FOOTSTEPS

No.12 SEPTEMBER 1992 PARTNERSHIP IN HEALTH

Partnership in primary health care

by Isabel Carter

The idea behind primary health care is to move the emphasis away from large institutions with professionally trained people and to share the responsibility for health care with ordinary people. The emphasis is not on curing health problems, but on preventing them. Information about health needs to be shared with everyone. Ordinary people who are helped with clear, simple information can prevent and treat many common health problems in their own homes. In 1978, over 150 governments from around the world signed the Alma Ata Declaration to support primary health care in their own countries.

In this issue we hope to open a discussion on how to encourage community based primary health care. We hope also to raise the difficult question of how primary health services should be paid for. Should community health workers (CHWs) be paid, and if so, how much and by whom?

Some primary health work appears to be very successful and involves the participation of the community in all sorts of ways. But other projects are split by problems with leadership, problems over funding, allegations of corruption or community health workers who refuse to work because they are not paid enough.

How can we encourage primary health care which really involves the community, which does not depend on outside funding to continue, and which brings self awareness and dignity to those involved? What part does our Christian motivation play in these matters? These are huge issues, but we can **begin** to look at some of the answers. We hope that the points raised will be helpful and thought provoking in your own work. While established projects cannot begin all over again, it is always possible to change the emphasis within health work.

