Some hospital workers said 'LET'S TRY PREVENTION'. They looked around to where people went for primary care. (LINK 1 & 2)

They tried various ways to bring their expertise to the people. (LINK 3)

There was too much to do by themselves, so they looked at the area, society, the people. (LINK 4)

They came to realise about customs, culture and tradition. (LINK 5)

They taught some community health workers, or rather told them - they failed. (LINK 6)

Finally they saw their expertise was good, but the community's vision of life must be shared too. (LINK 7)

**LINK 8 remembered HANDICAPPED PERSONS**

**LINK OBJECTIVES** — I'm asking you .... Has LINK fulfilled these? If not, where can it improve? Do you feel there should be other objectives? Let me know, please!
Do you remember in LINK 7 the health workers and certain members of the community did a community survey? Then they gathered to present the facts to the whole community.

Graciously the leader asked the health workers to give their views - after the introductory remarks.

The HWs said that their main causes of concern were

1. the number of children repeatedly having diarrhoea and the deaths it caused.
2. the underlying malnutrition, especially in the smaller children.
3. the fact that many people seemed to have TB and were not on treatment.

They then remarked that there should be

1. attention to the water supply.
2. more research into the local cause of malnutrition.
3. a special TB survey before further plans.

But when the people spoke they said the water supply was fine - they'd always had it - and here they were - none the worse for it. Their No.1 priority was a little health clinic where mothers could deliver their babies safely here in their own place, and the sick could get treatment without spending their life's savings.

Then the women said, there was nothing wrong with the feeding of their children - the No.2 priority was a grinding machine for cassava because as it was now, the women were labouring long hours to do it by hand.

Then the men said 'Nearly all old men have a cough, it is usual. Our concern is that our school leaving children have no jobs - that's No.3 (if not No.2). Yes, jobs for our teenagers so they won't leave and go elsewhere.

When the HS's got home that night they said 'Now what have we got ourselves into. How are we going to sort this one out?'

So the next day they sat down and said 'Let's start at the beginning - what is our purpose in being here?'

Is it that you and I between us, working as hard as we can, with the local people to help us, aim to RAISE THE STANDARD OF HEATH in this area?

Well - we do want to raise the standard of health - but let's look at what we wrote down about our beliefs and purpose - and they found:-

"We believe in the dignity of all people and that includes these people.
- we believe in their intelligence and their special insight into life in this place.
So our purpose is to work with them so that realising their dignity, they will communicate with each other, and plan together to shape their own lives - and to try to solve their own problems including health problems, with available resources. 

AND we are here to work with them!

Then they remembered the four criteria that must be considered to come to a Community Diagnosis

- Community concern
- Prevalence
- Seriousness
- Susceptibility to management

Usually a score of X to XXX is given to each and the scores multiplied to give a total score for each problem.

Then they said: ‘When deciding priorities, we forgot the fact of community concern and just spoke of our concern’.

- “We hadn’t really listened to what people were saying - we were judging everything ourselves. I do remember women complaining of aching backs, from grinding cassava

- we didn't bother too much about community attitudes - that women believed babies just do die of diarrhoea. We didn't ask them why they thought that and then if we had they may have faced up to the situation and realised it was a problem.

- we didn't see distance as they see it - we went round in a car - we see now why they think their own clinic is the answer.”

From now on we will listen more and be more aware of their lives.

They then went back to the leaders, said they’d been thinking it over and now understood the people's point of view better; could we all meet again?

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>COMMUNITY CONCERN</th>
<th>PREVALENCE</th>
<th>SERIOUSNESS</th>
<th>SUSCEPTIBILITY TO MANAGEMENT</th>
<th>TOTAL</th>
</tr>
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<tr>
<td>Diarrhoea</td>
<td>X</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>64</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>X</td>
<td>XXXX</td>
<td>XXX</td>
<td>XXXX</td>
<td>36</td>
</tr>
<tr>
<td>T.B.</td>
<td>-</td>
<td>? XXX</td>
<td>? XX</td>
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<td>18</td>
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<tr>
<td>Problems during labour + delivery</td>
<td>XXXX</td>
<td>X</td>
<td>XXXX</td>
<td>XXXX</td>
<td>96</td>
</tr>
<tr>
<td>Lack of jobs for school leavers</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>X</td>
<td>64</td>
</tr>
<tr>
<td>Lack of grinding machine</td>
<td>XXXX</td>
<td>XXXX</td>
<td>X</td>
<td>X</td>
<td>64</td>
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Paulo Freire believed that to be human is to have relationships with others and with the world — men apprehend reality through reflection, not reflex (like animals).

The normal role of human beings is not passive — they can intervene in reality in order to change it. Such a person is a SUBJECT — one who is subjected to the choices of others as an OBJECT.

Men — relating to the world have:
- a series of aspirations — concerns — values
- certain ways of being and behaving

Freire calls these EPOCHS

![Diagram showing concepts related to EPOCHS]

But when NEW CONCERNS come along, the THEMES are superseded.

The 'wave' of new themes may advance, retreat but gradually gain ground.

Man needs to be more than ever integrated into his reality to perceive the 'mystery' of the change.

WE WILL NOT BE ABLE TO MAKE A COMMUNITY DIAGNOSIS — We will not be able to understand why people make the choices they do unless we are aware of the THEMES of the community in which we live.

I am told "the villagers will not pay their village health workers".
- the villagers will not contribute to getting the broken water taps replaced so they can get good clean water.

![Question mark]

But what are their themes?

Are they hungry? What are they talking about? The price of garri, millet, bananas, maize, chickens — and drink?

Or in the cities. The difficulty of getting paid work? The time spent on buses — perhaps 5–6 hours a day. The wife's illness. The money to be paid before you can see a doctor?
When people's interests centre totally around survival - then the sphere of perception becomes limited, discernment is difficult and men may fall prey to magical explanations - Freire calls this INTRANSITIVITY and it is characterised by

- oversimplification of problems
- nostalgic for the past
- underestimation of the common man
- gregariousness
- lack of interest in investigation
- taste for fanciful explanations
- a strong emotional style
- long speeches more than dialogue

Responsibility cannot be acquired intellectually but only through experience. Assistencialism offers no responsibility, no opportunities to make decisions, but only gestures and attitudes which encourage passivity'.

So how will man emerge from INTRANSITIVITY? Freire says only by education and conscientisation - the education of 'I do' rather than 'I wonder'.

Ref. - Points taken from Education for Social Consciousness - Paulo Freire.
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- a strong emotional style
- long speeches more than dialogue

says: - "For this need to be satisfied it is necessary that a man should often have to make decisions in matters great and small affecting interests that are distinct from his own, but in regard to which he feels a personal concern". (The Need for Roots". New York 1952 p.15).

Responsibility cannot be acquired intellectually but only through experience. Assistencialism offers no responsibility, no opportunities to make decisions, but only gestures and attitudes which encourage passivity.

So how will man emerge from INTRANSITIVITY? Freire says only by education and conscientisation - the education of 'I do' rather than 'I wonder'.

Ref. - Points taken from Education for Social Consciousness - Paulo Freire.

He believes "the important thing is to help men (or nations) to help themselves; to place them in consciously critical confrontation with their problems, to make them agents of their own regeneration. In contrast ASSISTENCIALISM robs men of a fundamental human necessity-responsibility of which Simone Weil
The Appalachian mountains stretch from north to south in the Eastern United States. There's an eastern and western range with a trough in between, carved into ridge and valley by the numerous rivers. The long narrow valleys are called 'hollers' locally.

In the old days magnificent trees covered the hillsides, hunting was good and the rivers full of fish. Then the timber prospectors came and worked systematically through the land left the hillsides denuded.

When coal was found more prospectors came and covered the land with mines - both surface and deep. As one seam was worked out the slag heaps and debris were left on the bare hillsides and a new piece of land gouged out. Then the coal supply dwindled.

When I first met the Appalachian people fifteen years ago they were the families of out-of-work miners and living on social assistance. Their wooden miner's cottages were cold and bare. Many received 'comfort' from alcohol distilled at home. The sparse land along the river bed was stony and poor, and the rivers polluted with chemicals washed down the hillsides from the slag heaps.

The large mining companies had done little for the people or to preserve the land. A general feeling of hopelessness and helplessness pervaded.

Now the M.M.N's have joined others who have gone there to live with the people and to try and bring 'hope'. From their miner's cottage they go out and enter into Clinchco's neighbourhood activities.

It takes some months before a newcomer can understand and converse in the unusual idiom of speech and intonation - and if they don't they're still 'outsiders'.

When I visited a few months ago Sr. Teresa was 'getting to know' the families - and their needs - and visiting the sick and elderly. Sr. Paula was just finishing working with the Frontier Nursing Service.

Sr. Bernadette told me their aim was to help build persons, families and communities. This they did by

- VISITING the people as friends and neighbours and also by giving nursing care when it was needed.
- HELPING TO BUILD COMMUNITY in a group - black and white - who meet weekly. They were learning through doing about relationships, how their bodies worked, nutrition and also counselling each other.
- HAVING OWNERSHIP TOGETHER in a co-op which sought to counter balance consumerism and a profit making philosophy.
- AN AWARENESS OF SOCIAL JUSTICE, working with the legal services so that the rural poor received their rights.
- A COMMUNICATION OUTREACH through a weekly radio programme encouraged people to look at their life style - cigarette smoking - alcohol consumption, nutrition and so on.

PRAYING TOGETHER, affirming Jesus Christ as Lord, experiencing the Spirit in each one and the gift that life is for each.

Here is an example of the sharing of life and the patient working together for conscientisation.
THOU ART
THE ONLY ONE

Prayer made by Anuak of Sudan.

O God, thou art great,
Thou art the one who created me
I have no other.
God, thou art in the heavens
Thou art the only one,
Now my child is sick
And thou wilt grant me
My desire.

LINKS

Many thanks for your letters and reports - they'll find their way into LINK with their 'theme'. I guess everyone got the Ethiopian follow-up - a real example of team work.

AMREF, Kenya sent me a copy of 'DEFENDER' a Health Journal for Africa i.e. for the man in the street - I should think it's a best seller.

PHAM The Private Hospital Association of Malawi held a workshop on Primary Health Care in October. St. Lucia and 36 others attended. She is now working on a course for N.H.W's.

