society are more important than the value and interests of the newly conceived human being.
**CAN WE STAY QUIETLY ON THE SIDELINES?**

If I choose to live CONSCIENTIOUSLY I need:

- TO ACT WITH HUMAN FEELING - there is a danger of looking at people as 'cases' or 'problems'.
- TO BE WELL INFORMED - in medical and scientific procedures today we need to know the facts, the actual procedures, the results.

Often we don't know how to respond to new scientific findings because we don't know the full implications.

Human skill and science are neither GOOD nor BAD. It's what they're USED FOR that makes them good or bad.

**MEDICAL SCIENCE** has many techniques that can be used - to destroy or to cure and heal.

**REALLY!** Standing in the Health Centre here or working in this P.H.C. programme - does all this affect ME?

ONLY you can decide - but in many parts of the world people - children - newborns - babies in the uterus are being classed into 2 groups:
- WANTED - let's do everything to cure them.
- UNWANTED - let them die - or help them to die.

Who decides? It depends on the country where you live. Do you agree? Could you make a list of 'wanted' and 'unwanted' in your area?

**IT'S A QUESTION OF POWER**

One country's strong economic situation may give it POWER over another one, even in matters relating to life, e.g. in the method of family planning in your clinic.

Research worker's desire for power over life and death may pressurise governments who desire prestige, e.g. to legalise and support their programmes.

Politicians or the State may have POWER to pressurise people to act against their conscience.

Scientists may have POWER over hundreds of human beings - embryos in their laboratories.

**WE ARE UNDER PRESSURE**

Subtle pressure through the media. Through training programmes. Through the desire for prestige or wealth. And sometimes ... through force!
Some are making a stand

Medical News - June 1984

- ENGLAND. "The Royal College of General Practitioners is preparing to take a forceful stand against the licensing of research on IN VITRO fertilisation up to 14 days...(they are) lining up against the whole of the rest of medical opinion".

Some gynaecologists support them - Sir John Peel has warned that experiments were bringing us to the brink of something comparable to the atom bomb because the potential was 'quite horrific'...

Expressing concern that other species might be used to grow human embryos, he declared "We are dealing with human beings, not animals."

- IRELAND had, not a vote of politicians, but a vote of the people on abortion, the majority voted against legalising abortion.

- AT THE OSTEME CONFERENCE we heard of LIFE activities from many countries including Yugoslavia where, in fact, a group persuaded the government to give their permission to prepare a pro-life film and leaflets. These have been used with groups stressing that love of children and the family is our main hope.

- IN SWITZERLAND pro-life medical workers have come together and they have put pressure on the government who had required them to sign that they would do abortions. Now after 6 years the government has agreed that it is a fundamental right of freedom not to perform abortions if it is against their conscience - and this without losing or failing to get a job.

There is now a popular initiative - many signatures - to change the Constitution regarding legal abortion.

- PORTUGAL passed a law legalising abortion August 9th 1984. This will effect Portuguese language groups in the world. Brazil has joint citizenship with Portugal.

The abortion law was pressurised by IPPF money, we were told - Many doctors are not co-operating with these new laws.

- INDIA - We heard that in some cities in India amniocentesis (removal and examination of the fluid around the baby in the womb) is being done - so that the sex may be discovered. Females may then be aborted. Large scale programmes diffuse an anti-life mentality - and there is pressure on doctors. Pro-life doctors are also acting; they 1) focus on Natural Family Planning, 2) run special workshops for doctors and health workers 'A Programme on Respect for Life,' 3) have courses for schools and colleges, 4) see the necessity for discussions with theologians and seminaris. 5) arrange Medical Ethics courses for medical students.

- Belief in the right to life unites people. A Moslem representative sent his Code of Medical Ethics to the Congress as he was unable to come. In U.S.A. people of all creeds are also uniting in an awareness of the threats to human life in this present day.

What are your comments on this Link?
There is so much more to say. Should it be continued?

Acknowledgements

2. Zachary R.B. "The Humanity of the Fetus".
3. Iglesias I. "A basic ethic for the well being of man". Paper given at the Conference - Much of the material in the following pages of LINK are from this source - obtainable from "Federation of Doctors Who Respect Human Life" - Mayfield, 75 St. Mary's Road, Huyton, Merseyside L36 5SR. (£1.50).

Sr. Pauline Dean, M.M.M.
THE HOLISTIC APPROACH TO HEALING

What exactly is it? Recently I have been trying to find out as we CALLED ourselves to follow such an approach in our Chapter 1985.

Is it the approach of people in many countries who seek the cause of illness by asking 'WHO caused it?' rather than 'WHAT caused it?' and who seek healing by repairing relationships with the appropriate persons?

In some degree, yes, but it is more than that.

Is it seeing ourselves in relation to our universe? ¹.

Universe
World
Nation
Society
Community
Family
Spirit
Mind
Body
Systems
Organs
Tissues
Cells
Molecules

Much of conventional medicine focuses around cells, tissues organs.

But as you go up each is part of the one above - the person is part of the family, the family part of the community and so on.

So it is this and also more than this.

Is it the same as Alternative Medicine, such as herbal medicine, acupuncture, reflexology, homeopathy? These may be involved in the holistic approach, but it is more than this.
WHAT ARE KEY FACTORS

RELATING TO WELL-BEING — HEALTH?

A paper by John Heron1 gave answers to my question.

WHO or WHAT determines my health and is RESPONSIBLE for my well-being?

Beliefs may either be:

- POWERFUL OTHERS — doctors who have power to cure.
  - perhaps spirits or those who use charms.
- MY SELF
- I SHARE with one or more others.

The holistic approach believes in shifting these perceptions so that SELF CARE AND COMMUNITY CARE become vital.

WHAT WILL BE DONE?

HOW WILL IT BE DONE? Either:

- THROUGH MY OWN INNER SELF — INTERNAL
  - My ability to control my mind and body
  - Including mental acts, such as meditation,
    - reflection and change of attitude.
  - Including ability to change my behaviour
    - to change my diet
    - to exercise
    - to alter the way I relate to persons.
- OR BY AN EXTERNAL AGENCY
  - such as a person, or some equipment that acts on me.
- OR BY COMBINING INTERNAL AND EXTERNAL FACTORS
  - such as combining meditation and medicine.

Both conventional and alternative medicine have relied strongly on external agencies, whether it be drugs, surgery or herbal remedies and acupuncture needles, Heron believes.
We all have **DIMENSIONS OF BEING**

- **PERSONAL** - involving both the **SOURCE**, the well-spring whence a person emerges. - the conscious and unconscious levels.

- **PSYCHO-SOCIAL DIMENSION** - both within the person and in relationship with others.

- **ENERGETIC - PHYSICAL DIMENSION** including the physical structure and energy processes going on within.

Both conventional and alternative medicine intervene largely in the **ENERGETIC - PHYSICAL** dimension.

**THE PROCESS INVOLVED**

**ALTERNATIVE MEDICINES** argue their approach is

- **CATALYTIC** - that it harmonises and re-aligns and restores wholeness of being. It seeks to encourage the body-mind to deal with its own disorder from its own resources.

**CONVENTIONAL MEDICINE** is **CONFRONTING**, they say, and deals with the disorder directly. It assaults the disordered part to subdue it or eliminate it, e.g. drugs, surgery or radiation. They argue they are used excessively, unnecessarily and inappropriately.

**CONVENTIONAL MEDICINE** charge that alternative medicine has never been based on adequate proof and that the supposed catalytic effect may only be a placebo effect, or following suggestion or normal recovery.

Actually both sides have used both approaches at different times!
So back to the question **WHAT IS THE HOLISTIC APPROACH?**

▲ IT IS A WHOLE PERSON APPROACH.

It focuses on the uniqueness of the patient rather than the uniqueness of the disease. The individual is not just a number of 'organs' but a person with a unique and complex history. There is also the idea that physical, mental, spiritual, psycho-social and environmental factors affect our state of health and well-being. This approach is an ancient one and was present in India, China and other parts of the world many centuries ago. Health was seen as the harmonious balance both within the person and between the person and his or her way of life in the environment.

▲ OPEN TO A WIDE RANGE OF INTERVENTIONS.

The possible cause may vary widely, so the treatment must also vary and be appropriate. The caring practitioner is aware of a wide range of interventions that may be needed. This implies a critical openness to a broad spectrum of conventional and unconventional therapies as well as a sensitivity to what level - body, emotion, mind and spirit - needs help. Environment, family and work situation also need consideration. An individual practitioner can only hope to be personally expert over a limited field. This makes it all the more imperative to be aware of what other effective therapists have to offer.

▲ EMPHASIS ON SELF-HELP.

Personal life style remains a factor of tremendous importance in diseases to-day. Holistic therapy emphasises education rather than just treatment. People are beginning to value exercise, healthy eating habits, meditation and relaxation as factors to promote one's own health. The increase in personal responsibility also tends to change the relationship between doctor and patient towards one of more active co-operation rather than just the more traditional passive dependence.