IN THIS ISSUE

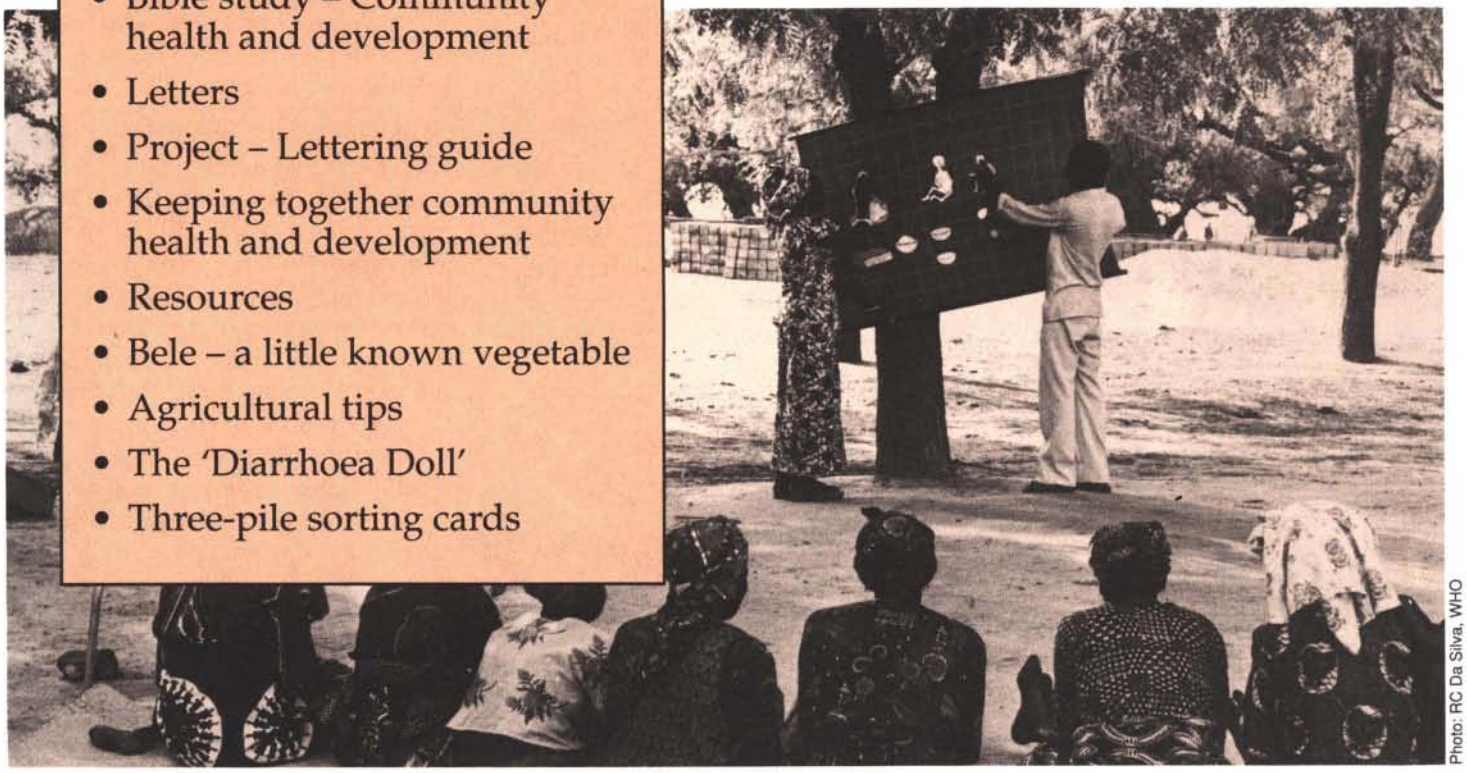


Photo: RC Da Silva, WHO

Primary health care shares the responsibility for health care with the community.

FOOTSTEPS

Footsteps is a quarterly paper linking health and development workers worldwide. Tear Fund, publisher of *Footsteps*, hopes that it will provide the stimulus of new ideas and enthusiasm. It is a way of encouraging Christians of all nations as they work together towards creating wholeness in our communities.

Footsteps is free of charge to individuals working to promote health and development. It is available in English, French and Spanish. Donations are welcomed.

Readers are invited to contribute views, articles, letters and photos.

Editor: Isabel Carter
83 Market Place, South Cave, Brough, N Humberside, HU15 2AS, UK.

Editorial Committee:
Jerry Adams, Revd David Applin, Dr Ann Ashworth, Mike Carter, Richard Franceys, George Goddard, Sue Hanley, Dr Ted Lankester, Sandra Michie, Nigel Poole, Jim Rowland, Muriel Scott, José Smith, John Wibberley

Illustrator: Rod Mill

Design: Wingfinger Graphics, Leeds

Translation:
Alison Coz, Totoya Dew, Helen Machin, Nicole Mauriange

Mailing List:
Write, stating preferred language, to: Footsteps Mailing List, Tear Fund, 100 Church Road, Teddington, Middlesex, TW11 8QE, UK. Tel: 081 977 9144

Published by Tear Fund. A company limited by guarantee. Regd in England No 994339. Regd Charity No 265464.

TEAR FUND
CHRISTIAN CONCERN IN A WORLD OF NEED

Case studies

These examples give some idea of the variety of approaches in primary health care, looking in particular at the selection and training of community health workers, community involvement and funding.

With many thanks to those who helped provide this information.

GAHINI COMMUNITY HEALTH PROJECT, RWANDA

CHWs	The CHWs receive an initial three week training based at the local hospital, followed by one day refresher courses every two months. The CHWs are not paid, but their families have free medical care. They are also excused the one morning a week of obligatory community service.
Community	The community selects the CHWs. They are regarded with respect, though people are often reluctant to follow their advice. In this area, people are not grouped into villages, so there is very little sense of community. Also, the CHW tends to be seen as belonging to the hospital, not to the community.
Funding	The project is very dependent on outside funding, from one overseas donor.
Other	We try to discuss situations together encouraging the CHWs and community to identify their problems and priorities and to seek their own solutions. This can be a slow and frustrating process, but will help the community to become gradually less dependent on foreign aid.

Developing partnership

Primary health care is often only thought of in medical terms. However, the key to successful community based health care is to work in partnership with the community. This, an often revolutionary aim, is too often neglected.

As health workers, our chief task is to enable communities to set up and manage their own health programmes. When health care is provided through large curative institutions, funded by the government and other agencies and dominated by doctors, people come to expect things to be given **to** them and done **for** them. However, our aim should be to promote health care **with** the people, not to provide medical care **for** them.

Partnership will bring dignity to the poor. People soon realise that they no longer need others to do things for them, or give things to them. They come to see that they can do things and obtain things for themselves. This new self-reliance gives a sense of value and worth. The ASHA project in India has transformed the lives of many of the women training as CHWs. They have developed a sense of self-reliance, determination and power – realising that together they can make real changes in their communities. Partnership means that equipment is better looked after. When people feel it is **their** clinic, **their** forestry plantation, **their** water pump, they will take pride in looking after it.

A discussion group is usually a good way of preparing the community.