Happy New Year!
Sr. Pauline Dean

BOOKS

1. Training and Support of Primary Health Workers

3. How To Look After a Refrigerator. from AHRTAG, 85 Marylebone Street, London, W1M 3EE.

4. For a catalogue of their books designed for front-line health workers write- AMREF, PO Box 30125, Nairobi, Kenya, East Africa.

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IN REAL LIFE

THAT DOESN'T HAPPEN

someone remarked after reading "Presentation of Community Survey" in LINK 9. You just don't have total disagreement at one meeting, and total working together at the next.

Quite true – and LINK only gave a summary of the story. This is what actually happened:

The two Health Workers (H.W's) realised after discussion that they had not always listened to, discussed with or appreciated the day to day difficulties of the people they'd met.

But quite possibly there could be more reasons for the clash at the meeting.

So they sat down with their three Community Workers and asked them what they thought about the meeting. They said "It was not good, in fact some people had decided to speak against you!

The H.W's said "But why? We came to this area with our special skills, we visited the Community leaders and local government officials; we asked them about their problems relating to health and life in general and they discussed with us. We asked them if they would be interested if we came to know more about the community (in a community survey) and then we might work together to see if we could solve some of the problems. All this was agreed and now see what has happened".

The three co-workers nodded their heads and looked miserable.

They all agreed we had a big problem.

Then one of the H.W's remembered she'd done a course at AVEC in London, and searching out the recesses of her mind said "I know what we can do to solve our difficulty."

Before you turn over what would you have done?
After placing a big piece of paper on
the wall they sat down and said 'Let's
first write our AIMS in doing this
survey' -

Then they went through the events of the
past three months, checking with their
diary. They noted what they'd done
first and why, who they had approached,
the information they had sought and the
result.

Then they went on to what they had done
next, and so on until everything was
listed down.

After that they divided into two groups,
a H.W. in each, and went through these
events. They listed the ideas they had
as to why they may have failed - or ways
in which they may have done better,
bearing in mind the difficulties. They
didn't discuss at this stage but just
listed down the ideas they had. This
took twenty minutes.

Then the two groups came together and
one person noted the events briefly on
the wall chart, e.g.

1. Visited Chiefs
   a ...... result ......
   b ......
   c ......

2. Visited local Health Office -
discussion with
   a ......
   b ...... and so on.

The comments on the first event from one
group were noted, checking whether the
other group agreed or not. If they did
did agree, they said why. There was no
prolonged discussion but a ? was put at
the end of the comment. This indicated
that not all agreed on this point and
saved having a drawn out discussion at
at this stage.

After they had covered all the
significant happenings of the 3 month
survey one of them summarised. She
noted where they had not done so well
and they tried to decide was it due to
their attitude or lack of skill.

She mentioned again those points with?
after them - when they were not all in
agreement. Sometimes opinions were
reviewed after going over the whole story
-sometimes not. Either was acceptable -
people don't always agree on every point.

Here are a couple of examples.
The first thing they had done was to visit
the local Chiefs - and tell them they
wanted to work with them and the people.
They realised that they were really
strangers in the area - Emmanuel's
comment was, that although they'd said
that, in actual fact the H.W.'s talked
privately to each other and made all the
decisions - they did not keep the Chiefs
informed of what they were doing - so
that the Chiefs heard it from other
people instead of knowing about it first.

Commenting on another thing that had
happened the H.W.'s said they'd agreed
to work together with the community on
part of the survey, where half the
people failed to turn up. Later they
realised they belonged to the smaller
tribe in the area, who felt piged as
the H.W.'s always seemed to favour the
dominant tribe (they said). Then the
question was asked "Why do they feel
that?"

For these - and other reasons which came
to light during the SITUATION study some
people had attended the Community Survey
with hostile feelings!

The workers then in small groups suggested
how - in each event - they could have
acted so as to reach their aim more
successfully.

Finally they put their heads together to
plan WHAT THEY COULD DO NOW to improve
matters in relation to each situation.

When all this was done - and it took
some time, the second meeting was
called.

Then the Community Diagnosis was made in
agreement by all present - and there was
a good turn out - also in LINK 9).
DOING A CASE STUDY

When things go wrong is rather like a consultation or a medical problem ...

In brief:-

THE WRITTEN HISTORY - or the 'story' of what happened and what went wrong. Only those who feel there is a problem and feel concerned should be involved.

THE DIAGNOSIS.

In small groups - going through the story, event by event and noting down what the workers did or didn't do that led to the unsatisfactory end.

Another person can note down what was done well!

INVESTIGATING IMPLICATIONS

Listing the events in order

(a) the situations (where and with whom?)

(b) the purpose (what for?)

(c) the method (how?)

the small groups consider how the workers may have had a better approach.

Together in the total group the approaches are listed on the board one at a time. Alternatives are noted and discussed.

THE COURSE OF ACTION (THE TREATMENT)

Once you've got the full story and the diagnosis the next courses of action come to mind relatively easily - (although they're not so easy to carry out!)

So in small groups, considering the events as a whole a plan of action is made, in a definite order e.g.

1. VISIT THE CHIEFS - the purpose being ..........  
   .......... will be visited first by ..........  

2. VISIT THE WOMEN'S GROUP .......... purposes etc.

FINALLY coming together again each group describes their planned course of action and explains why they planned to do things in such a way, in such an order. When the various suggestions have been heard and discussed - pros and cons - a final plan is made.

BUT WHY GO IN AND OUT OF small groups you may well say! The value is that everyone has a chance to voice their ideas. In larger groups the more vocal people monopolise the floor and so good ideas and alternative suggestions are lost.
WE'D REALLY NEED A TEAM

So the community and the H.W.s finally agreed together which of their problems and concerns were priorities (LINK) and these were:

- problems during labour and delivery; lack of jobs for young people; no grinding machine; diarrhoea and its effects in young children; malnutrition and T.B.

They all thought - "what a mix - and there's so little we can do by ourselves. We'd need people with experience in education, and job training, agriculture organisation, water supply, social work, nutrition, development, perhaps credit unions, animal husbandry and on and on and on.

In other words - we'd really need a TEAM.

Before you go further - consider three questions

We were asked at AVEC
1. What are the potential good effects of setting up a team?
2. What can cause bad working relationships? or what inhibits good team work?
3. What can you do when you set up a working relationship to make it more likely to be a good one?

GOOD EFFECTS OF A TEAM

- Greater variety of ideas - skills - support.
- Ease of workload.
- Gifts of discernment
- Could be a Xian community highlighting

Now what about your ideas?
WHAT CAUSES BAD WORKING RELATIONSHIPS?

- Insecurity
- lack of knowledge of what job involves.
- lack of training
- lack of respect for others’ point of view
- Go it alone attitude
- not meeting to plan and share ideas.
- criticism
- jealousy
- haughty disinterested attitude
- selfishness
- different objectives
- sleeping partner

WHAT CAN YOU DO TO SET UP GOOD TEAMWORK?

- Plan it together
- No hidden agenda
- draw up the lines
- balanced work load
- take account of personal needs
- allow for mistakes
- relax together

Our artist was Stephen Haslem - More - another time!
The following letter reached me some weeks late as it travelled to Nigeria first. But it is not too late - to print - the annihilating effect of shattered relationships.

Nyeri, Kenya.
Christmas 1981

Just as we were sending our last Christmas letter to you we were visited by a consultant to our project in Primary Surgery. He remarked that its main use might not be in the developing world, for which it is mainly intended, but in Europe after an atomic war. Conversations with him brought home to us the appalling danger now hanging over the world and particularly our family and friends in Europe and America. Despite the widespread apathy and resignation to this horror, we are convinced that not only is this the greatest challenge to public health of all time, but it is also a monstrous evil we can do something about. Hence among other things this Christmas letter. Never was there a greater need for the Christmas message of peace and goodwill on earth than this.

The arsenals of the world now contain the equivalent of a million bombs of the kind that fell at Hiroshima, and are equal to about 3 tons of TNT for everyone on earth. More energy can now be released by one weapon in one microsecond than in all conventional wars of history. A 400 megaton counter attack is expected to kill 50 million people on one side alone. After a 10,000 megaton nuclear war 5 - 10 million people might die from cancer due to nuclear radiation. Hundreds of millions of people might starve to death. There is a danger that mankind might destroy itself.

Not only is there a very real chance that all this will happen, but such is the unreliability of military computer systems that it is quite possible that it might even happen by mistake.

The error of the conventional wisdom of deterrence is that it thinks in much too short a time scale. We should surely be thinking, not what will happen in the next decade, but in the next hundred or thousand years. The tyrannies of the past have in due course always ended. If it comes to the crunch, and it is the crunch that really matters, our civilisation is more likely to survive, absorb and eventually throw off the tyranny of totalitarian domination than it is to survive the effects of major nuclear war. It is to a nuclear-free Europe, to the strength of the spirit, to the courage, indomitableness and tenacity of Poland and Afghanistan that we should look, not to cruise missiles. If 85,000 men are needed to hold down the tribesmen of Kabul, then we too can give a good account of ourselves. Put crudely, it is better to be red than dead. But over the generations that red will become pink, purple, and perhaps finally even blue. Meanwhile our children and our children's children will live - and struggle. If they and we have half the qualities of the Poles or the Afghans they will have the only freedom that matters. The cultural heritage that our ancestors have done so much to create will survive. This is the vision we would leave with you at this Christmas time.

With this then our warmest Christmas greetings, and the hope that you will join with us in perhaps the most critical step in the history of our species and pray, think, persuade, write, lobby and if necessary even march in the hope that we and our children may yet write to one another in the Christmases that will follow this one.

That said, and it must be said, if what really matters is to be communicated at all among friends in this critical time, news of ourselves seems not to matter very much. Nyeri is once again purple with Jacarandas. We have enjoyed another year among kind people in this lovely place, Felix has continued her work for TACT, the children have kept their end up remarkably well in 'Nyeri Primary'. Primary Anaesthesia has appeared, and the first part of Primary Traumatology should be out soon after Christmas. It is a fascinating but laborious task.

Maurice and Felicity King.
And at the other end of the scale — a letter from two MMM's now living as newcomers in a strange environment. The people are not used to strangers — so slowly Pauline and Theresa Jane are getting to know the people in a small village in Northern Nigeria.