Another insight is that we are all WOUNDED so we have the expression 'WOUNDED HEALERS'. Healers who experience their own woundedness often accomplish more. We are also all HEALERS - if we want to be. The power is within us both to have a healing effect on ourselves and on others.
BUT WHAT ARE THE IMPLICATIONS IN REAL LIFE?

A WHOLE PERSON APPROACH

Does that just mean 'just for us', for our healing?
Or for all persons? Can we be aiming to have a 'harmonious balance' between ourselves, others and the environment when we are considering HEALTH but at the same time forget it in relation to our countries, some of which are

* building up piles of nuclear weapons so as to create fear in our potential enemies.

* having a huge arms industry - it being a profitable market to sell weapons to others - so they can destroy their neighbours.

* denying help to the poor and hungry of the world through the money spent on arms?

OPEN TO A WIDE RANGE OF INTERVENTIONS

I went to a workshop recently on 'Innovations in Everyday Health Care' to learn and listen. I discovered that there are official bodies of properly trained people in various fields such as acupuncture and herbal medicine, but also there are others who practice without official training, and without the approval of these bodies. It was also interesting to find that some 'conventional' doctors have also trained in other fields of complementary medicine. Of course some interventions do not need a long official training and we can help heal ourselves and others if we learn them e.g. meditation, visualisation & intuitive massage. But what about 'being open' in some places where market drug sellers, untrained people who give injections, and some who call themselves native doctors leave a trail of damage and often death behind them?

Can we be open to them?
The traditional practice has been to condemn these practices and keep away from them. I wonder if we got to know these people and started a dialogue with them, is it not possible that the situation would improve?

Not long ago a market seller from Africa wrote and asked me to send him my 'Out-Patients Manual'. I happened to tell David Morley and he said 'Of course send him one - he's giving out drugs anyway - now he will know the appropriate drug and the correct dose'. So I did.
IMPLICATIONS OF SELF-HELP

FIRST - AN EXAMPLE OF COMMUNITY SELF HELP - BRASIL -

SÃO PAULO'S POPULAR MOVEMENTS FOR COMMUNITY HEALTH

Origins and Structures
Today there is one united movement whose mechanism depends on well-articulating local Popular Commissions for Community Health (PCCH). These have a variety of origins, but their growth-pattern seems to be something like this:

Some people get together to discuss health problems, maybe on the initiative of some community leader, or pastoral agent, or opposition political candidate - or perhaps after a tragic incident in the neighbourhood such as the death of a young person from a preventable cause. If, after the initial few meetings, some commitment is achieved to maintain group interest through regular meetings which try to understand and solve one or more health problems in the neighbourhood, then you can say a Popular Commission for Community Health already exists in embryo. But until it develops the capacity to attract the regular participation of a reasonable number of residents of the neighbourhood, it hasn't yet become a PCCH properly so called.

This work is all extremely popular in style, with wide use of pamphlets, bulletins, open letters to the population, slide shows, open-air meetings, door-to-door questionnaires and practical exercises like community attempts to clean up rubbish dumps, "war on rats" campaigns etc.

After some time gnawing at the problems locally, the PCCH may decide that no further progress will be achieved unless several districts unite to make joint demands regarding whatever their grievances may be. So ambassadors are sent out to the nearby neighbourhoods - visiting mothers' clubs, residents' associations, youth groups, basic ecclesial communities, etc.

These neighbourhoods are incentivated to hold similar meetings and to form their own local PCCH, if one does not already exist. No questions are asked about religious commitment, nor political affiliation - for these popular movements cross such frontiers.

Sooner or later a date is fixed for representatives of all the participating neighbourhoods to come together and draw up a programme of action. When these inter-commission meetings become a regular feature of community life in the district, it can be said that there is a broadly based, truly popular movement for community health in that area. Such movements are hard to reverse and impossible to ignore.

Growth and Potential
Bureaucracies move slowly - but without public pressure they tend not to move at all. One of the jobs of the popular health movement is to keep up the pressure, so that the people can enjoy the health services which are their right and for which they are paying taxes. I say 'one of the jobs' because, ideally, the popular movement in urban community health care should not have to direct all its energies to the political aspect. It does not take much imagination to picture the powerful role which these movements - and especially the PCCH - can play in other aspects of popular health education when its energies are not totally consumed by the battle to secure a minimum of essential health services for the neighbourhood.

This potential is already recognized by at least some of the professional people working in community health care in São Paulo. As I heard one young doctor say at a recent meeting in the Prefecture's Secretariat for Health: "what is important is that we professionals look on these movements as drops of water that will grow and grow till, eventually, they become transformed into a vast river that will give life to this whole city".

Sr. Isabelle Smyth m.m.m.
"A CHILD SURVIVAL REVOLUTION - A SELF HELP APPROACH"

"THE STATE OF THE WORLD'S CHILDREN 1986" is an excellent and very readable report by UNICEF which I would recommend all to read. Briefly there is GOOD NEWS in that several nations have doubled or trebled their levels of immunisation. With the spreading use of Oral Rehydration Therapy (ORT) over one million children have been saved - to name two of the least expensive of all child protection techniques.

But the BAD NEWS is that nearly 4 million children die each year of diseases preventable by immunisation, and another 4 million are disabled. Diarrhoea is still the greatest killer of children in the developing world and a great cause of malnutrition.

THE REVOLUTION is based on a small number of methods that mothers and families can use to reduce these figures and protect children's lives and growth. There is nothing very new to us in many of the following points, but there are also some new factors which perhaps seem so simple we may have overlooked them. Selected items, only, are given here - it does not do justice to the report!

IMMUNISATION

Depends not only on supply but demand. And also they can:

AND THIS CAN BE INCREASED IF PARENTS took advantage of EXISTING SERVICES.

- If children were brought for their 2nd and 3rd immunisation, as well as the 1st.
- If parents were empowered with information.
- If services were available at CONVENIENT TIMES and CLOSER TO PEOPLE'S HOMES

GROWTH MONITORING

The INVISIBLE slowing down of growth happens BEFORE the child APPEARS malnourished. Regular monthly weighing and use of the GROWTH CHART provide an early warning. At this stage malnutrition is relatively easily prevented.

TO PREVENT MALNUTRITION

As INFECTION is the commonest cause of malnutrition, mothers can:

- have their children immunised.
- treat diarrhoea with ORT.
- breast feed rather than bottle feed
- NOT give 'left-overs' to infants as they are likely to be contaminated.

- wean the infant at 5-6 months.
- AND continue breast feeding.
- when weaning give small frequent feeds, and increase the energy.
- value by using some oil in cooking

ORAL REHYDRATION THERAPY

Diarrhoea is associated with 1/3 of child deaths in developing countries. Tow points:

- The use of rice water or carrot soup in making up ORS is more effective than water.
- continue feeding during diarrhoea to prevent malnutrition.

BREAST FEEDING

We all know the advantages of breast feeding.

- Do health workers remember that mothers hardly believe them if they themselves bottle feed.
- breast fed babies have fewer bacterial and viral attacks than bottle fed babies - and are more likely to survive in developing countries.
IRON, IODINE AND VITAMIN A

Deficiencies contribute to a high rate of death and disability among children.

- IRON SUPPLEMENTS prevent anaemia.
- IODINE supplements either as iodised salt or a single injection of iodised oil which lasts 3-5 years prevent goitre.
- VIT. A deficiency causes not only night blindness but an increase in respiratory and diarrhoeal infections, prevented by a diet rich in Vit. A (e.g. dark green leafy vegetables) and by taking Vit. A capsules where necessary.

ACUTE RESPIRATORY INFECTIONS

Children in developing countries get as many respiratory infections as in others, but have 70 times greater chance of dying. The deadly alliance of diarrhoea and ARI underlies 1/3 of all child deaths.

- Immunisation reduces the incidence.
- Most can be treated successfully as long as mother continues giving food and drinks - and continues breast feeding.
- Mothers and CHW's can learn to recognise warning signs when the child needs antibiotics.
- Reducing parental smoking and air pollution helps to reduce ARI.
- Parental penicillin is generally the drug of choice for the initial treatment.

REFERENCES

1. From a talk on Holistic Health by Patrick Pietroni.
3. Information from the Holistic Health Newsletters.

I would like to remain on the CHC LINK mailing list.

NAME ..............................
ADDRESS ..............................

COMBATTING MALARIA

Malaria, one of the 5 main causes of child mortality.

- The widespread use of prophylactics is not recommended any more - because of toxicity: it is impractical on a large scale; it can prevent natural immunity and its use may accelerate the emergence of resistant drug parasites.
- Chloroquine is the drug of choice at community level, but referral facilities should have alternative drugs.
- With elementary training mothers and CHW's can be taught to give chloroquine treatment.

THE 3 F'S

These are FEMALE EDUCATION, as it increases - so child mortality decreases. FOOD SUPPLEMENTS to pregnant women 'at-risk' which will reduce numbers of low birth weight infants.

And FAMILY SPACING which has a dramatic effect on the health of mothers and children.