PREM SEWA HOSPITAL, UTRAULA, INDIA

CHWs	Training of CHWs is linked to the hospital. Training is given by Field Supervisors, who then supervise the CHWs in the community.
Community	Meetings to discuss development are poorly attended. The lack of support is very discouraging.
Funding	It is hard to encourage any financial support of the health work which will be vital when the present five year overseas funding finishes.
Other	The village health work is a recent development. People are used to the services provided by the hospital and it is very hard to change their outlook.

ADIOKOR RURAL CLINIC, GHANA

CHWs	Traditional Birth Attendants (TBAs) and most CHWs do not receive salaries. It has been taken for granted, particularly by Christians, that this work is sacrificial.
Community	There is good community support of our health workers. They are selected and paid for by the community members themselves. People regard them very highly within the community. Many of the health workers, especially the dedicated Christians, receive a lot of gifts from the community to supplement their income.
Funding	Training is provided by the Government. We receive funding from some overseas agencies as well as the Government and community.
Other	The local churches often invite our CHWs to give health talks and organise meetings.

BURTIBANG COMMUNITY HEALTH PROJECT, NEPAL

CHWs	They are selected by Village Service Committees. Training is usually done in the villages. If training is given at the offices, then an allowance is paid due to the walking distances involved. After training, the CHWs are provided with an initial stock of medicines and basic instruments. They are supposed to charge a small fee when treating patients.
Community	The community values the work of the CHWs. Improvements in health are linked with the provision of clean drinking water, improved diet through animal health and agriculture, and literacy. Government basic health staff also receive our training.
Funding	This is all provided by three overseas agencies.
Other	The local church has no involvement with the work. Health is not seen as a priority here. Also, people in Nepal expect health services to be free of cost, since this has been Government policy. To change these attitudes will take time and effort. I believe there is money available, even in the poor communities, since a lot of money goes to the witch doctors.

CHANDRAGHONA CHRISTIAN HOSPITAL, BANGLADESH

CHWs	Health workers are selected by the local committee. Training is mostly provided by one expatriate trainer (with 17 years experience and well accepted by the community) with some help from visiting specialists in the hospital. A training session of one or two days is held every six months. The CHWs are paid a wage.
Community	The health care work is well established and appreciated by the community. Clean water and sanitation, literacy work with women and income generation have been part of the work.
Funding	No financial support is given by the community. Funding and training is provided by four overseas agencies. Local income is raised through our income generating scheme, fees at Under Fives clinics and also the sale of locally produced health books.
Other	The work is based in the hospital and most staff are Christians, though not all the health workers.

Preparing ourselves

We will never work in genuine partnership unless our own minds and attitudes are carefully prepared. We will need to be…

- Really committed to the idea of participation.
- Ready to share knowledge and skills at every opportunity. All too often a project may depend too much on the skills and energy of one person. If only one person can do certain tasks, then it is time to pass on those skills.
- Flexible – being prepared for mistakes, delays and experiments.
- Ready to trust others.
- Ready to give respect and credit to others. 'Our job is not to be heroes ourselves but to make heroes of other people.'
- Prepared for a long-term commitment as facilitator.
- Willing to give up control and stop being the boss. Aim to pass on leadership and training skills to many people instead of just working alongside one or two individuals.

The biggest block to participation is not the unwillingness of the community. It is the possessive attitude of the health worker wanting to gain credit and keep control.

Preparing the community

Partnership will not just happen if we arrange a few meetings and hope for the best. Like other community health skills, the ability to bring about participation has to be learnt and practised. At the beginning, many of the poorest, neediest and most exploited communities will not be ready to participate.

How can we 'teach' participation?

- By building trust and friendship and by making our aims clear.
- By starting discussion groups. These can consist of interested community members, CHWs, community leaders, etc. A project member can act as facilitator and guide the discussion. Problems will be raised and real causes can be identified. For example, we can use the 'but why' approach:

> 'The child has an infected foot.'
> 'But why?'
> 'She stepped on a thorn.'
> 'But why?'
> 'She has no shoes.'
> 'But why?'
> 'Her father is a landless labourer and cannot afford them.'

  Solutions can be discussed and suggestions can now be followed up. This approach to participation quickly leads on to awareness raising. This is an essential part of community development and is a valuable tool in community health.
- By arranging visits to other projects. 'Most visions are caught, not taught.'