Gussoro
Nigeria

"Our efforts continue here in a slow way. Theresa is at Minna at present, learning Hausa.

The people are happy to have us among them, yet when it comes to something beyond that there is a backing away. Anything to do with fact finding is a threat.

We've had a number of attempts at holding meetings, something always seems to crop up. One village is having health and literacy discussions — and that is their choice.

The people across the river are more ready and now it is the dry season, they are more accessible, so we are arranging our trips there. We are still visiting the people and the sick and if it is necessary we refer them to a local trained health assistant who has a pharmacy."

My heart goes out to them — but there are the priorities — learning the language and gently getting to know the people — not overriding the local trained health assistant!

From Elizabeth Hillman
Janeway Child Health Centre,
Newfoundland.

"LINKS are just as applicable in our frozen northland as in Africa ... Just back from the Labrador Coast where we are looking at nutrition ... treated children with trichinosis from uncooked caribou meat ... instigated a study on origin of violence in a tiny remote Inuit community which is being thrust into this century willy-nilly ... talked to a doctor who is training "village health workers" in remote fishing communities in Labrador "the land God gave to Cain"; we have just enjoyed a three month visit of a wonderful Ugandan nurse, Helen Mateega, who participated in our "outpost nurse" training program.

Most exciting of all — Don and I are on our way back to Uganda as "external examiners" in pediatrics at Makerere and Canada has funded our project providing two years of senior child health teachers for Makerere ... we'll go as the first and we are delighted.

E.S. Hillman, M.D.
Professor of Pediatrics

In May 1981 I heard from Dr. Hazel Scott from the Salvation Army H.Q. in Kerala, S. India where she and her husband had recently been transferred. There she was involved with 6 clinics, and 2 more soon to be opened. These were doctor oriented and had no outreach programme. She was then about to grapple with a new language and to try and put some Community Health concepts into practice.

Perhaps it was she who contacted Major Paul du Plessis, M.R.C.P. their Medical Adviser in London. He wrote and suggested that LINK go to their key personnel in thirty countries and this has been arranged — through him.

So now we have LINKS with Zaire, Congo, Ghana, Zambia, Zimbabwe, India, Pakistan, Bangladesh, Bolivia, Haiti, Japan, Indonesia, Hong Kong, Papua New Guinea and Phillipines.

Surely LINKS lead to PEACE?"
He is still with us
in the poor
in the homeless
in the oppressed
in those suffering from injustice
in those in fear of nuclear war

He is still with us
in his power
in his might
in his love
in his joy

May you be aware of Him
in your heart!

REFERENCES

1) The Non-Directive Approach and Training for Community Development.
   T.R. Batten. Oxford University Press.

2) AVEC - an agency which helps workers acquire more skill in working with rather than for people.
   Courses - in two parts.
   LONDON May 10 - 14/June 14-18
   NEAR BELFAST April 26-30/July 12-16.
   Information from 155A King’s Road, LONDON.

1982 INTERNATIONAL HEALTH CONFERENCE
N.C.I.H. June 13-16 at George Washington University, Washington D.C.

Information:- Conference Coordinator

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Sr. Pauline Dean
"The Time has Come"

The Chairman of the next Community Meeting said - "A PROGRAMME OF ACTION!"

The Health Workers sat back and let the Community leaders and people speak.

They said "Let us work on three of our problems first, and when these are going well, we'll tackle the others.

So first of all we will ask the HM's to help us build a Maternity Clinic and they can run it for us and train our girls. Is this not a good idea?"

The HM's said they were not at this present time going into clinics, in fact, they had just come out of them - for good reasons. But they had observed that there were some fine babies in the area, therefore the Traditional Birth Attendants (TBA's) must be doing a good job. But, as they knew, sometimes things were difficult. The HM's would be glad to share their knowledge, and then there should be no fear of delivery for both mother and child.

The people looked surprised and said there must be more talk about this.

Regarding the LACK OF A GRINDING MACHINE, forty two women said they had already got together and agreed to pay £1 a week for 5 weeks. Then they could get one of their own. They remarked how strange it was that they had never come together in such numbers to be able to do this before.

The most pressing problem now was the lack of jobs for school leavers and much discussion followed.

In brief - points brought up were:-

- all the craftsmen they already had could train others, carpenters, metal workers, house builders, potters, tailors, boat builders and so on.

- many were already farmers and fishermen. Many women kept goats and hens. If only they could get help from the Ministry of Agriculture for fertiliser and seeds.

- form the Water Authorities to irrigate the dry land.

- form the Fisheries to help with nets and boats, then there could be more work.

So they said "And why can't we? We'll form a committee and approach them."

Others suggested contacting all the 'Sons of the soil' in the country's big cities and invite them back to help them.

All went home satisfied this time. The Health Workers said to each other - "When the T.B.A. training is under way, they may then see the value of Community Health Workers, and then we'll all tackle the other health problems."
Excerpts from Keynote address West African College of Physicians workshop on poliomyelitis

"World Overview of Poliomyelitis" - Dr. Nicholas Ward

In 1978, 35,590 cases of poliomyelitis were reported to the W.H.O. That figure suggests that polio is not a major world problem.

Two factors, however, change the situation completely, firstly the disease is seriously under-reported and secondly it is probable, unless present immunization programmes are very much improved and reach a much higher coverage, that the actual incidence will rise in the future.

As a result of the excellent studies by Nicholas and Ofusu-Ariaah in Ghana in 1974, a prevalence rate of polio-paralysis of 7 cases per 1000 children examined, with incidence rate estimated to be at least 280 cases per million population was found. Too much significance can not be placed on this work. From a world complacent thinking it had solved the major polio problem, we realised that we had hardly touched it, indeed had been completely unaware of it.

Other studies in Thailand, India, the Philippines, Malawi and Brazil have all produced surprisingly constant figures, a prevalence rate of paralysis between 4 and 8 per thousand children and an annual incidence rate between 100 and 300 cases per million total population.

The second cause for concern, is the possibility of polio becoming a more common and a more devastating disease in the future.

As we know now, it was almost certainly the provision of clean uncontaminated water and, especially, the installation of efficient sewage disposal which, by removing the circulating wild virus from the community, brings about the change. The improvements in hygiene meant that infants were being born without the benefit of transplacental antibodies or of their booster in colostrum and breast milk, and without the "privilege" of being exposed to polio viruses during their very early years.

Whereas when polio virus circulates freely in a community, we get slow endemic spread, affecting 5 to 1% of all susceptible infants, usually aged 6 months to 4 years, when the spread becomes epidemic attack rates are much increased and the disease affects an older population. As a generalisation, the older the victims of polio, the more severe the disease.

As the level of hygiene of the world slowly improves and as countries slowly become more industrialised, populations move to the cities, clean water and sewage disposal become more available to more people. With it must come this conversion of polio spread from an endemic to an epidemic disease.

Even within an endemic area, epidemics will occur, but, of course, these only affect young infants, not the entire population. However, they do cause 'waves' of cases in certain years. Unless we establish really effective programmes of immunization, this catastrophic epidemic spread, affecting older people, possible the family bread-winner, will inevitably become much more widespread. The change-over of the nature of polio from an endemic disease, mostly affecting infants 6 months to 4 years of age, to an epidemic disease affecting all ages, is the single most vital factor in understanding the present day situation.

Now, even I, an ardent polio-enthusiast can hardly discourage the provision of clean water and sewage disposal, merely to avoid the risk of epidemic polio, and the only other choice available is to institute really effective immunization programmes and, to be honest, the only effective polio immunization programme is an expertly managed one, reaching 80% of the susceptible population with potent vaccine. Anything less will not stop cases occurring. There can really be no longer any doubt as to the efficacy of polio vaccines, both the injectable killed or the attenuated oral type.

It is imperative however, once high levels of immunization coverage have been reached, that they are maintained indefinitely and many excellent immunization programmes,

Cont'd on p.7.
COMMUNITY HEALTH PROJECT.
JINNA - GAMO GOFFA, ETHIOPIA.

Introduction: From August 1979 to November the four-member team of the present Community Health and Development Programme arrived in Jinka at different stages. The members were a priest, two C.S.Sp. Sisters and 3 M.M.M. Sisters. Between them their qualifications and interests extended to Community Development; Health Education; Community Health and Primary Health Care; and most important for this isolated area – mechanical expertise to keep our Landrover on the road.

Project Location: Jinka is situated in the southern Province of Gamo Goffa, Ethiopia, with international boundaries with Sudan and Kenya. Within the Province there are 4 Administrative units or Awarajas. Geleb-Hamer-Baco is the largest of the units, and it is in this Awaraja that Jinka is situated, as the capital of the Awaraja. Within the Awaraja there are 5 Weredas (subdivisions); Jinka is centrally placed in the Baco-Gazer Wereda, which latter has an estimated population of 143,000. The people are mixed peasant farmers and nomads and are organized into Mehabers - i.e. Farmers' Associations; Nomad Associations; Women's Associations and Youth Associations. There are now 54 Farmers' Associations in the Wereda.

Approach to Programme: The approach to the programme as it has developed is the result of much soul-searching; discussions; numerous meetings and frequent, regular contacts with individuals and Departments. As a first step we were decided to undertake a community study in the Wereda as a means of getting to know more about the people, their problems and living situations. This study was undertaken from January to June 1980, and certainly made us more aware of the difficulties of the people in the area, with whom we were hoping to work.

They were out on FIELD WORK for six weeks - Sister was asked "Do you want to bring your own food?" "No" she said. So finances were shared and they bought candles, matches, sugar, salt, spaghetti and so on.

There were some mules for the JOURNEY, but not enough for all, so they took it in turns to ride and also to let the mules carry the loads. On shorter distances they walked, i.e. up to 5 - 6 hours a day.

AT NIGHT the group camped down at local central meeting houses. The question every evening was "Would you like pasta or macaroni?"

So they WENT OUT for 7 - 10 days at a time then returned home to base. The information sheets were handed to the correlators and they set out in another direction.

"As a result of our study we decided that if we were to make any contribution to the welfare of the people in the area the only hope would be through ensuring the best possible use of the limited personnel and material resources available, especially as we were dealing with scattered communities with very poor or non-existent road communications."
We therefore decided to proceed only with such projects as would have the approval of the local, regional or central appropriate authorities.