Thank you for all the letters following LINK 22. There has been a long gap! Congratulations to the people of the Philippines on their liberation from oppression and especially to Sr. Pilar Versoza, who for so long was under house arrest. I would like to thank MISEREOR for the grant they gave me to produce C.H.C. LINK. That has now come to an end. It has been most interesting to do it and I have met in correspondence many wonderful people from many countries. There are about 400 addresses in the file and I feel that many people must have moved on by now. If LINK does continue and if you want to be on the mailing list, please fill in the form here.

Also any comments on this LINK?

Sr. Pauline Dean
THE POOR OF THE WORLD

- are either NOT GETTING THE DRUGS THEY NEED
- or ARE getting the DRUGS THEY DO NOT NEED
- or are HAVING TO PAY EXCESSIVELY for drugs
- or are MISLED BY ADVERTISEMENTS or by THOSE TO WHOM THEY GO FOR HEALTH CARE TO PUT UNFOUNDED FAITH IN DRUGS.

WHEREAS OTHERS

- are BECOMING RICHER
- and MORE POWERFUL

because of their association with PHARMACEUTICAL DRUGS.
(Here we are not writing about habit forming drugs, such as heroin or cocaine)

WE ALSO KNOW

- that ILL HEALTH is not caused by lack of drugs, but is concerned with:
  + poverty-malnutrition which lowers the body’s resistance
  + inadequate water supply and lack of sewage disposal
  + poor housing - unemployment and all that follows on from these factors.
- Some societies also consider that ILL HEALTH is concerned with:
  + offending ancestral spirits or the work of sorcerers and witches,
  + fate or natural causes.

YET ALL SOCIETIES, from time immemorial, have sought out and used medicines from plants, trees and other matter from the natural world. And although they are still being used, people in most parts of the world also rely on drugs from the pharmaceutical industry. There also seems to be a swing TOWARDS natural remedies and the wholistic approach, which is gathering momentum, yet is is generally accepted that DRUGS are
SO WHY ARE DRUGS

- which really meet a medical need, i.e. are ESSENTIAL
- are SAFE
- are REASONABLY PRICED

NOT REACHING THE POOR?
or even 60-80% of people in developing countries?

@ FOLLOWING THE DRUG
FROM SOURCE TO CONSUMPTION

WHAT ARE THE FACTS?

WHO PRODUCES?
- MULTINATIONAL DRUG COMPANIES are the main producers - and 25 companies produce 60% of world production.

WHO GETS THEM?
- 80% of CONSUMPTION is in industrialised countries - so 20% ..... Most new drugs are produced for the rich world. In 1980 of 50 million US dollars spent on research on drugs, only 1% was spent on research for diseases relevant to developing countries.

ARE THEY ESSENTIAL?
- It is estimated that 50-70% of pharmaceutical drugs are INESSENTIAL and/or undesirable - i.e. tend to impair health. In the British National Formulary, 1 in 5 of 4500 preparations are rated "less suitable for prescribing".

In the developing countries it is worse, there are a greater variety of drugs (or brand names) but seldom enough useful ones. In Bangladesh when the Government did clamp down in 1982, 1700 unwanted drugs were banned by law.

WHO GAINS?
- THE PRICE OF DRUGS REMAIN HIGH because:
  - PROFITS are higher than in other industries who make 10-15% of sales turnover. Drug companies make 15-30%
  - COMPETITION is not by lowering prices but by:
    - DEVELOPING NEW PRODUCTS protected by PATENTS and BRAND NAME PROMOTION. They're not new products as a rule but variations of drugs, often called 'me too' manipulations of already patented drugs.
    - So PROMOTION is vital to create a strong brand name preference among prescribers.
    - The BRAND NAME variety are inevitably more expensive than the GENERIC name. For example - Aspro the brand name - aspirin the generic name.
  - Producing COMBINATIONS OF DRUGS also increases the price - they are more expensive than the single drugs, as well as being undesirable, especially combination antibiotics. Here the desired effect may be diminished and the risk of side effects is greater. In USA they have been removed from the market by law - they are still common in developing countries.
  - EVEN DRUGS PRODUCED LOCALLY may be priced excessively highly and drug control agencies find it difficult to control these prices. In many countries attempts to control profits on drug sales have resulted in less production of low cost essential drugs. For example, in some countries, tuberculosis and leprosy are major health problems, but the production of drugs to treat these diseases has been dropping sharply as it is unprofitable to produce such drugs.
The AIM is ENOUGH AVAILABLE - ESSENTIAL, SAFE AND REASONABLY PRICED DRUGS

HOW CAN PROMOTION and DISTRIBUTION affect these factors?

- OVERPROMOTION for example of:
  - VITAMINS ANDTONICS. In any given area or country possibly one or two vitamins are in short supply and the rest are available in the ordinary food. But expensive multivitamin preparations are promoted with catchy ads. 'TAKE ------ for POWER' and other slogans which imply that taking this 'TONIC' will solve all your social, business and personality problems!
  - ANTIDIARRHOEAL DRUGS. As 4-5 million children die each year from diarrhoea globally, the pharmaceutical industry receives 400 million U.S. dollars annually from antidiarrhoeal drug sales - most from the 3rd world. The bulk of them are either useless or dangerous or both.

  o LOMOTIL - a cause of fatal toxic reactions in young children. It paralyses the gut, the diarrhoea stops, the fluid loss into the gut continues and severe dehydration is masked.
  
  o "ANTIBIOTIC and SULPHONAMIDE PREPARATIONS should be avoided for the treatment of diarrhoea even when a bacterial cause is suspected because they may prolong rather than shorten the time taken to control diarrhoea and carrier states. Bacterial resistance to antibiotics may develop and they may cause bacterial diarrhoea and pseudomembranous colitis." (BRITISH NATIONAL FORMULARY).

  Whereas, Oral Rehydration Salts (ORS) can save millions of lives but they are not promoted because there is no money to be made out of them.

- MISREPRESENTATION

  o DOUBLE STANDARDS - DEVELOPED/DEVELOPING COUNTRIES

  Drug firms may give different information regarding indications and adverse reactions of a particular drug depending on the drug control regulations of the particular country. In developing countries who may lack regulations, multinationals or their subsidiaries, overpromote their drugs - either by claiming extra indications or mentioning fewer hazards than in another country with an enforced drug control policy. But MISREPRESENTATION can occur anywhere - e.g. in 1985 a major company was fined 25,000 U.S. dollars for covering up illness and 61 deaths associated with one of their drugs.

  o PRESSURE - that is - 'financial pressure' is put on Government officials, Ministers, Customs Officials, Hospital Administrators, and so on, to promote the Company's products or a particular drug.

  A new product may cost millions of dollars to develop, but a single national market which accepts that drug may recover that expenditure because of pressure on the policy makers of that nation.

  So although individuals in the industry may see themselves as helping to solve health problems - the reality of the market create the temptation to CORPORATE CRIME.
DISTRIBUTION

FIRST WORLD
In any one country - less variety but more useful drugs

THIRD WORLD
A greater variety of drugs (because of brand names) but seldom enough useful ones.

Drugs banned here because of being unsafe or ineffective may be EXPORTED or even PRODUCED in the company's overseas factory.

- PUBLIC SECTOR
  
  URBAN CENTRES
  HOSPITALS
  are favoured in distribution

  RURAL AREAS
  CLINICS, DISPENSARIES, PHC receive very much less

- PRIVATE
  NO GOVERNMENT ORGANISATION
  GROUPS in some countries have their own co-ordinating associations that buy and distribute drugs to their health facilities - e.g. CHANPHARM in Nigeria, LDA in Lesotho and GPL in Bangladesh.

In both public and private sectors, drugs finally reach the shelves in the hospital, health centre dispensary or village health worker's box. All too often a few days later, they are no longer there! Have they walked out?

- DRUGS ARE ALSO DISTRIBUTED not only by health professionals and PHC workers, but also from drug sellers in the market; someone in the village who happens to have a syringe or nowadays some traditional healers who mix drugs with traditional remedies. The important point is that drugs are not only being PROVIDED but also PRESCRIBED.

- PRESCRIBING MAY BE
  - INAPPROPRIATE - e.g. giving penicillin for the common cold
  - IN INCORRECT DOSAGE - like the market sellers who sell antibiotic capsules singly, depending on what the patient can afford.
  - DANGEROUS OR ACTUALLY LETHAL - as I have seen the results of powerful purgatives being given to infants - and of injections causing
THERE MAY BE
- OVERPRESCRIBING—giving drugs when they are not needed - especially to those who can pay. Notable examples are antibiotics, tonics and vitamins.
- MULTIPLE PRESCRIBING especially by those who cannot make a diagnosis - so they treat every symptom. The drugs may interact with each other and so reduce any possible good effect.
- UNDERPRESCRIBING may occur when those who cannot pay are refused essential drugs.

THE PRESCRIBER is affected by:-

PRESSURE from the PATIENT
They like something to take home - and the prescriber can find nothing wrong. Or maybe what they really need is FOOD, a listening ear, or relief from an intolerable situation. So drugs or tonics are ordered. An INJECTION may be demanded and given instead of tablets - more expensive and also dangerous now because of AIDS.

from PROMOTION
Many doctors and prescribers do not read medical journals and obtain their information from drug company salesmen. One figure quotes - 1 drug representative for every 20 doctors in UK, but 1 for every 4 doctors in Tanzania. (Distances are immense, of course). So free information and 'UP DATING' plus gifts, free samples, free places at medical conferences - in other words - subtle pressure produce results. Only strict and enforced Government policies could limit these activities.

from IGNORANCE
Failure to keep up to date may lead to IGNORANCE regarding - a drugs uses or adverse effects, for example the dangerous effects of chloroquine especially by injection for children, when the dose is chosen arbitrarily and not by WEIGHT.
- possible alternatives - the cheaper generic name.