First steps in partnership

It is helpful for the community first to learn how to take an active part in one main activity. Later this can be extended to others.

A good subject to choose should be seen as a need by the community, should be within reach, and should bring an early, obvious benefit.

For example, one project was able to work with the community in sinking tubewells, so bringing clean drinking water and ridding the community of guinea worm. All were excited and wanted to work together on a further activity.

Other improvements may not be so immediately obvious. The community may fail to notice changes unless they are helped to look back and see how much things have improved since they started. We must teach the community to evaluate progress in terms of real changes.

Avoiding the pitfalls

Common ones include...

- **Partnership is in name but not in practice.** Participation may seem to be present; community members join in, but more as workers than as partners – more on the project's terms than on their own terms.
- **Partnership fades away.** We may originally aim for genuine community partnership. When the health committee chairman runs off with the funds, we may quickly change our minds!! We must keep encouraging participation even when problems arise and we are tempted to retake control.
- **Partnership may lead to division.** The process of partnership may get out of control. Issues raised may be so strong that they split and destroy communities.

Participation is a powerful process. Carried forward correctly it can help the poor, include the rich and benefit the community. Handled wrongly, it can leave a community wounded and unstable.

Supporting the community health worker

When first trained, the CHWs will rely heavily on the health team and the supervisor. The community may not believe in them, their families may mis-understand them; they may scarcely believe in themselves. They will need back-up and regular meetings with the other CHWs to encourage them, and to see that others are facing similar situations.

The village health committee is a vital part of the support for a CHW. The committee should be made up of committed, responsible villagers who have a concern for the poorer members of the community. Members should be encouraged and receive training for their role.

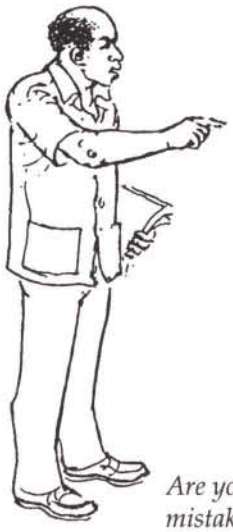
As they gain in maturity and knowledge, the CHWs will learn self-dependence and outside support will be less necessary. They will receive more of their encouragement from the community and their own sense of self-worth.

Should a CHW be paid?

This is one of the hardest questions to answer in community based health care. Arguments over CHW salaries are one of the commonest causes of failure in primary health work.

Wherever possible we should aim to set up CHW programmes in partnership with the community where CHWs are unpaid. This may be possible under the following circumstances:

- Where CHWs work a maximum of two days a week, ideally less. This means each CHW will be able to care for 100 families or less.
- Where CHWs possess a strong sense of social or religious motivation.
- Where CHWs receive their support and encouragement in ways other than through payment. Job satisfaction and the appreciation of the community are common examples.



Are you prepared for mistakes and delays?

- Where at the start of the programme, everyone understands that payments will not be provided and that CHWs will work out of service to their community.

It needs to be made clear that appointment as a CHW is not a path to fame and fortune either for the CHW or their family!

If payment does appear to be essential, there are various methods that can be used.

- **Payment through a health committee** is very useful if this can be organised. Ideally the community so values their CHW that they are willing to pay them and are able to work out a fair and efficient way of collecting and paying out the money. But the CHW must be mature, motivated, trained and honest!
- **Payment for treatment** from each patient as they are treated. This can work well, but the main drawback is that fees are often based on medicine used. This conflicts with one of the main roles of the CHW – to help improve the health of the community so that illnesses become less common and medicines become less necessary.
- **The Government** may provide funds, but may also wish to exercise control over the project. Government funds should ideally be channelled through the project or health committee.
- **Outside funding agencies** may seem the simplest or, indeed, the only solution at first. But once outside funding begins, people's expectations may rapidly increase.

Don't start paying salaries that cannot be maintained. The world has too many CHWs who were well paid at the start and have now stopped working because the project has run out of money. It is better for CHWs to start receiving no wages or low wages that can continue, rather than high wages that have to be stopped.

In conclusion, community involvement seems to be the basis of almost every successful, long-term health programme.

Genuine partnership will make a project permanent. If people themselves learn to change wrong health patterns and adopt correct ones, then when the experts leave and the funding stops, their health will be permanently improved.