**Development or Projects:** Within the programme several projects have got off the ground, but the process was slow and demanded time and patience. However it was felt this was worthwhile as the community involvement formed an important aspect of the development for us.

**May 1980** - Construction of the New Health Centre began, planned with the approval of the Ministry of Health - when all is completed it will be handed over to them.

**June 1980** - Nutrition survey in two Weredas (in response to a request from the Regional Health Dept.) in order to identify areas of drought and famine.

**May - July 1980** - Collaborating with Health Centre personnel the group were involved in training 20 Community Health Agents (C.H.A's). These C.H.A's are expected to give a P.H.C. service in their own Mehabers as well as concentrate on improved water supplies, sanitation, health education and H.C.H. services.

**May 1980** - Construction of a Demonstration Model House - in two places.

**June 1980** - Involved in training Mobile Health Agents in collaboration with Ministry of Agriculture personnel. These M.H.A's are selected by the Women's Associations and are expected to teach other women on their return.


**Oct. 1980** - MCH Services started Kako Health Station - Spring protection at Neri Mado Mehbe investigated.

**Jan. 1981** - At Arkisha Mehbe nutrition clinic started with C.H.A., which later developed into a M.C.H. clinic.

Simultaneously investigations on water supplies and sanitation in Arkisha went ahead.

**April 1981** - Follow-up of trained KHA's. Well protected Neri Mado. Training of two candidates as Child Development teachers was undertaken.

**June 1981** - General survey on provision of water supplies by Ethiopian Water Works Construction Authority, Awassa at our request. Personnel from EWCA Addis Ababa later made a survey after which negotiations were made to undertake a water project in the area.


**Nov. 1981** - Because of the many requests we asked for a meeting with the Awaraja Administrator and R. Cultural and Development Committee. At this meeting we explained that there were many requests coming to us and we would like to inform the Committee about our areas of interest and our priorities. We also had mentioned earlier to the Administrator that we felt a number of Departments had the same needs and it would be
helpful if their needs and requests could be co-ordinated.

Training of personnel was a common area of interest, both to the Committee and us. From this discussion arose the finalisation of the proposal of a common Training Centre for the area: a Centre which would serve the various Departments for their training programmes.

Town water and sanitation was also discussed and Committees were set up for both projects; i.e. a Planning Committee for the Training Centre and a similar one had been in action for the Water and Sanitation."

The report then tells of other projects including a Cattle Dip Tank, a training course for Traditional Birth Attendants, a seminar for Health Assistants to orientate them to P.H.C. and most important, supervision of C.H.A’s and T.B.A’s.

Finally "Much of our time is really given to facilitating others to do a better job. We have a very open house - personnel from any of the Departments are likely to arrive at any time and a great deal of the planning is actually done for the house.

At the moment actual field work is curtailed due to heavy rains. Rivers are flooded and impassable, also low-lying areas have mud or stagnant water ponds hip high. It is good to have periods to sit back, take a good look and from there try to evaluate and develop new approaches.

Situations are always changing and opportunities opening up if only we take the time and interest to open our eyes and ears.

Just now we have reached a plateau where we can see the Health and Development Programme becoming more integrated in its various aspects and stages. However there are many more uphill struggles and plateaus to be reached before anyone could ever say we are near a summit. Of course, here I am referring to 'we' as all the people who are involved; - the various Ministries, the local population and ourselves.

Needless to say a few people can climb a mountain much easier than thousands together. But then, who would profit by that? ...........

PAUSE a moment

Reflecting on this Ethiopian experience what VALUES do you see?

________________________
________________________
________________________
________________________
VALUES

Here are a few that came to my mind.

GOING INTO THE UNKNOWN

Leave the relative security of the people and place you know and "go to a country I am going to show you".... to a place where you are not known - to a place that could be lonely.

GETTING TO KNOW THE PEOPLE

by travelling among them, and so being more aware of their difficulties

WORKING WITH THEM

Others came forward with suggestions and plans - and all that was done was 'with the approval of the authorities'. The actual work is obviously with all kinds of ordinary people.

PUTTING THEIR TRUST IN PEOPLE

especially going off on the community survey, in what was then - a strange country. This trust continues "Much of our time is really given to facilitating others to do a better job". How often have I failed to trust others to do the job!"

NOT RETAINING THEIR EXPERTISE

but training others and passing it on; also in planning with the Administration about Training.

IN JOURNEYS OFTEN

"On shorter distances they walked i.e. up to five or six hours a day". That was in the survey - but the journeys have continued to meet the women's groups, the farmer's groups - to go to the Health Centres and so on.

GIVING TIME

for things to happen and going along with the community - "a few people can climb a mountain much easier than thousands together."

REALISING THERE IS A UNITY in life ..... that we cannot do 'health work' on its own. It is linked with many other things ... water supply, agriculture, farming, education ........

BEING ALIVE AND OPEN

to the signs of the times. "Situations are always changing and opportunities opening up if only we take the time and interest to open our eyes and ears".


Do any of these speak to you in your situation.

Why not write your comments to LINK?

VALUES and IDEALS

When talking to Bill this week about 'values' he said something like this - "You know we often say that such a thing is a value to us, for example - our group is trying to live a certain gospel value - e.g. of being for the poor, or of being happy to be insecure as God is our security. But when you look at what our group is actually doing or how we are actually living it is obvious that these things are IDEALS - not VALUES.

We live according to our real values. Maybe security is my real value. Total trust in God is only my ideal (at the moment).

But as they say in my adopted country "We are trying".

So thank you Bernadette, Jo Ann and Maura and all sharing this vision and hard work - thanks for encouraging us!
Polio Contd. from p.2.

started with enthusiasm and success, have faltered because high levels were not maintained beyond the first phase. The speed with which the virus becomes re-established again within a community by the birth of susceptibles not being immunized or the in-movement of unprotected immigrants can be quite alarming.

One interesting phenomenon in Europe in 1977 was the occurrence of 2 outbreaks of polio in Sweden and in Holland among communities that completely rejected immunization. These outbreaks occurred in spite of being in a country which had virtually been polio-free for the preceding 20 years. Clearly one can never relax, possible ever, but certainly until the entire world has had no cases of polio for many years.

Much doubt has been cast on the efficacy of the oral attenuated-virus vaccine in the tropics, and again much valuable work has been done in West Africa, notably in Nigeria and Cameroon on this subject. Frequently sero-logical surveys showed apparent failed sero-conversions and these findings have seriously affected the planning of polio immunization campaigns. Some of these failures may have reflected impotent vaccine, possibly not always stored at its optimum -20°C, some possible effect of gamma-globulin like substances in breast milk, some undoubtedly reflected either interference by other entero-viruses or by the implanted polio virus still being excreted from a previous dose, and undoubtedly some reflect the inadequacy of our laboratory tests to demonstrate extremely low levels of anti-bodies which may not be measurable but are still present in sufficient quantities in the intestinal mucosa to prevent virus entry and subsequent viraemia. By no means do we know all the answers yet. However, the solution must eventually be found in epidemiological surveys reflecting the incidence of disease, nor the seriological results reflecting theoretical immunity. A sufficient number of immunization programmes, mostly in small controlled populations, have undoubtedly eliminated polio and show that the vaccines, oral and injected, are effective in the tropics.

For example in Cuba from 1960 onwards, all children below 5 years have received 2 doses of oral vaccine annually, one in January, one in March. There have been no reported cases for 16 years. Other successful programmes have occurred in Chile, Puerto-Rico, Panama, Uganda before its tragic political problems and in areas of Brazil. So, I believe oral polio vaccines are effective in the tropics, possibly as the Nigerian workers have suggested. Not so effective as would be giving a combined DPT and killed polio vaccine, but still very effective and very easy to give using unskilled workers.

I may here quote Sabin of vaccine fame who maintains that the barriers to eliminating polio in the tropics are administrative not epidemiological or immunological.

World Trends

In Northern Africa, it is vital that, as well as worrying about yellow fever, cholera, malaria, travel agents advise all visitors to these parts to be immunized against polio.

In Eastern Africa, what looks to be a disappointing picture certainly reflects improved reporting, with 1020 cases in Kenya and over 200 in Uganda. In Kenya, at least in certain places, we may even be seeing the start of epidemic polio. In Sudan, Ethiopia and Tanzania, the trend is definitely of increasing numbers of reported cases. I believe that, eventually, this increased reporting will prove to be a most healthy trend, leading to increased awareness of the problem which will in turn convince the health planners and then the politicians, leading to increased action against it.

And finally West Africa. Figures suggest to me a continuing endemic polio situation, showing evidence, probably, of improving reporting but, as yet, relatively little effect from immunization programmes but I may well be wrong.

What about the future. The establishment and promotion by the WHO of an Expanded Programme of Immunization in 1976 was the start of what I believe will be a major immunization breakthrough, possibly more for DPT and BCG than for polio. It is unlikely, although by no means impossible to eradicate polio as we did smallpox. The smallpox virus only occurred in humans, polio can affect monkeys and apes. The smallpox virus rarely survived outside the human body, the polio virus can survive for months, and so on. However if countries really commit themselves, and co-operate across borders, I believe that results as dramatic as those with smallpox can be
Polio contd.

achieved. There is no reason why we should not eliminate paralytic disease even if the causative virus, somehow, manages to remain around.

Immunisation of 80% is a very, very difficult target to achieve when combined with injected vaccine. Cuba I have told you about with its twice yearly dose given by superbly administered volunteers, barely using health staff at all.

In one or two countries, especially the Philippines, Brazil, Malawi and Swaziland, Ministries of Health have gone all out, on a village to village basis, to try and reach all eligible children. The programmes are backed up by careful programmes of supervision and surveillance.

The activities of WHO and UNICEF and the exploration of cold chains is, so far, the best thing that has happened to polio elimination since the vaccines were developed in the fifties and were shown to be successful.

We must, in our enthusiasm for stopping the disease, never forget those unfortunate individuals who have already suffered from it. Our own survey in Malawi showed that in a country of 5½ million people, at least 25,000 were crippled by polio, 14% could not walk at all, another 14% needed sticks or calipers and possibly the same figure required surgery. A frightening figure, and a terrible backlog of work to be done.