The TRAINING received.
Medical schools supported by pharmaceutical firms promote the linking of ILLNESS with DRUG TREATMENT. Doctors are not trained to deal with underlying causes of disease - poor water supply, sanitation and so on. That they become AWARE is a 1st step.

PRESSURE OF WORK
If there are 100-200 patients waiting outside to see you there is great pressure to give a prescription quickly and get on to the next one. Only by TRAINING other health workers in diagnosis, treatment and most important - when to refer - will these huge numbers waiting be reduced.

SELF MEDICATION affects distribution also:-
Some cultures take potions to PREVENT such misfortunes as loss of power, virility and also to PROMOTE success. So when these beliefs are applied to western drugs it is easy to promote and distribute expensive tonics which either PROMOTE a desired effect or PREVENT a disastrous one. Does it matter that people use them? Yes, because so often the money that the poor would have spent on food is spent on them - and they are virtually useless.
What RESPONSES to this situation?

**ESSENTIAL DRUG PROGRAMME (EDP)**

has resulted from collaboration between member states of WHO, UNICEF and other international organisations as well as Non-Government Organisations (NGOs).

The AIM is support for member states to:
- improve their drug supply by national drug policies and legislation.
- to ensure the availability of safe and effective drugs at the lowest possible cost.

It is based on the fact that nearly all serious health problems can be tackled by 250 ESSENTIAL GENERIC DRUGS.

It realises the need for three separate lists of essential drugs for:
- PHC centres - about 39-46 drugs.
- District Health Centres and local hospitals and
- major referral hospitals.

The lists are just guides - the actual selection for a particular population depends on the diseases in the area, available finance and local preference.

But not only national and international groups have responded, many local groups - consumer movements - have formed throughout the world whose aim is to raise awareness concerning drugs - and to promote action.

**HEALTH ACTION INTERNATIONAL (HAI)**

founded in 1981 is a global network of 50 such groups in about 40 countries.

Its AIMS are:
- to convince the industry to produce drugs that have real therapeutic value, are safe and offer satisfactory value for money.
- to promote the WHO Action Programme on Essential Drugs.
- to campaign for better health for the world's poor.
- to look for non-medical solutions to health problems caused by conditions of poverty.

Groups pool their knowledge and cooperate internationally and as their responses are so various the pharmaceutical industry does not know what to expect next.

HAI's priority was to get through the WHO Assembly a Code of Marketing Behaviour for pharmaceutical firms. Meanwhile the industry hearing of this prepared their own code of behaviour. HAI found it 'worthless' and drafted a tougher version. But as the US is the principle funder of every UN agency, cutbacks in financial contributions have been threatened. So progress has been slow on this front.

But action continues on other fronts. Several individual drugs have been designated non-essential or unnecessarily hazardous, e.g. the anti diarrhoeal products containing chloroquine - which led to large scale nerve disorders in Japan. The company concerned has withdrawn that product.

In mid 1986 HAI launched its PROBLEM DRUGS pack claiming that 70% of products on the market are unnecessary, hazardous or irrational and should be removed. This is essential source material.

For some participants of HAI see P8.

**CHURCH RELATED ORGANISATIONS**

More groups in several countries have been formed to operate essential drug purchasing and distribution at reasonable prices. For example:

INDIA - THE VOLUNTARY HEALTH ASSOCIATION of INDIA (VHAI) has brought out an excellent pack 'RATIONAL DRUG POLICY for RATIONAL DRUG USE'. Fact sheets on Essential Drugs, the National Drug Policy - Our Concern About Drugs - Hazardous Drugs, the ALL INDIA DRUG ACTION NETWORK policy and other items are included. The well presented inside pack cover has a number of flip sheets with cartoons giving the summary of the whole situation.

**HOW IS EDP RECEIVED?**

- DOCTORS - many take it as a restriction of their freedom.
- THE DRUG INDUSTRY - is horrified and have pressurised Governments and WHO.

They realise:
- their image of protectors of health is shaky.
- especially after dumping dangerous medicines on distant markets.
- and when their inflated profits are known world wide.
COUNTRIES have varied in their reaction, for example:

- **BANGLADESH** — one of the first to act.

1982. Recommended banning 1707 **DRUGS**

**BUT**

- **U.S. GOVERNMENT** and other embassies

**EXERTED**

**PRESSURE**

**YET**

1982 - 273 **HAZARDOUS DRUGS** were **DESTROYED**

1983 - 135 Schedule II and 691 Schedule III (of little therapeutic value) were **BANNED**

**RESULT**

- Drug Companies now produce sufficient **ESSENTIAL DRUGS**
- Prescriptions now more rational — not 6-8 items.
- People's health improved.

- **KENYA**

  Designed a new drug supply system.
  So that RURAL AREAS really receive 39 ESSENTIAL DRUGS in prepacked ration kits.
  Now 30% more patients are covered and fewer people attend out patients in hospitals.

  **G.B.** took 1800 drugs off the National Health Prescription List i.e. expensive brand names with generic equivalents.

**IMPLEMENTATION OF EDP**

**WHAT STEPS?**

<table>
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<tr>
<th>CONSUMERS</th>
<th>Discussions between prescribers and people receiving the drugs could benefit both.</th>
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<tbody>
<tr>
<td></td>
<td>- People could learn something of the action and potential dangers of some drugs, e.g. taking antibiotics haphazardly or in the incorrect dose.</td>
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<tr>
<td></td>
<td>- Prescribers, who may not come from the locality, could gain an understanding of the local culture and thought in relation to health, sickness and the place of drugs and potions.</td>
</tr>
<tr>
<td></td>
<td>- Action might follow in relation to the local situation concerning prices, dangerous drugs being sold in the market and the promotion of unnecessary medicines.</td>
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MORE STEPS

DOCTORS - and not only doctors - other prescribers do not like to change their prescribing habits.
- Could we not give some time to reading and discussing with others so as to become aware of the drug situation?
- Have we checked to see if the EDP list really supplies (in our view) a far better supply of necessary safe and reasonably priced drugs.

HOLD DRUGS

HERE IS A PROBLEM occurring in many, not all, places. But drugs meant for patients in a certain health facility 'disappear'. Perhaps if it was 'NAMED' in a group where all concerned including local people were present, solutions would emerge. The latter know that drugs which are procured for them at a reasonable price disappear and reappear in the market at an unreasonable price, given in an incorrect dosage and frequently inappropriately prescribed.

ONCE NAMED ------------ there will be suggestions for action.

PROMOTE an efficiently organised DRUG SUPPLY SYSTEM
- Improve STORAGE conditions and DISTRIBUTION
- PROMOTE TRAINING and RETRAINING for all prescribers. Ministry of Health Zimbabwe has put out a pocket sized Essential Drug List which also gives information on each drug. All Government prescribers receive one.
- Put pressure on Medical Journals to require drug advertisements to include the price.

GOVERNMENTS

- Have and ENFORCE DRUG REGULATIONS concerning REGISTRATION of drugs and IMPORT CONTROLS.
- BAN HAZARDOUS and IRRATIONAL DRUGS.
- The Voluntary Health Association of India (VHAI) information drug pack suggests a prison sentence or a large fine for dealing in substandard drugs.
- ENSURE CORRECT INFORMATION on drugs. VHAI again suggests punishing all those who sell medicines without stating side effects in local languages.

SOME SOURCES

- Essential Drugs and Developing Countries.
  London School of Hygiene and Tropical Medicine.
- Drugs and World Health. Charles Medawar - Social Audit.
- Drug Information Sheets for the Use of Community Health Workers. WHO.
- Voluntary Health Association of India Drug Information Pack, C-14, Community Care Safdarjung Development Area (Opp. I.I.T. Main Gate) New Delhi 110016 (the pack is excellent).

SOME VHAI PARTICIPANTS

- MAI OFFICES, Emmanstraat 9, 2595 EG The Hague, The Netherlands.
- UK SOCIAL AUDIT, P.O. Box 111, London, NW1.
- OXFAM, 274 Banbury Road, Oxford, OX2 7DZ.
- U.S. The Committee for Responsible Investment of the MEDICAL MISSION SISTERS, 338 West Street,
MATERNAL DEATHS and MORBIDITY and
CHILD DEATHS and MORBIDITY

are affected by several factors. Many of these affect both.

This LINK will look at some of these factors. The ideas came largely
from a recent Paediatric Priorities Course at the Institute of Child
Health.

Realising these linkages, how are we applying it to our life situation?
What more could we do to - increase our awareness
- take steps to find out the facts and to pass them on
- act on them?
MATERNAL MORTALITY

In the 1986 World Health Organisation (WHO) Report on Maternal Mortality Rates:

WORLD WIDE the figure is at least 500,000 women/year!
- 99% of these are in the developing world.