This article was compiled by Isabel Carter, based largely on material from Dr Ted Lankester's new book 'Setting Up Community Health Programmes' (which will be reviewed in the next issue). We would welcome letters which continue the discussion on these issues.

BIBLE STUDY

Our approach to community health and development

by Stan Rowland

Many Christian groups are concerned with meeting either **spiritual** needs or **physical** needs.

What are our priorities as Christians? What can we learn from the Bible on this subject?

What were Jesus' priorities?

Read Luke 4:18–20. Here Jesus, for the first time, introduces why he came. This was also written about in Isaiah 61:1–2, hundreds of years before the birth of Jesus. What are the reasons which Jesus gives for his coming? Are they more to do with people's spiritual needs, or their physical needs – or both?

What are our priorities?

Christian community development must be based on what Jesus said and did.

Read Luke 10:27. How are we to love God? What does it mean to love our neighbours as ourselves? Are we truly concerned with their welfare, both physical and spiritual?

Jesus was concerned about the whole person. He healed the sick as he preached and taught. We too must share his concern. When Jesus sent out his twelve disciples to minister to others, he commanded them to heal the sick and to be concerned for the physical needs of others as they preached the good news of Jesus Christ.

How should we put this into action?

Read Matthew 28:19–20. This is known as the 'Great Commission'. It is not optional for us as Christians – it is a command! If we follow this command, all of us who are involved in community health and development also need to be involved in sharing our faith and making disciples.

I believe that social action (through community health and development) and evangelism are intertwined and should not be separated. One without the other is incomplete.

Dr Gordon Moyes at *Amsterdam '83* made the following comparisons:

'Evangelism without social action is irrelevant to human need. Social action without evangelism is flowers without fruit. Together word and deed become the most powerful commitment, relevant and responsible both to our Lord and to our neighbours.'

LETTERS

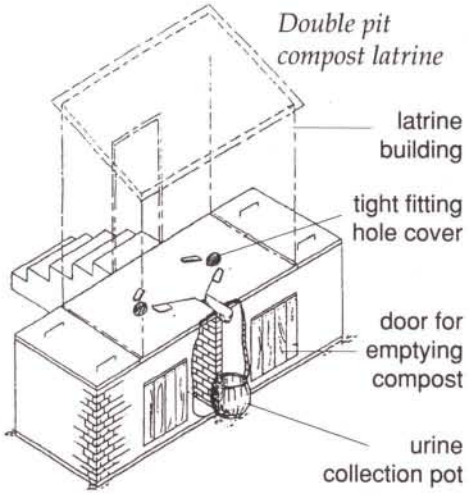
Composting toilets

THE SANITATION GUIDELINES outlined in the December 1991 issue of *Footsteps* give readers a helpful guide to the relevant issues in sanitation. My point is that other toilet systems, like composting, should be included in any survey of sanitation programmes.

A good sanitation system should be pleasant for people to use, prevent pollution and protect public health. A properly designed composting toilet is odourless. It not only contains excreta but processes it into a useful product that is safe to handle and appears much like earth. Added to soil, the compost is an excellent soil conditioner and fertiliser. The composting toilet is an important option for a sanitation programme.

Laura Orlando, ReSource Institute
Massachusetts, USA

THANKS for your wonderful publication – it is informative and relevant. I appreciated your nearly full edition on the latrine. A different approach to sanitation is needed almost everywhere, as water over-use and pollution as well as disease are growing problems.



Double pit compost latrine

We use a composting toilet and would like to make a few suggestions that would add efficiency to the breakdown of waste into a safer and more valuable end product:

- Daily introduction of coarse cellulose (sawdust is best but many other things such as shredded plant material will do). This will lighten the pile and help get oxygen to micro-organisms for aerobic activity.
- Air vents of some sort, perhaps pipes from above.
- Sloped bottom with drain to aid in drawing off excess liquids (this is not necessary in very dry areas).
- Drain near bottom for liquids.
- Access at bottom to poke or turn pile and remove finished product.

I think these changes could be made without adding too much cost and would be worthwhile. I could send more information to anyone interested.

Lee Piche
Box 957, Hillsboro
NH 03244
USA

Richard Franceys comments...