OUR APPROACH

"In this unity of mission, which is decided principally by Christ himself, all Christians must find what already united them, even before their full communion is achieved. This is apostolic and missionary unity, which enables us to approach all cultures, all ideological concepts, all people of good will. We approach them with esteem, respect and discernment.

The missionary attitude always begins with a feeling of esteem "for what is in man", for what man has himself worked out in the depths of his spirit concerning the most profound and important problems. It is never destruction, but is taking up and fresh building, even if in practice there has not always been full correspondence with this high ideal." 

Redemptor Hominis 12

OUR UNIQUE PROBLEMS

Very often in life our difficulties seem too much for us. We may hear "It's alright in that place but here:-

- the Government gives no help whatsoever not even to the poor or handicapped.
- its impossible here because the people are nomads.
- there's so much poverty here, food, water, drugs, petrol, diesel are all scarce.
- the government has control of everything - what can we do?

When I hear that one, I'll think of JINKA!

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Sr. Pauline Dean
COMMUNITY HEALTH CARE

What exactly is it?

But first of all - What is COMMUNITY?

The dictionary says:

"The quality appertaining to all in common - Common character - agreement - identity - Social intercourse - communion - A body of people organised into a political, municipal of social unity."

As H.M.M.'s we profess to be "One with our sisters and one with all God's pilgrim people".

Of course God's pilgrim people weren't always and aren't always a community. In Exodus 12 "The sons of Israel left Rameses....... and people of various sorts joined them in great numbers." and Bernhard Anderson adds:

"Only later as they shared the experience of the desert and remembered their common history were they forged into a community - the people Israel."

So people of various sorts in great numbers aren't necessarily a community. And that is the problem.

In the Exodus these many people had also been oppressed and had, with the sons of Israel, been through many trials before they were freed. Yet Anderson implies that the common experiences alone had not brought any sense of unity.

It was the desert experience, the wandering and searching, the hunger and thirst, the fatigue and frustration, the need of each other; the gradual realisation that life was not chance, that it did have meaning; that God was always with them and would lead them if only they would let go - and let him.

It was remembering and reflecting on these experiences that forged them into a community.
In your experience when have you been more aware of the presence of community?

In my experience

in very isolated communities where groups of families have built their homes in such a way that their desire to be together is obvious. Seeing the Bedouin in their tents made me feel the same.

In some towns there can be recognisable communities within the larger mass of people.

Cities also may have small communities, particularly in the poor areas. Very often they are brought together because they are people from the same 'home place' in the country. (So they remember their common history).

BEWARE OF THE DOG
When you see this notice - in other words "Keep Out" - you know you are at the other end of the scale - It is difficult for the rich to experience real community!

Talking about community, Martine, a very experienced village health worker said "It sounds romantic - 'Let the community select their health worker.' But villages are all at different levels, with some rich and some poor. Sometimes there is little communication, or if there is, the rich look down on the poor. The rich have a bigger tongue - the poor man's voice is not heard. In a community people should be equal, but it's difficult to see in practice - I guess it exists idealistically but we have to face reality."

John said "Where I am there may be one home here, and then miles away the next, so community in this situation is how people get together."
PROJECT PIAXTLA AND THE HESPERIAN FOUNDATION

In the Sierra Madre of Sinaloa and Durango in western Mexico lies a rugged and strangely beautiful region, as yet untraversed by even the most primitive road. Referred to as las barrancas, this land of cliffs and ravines is dotted with small villages and ranchos linked by narrow mule trails. The people, of mixed Indian and Spanish extraction are proud, hardworking, resilient, with much song and laughter. Yet the majority live on a subsistence level, suffering many physical hardships. They are plagued by myriad diseases endemic in poor diet, poor hygiene communities -- everything from pellagra to intestinal parasites to tuberculosis and leprosy.

Although Mexico's public health program has made important advances, its services do not effectively reach this vast mountain area. The villagers are too poor and too remote to attract doctors. The people must rely on their own resources for medical and health care. Folk healers include curanderos (herb doctors), witch doctors, bone setters, midwives and spiritual healers. More recently there are the so-called médicos practicantes or empirical doctors who, although untrained, obtain and administer many modern medicines. Although all of these folk healers provide important services, health care remains inadequate. Malnutrition and infectious diseases are prevalent; even minor injuries and ailments often become serious and sometimes fatal.

Project Piaxtla is a campesino-run health care network that covers several thousand square miles of mountain terrain and serves a population of more than 10,000 persons living in more than 100 small settlements and villages. It attempts to involve the mountain communities in a process of meeting their own health needs in a manner that is economically realistic, ecologically sound, and personally humane.

The project is essentially a personal venture founded on friendship, dedication and trust. It has evolved slowly, by trial and error, since 1963 when David Werner, an American biologist and former high school teacher, first hiked through the barrancas in search of interesting birds and plants. Struck by the beauty of the landscape, the friendliness of the campesinos (farm people), but also by the enormity of their health problems, David later returned to work with the people.

Villagers -- especially some of the enthusiastic village children -- were involved with the health work from the start. For a number of years, however, a great deal of the health services were provided by young American volunteers. Although most of these young Americans were sensitive, dedicated, and worked very hard, the net effect of their presence was to increase the dependency of the villagers on outside assistance. The decision was finally made that all outsiders, including visiting professionals, would come not to provide services but to teach, not to practice their respective skills but to train others -- to leave something of their skills behind.

Today the community-based health program is run and staffed completely by local villagers. The main referral and training center is in the small village of Ajoya, at the base of the mountains and accessible by a dirt road. The Center operates an out-patient (and occasionally in-patient) clinic complete with laboratory and X-ray facilities. Also locally trained dental technicians drill and fill teeth, extract, and make dentures. Other activities include primary veterinary services and repair of orthopedic braces. All this work is done by the villagers themselves, most of whom have not gone beyond the sixth grade of formal education. Rosa, who is in charge of the clinical laboratory, has never attended school.
Over the years increasing emphasis has been placed on preventive medicine and health education. Early, sensible curative medicine is considered part of prevention. Every clinical consultation is seen as an opportunity to discuss with the sick person and his family the causes of his ailment, its rational treatment, and how to avoid it in the future.

The program also conducts an "Under Fives" clinic, mothers' classes in the school, and involves the families and school children in a variety of public health activities, including construction of latrines and preparation of garbage disposal areas. The dental preventive program focuses on pre-school and school children and includes systematic application of fluoride and instruction on the care of the teeth.

Perhaps the most important activity of the program is the training of village health workers, called promotores de salud. These come from remote ranchos and villages farther back into the mountains. Selected by their own communities, they spend two months training in Ajoya. The "learning through doing" approach to training includes preventive and curative medicine, with a strong emphasis on community organization, conscientización (consciousness raising), and teaching techniques. The most recent course was taught completely by the Ajoya village team, headed by Martín Reyes, the project coordinator. David Werner and his co-worker, Bill Bower, assisted as consultants but remained very much in the background.

Now completely self-sufficient in terms of personnel, the village health team is working very hard to achieve financial self-sufficiency. Already the promotores in outlying villages are self-sufficient; they are part-time health workers who continue to earn their living through farming and make very modest charges for their services, providing necessary medication at cost. Their communities even contribute half the cost of their room and board during the training program.

Financial self-sufficiency has proved far more difficult for the operation of the referral and training center, which now has six full-time and four part-time salaried workers. The team has undertaken various self-sufficiency activities to help meet program expenses while continuing to provide health services at low cost. These include chicken raising, hog raising, a cooperative corn bank, and a vegetable farm. All clinic workers put a third to half their time into these self-sufficiency activities. The nature of the activities not only helps bring additional income into the center, but through providing additional nutritious food and improved stock helps both to upgrade the nutritional level of the village and to serve as a model for improved farming.

Villagers may pay for health services either with money or with work. During the summer rainy season, "work fiestas" have been conducted in which many villagers pitch in to plow and plant fields loaned to the clinic. For each two hours of work, a family receives credit for a consultation, complete with medicine if needed.

To keep upgrading their knowledge and to learn new skills, the village team continues to invite doctors, nurses, dentists, veterinarians, lab techs, and other professionals to visit in a teaching capacity. Such visitors are encouraged to maintain a low profile and to limit their contribution to teaching and making suggestions. It is felt important that the visits of professionals be brief (usually two to six weeks) and that they serve as auxiliaries or assistants to the local team that provides the continuity of care.

One of the most recent and exciting developments of the project is that it appears to be self-seeding. On the far side of the mountains, in the state of Durango, a group of villages has long been peripheral to the area of coverage of Project Piaskta and eager to have a similar program. In 1976, Martín Reyes began to help the villagers of the Huachi-metas area of Durango organize and raise funds for the building of a health center and the
training of health workers. Community participation has been phenomenal. The new clinic is already completed and three health workers from the area participated in the 1978 promotores training program in Ajoya.

In addition to helping launch a sister project in a neighboring area, Project Piaxtla has begun a program of student exchange with other rural health programs in more distant parts of Mexico and as far away as Honduras. Thus the team in Ajoya is beginning to gather ideas and to have an impact far afield.

Project Piaxtla has no formal ties with the Mexican Health Department. However, it collaborates with health authorities in vaccination campaigns, malaria eradication, and tuberculosis control. The Ajoya clinic has special arrangements for patient referral to outstanding doctors on the coast who sympathize with the community-based program and charge reduced rates to those who are poorest.

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Project Piaxtla is in some ways similar to other community-based health care endeavors in Latin America. It differs from most, however, in the following ways:

1. It is now completely run and directed by the villagers themselves.

2. The majority of the financing for the ongoing program, including the referral and training center, is generated locally. An additional portion of the funding is raised through outside sources, but most of this fund raising is undertaken by the local team.

3. The program is run, directed, and supervised completely by local non-professionals. Visiting professionals are secondary to and supervised by the local team, not vice versa.

4. The medical sophistication of the local non-professional team is exceptional. While health promoters are able to cope adequately with eighty to ninety percent of the patients they see, the village team in Ajoya (the referral and training center) can adequately manage ninety-eight percent of patient visits. For the most part, the team provides better and more appropriate care at a far lower cost than that received by patients who go to medical facilities along the coast.