MATERNAL DEATHS:

Western Europe/USA 10 or less maternal deaths/100,000 live births.
Developing countries 300-1000 maternal deaths/100,000 live births.
Women in developing countries have 50-100 times the risk of dying in childbirth.

THE LIFETIME RISK to women in developing countries of dying in pregnancy or of pregnancy related causes is 1:25 - 1:40, the highest being in Africa.
One factor is the number of pregnancies per woman.
In the developed countries it is 1:2000

FOR THE THOUSANDS WHO DIE MILLIONS ARE LEFT DISABLED and often infertile.

THE ROOT CAUSE of these figures is the fact that women have diminished status in the political, social, cultural and economic fields compared to men. Women are discriminated against in access to health care, in the amount of work they have to do, their nutrition, education and access to economically viable jobs.

RISK FACTORS
- AGE OF MOTHER, higher in teenagers and those over 40 years
- SHORT BIRTH INTERVALS
- HIGH PARITY - especially birth number seven onwards
- LACK OF ANTENATAL CARE and appropriate care at childbirth
- PREVIOUS HISTORY of trouble during pregnancy or labour - those 'at risk'
- THE POOR AND DEPRIVED
- THE UNWANTED PREGNANCY

PROMOTING SAFE MOTHERHOOD

COMBATTING RISK FACTORS

- EDUCATION for political, social, cultural, religious and economic leaders to enable them to be 'change agents' to face the root cause and reduce the risk factors.
- RAISING COMMUNITY AWARENESS, especially women, so they will be involved in planning and action.
- EDUCATION for GIRLS and WOMEN relating to their VALUE, health and reproductive cycle, Natural Family Planning and family life.
- BIRTH SPACING through promoting BREAST FEEDING and NATURAL FAMILY PLANNING (NFP)
- WORKING WITH TRADITIONAL BIRTH ATTENDANTS (TBAs)
- CONTINUOUS EVALUATION of HEALTH SERVICES, including the ones we work in or with, and subsequent action in the light of these APALLING FIGURES

A TARGET - TO REDUCE THE MATERNAL MORTALITY 50% in 10 YEARS
WORKING WITH T.B.A.'s

DOES IT REALLY MAKE A DIFFERENCE?

Here are some points from a report by Sr. Maureen Brennan, Obstetrician at St. Mary's Hospital, Urusa Akpan in Nigeria.

They have an average of nearly 3000 deliveries/year.
50% from out of state (OS) - 20 miles and over
25% from outside the local government area (OLGA)
25% from the local government area (LGA) - a radius of approximately 10 miles

The report covers 1979-85 excluding 1981 when the author was on leave.

MATERNAL MORTALITY for 6 years (excluding 1981)
Maternal deaths 104
Booked 29 and unbooked 75

Distance from hospital:
70% from within 20 miles
50% from as close as 10 miles

6 MAIN CAUSES OF DEATH
  - Ruptured uterus 22
  - Septicaemia 22
  - Hepatitis 20
  - Eclampsia 9
  - Hypertension/nephritis 5

Each year up to 1983 an average of 250 unbooked local women arrived at the hospital too late, with prolonged labour, haemorrhage, infection and other complications. The end result was often vaginovasal fistula (VVF), infertility or other complications.

In 1982 a PRIMARY HEALTH CARE (PHC) programme was started in the 5 local clan areas comprising 71 villages. When this became established a survey was done by Sr. Bernadette Unamah, then a sociology student (now graduated). She is from this area so had no problem with communication. The purpose was to find the proportion of women delivering at home to those delivering in hospital, and also the number of remembered deaths in those delivering at home.

Using a sampling technique 190 women were interviewed.
RESULT - Of 723 deliveries 337 took place at home. Of these there were 39 remembered maternal deaths.

TBA TRAINING was set up in 1983 to try to prevent these tragedies at source.

Having consulted with Chiefs, clan heads and TBAs the programme got going. Since that time 75 TBA's have completed their course.

One of the most important objectives was to win their confidence and cooperation in referring patients when indicated.

The COURSE consists of 3 hourly meetings every Saturday for 3 months. When all is completed satisfactorily a certificate and delivery kit are given.

THE EMPHASIS now is on
  - Ongoing SUPERVISION in the community by the PHC team which visits 18 different centres, many in a TBA's compound or else close to one.
  - SEMINARS in clan areas every 3-4 months.
  - Encouraging mothers to attend immunisation sessions with their children.

FROM JUNE 1983 - JUNE 1986
TBAs referred 320 women to the hospital
Maternal deaths 2
Perinatal deaths 38

The 2 maternal deaths were from PPH - women who had delivered in the village. The problem was TRANSPORT to hospital, so they came very late. There was also a problem procuring blood.

TRAINING TBAs HAS MADE A DIFFERENCE!
  - THE MATERNAL MORTALITY AND MORBIDITY ARE DOWN
    The number of unbooked deliveries has reduced by 40% and therefore the incidence of prolonged complicated labours with infection have reduced
  - BEFORE TBA TRAINING - 1980, '82 and '83
    31 deaths, unbooked from LGA
  - AFTER TBA TRAINING - 1984, '85 and '86
    8 deaths, unbooked from LGA
THE CONCLUSION: Sr. Maureen writes 'This study shows that the training of TBA's has helped to reduce maternal mortality and morbidity rates among local women. Also over 16,000 children have been immunised through the PHC-TBA project.

In a traditional society child birth is a social event rather than a medical one. TBAs play an important role in the ritual and religious aspects of childbirth. Many are elderly women, some middle aged. Most regard their profession as a gift from God and many have prayer homes. They have acquired practical skills over the years - some good and some harmful.

Their traditional beliefs greatly influence their understanding of disease and complications encountered during labour. However, their co-operation and participation in our health care delivery service is an important one and I feel this paper highlights the beneficial aspects of their training, namely observing the rules of hygiene, early referral of women to hospital (when indicated), encouraging village children to come for immunisations and generally using their influence in the cultural, ritual and religious life of traditional society to become good health educators.'

St. Mary's Hospital, Urua Akpan, Ikot Ekpene, Cross River State - NIGERIA

SPACING BIRTHS REDUCES DEATHS

In traditional societies when mothers BREAST FED for 2 years and over, births were spaced at about 3 yearly intervals. Nowadays with modern families the BIRTH INTERVAL IS LIKELY TO BE LESS THAN 2 YEARS!

MOTHERS do not need to be told that they become fatigued, exhausted, less able to cope and make ends meet - also more likely to be anaemic, to succumb to infections, have severe bouts of malaria in certain areas, and to be unable to avail of health services because of their life style or lack of money. Most importantly they are less able to care for their children.

SPACING BIRTHS TO 3 YEARS OR MORE WILL OBVIOUSLY AFFECT THIS SITUATION.

<table>
<thead>
<tr>
<th>Spacing between births</th>
<th>Infant deaths/1000 births</th>
<th>Toddler deaths/1000 alive</th>
<th>Child deaths/1000 alive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-1st birthday</td>
<td>1st-2nd birthday</td>
<td>2nd-4th birthday</td>
</tr>
<tr>
<td>Less than 2 years</td>
<td>185</td>
<td>42</td>
<td>81</td>
</tr>
<tr>
<td>2-4 years</td>
<td>89</td>
<td>28</td>
<td>62</td>
</tr>
<tr>
<td>Over 4 years</td>
<td>58</td>
<td>10</td>
<td>27</td>
</tr>
</tbody>
</table>

All twenty-nine other countries studied showed similar trends

SPACING BIRTHS REDUCES DEATHS

The extra care provided by the mother in well-spaced families is associated with a much reduced mortality in the children.

From 'MY NAME IS TODAY'
David Morley and Hermione Lovel
BREAST FEEDING'S CONTRACEPTIVE EFFECT

This has usually been regarded as an unreliable myth by those in developed countries. R.V. Short\(^1\) writes that the failure of physicians, administrators, theologians and politicians to appreciate the significance of breast feeding has had very serious consequences.

WHO estimates that 17% of couples in developing countries are using modern contraception and 83% are dependent on natural checks of which breast feeding is the most important.

Because of the discontinuance of breast feeding there has been a recent sharp rise in fertility, for example, 8 births per woman in Kenya.

He goes on to describe the KUNG people of the Kalahari desert who have no taboo on intercourse during lactation, don't have late marriage or infanticide yet the average completed family is 4.7 children and the mean birth interval 4.1 years.

Mothers carry their infants everywhere feeding for short periods frequently during the day - and they also suck at night when the mother is sleeping.

Another reason why breast feeding is vital in developing countries is because the mother makes antibodies in her gut against the pathogens which enter there and these antibodies are also secreted in the milk. On breast feeding they then remain in the infant's gut to prevent gastro-intestinal infection. No artificial milk can do this!

He ends by saying that the decline of breast feeding is a major human tragedy causing an excessive increase in human fertility and enormous increase in infant mortality.

1. SHORT RV, Scientific American. 1984;250:435-41

WHY DOES BREAST FEEDING SO OFTEN FAIL?