Composting toilets are wonderful things if they are managed correctly. They can produce odourless material that makes an excellent soil conditioner as Laura describes. ***But*** *to do that requires all the extras that Lee describes, including the drains, air vents, bottom access and the regular introduction of vegetable matter. Where people are prepared to invest extra time and the money for construction costs, then composting toilets can be recommended. However, experience of projects in several countries has shown that the required management usually does not continue beyond the initial phase of sanitation projects. Studies from Vietnam, the country where they have been used most commonly, show serious levels of infection resulting from early use of the material as fertiliser before it has fully composted.*

Striga control

I WISH TO COMMENT on the article about striga control in Issue No 9. Although it is not common here, I became involved in the fight to control it through the cultivation of sunnhemp (*Crotolaria ochroleuca*). Some years ago a missionary priest near Tabora, where striga is very common, discovered that sunnhemp will kill striga completely. He ordered huge quantities of sunnhemp seed that was used successfully in that area.

In addition, we have developed alley-cropping with sunnhemp; this is very simple. When the field is ploughed and sowed with maize or sorghum, sunnhemp is sown all over the field (10 kilos mixed with 20 kilos of sand per acre).

At the time of weeding, sunnhemp is left standing in every third row without minding that it will kill the maize. After seven or eight months, the sunnhemp seeds are harvested and the dry stems are placed in the furrows and buried. Sunnhemp is a legume and adds nutrients to the soil. It provides good soil cover and prevents weed growth. Continue this process in the following years and you will have sustainable agriculture free from striga.

If you would like more information on sunnhemp, please request material. Alley cropping with sunnhemp is the agriculture of the future for the tropics.

Father Gerald Rupper
St Benedict's Abbey
P O Peramiho
Tanzania, E Africa

Local treatment for whitlow

THANK YOU for the newspaper *Footsteps*. It helps me a lot in my work and it contains much to share with others. I was interested to read about the neem treatment. It is good to hear about different local treatments.

It happened that one of my village health workers told me about a local treatment for whitlow (an abscess on the finger) that he had found successful. Until now we treated this painful infection with expensive antibiotics and ointment, but often these are either not available or they are too expensive to use.

- *Grind together 1 small onion and ⅛ cup salt.*
- *Mix together with ½ cup of cooked corn dough (cooked to a firm consistency).*
- *Apply this paste to the whitlow several times a day and repeat for 3 to 5 days.*

I hope some of your readers may find this helpful.

From a village health worker in Ghana (name withheld).

Dr Ted Lankester adds...

If available, the normal medical treatment of lancing and antibiotics is still the best to use for the treatment of whitlows. This poultice is a useful addition.

Traditional labour treatment

MANY OF THE POINTS concerning this *Knotty Problem* in Issue No 7, concerning Anaustasia who suffered a ruptured uterus following treatment from a local medicine man, have already been looked at.

It is important that the whole community is taught about health matters. People will then learn the dangers of combining hospital treatment and native medicine. It is important that husbands as well as wives should be educated. In some cases, the wife will reject native treatment but her husband may order it. Mothers-in-law need to be taught not to interfere with their daughters-in-law's hospital treatment.

It would be very helpful for antenatal waiting rooms to be built near hospitals for pregnant mothers likely to have complications. These mothers could then stay near the hospital when the time of birth approaches. Most mothers resort to native treatment because of lack of transport and bad roads. Local medicine men can be educated and taught about correct dosages. Many have improved through this method.

The root that caused such strong contractions should be researched. Something good will come out of it in the future.

Mrs E M I Nwachukwu
Matron – Sick Bay, Okigwe
Imo State, Nigeria

Valuable lessons

I WISH TO CONGRATULATE YOU and your organisation on the the production of *Footsteps*. This paper has always reached us through your kind contributions and it is a very handy paper for us who are community development workers. We use the articles as teaching lessons to community members.

So far we have trained them on building ferro-cement tanks and tree nursery establishment. We use the Bible study greatly to relate to the lessons taught. We are are very thankful for your help.

Hellen Yego, Diocese of Eldoret, Kenya

AIDS, famine and war

THANK YOU for sending us *Pas à Pas* (the French version of *Footsteps*). We have welcomed it and read it with enthusiasm and great interest and hope that it will be a way of encouraging our women's Christian group.