5. The project has a vision of community health that includes equity and social and political justice. Increasingly, the local team as a group and as individuals has begun to confront issues of land tenure, exploitation, and corrupt village leadership as it discovers that the health of people depends as much on these factors as on "health care" in the more limited sense.

6. Emphasis is placed on the sharing of knowledge and treating everyone as equals. An attempt is made to demystify medicine -- to make it both simple and sensible. Often the health worker will open a book and read about an illness together with the sick person. There are no uniforms, diplomas, or other ordained structures to institutionalize health care or divide the health worker from his people.

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A book of methods, aids, and ideas for instructors at the village level

Helping Health Workers Learn

David Werner and Bill Bower

Helping Health Workers Learn is a collection of methods, aids, and 'triggers of the imagination'. It is written in clear, fairly basic English, for use by village instructors who may have limited formal education. Hundreds of drawings and photographs emphasize the key points.

The book is based on sixteen years of experience with a villager-run health program in the mountains of western Mexico. Although many of the teaching ideas described here were developed in Latin America, methods and experiences from at least thirty-five countries around the world are discussed. One section of the book concerns helping health workers learn how to use the village health care handbook Where There Is No Doctor by David Werner.

The focus of Helping Health Workers Learn is educational rather than medical. It has been written especially for instructors and health workers who identify with the working people and who feel that their first responsibility is to the poor. Rather than trying to change people's attitudes and behavior, this community-based approach tries to help people analyze and change the situation that surrounds them.

The key to health lies in the people themselves.
Although the International Year of Disabled Persons has passed - the need for rehabilitation for those disabled will never pass. So for those of you who may have missed it:-

DECLARATION OF RIGHTS OF DISABLED PERSONS


1. A "disabled person" is any person unable to ensure by himself or herself a normal life, as a result of a deficiency in his or her physical or mental capabilities.
2. Disabled persons shall enjoy all the rights set forth in this Declaration without discrimina- tion on the basis of race, colour, sex, language, religion, political or other opinions, state of wealth, birth or any other situation applying to the disabled person, or to the person's family.
3. Disabled persons have the inherent right to respect for their human dignity. Disabled persons have the same fundamental rights as their fellow-citizens of the same, age first and foremost the right to enjoy a decent life, as normal and full as possible.
4. Disabled persons have the same civil and political rights as other human beings.
5. Disabled persons are entitled to measures designed to enable them to become as self-reliant as possible.
6. Disabled persons have the right to medical, psychological and functional treatment, to education, vocational training and rehabilitation and to other services which will enable them to develop their capabilities to the maximum and hasten their social integration.

WHAT AM I DOING FOR DISABLED PERSONS? WHAT COULD I DO? WHAT COULD WE DO?

AIDS FOR DISABLED CHILDREN.

LOW COST AIDS - a book of designs for making a range of aids - from walkers and climbing frames to chairs and beds. Countries excluding UK and U.S.A. £3.00 airmail from AHRTAG, 85 HARYLEBONE HIGH STREET, LONDON W11 3DE.

PLAYING TOGETHER - are sets of pop up drawings of aids - for disabled children. The sort of thing a father could make for his child at home and perhaps change the child's whole life. Also from AHRTAG (£1).
Although this is the "July" number I'm actually preparing it in March. In late April I hope to go into 'the desert' in North Wales and then on to Drogheda for the course. So apologies if I do not answer your letters during these weeks. I will not forget you during this time.

I had an answer to my question about the aims of LINK - "I would perhaps have a suggestion of emphasis ONLY in the area of DIFFERENT APPROACHES, collecting ideas that have worked in the field." Asking myself "What possible alternative could I use has increased my awareness. E.g. Nutrition - do you think bean sprouts could be used in the 3rd World? Another suggestion - the mention of POSITIVE MENTAL HEALTH ATTITUDES."

Thank you for those suggestions I'll take them up. LINK II looked at CHC in Ethiopia where there is a certain situation - e.g. a very rural area - LINK III will look at CHC in the urban situation.

1. WHERE THERE IS NO DOCTOR
   also in Portuguese, Spanish and French.

2. HELPING HEALTH WORKERS LEARN
   both available from Hesperian Foundation
   P.O. Box 1692, Palo Alto, Ca 94302 U.S.A.
   and from T.A.L.C. Institute of Child
   Health, 30 Guildford St. LONDON WC1 NEH.

3. NEW DEVELOPMENTS IN TROPICAL MEDICINE.
   stressing interrelationship between
   tropical medicine and public health - Main
   topics - P.H.C., Health Problems of
   Refugees, Parasitic Infections, Diarrhoeal
   diseases - from N.C.I.H. 2121 Virginia Ave.

Mairead is based in a leprosy hospital which she and her co-worker were rehabilitating. She writes "I have just spent a week in the field with one of our leprosy workers. It is easy to get tied down in the center, but supervision in the field can prevent the very complications that bog us down here - I have one medical student (final year) per week for January and February - sometimes two - Its the first time they have been than much exposed to leprosy - Thank God things are going well here and we are able to be of service - The medical facilities are much better than last year. The agricultural project is doing very well and the patients love it.

COURSES
1. A.P.S.O. Agency for Personal Service Overseas. 29 Lir Baggot St. - Dublin 2, Ireland. Following are given through the year.
   - Induction Courses
   - Health Care in the Developing World. for nurses and for doctors.
   - Teaching Overseas.
   - Counterpart Training.
   - Community Development.
   - Leadership Skills.
   - Swahili Language.

REF. 1. M.M.M. Constitutions 2.2.
2. The Living World of the Old Testament
   Bernhard W. Anderson p. 51

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Sr. Pauline Dean
HEALTH in the WORLD and TIME

It is vitally important to be aware of the present situation regarding health in the world, but we will only understand it if we look back in TIME.

"To have no past is to have no identity. People who lose their memories do not know where they are going.

To have no present is to have no community. People who cannot live in the present commit themselves to loneliness and alienation, and are without spontaneity and emotional response.

To have no future is to have no hope, and to be committed to despair and suicide.

We all of us take on the characteristics of past, present and future people. The danger lies in being committed exclusively to one of these categories -

People who constantly live in the past enshrine history and try and repeat it, because their values lie in the past - People who live exclusively in the present have no foundation in their life - they drift. And people who live exclusively in the future are so busy planning tomorrow that they miss to-day's people and to-day's life - Fortunately no one is exclusively past, present or future, but we tend in our life and personalities, to veer towards one or other - We have to juggle with these three aspects of time to come up with the right mix for life."

Michael Carroll.
OVERVIEW of HEALTH CARE

FROM EARLIEST TIME

HIPPOCRATES
Respect for life.
Value of diet.

BARBER SURGEON

COMMUNITIES (e)

TRADITIONAL HEALER (T.H.)

TRADITIONAL BIRTH ATTENDANT (T.B.A.)

EGYPTIANS
and INDIANS
PRACTISED SURGERY

ARABIAN SCHOOLS OF MEDICINE

Schools of medicine and surgery flourished and declined.
Local communities continued to rely on their traditional healers and birth attendants.

NORTH

SOUTH
**C18**

**Jenner**
Smallpox vaccine

**C19**

**Agricultural Reform**

- Improved Nutrition

**1870 Sanitary Reform**

- Water and Sewerage

**Pasteur**

- Isolated Bacilli

- Each discovered Vaccine

- Lister's 'antiseptic' process

**Deaths and illness due to infectious (mainly killer) diseases greatly reduced, even before the effect of these...**

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**C20**

**Social Medicine**

**Public Health Immunizations**

**Antibiotics**

- But it was not here that medically reduced in factories, but improved nutrition and sanitation - i.e. 1870 - 1920

---

**Infections still the killers.**

**T.B.A.**

- T.B.A.'s continue to deliver millions of babies successfully
The Medical Care System Comprised

Teaching Hospitals using new technological developments treat those suffering from effects of local hospitals

Health Clinics

General Practitioners often over-worked and rushed.

And some said 'Let's transfer it all to the south!'

But the teaching hospitals took 40-55% of the total health finance.

Local hospitals were mainly in cities and towns, while 70% of people were in rural areas.

Health Clinics had little support, drugs or backup.


Some leaders say 'We want more teaching hospitals and more doctors and nurses.'

They forget the hospitals treat those only already damaged; that they consume all the money; that doctors and other staff leave the mass of people to join them.

Enlightened leaders say 'Let's help people where they are in the community.'
Team Work with Traditional Birth Attendants

Many countries, encouraged by WHO and UNICEF have started TBA Training Programmes. The following is drawn from a programme based in Calabar, Eastern Nigeria - I met the organisers, the teachers and our 40 T.B.A.'s at their First Programme for Presentation of Delivery Kits in 1979.

Why Work With T.B.A.'s

Most T.B.A.'s are older and respected people, with little or no formal education already delivering 80-85% of babies in many countries. We must admit they do this with great success when we look at the thousands of children around us. Yet hospital and clinic staff know only too well the familiar sight of women in advanced obstructed labour, or with ruptured uterus, gross infection and dehydration, and babies with tetanus and other infections.

The trained midwife shortage in rural areas is not likely to be overcome in the foreseeable future. With some training the T.B.A.'s practices can be made safer and unnecessary deaths of mothers and babies prevented. Their influence can be used to promote health and family spacing education. Such a programme can bridge the gap between the modern nurse midwife and the traditional customs and practices so that maternities become more adaptive to local customs, and T.B.A.'s more willing to refer problems to maternities.

1. Objectives of Training Traditional Birth Attendants

The Goal is to decrease maternal and neonatal mortality.

1. Attitude objectives
   1. The TBA feels greater self esteem as a member of health team.
   2. The TBA is convinced of the value of MCH/FP services and willing to refer mothers and babies for these services.
   3. The Heath Centre Staff respect and value the work of the TBA.

11. Knowledge objectives
   1. The Health Centre Staff know the local beliefs and customs surrounding human reproduction, and the practices of TBA.
   2. The TBA can offer healthy advice to women regarding themselves and their babies such as:
      a) Recognition, symptom treatment and diet in pregnancy.
      b) Recognition, symptom treatment, activities and diet in birth.
      c) Breastfeeding, child spacing and childcare following birth.
3. The TBA can explain the health services available to the people.
   a) Location and hours of clinics, fees, names of staff.
   b) Purpose of prenatal folate, iron, vitamins, tetanus immunization and high risk screening.
   c) Value of well child care, immunization, and weight charts.
   d) Value and methods of child spacing.
   e) Value and urgency of hospital referral in complicated delivery.