Felicity Savage-King spoke on this question. Space only permits me to mention a few points here but see in 'Further Steps' facilities for updating.

REASONS FOR CHANGING TO ARTIFICIAL FEEDING (AF)

MOTHER'S REASONS
- 'insufficient milk' or 'milk not good' and so on - 60%
- working and no facilities to feed the baby during this time - 20%
- other problems - 20%
  e.g. sore nipples, engorged breast or baby ill

COMMERCIAL REASONS
- baby foods available and cleverly promoted - (another long story)
SUCCESSFUL BREAST FEEDING

is promoted by MATERNAL BONDING

Kennell and Klaus who wrote 'Maternal Bonding' found that if a mother and infant have early contact, within 2 hours of birth, the whole maternal behaviour is changed. She fondles more, looks face to face more and kisses more. Mothers are more likely to breast feed longer and at 2 years toddlers are happier.

WHAT INTERFERES WITH BONDING?
- DELAY in starting breast feeding, as often happens in hospitals and even in clinics.
- IF EARLY SUPPLEMENTS or PRELACTEAL FEEDS, even glucose water are given.
- The baby not sucking OFTEN ENOUGH as when they are separated when the mother is working.

THE RESULT IN EACH CASE IS THAT THE MILK SUPPLY DECREASES.

The LEEFSMA study followed babies up to 6 weeks in relation to what had happened in hospital. In summary:

IN HOSPITAL

<table>
<thead>
<tr>
<th>No prelacteal feed</th>
<th>62%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 prelacteal feeds</td>
<td>54%</td>
</tr>
<tr>
<td>4 prelacteal feeds</td>
<td>36%</td>
</tr>
</tbody>
</table>

So 'ONLY ONE OR TWO BOTTLE FEEDS TO GET STARTED' or 'TO GIVE THE MOTHER A REST' can have far reaching consequences.

AND LOOKING AT SEPARATION AFTER DELIVERY

<table>
<thead>
<tr>
<th>BREAST FED AT 6 WEEKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those breast fed immediately</td>
</tr>
<tr>
<td>After 5-9 hours</td>
</tr>
<tr>
<td>16 hours or more</td>
</tr>
</tbody>
</table>

In a Sri Lankan hospital, we heard, that after the baby is born, it is put to the breast, then they both sleep – the baby lying with the mother.

SO NO PRELACTEAL FEEDS – GIVE A CHANCE FOR MATERNAL BONDING IMMEDIATELY AFTER BIRTH

NIPPLE CONFUSION

At any time, but particularly in the early days, if the baby is bottle fed it is difficult then to readjust to breast feeding. The MECHANISM OF SUCKING IS DIFFERENT, and the position of the baby in relation to the breast is different – and if breast feeding follows the baby has 'nipple confusion' and bites on the mother’s nipple.

SO NO ‘ODD BOTTLE FEEDS’ AS THE RESULT MAY WELL BE SORE NIPPLES

HEIGHTENED EMOTIONAL SENSITIVITY

is natural after childbirth. The mother is often very anxious. Skilled and sensitive support to encourage her in breast feeding is vital if there are no relatives or friends nearby to fulfil this role.

Often this experienced and skilled support is not available because health care workers have BOTTLE FED their own babies.

DO WE GIVE THOSE WHO WORK FOR US AND WITH US THE OPPORTUNITY TO BREAST FEED THEIR BABIES? OR DO WE JUST PREACH WITHOUT HELPING OTHERS TO PUT IT INTO PRACTICE?

On the whole hospital and clinic practices are going towards:
- rooming in
- demand feeding
- no prelacteal feeds
- no bottle feeds

and in some places:
- babies are breast fed in the first 2 hours
- help is given with positioning the baby
- support and encouragement given after going home

Many babies have a satisfactory weight gain and are also satisfied themselves up to 6 months or even more on breast feeding alone. When this is the case arbitrary rules to start supplementary feeds at 4 or 5 months are inadvisable. Exclusive breast feeding for 6 months should be encouraged so as to:
- help to maintain the supply of breast milk
- reduce exposure to infection
- maintain the contraceptive effect.

For further Information See P.8
NATURAL FAMILY PLANNING

Dr. Anna Flynn sums up the reasons for the world wide interest and trend towards Natural Family Planning. (NFP)
'The last decade has witnessed an increasing disillusionment with 'the age of plastics and a growing realisation, especially among youth, of the wisdom of learning to live in harmony rather than at odds with nature. The rapid growth of the ecological movement, with emphasis on healthy living, the need for a good diet and exercise and the positive benefits of natural methods of birth control and breast feeding are all growing expressions of the growing desire of ordinary men and women to be 'liberated from the tyranny of technology especially in the intimate area of sexuality and fertility.
In the past, ignorance and mistrust of their efficiency made many people reject natural methods. Today, however, this situation is changing mainly due to modern scientific discoveries about how the reproductive system works and the fact of certain health risks associated with current contraceptive techniques. Thus, worldwide, there is an increasing interest in natural methods.'

WHAT IS IT?

Natural Family Planning (NFP) is family planning without resort to withdrawal, barriers, spermicides, hormones or intrauterine devices. It is a way of life freely chosen by a couple who decide to achieve or avoid pregnancy with selective intercourse as appropriate during the fertile and infertile phases of the cycle. The couple discover the fertile period by interpreting the signs and symptoms that occur naturally during the cycle. It is implicit in the World Health Organisation (WHO) definition of NFP, that when used to avoid pregnancy, there is abstinence during the fertile phase of the menstrual cycle.

Those who are not aware of the major breakthroughs relating to the cyclical processes of fertility and their manifestations which can be interpreted, still think that NFP consists only of the original rhythm calendar method.

THE MOST COMMONLY USED METHODS OF NFP ARE

- The symptom, mucus or ovulation method pioneered by Dr. J. Billings
- The sympto-thermal method which is combining the symptom or ovulation method with the temperature method.

People decide for themselves which method they will use - more people choose the mucus observation (ovulation method).

Although books and articles on NFP are helpful as reference material, the success of NFP depends on the teaching by a correctly trained NFP teacher who may be a health care worker but are more likely to be trained married people.

HOW EFFECTIVE IS IT?

The method failure rate in the WHO study (1983 and 1984) of the ovulation method was 2.8%. The WHO study was conducted in El Salvador, India, Ireland, New Zealand and the Philippines. There was a wide range of socio-economic background with 13% of the subjects being illiterate and 8% having university education. In the first cycle following instruction by a trained teacher 93% were able to identify the cervical mucus symptoms of the fertile period. A history of pathological vaginal discharge did not affect the subjects' ability to recognise the mucus pattern.

The method can be used in all circumstances throughout the reproductive life (the sympto method is most useful following childbirth, during lactation and in the menopausal period).

The methods are not restricted to the educated or those of higher social class. Natural methods are used efficiently by the less intelligent, the handicapped, the blind and the poor of society.

References:
EVALUATION

is vital whatever we are doing. But it is something that we often miss out on. For example WORKING WITH TBAs does not finish with giving the certificate, but is on-going.

A report on a study of 'SUPERVISION as a TOOL to SUSTAIN OPTIMUM ACTIVITY' on the part of TBAs and CHAs (Community Health Agents) was made in 1984 in Gamo Gaffa, Ethiopia. Experience showed that implementation of PHC is not quite as simple as it seems at first sight. Space here does not allow full coverage of the study but is trying to highlight the need for evaluating progress.

Although they found that PHC services, including those of the TBAs were being more accessible to an ever increasing population 12 problems emerged from the study - e.g. - inadequate preparation of the supervisors regarding the structure, content and focus of their supervisory visits.
- inactive Health Committees. Then as problems were identified a way to respond creatively to the challenges was presented.

Two interesting facts are firstly that those involved in the work did the evaluation themselves. Secondly one could not say 'It would be too difficult in our area' because 'most of the field work in this study was carried out with the aid of mules, where possible, otherwise by going on foot!'

GMM Community Health Project, c/o JINKA
P.O. JINKA, GADO GOFFA

A RECENT BOOK ON EVALUATION:

AIDS

In an update on the current situation on AIDS there were suggestions as to what we could and should do. One vital point was 'Through our involvement with EPI programmes stress the importance of using one sterile needle and one sterile syringe for each injection'. People may say 'Impossible. Impractical!' ECHO, the Joint Mission Hospital Equipment Board are making it one of their priorities to have sufficient stocks. Syringes and needles are light and their charges for carriage overseas are reasonable. Their address is: Ullswater Crescent, Couladon, Surrey, CR2 2HR, U.K.

TAKING STEPS

READING
- Maternal Mortality Rates. WHO FHE/86.3
- Traditional Birth Attendants. A field guide to their training and evaluation. WHO Offset No 44. £5
- Breast Feeding in Practice - A Manual for Health Workers: E. Helsing and F. Savage-King. £1 from TALC.

SLIDES on Breast Feeding
Sets of 24 with script.
- Breast Feeding (Bf)
- Breast Feeding Problems (BFP)
From TALC - Excellent to review and renew one's knowledge

ADDRESS
For WHO publications:
HMSO Publications Centre, P.O. Box 276,
LONDON, SW8 5DT, U.K.
TALC, P.O. Box 49, St. Albans, Herts,
AL1 4AX, U.K.