4. The TBA knows how to recognize problems, which should be referred.
   a) In pregnancy: fever, bleeding, severe abdominal pain, swelling of face, frequent fainting, rupture of membranes.
   b) At delivery: labour prolonged over 20 hours, prolapsed cord, fever, haemorrhage, convulsions, malpresentation.
   c) Postpartum: Fever, bleeding, breast infection, birth injury or anomaly.

III. Skill Objectives
1. The TBA can assist at normal deliveries with skill so that:
   a) No injury is done to mother or baby. Gentle technique.
   b) No infection is introduced into mothers uterus or baby's cord. Good hygiene.

2. Emergency management by TBA for:
   a) Breech delivery
   b) Postpartum haemorrhage
   c) Neonatal asphyxia

3. The TBA demonstrates her skill in:
   a) Use of the contents of the TBA Kit
   b) Scrubbing prior to delivery
   c) Tying and cutting of umbilical cord.

2. DEVELOPMENT OF T.B.A. PROGRAMME

   Step 1. Becoming familiar with T.B.A.'s
   Step 2. Planning the programme
   Step 3. Training the teachers
   Step 4. Training the TBA's
   Step 5. Follow up.

Step 1. Becoming familiar with the TBA's

   The problem may be to identify the T.B.A.'s as they are often mistrustful of health clinic staff. In many areas it would be advisable to approach the Chiefs and discuss the purpose of the proposed programme with them. There may be suspicions that the health staff want to 'take away' patients from the T.B.A.'s. If the health clinic staff really want to 'work with' the T.B.A.'s it should be possible to convince the Chiefs. Then the question may be asked "Will they now be under Government/Mission and will they receive a salary?" Again the Chief must be convinced that this is not so but there will be mutual helping of each other. Once that is clear the names of the T.B.A.'s are usually made available after he has discussed with them.

   It is not wise to wear a professional uniform when going to visit T.B.A.'s in their homes. If community health aide or village health workers visit in
ordinary dress there is less suspicion. Later on the more senior staff could visit, and possibly invite the TBA's to see the Health Centre. In some programmes the TBA's visit and have their meetings in a hospital. I think this is inadvisable. I have heard that if T.B.A.'s are considered to be hospital and even clinic staff they will not receive their traditional gifts and payment.

Step 2. Planning the Programme

If planning for large areas the booklet 'Training Birth Attendents' WHO No. 44 may be useful. If planning on a smaller scale the plan includes:

- Teachers - e.g. Community midwives
- Places - e.g. health centres or better still places in the village where the TBA will feel more 'at home' - This does not exclude a visit or two to the health centre.
- Numbers to be trained - About 8 per teacher.
- Funds may have to be sought.
- A timetable drawn up with the dates of the teachers' workshop, then the T.B.A. training to start shortly afterwards.
- Explanation of the proposed programme to the various officials in the Ministry of Health and local government. There may be some who are against it fearing that women may attend regular clinics less. It can be explained that clinics can expect more patients if TBA's refer high risk patients.
- If the programme is associated with government, T.B.A. kits can be ordered from UNICEF.
- A register for TBA's to be kept in the Health Centre printed.

Step 3. Training the Teachers

At the opening of a 3 day workshop members of the local government can be present so policies may be explained to them. It is also wise to mention that the TBA's will receive a small sum as travelling allowance to the meetings and the midwife a larger sum for each meeting she conducts. So the cooperation of all is more likely.

The workshop covers the objectives and policy of the programming, methods of working with illiterate or semi literate people - (use of local language, no 'medical' terms but local names.) Various training topics can be presented as role play and demonstration by the midwives. This is an effective method of learning especially if followed by comments.

To be continued in LINK 14.
WORLD LINKS

DROGHEADA

Apologies that this LINK did not look at an urban situation as promised. Hopefully LINK 14 will.

In Drogheda June 9-11 we had a P.H.C. workshop. Sharing of the experiences of others was a highlight. Sr. Leonora demonstrated her work through a most enjoyable role play - Sr. Ignatius Rooney illustrated her talks with slides which conveyed so much more than spoken words - Sr. Louise Ritchie opened up to us the world of Pastoral Care.

On June 13-17 we had a workshop on "COMMUNICATION IN P.H.C." with Fred Abbatt who runs a course for trainers of village health workers at the Liverpool School of Tropical Medicine.

Apart from a very excellent input I learnt a great deal from observing how he listened to everything said, and did not run the course only to his own agenda. For example he noticed a sense of near hopelessness in some participants doing P.H.C. because of lack of results over 2-3 years work. He brought us to understand how we must GIVE TIME for people to change their attitudes and habits of a life time.

I also learnt the value not only of role play, but of the interpretation of the role play. We can learn a lot about ourselves this way!

MALAWI

Sr. Lua is now working in the MAP project - that is MALAWI AGAINST POLIO

There are some 50,000 people in Malawi disabled because of polio. These are being helped by orthopaedic appliances and corrective surgery, if needed. More important - mass immunisation is underway.

GOSPEL REFLECTION

It's sometimes difficult to reflect on the Gospel and apply it to our own lives. Sr. Pierre Simpson O.F. gives us here a list of readings and then some questions we can ask ourselves.

The theme is the relationship between Jesus and his disciples - his fellow workers.

Mark 1: 16-20, 2: 13-17, 3: 13-19,
8: 27-33, 9: 14-29, 10: 35-40,

24: 36-40.

1. What was there in the disciples of Jesus that would qualify them for the work? - disqualify them? Why did he choose them?
2. What was His reaction & their limitations and failures? - rejection? impatience? trust?
3. Could we basically say Jesus trusted His disciples whatever happened? Why?
4. What is our attitude to our fellow workers? Do we accept that they are limited - make mistakes? Why/Why not?
   Do we trust them - Why/Why not? What could we do to help mutual trust to flow between us?

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Sr. Pauline Dean
Sao Paulo is the fastest growing city in the world. There are said to be over thirteen million people there now and there could be twenty five million by the year 2000 if the present rate of growth continues.

Like most large cities the office area is central surrounded by the residential areas as one moves outwards. On the periphery of this planned city thousands of people move in annually from the country seeking a livelihood. The newcomer arrives to an already overcrowded area without the usual facilities. It is natural to join up with people from 'back home' who have settled there before them. Help and support are needed to find or make a place to live and to get a job.

In some areas the people are trying to be real Christian communities or Basic Ecclesial Communities (B.E.C.'s). Scattered through the neighbourhood would be Christians who are really alive -

These people welcome the newcomer and the neighbours to read and reflect on the Word of God together, to pray and to see what Christ is saying to them today - in this situation and to ask themselves how they should respond.
Community Health Care fits easily into the Church’s pastoral work when a group of Christians accepts that their vocation implies a commitment to caring for one another in the neighbourhood in which they live. Each well-formed basic ecclesial community has an animating team for every important service, e.g. youth, health, marriage, workers, human rights, catechetics, social assistance and so on. Organising a pastoral service in the area of health-care can also be a way of helping a young Christian community to assume its responsibilities in the neighbourhood.

Basic ecclesial communities vary a lot in structure and organisation, but here’s how we try to fight the battle for better health in a group of parishes on the south-west periphery of São Paulo, Brazil. Phyllis Heaney, mmm, is the full-time pastoral agent responsible for health-care in the area.

Community Health Team

The health team usually consists of about six or eight members, who join because of their desire to work in the health pastoral, not because of any expertise they may have. They receive preparatory and on-going training at the monthly meetings of the team, through Phyllis’ supervision throughout the month, and through meetings and formation days at other levels, as will be mentioned below. Many also participate in a part-time intensive programme for health attendants organized by Phyllis from time to time.

Different Jobs

At their monthly meetings the members of the health team report on their work and on any problems encountered. Not all members have the same jobs to do, although they all dovetail. If there is a team of say seven, three people are responsible for home visiting. They visit chronically sick people in the few streets assigned to each one. Ordinarily, sick people go to the local health centre or hospital for treatment, but if the health-team meet a person who seems to need special advice or care then they will contact Phyllis. If the person needs spiritual help or social assistance, the team will contact the priest or social worker on the parish team. The health team members who do home visiting also talk to groups of residents on practical steps to prevent illness, e.g. vaccination, prevention of worms, importance of prenatal care and so on.

Two more members of the health team keep in touch with physically handicapped people in the neighbourhood, and participate with them in functions organized by the Christian Fraternity of the Handicapped, which is very active in many basic communities.
Political Dimension

The remaining two members of the team are responsible for animating socio-political action to conscientise the people of the district, i.e. to help them analyse existing health problems and to criticise public health problems and to criticise public health services for which they are paying taxes if the services provided are inadequate - These members also collaborate in socio-political action with other teams (e.g. the community's teams on human rights, workers or social assistance) or with diocesan agencies (such as Justice and Peace Commission, Commission for the Defence of Human Rights, etc.) or with secular popular movements (such as residents' associations, trade unions or political parties). Such action might be a petition or protest to a public authority about a particular service, or it might be part of the ongoing protest against the current world economic order which is seen to be a root cause of the poor health chances and the social deprivation of the vast majority of people in the Third World.

At least the above gives a general idea of how the health team in the basic community is meant to work. It may sound all highly organized - and indeed a lot is happening - but let no one think it all runs smoothly! The reality is very untidy, often frustrating, and always falls far short of bridging the wide gap between reasonable health standards and the appalling living and working conditions of this enormous and poor population.

Spiritual Dimension

Another activity of the health teams is arranging periodical special Masses with the Sacrament of the Sick in the basic communities. They do this in collaboration with other teams, e.g. married couples, youth, etc.

The spiritual and practical orientation of the teams is helped by a continual supply of good publications from the Church. Their work is also closely linked with the annual "Campaign for Human Brotherhood" which is launched each Lent at national level by the Conference of Bishops, and which continues throughout the year in various ways.

In 1981 the theme of this Campaign was "Health for All" so obviously health teams were deeply involved in activities associated with it. In 1982 the theme is "Education and Brotherhood." To collaborate in this Campaign the health teams will be working hard to promote the local popular initiatives to improve education in health care. The Lenten Campaign is one of the ways in which together, as a community, we repent of our social sins of neglect, and turn back to God in practical projects aimed at transforming our society into His Kingdom.
SAÚDE PARA TODOS

CAMPAIGN FOR HUMAN BROTHERHOOD

How does this Campaign for Human Brotherhood work in practice – and what are the publications from the Church?

One example is the book of Scripture readings and accompanying song book put out each Lent in relation to a particular theme.

The cover printed here 'Saude para Todos' means 'Health for All.'

One week the theme might be 'water' so the groups reflect on the Old Testament and the Gospel readings, reminding themselves how God gave the people water in the desert in their great need. They themselves may well be in the same situation of having no water supply or a very inadequate one.

So they judge the reality of their life, in relation to the quality of life God wants for His people, and organise suitable action to change the situation. The residents of the area might form themselves into an association; perhaps call on the youth group to help them collect the people's views, and together all the people would decide on what demands they wanted to make to the authorities.
PASTORAL PLANNING

PARISH LEVEL

The parish mentioned here has 100,000 people. There are 14 Basic ecclesial communities – 8 have active health teams, the rest are not quite formed yet. Once every 4 months all members of the health teams come to a Formation Day – for evaluating, planning and developing a deeper understanding of health care as a specific pastoral service.

THE SECTOR

is a very important unit in the structure of the Church in Sao Paulo. It consists of a group of 4 - 6 parishes, each of which is comprised of a number of basic ecclesial communities. The sector provides a lot of support to struggling communities in the early stages of formation, as well as an opportunity for continual collaboration between a group of well-formed communities.

Phyllis is also co-ordinator of the health pastoral in her sector, which is comprised of 6 parishes, or about 43 basic communities. Of these, some 30 communities have active health teams. Every two months Phyllis meets with representatives of these teams. At this meeting they use the "see-judge-act" method of reflection. They look at the overall reality of their district, or at a particular area of need and ask "do the conditions for good health exist – in terms of water, leisure, food, services at the health centre, etc?" They judge this reality in the light of the Gospel, choosing an appropriate text for reflection. Then they decide what action they are called to take in the spirit of the Gospel.

A REGION

In Sao Paulo, a "region" is a division of the Archdiocese cared for by an auxiliary bishop. In Phyllis' region there are 4 sectors, and she is at present trying to respond to her bishop's request to co-ordinate the health-care teams in all the sectors at regional level. It is not easy to find time to do all of this, since she also runs 3 weekly clinics in her own parish, which are still needed in areas where there is no adequate health centre. But we hope the day will come when we can phase out of clinic work.

We've tried to give you an idea of how community health care is inserted into our pastoral work. There is a strong emphasis on prevention of disease and improvement of public health services. But this is not separated from active concern for and response to the needs of the sick in their homes, and action so that the State sees the need to provide adequate facilities for the care of those needing hospitalization.

The health pastoral is a work we MMs in Sao Paulo believe in deeply, but we know it is unlikely that we will see the fruits of our labours in our own day.
TEAM WORK
with TRADITIONAL BIRTH ATTENDANTS

(Continued from LINK 13)

... is material is taken mainly from a report from Calabar, Nigeria and given to me by Dr. E.E. Ekoma who played an important role in it.

Step 4. Training the TBA's

1. Selection of TBA's - No more than 10 TBA's in one course - Those selected should be well enough to participate - The local village leaders and local government should be involved in choosing the TBA's.

2. Incentives during training
   Each TBA - N2.00 per meeting attended.
   No money given to TBA's following completion of training nor is there any salary after training.

3. Presentation of Delivery Kit after training to those who attended at least 10 meetings.

4. Meetings
   (a) Location - the nearest Health Centre
   (b) Schedule - 12 meetings - arrange weekly on a day convenient to all.
   (c) Duration - Not more than one hour - start on time.
   (d) Furniture - Chairs in a circle
   (e) Refreshments - available after meeting.
   (f) Clinical cases - if any are present e.g. prematurity or post partum sepsis, show to TBA's.

Planning the meeting - Plan the day before - write down the most important thing that should be learnt about the topic - Repeat this important point several times at the meeting.
- Avoid medical terms. Always use the local language. - Use stories - use humour and demonstrations - Encourage discussion and avoid lectures. Involve the quieter ones.

5. COURSE OUTLINE

TOPIC 1. ORIENTATION.
   (Welcome - Registration - purpose of programme Discussion of local beliefs and customs).

TOPIC 2. INFECTION.
   (Causes, prevention, practise scrubbing).

TOPIC 3. CARE IN PREGNANCY
   (Role of TBA, diet, referrals, high risk)

TOPIC 4. ANTENATAL CARE IN HEALTH CENTRES
   (Observation of history and palpation)

TOPIC 5. LABOUR
   (Role of TBA's Care in labour. Referrals)

TOPIC 6. DELIVERY ASSISTED BY TBA.
   (Role of TBA. Demonstration of use of Kit).

TOPIC 7. PROBLEMS AT DELIVERY
   (Prolonged labour, malpresentation, cord presentation)

TOPIC 8. NEWBORN AND PLACENTA.
   (Tie and cut cord. Resusitation. P.P.H.)
TOPIC 9. CARE OF MOTHER AFTER BIRTH.
(Role of TBA. Sepsis, home visits)

TOPIC 10. CARE OF INFANT.
(Breast feeding, immunisation, referrals)

TOPIC 11. CHILD SPACING.
(Health benefits - Ovulation Method)

TOPIC 12. REVIEW and FOLLOW UP
(Reporting birth, Refill of supplies, Care of Kits).

SAMPLE OF SOME QUESTIONS AND ANSWERS

TOPIC 3. CARE IN PREGNANCY

Objectives - midwife understands TBA role in pregnancy
- TBA knows common problems and what to do.
- TBA knows which are serious and need referral.

3.1 Q1. What does the TBA do for a woman during pregnancy?
A. The TBA's must answer themselves,
Midwives will learn from the answers,
Do they see women in pregnancy - why?
Where? What advice is given? Does she examine the abdomen?
Does she give local medicines - massage?
Does she use prayers and blessings?

3.2 Q. How can a woman know she is pregnant?
3.3 Q. How do we know when the baby will be born?
3.4 Q. When should a woman avoid heavy work.
A. Last 3 months, because ..............
3.5 Q. Why is good diet important?
3.6 Q. What is a good diet?
3.7 Q. What problems do pregnant women have?
A. List the answers they give - e.g. Nausea, vomiting, fatigue, fainting,
constipation, frequent urination, backache, cramps, abdominal pain,
heart burn, internal heat, fever, swelling and bleeding.

3.8 Q. What can we do for nausea and vomiting?
3.9 Q. What can we do for fatigue and fainting?
3.10 Q. What can we do for constipation?
3.11 Q. What can we do for backache?
3.12 Q. What can we do for fever?
3.13 Q. What can we do for swelling of face, hands and legs?
A. This sickness needs treatment in hospital -
Send the woman to the midwife in the clinic who will advise - or else send to
a nearby hospital.

3.14 Q. What can we do for bleeding?
A. This is serious. Sometimes it stops, sometimes it continues until it kills
the mother. Even the midwife cannot stop this kind of bleeding and she will
send the woman to a doctor in hospital.

TOPIC 7. PROBLEMS AT DELIVERY.

7.1 Q. How long does normal labour last?
A. For the first baby 10 - 16 hours - for others 6 - 12 hours.
Explanation. Some mothers are in labour 2 - 3 days - but this is not normal -
if labour last more than 20 hours something is wrong. If the mother does not
get help the baby may die. How can a TBA arrange to refer such a woman? Why
do some reach hospital too late - How can a woman be transported?

7.2 Q. What is rupture of the womb?
7.3 Q. What are some of the reasons a baby cannot be born?
    A. (1) Baby's head too big.
       (2) Mother's pelvis too narrow.
       (3) Baby's position not normal.
       (4) Mother's womb too tired to contract well.
       (5) Sometimes a full bladder or full bowel.

7.4 Q. What parts of the baby sometimes come first instead of the head?
    A. Legs, buttocks, arm, face, or cord.
       Explanation: If you find one of these parts coming, call the midwife -
        If the legs or buttocks come first, often the baby will be born alive.
        If the arm or cord come first the baby will usually die unless the mother
        can be sent quickly to hospital.

7.5 Q. What should the TBA do if an arm or hand appears first?
    A. Mother will need to be sent to hospital at once.

7.6 Q. What should the TBA do if the cord appears first?
    A. (1) Turn mother on her stomach with a pillow under her pelvis - (use local
        word)
        (2) Send to hospital as quickly as possible
       Explanation: We try to take pressure off the cord so blood can flow. If cord
        has no pulse for some time, the baby is dead.

7.7 Q. What should TBA do when cord is around the neck?

7.8 Q. What should TBA do when buttocks or feet come first?

7.9 Q. Why do hospital doctors deliver a baby by operation?

(If readers are interested LINK can include other T.B.A. Sample questions e.g. or
"Newborn and Placenta" "After Delivery" "Care of Infant".)

Step 5. FOLLOW UP

Ceremonies were organised for the presentation of KITS for those completing the
programme - I was at one of these ceremonies and it really was a celebration. It was
also an opportunity for developing community awareness as the Traditional Rules,
members of local government and the local Hospital Management Committee were there,
as well as all the local midwives and guests - The main objectives of the programme
were explained, and demonstrations were given including how to really scrub your hands,
deliver a cotton wool baby, tie the cord and recognise the separation of the placenta.

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**BOOKS**

- Good News To All. Impressions of the
  Church in Brazil. Drawings p3. are from
  this book - from C.I.I.R. and CAFOD.

- Training of Traditional Birth Attendants,
  Maureen Williams. C.I.I.R.1 Cambridge
  Terrace, London. N.W.1. 4JL.

- Traditional Birth Attendant.
  WHO. 1979. No. 44.

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**OUR UNIQUE PROBLEM!**

Remember them in LINK 11?

"It's impossible to do anything here as
the Government gives no help"

When I hear that one I'll think of what
can be done when there is a real Christ-
ian community

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Sr. Pauline Dean