NATURAL FAMILY PLANNING
- A well reviewed book: A Manual of Natural Family Planning by Dr. Anna Flynn and Melissa Brooks - from NFP Centre, Birmingham Maternity Hospital, Q.E. Medical Centre, Birmingham, B15 2TG, £2.95.

Further information on NFP may also be obtained from this centre, which runs many training programmes throughout the world.

By Sr. Leonie McSweeney:
BOOKS:- Love and Life - now in 6th Ed. Also in French and Hausa
- The Facts of Life
- Sex and Conception

VIDEO - Set of two 3 hour videos giving
10 half hour instructions + book of Love and Life. Irish £41.
- Specially edited version of large video called 'Understanding Fertility - Know Your Body' for schools or as Introduction to NFP (1) £9.95

TAPES - 4 with eight ½ hour sessions +

All from VERITAS Bookshop, Abbey St.,
Dublin, Ireland.

Further information on NFP also from Dr. Kevin Hume, P.O. Box 174, St. Paul's,
Randwick, SYDNEY 2031, Australia.

Sr. Pauline Dean GMM,
The main OBJECTIVES of LINK when it was started in January 1981 were to CREATE AN AWARENESS of PHC, to orient thinking towards it, and to share experiences about it.

Now, in this last number, I ask the question:
"In our preparation or training for PHC or Community Based Health Care (CBHC), HOW SHOULD WE TRAIN, OR RE-TRAIN for it?"

To answer this question, there are more questions:
- What are the DEEP BELIEFS and VALUES which underlie our lives and so what we do - our work?
- What has been our EXPERIENCE in PHC over these past years?
- What does our traditional health care training stress?
- How does this match up with our experience?
- Are we listening to the ECHO or REVERBERATION between our values and the world today?
  - Hunger for spiritual values, justice for all, peace between peoples.
  - Wholeness - Holism - shalom - in myself and with others.
  - Respect for our WORLD - ECOLOGY
- To the SPECIAL SIGNS of this time:
  - The THREAT TO ALL LIFE, to those who are weak, and to family life.
  - Refugees, AIDS, the flight to the cities, and the increasing numbers of poor people.

In the face of all this - WHAT TRAINING OR RE-TRAINING do we need?

ARE WE BEING TRUE TO OUR DEEP VALUES AND BELIEFS when we spend 3-8 years on a training which is geared for a certain type of work which we then leave?
BASIS ON DEEP VALUES
we believe that the source of our mission
is Christ's love, and the desire that
the world may have life and have it in
all its fullness.

SO WE ARE COMMITTED TO:

- CARE FOR THE SICK

- PROMOTE HEALTH and WHOLESOME of PERSONS and
  COMMUNITIES

- PROCLAIM the SACREDNESS of ALL LIFE and the DIGNITY
  of EACH PERSON - Working to bring about a WORLD of
  JUSTICE and PEACE where HUMAN DIGNITY and HUMAN
  RIGHTS are respected.

- LIVE and WORK in a variety of ways in our healing
  mission, not in positions of POWER but in SERVICE,
  living a life that is simple and ATTUNED to the
  local CULTURE.

This among people of DIFFERENT RELIGIONS and IDEOLOGIES, where
we constantly remind ourselves to HEAR THE CRY of the POOR, to
be with those who SUFFER, the OPPRESSED and those on the MARGIN
of LIFE.

To do this we are also committed to being OPEN TO CHANGE and
READY TO WALK NEW PATHS, reflecting on the SIGNS OF THE TIMES
and on our lives.

THE DECLARATION OF ALMA ATA
which described the positive aspects of health,

STRESSED:- the GROSS INEQUALITY in health status around the world

- that HEALTH CARE should be AS CLOSE AS POSSIBLE to where people
  live and work

- that PEOPLE HAVE A RIGHT in the PLANNING and IMPLEMENTATION of their
  health care in a spirit of SELF RELIANCE and SELF DETERMINATION

- the BASIC FACTORS on which physical health rest, food and nutrition,
  water supply and sanitation, immunisation and family planning,
  prevention and control of diseases and the provision of essential drugs.

ALL over the world people shared their anxieties and hopes and saw that here was
a new line of approach where it might be possible to share a vision and work in
a co-ordinated way with others of different nationalities.

Now, a few years later experience has shown that although many of the PROBLEMS
are the same the world over, others vary according to the county and location
of the work, such as - a village
- a teeming city
- or a rural area
A RURAL EXPERIENCE

Letter from Kitovu, Uganda

Having worked in the hospital since 1979, Sr. Margaret Quinn knew the common diseases, so many of which were preventible, and she decided to train as a Health Visitor. She decided to train in Uganda, so as to have a better insight into the customs and culture and also to come to know a wider circle of Ugandans.

I visited her in 1984 and the situation in the country was by no means stable. Food for all was scarce, travel was hazardous, there were many road blocks, yet as well as their formal lectures these trainee Health Visitors travelled quite long distances to gain a wide experience of health care in the community.

She writes "I took for my dissertation the nutritional status of the underfives in Ssenyenge village in my own area".

On finishing the course she took over some of the activities already underway by Sr. Dympna - immunisation, health education and home visiting with a team consisting of an assistant Health Visitor, a midwife, an enrolled nurse, 2 children's nurses and 2 auxiliaries.

She writes "I knew that in my area the problems were: malnutrition, lack of clean water and latrines. Many children were not immunised and there was a general lack of knowledge about health.

Our team first discussed together and decided that the best way to tackle the problems would be to train local community health workers. We arranged to meet leaders, chiefs and influential people. It was very slow work and there were interruptions due to instability, insecurity and later war in 1985. For six months we had no outside contact at all. But the leaders were interested and in July 1985 we were at the stage when the community knew enough to select the CHW's. They were given the usual criteria: age, maturity, of the same village, voluntary etc. also the need for men and women. They did the selection according to the highest number of votes. The whole process took 4 hours - no hurry - plenty of questions and explanations.

We then met them as a group to arrange when and where the training would be and the content. This is written up in another paper and covers home visiting, nutrition, environmental sanitation, immunisation and growth cards, the role of the CHW, various methods used in teaching, common diseases and nursing care of AIDS in the home.

When we first met they stated that their first priority was a health centre and at the end of the training they said it was clean water, clean homes and latrines and immunisation for the children.

THEY have made plans to realise these priorities.

THEY also have LONG TERM plans to have a mill in the village, so maize could be milled at a cheaper price. 

These 12 CHWs have their own secretary, chairman and treasurer and manage their own affairs. They have met groups such as: ROTARY INTERNATIONAL, CAFOD and medical students from Makerere.
Contact between the team and the CHWs continues in follow-up training, immunisation sessions and so on. We plan to start again in similar villages."

BUT THERE WAS A CLOUD OVER ALL THIS:

'SLIM DISEASE'

"Our own area and a nearby district first recognised ‘SLIM DISEASE’ (AIDS) in 1983-1984. We gave health education to groups such as school children, leaders, including Church leaders and also at workshops and other gatherings.

In 1986-87 there have been many people in hospital with full blown AIDS. There is a great need to support them and their families after they go home. Sr. Ursula has already started on this. There is really a great need for pastoral care."

I also remember hearing that because so many people are weak and ill with AIDS, and because so much time is spent at funerals the planting and farming is suffering - and so there is now an added cause for malnutrition.

AN URBAN EXPERIENCE
Letter from Lagos, Nigeria

Sr. Laurena Gallagher writes of: "THE CHALLENGE OF CHANGE"

These words had just been 'words' for me, until I found myself in a completely 'new' environment, with a 'new' approach to health care. Having worked in a 'curative' setting in a totally rural situation for almost 20 years, this change undoubtedly presented many challenges.

While the intention, when we moved into this area, was to promote Primary Health Care, in practical terms the attendance of so many very ill children - some adults too - demanded that much of the time was taken up with 'treatment', with a lower emphasis of health education and preventive medicine. When it was felt that it was becoming impossible to cope with the huge numbers at the clinic, fate intervened, and it was discovered that the roof was unsafe, so the clinic closed down for renovations.

Then we had time to reassess our health Care in the locality. I now had time for discussions with the local people and the complex reality of the make-up of the community became very clear to me. There were several ethnic groups, each with its own dialect, customs, traditions, and each with its 'roots' and interests based in their state of origin, and not in this new environment.

It was extremely difficult to arouse enthusiasm for the locality - not many people felt they really 'belonged' there. Those who are sure that they are the original people - those whose families were there before the advent of the thousands of people who arrived in the capital city in search of work and a place to live - were a small minority.

Our 'target' area had been delineated before this, and I discovered that these people were not happy about the boundary of it. They pointed out that the main road that was to define one section to the boundary, cut right through the area where most of this 'small minority' lived, thus excluding some of them. So a review was done, involving hours of discussion. This was
most enlightening exercise, although time consuming, and it resulted in a new boundary.

Some of the difficulties encountered in PHC in a populous urban area are:

1. Numerous ethnic groups/dialects, therefore slow to cooperate with each other.
2. Gross overcrowding in inadequate houses - often 1 room 8' by 10' per family - maybe 6-8 people.
3. Unemployment - therefore great preoccupation with petty trading and no time to assemble or meet.
4. Reticence on the part of potential leaders to volunteer because of language and ethnic differences.
5. Moving population - a) home for long periods to home state and b) better housing found elsewhere so they move on.
6. Total lack of any environmental sanitation services.
7. Very poor water supply - no drainage.

These are just some of the problems!

"I have tried to concentrate on the area where the real local people are within our boundary - and that is approximately 40,000 people. These people are very interested. We are doing a 'PILOT PROJECT' first, taking six of the bigger streets. We're still at the 'meetings' stage and they are in the process of selecting three leaders from each of the 3 streets. We'll do a programme in basic health education, environmental sanitation, hygiene and so on. Then they should be able to start something with their streets. It is very slow here as it is so hard to get a time to meet them that suits them. Nearly all are petty traders - things are bleak for them at the moment - so when trading on the street closes down, they set out and go hawking along the expressways! - in the traffic jams.

I see now clearly what is meant when we say we had security in our institutions. There is no feeling of that in this work, and I'm happy to experience it too!

I'm battling on in the hope that some good leaders will emerge from the women folk around. But honestly it is very difficult to get the idea of doing anything voluntarily in the streets. I often reflect on that and ask myself - why? I believe now that for somebody to 'freely give' of their time and so on - they have to have some kind of security behind them - and the people here really don't have any. Many are merely subsisting - hawking tomatoes and red pepper or petty trading like that. So it's really slow - but the concept of PHC is slowly sinking in."

SURPRISING - THAT LAST SENTENCE.

EXPERIENCES IN WIDE RURAL AREAS

These have been mentioned in several LINKS. Specific problems relate to:

DISTANCES between groups and people - so there are difficulties in:
- communication of all kinds, transport difficulties
- and problems of distribution of immunisations and drugs.

POVERTY - especially seasonal hardships in the rainy season when food supplies are finished and roads possibly impassable.
IN OUR TRADITIONAL TRAINING

We probably worked for a time in a COLLEGE or UNIVERSITY.

Then we trained in a building - an institution - in a DEPARTMENT.

In the department we learned by OBSERVING and LISTENING to those already there.

There were MODES of BEHAVIOUR within the department and in RELATIONSHIPS with other departments.

We LEARNT OUR ROLES.

We were SECURE.

We were PROFESSIONALS - SPECIALISTS in our field - with our necessary equipment around us.

The STRESS was CURATIVE and those who came for our care were 'PATIENTS'.

When we began to STRESS - PREVENTION and STRENGTHENING HEALTH and WHOLENESS in the life situation we found problems and challenges.

PEOPLE
Priority - curative care
Difficult to arouse enthusiasm
Difficult to maintain motivation
Potential leaders reticent

COMMUNICATION
Hours of discussion
Long distances
Transport problems
Roads impassable
Vision of life different

COMMUNITY
Complex make up
Several ethnic groups
Slow to cooperate with each other

PROBLEMS OR CHALLENGES
WAR
Insecurity
Isolated

HEALTH
Malnutrition
Not immunised
Lack of knowledge
Lack of immunisations and drugs
AIDS

ECONOMIC
Poverty
Lack of security
Unemployment
Seasonal deprivation
Long hours petty trading
Too weak to farm

DOES OUR TRAINING MATCH UP WITH THIS EXPERIENCE?
SOME PEOPLE will train in HOSPITALS as they intend to remain in this essential work.

THE QUESTION HERE IS - if a young person wished to work in PHC is it feasible to spend 3-8 years in hospital both in Europe and overseas - and only then go into PHC?

Of course some people now work both in hospital and also give time and interest to work in PHC. But experience shows that when there are staff shortages, or someone goes off sick or goes on holiday, then they are SUCKED BACK into the hospital full time.

SO WHAT IS OUR ROLE IN PHC - WHAT ARE WE TRAINING FOR?
The challenges in the two letters here give us some ideas - of course there are other situations too. Instead of starting with anatomy and physiology - perhaps we have to start with people - and the world as it is today.

HERE ARE SOME IDEAS - THERE ARE REALLY MANY MORE.

WHY POVERTY and OPPRESSION?
- spiritual, cultural and social analysis.
- BASIS OF POWER? Industry, finance, media, research scientists, politicians, as well as ideologies, military and nuclear power.
- ALSO the POWER of culture, of women together, 'people power' and above all the power of love - the Holy Spirit.

WHY FAMINE and DROUGHT, deforestation and pollution, land appropriation and unjust land laws, greed and ignorance?
- ALSO finding out what people are doing to counteract these things and supporting them.

WHY THE THREAT TO ALL LIFE on earth?
- Whether to do nothing or respond?

EACH UNIQUE PERSON
- The meaning of life
- The ladder of human needs (Maslow)
- Methods of self discovery and awareness
- Development of gifts and encouraging others

ALL ABOUT OUR SPECIFIC COUNTRY

HEALTH and HEALING
- Holistic living
- PHC - philosophy and practice
- Different modes of teaching
- Training of trainers of CHWs
- Some management skills
- Pastoral Care
- Responding to the signs of the times - AIDS, refugees and the flight to the cities.

LIVING and COMMUNICATING - GROUPS and COMMUNITY
- "Only through communication can human life hold meaning" (Friere)
- Skills in listening, observing, interaction and dialogue.
- Understanding others vision of life and motivation.
- How groups work - finding priorities together.
- Promoting leadership skills.
- Art, music, drama and culture.
- Negotiating and reconciling.
IS A RECOGNISED TRAINING
for PHC a possibility, including not only theory, but also practical experience in a life situation?

Such training programmes may well be in existence - and so it would be most interesting to hear about them.

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POSITIVE VALUES

In the two letters quoted here, the problems were picked up and highlighted, but one could also pick up the positive values such as: regard for culture, embarking on training in the country where one lives and works, 'giving time', listening deeply to minority groups and following this up with action, not giving up in the face of hardship, experiencing insecurity and being happy to experience it and giving time for reflection - to name but a few!

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BOOKS

RURAL DEVELOPMENT - PUTTING THE LAST FIRST
Robert Chambers. £2.50. Although not primarily a 'health' book, it is included. The central theme is that rural poverty is often unseen by outsiders, that professionals rarely appreciate the richness and validity of rural people's knowledge or the hidden nature of rural poverty. He argues for a fundamental reversal in outsiders' learning, values and behaviour. From TALC, Box 49, St. Albans, Herts, AL1 4AY.

COMMUNITY HEALTH FOR STUDENT NURSES IN DEVELOPING COUNTRIES. Mary Bradley. £9.95. Bailliere Tindall/W.B. Saunders. This excellent book fulfils a basic need and covers primary health in situations where there are no sophisticated resources at our disposal. From booksellers or publishers at: 33 The Avenue, Eastbourne, E. Sussex, BN21 3JN.

I want to thank all those who have written over the years and I have enjoyed reading from you. I also want to thank all those who have sent reports and apologise for those I have not been able to include in LINK - even the one across the page is very shortened. Most of all I acknowledge a great debt of gratitude to MISEREOIR who have financed LINK and provided a network for many people who work in isolated places.

MALNUTRITION and INFECTION

Malnutrition is the end result of interaction between infection related anorexia and a suboptimal diet. Poverty, ignorance and adverse economic conditions are contributory causes which we cannot ignore, but these notes are taken from a paper concerning DIETARY FACTORS.

Contrary to common belief, the main difference between the diets of rich and poor countries is due to difference NOT in their protein but in their fat content. Protein energy provides at least 10% of total energy in most diets; and this will be sufficient for growth needs, providing energy requirements are met. On the other hand, fat provides around 40% of total energy in the diets of the rich and 10% in the diets in poor countries. Since fat is "energy dense", providing more than twice as much energy per weight of food than carbohydrate or protein, it follows that a greater weight and volume of food must be eaten by the poor in order to supply their energy needs.

This becomes a real problem when appetite is affected by illness; in children this usually means infection - diarrhoea and measles being frequently implicated.

During the first days of measles children's appetites fall dramatically. They prefer fluids and their total energy intake falls to about a third of their intake when 'well'.

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\text{ENERGY INTAKE} > \text{EXPENDITURE} \rightarrow \text{WEIGHT GAIN}
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\text{ENERGY INTAKE} < \text{EXPENDITURE} \rightarrow \text{WEIGHT LOSS}
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In order to restore the energy deficit and regain the lost weight, a child must increase his energy intake.

It is easier for convalescent children to achieve the energy intake necessary for 'catch up' growth when the energy density of the diet is high - as in 'western' diets which are higher in fats, until the weight loss is recovered, and the child is steadily gaining weight. After this and when the level of infection has fallen the bulky diet of the poor countries is probably healthier.

These notes are partly from papers by Dr. Maureen Duggan who did research on this problem in Kenya. She is now at the Department of Paediatrics at the University of Sheffield, England.

Sr. Pauline Dean, M.M.M.