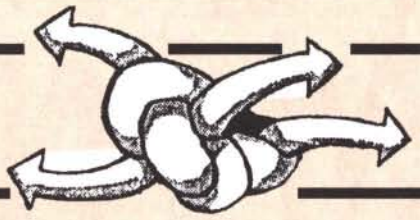
Certain articles such as 'Our Christian response to AIDS', the Bible studies, 'Soil fertility' and 'Gardening for better nutrition' have further encouraged us to work together to create a spirit of harmony and community development.

Pas à Pas has awakened us, especially in these critical times when AIDS, famine and war are raging in our society. It is in this sense that we have studied very carefully the Bible study of Peter Batchelor in Issue No 7 on the theme 'What is our responsibility before God and before our neighbours?' What is our responsibility for our brothers and sisters who are in despair because of the length of the war, the increase in stealing and young vagrants, mines everywhere, increased famine, the inability of doctors to cure AIDS and the lack of aid. What is our role?

Our group tries to help materially with our limited means, but also spiritually by giving encouragement to people and helping them understand that Gods' supernatural intervention begins where that of man ends (Mark 5:25–29).

Mme Nyirandemeye Pauline
Femmes en Action Pour Christ
BP 75, Kibungo, Rwanda

KNOTTY PROBLEMS



The Haunted Well

Mengo Hospital, near Kampala, have recently identified three wells in nearby villages, that they would like to 'protect'. These are 15 feet or so in diameter and look like stagnant ponds, although they are fed by underwater springs. They provide the only source of water for many local people, but are constantly being polluted by animals and humans.

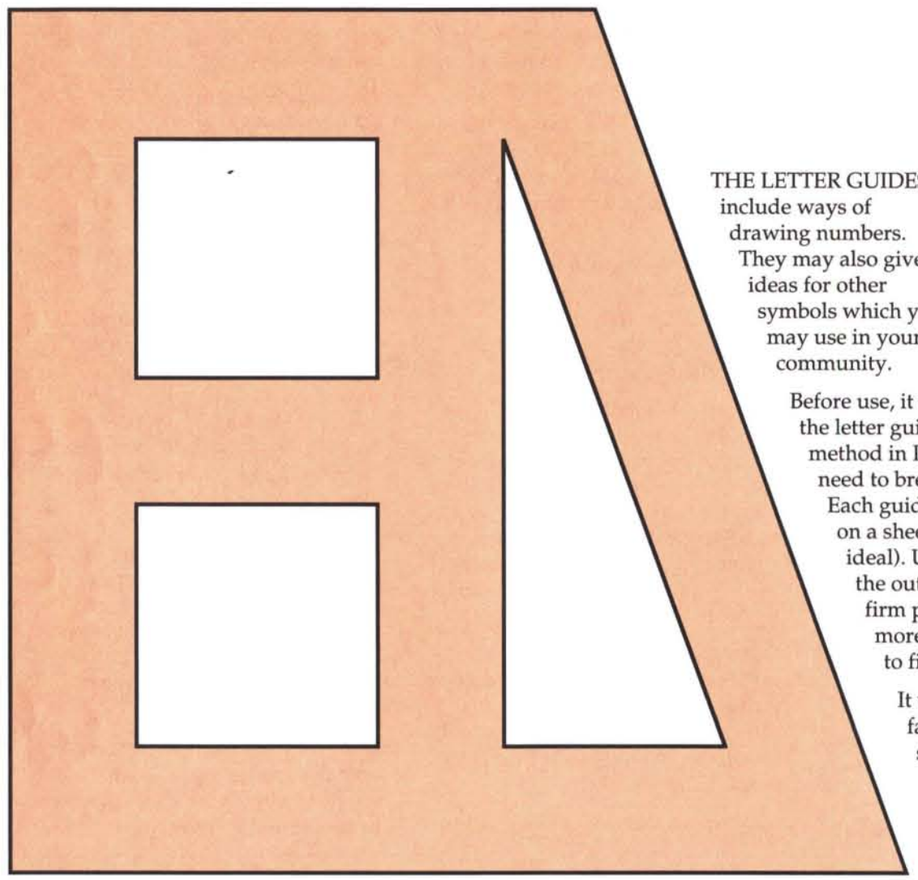
By covering the wells, the water would be kept free of pollution and clean water could be obtained by a pipe. This would immediately help to improve the health of those who use the water.

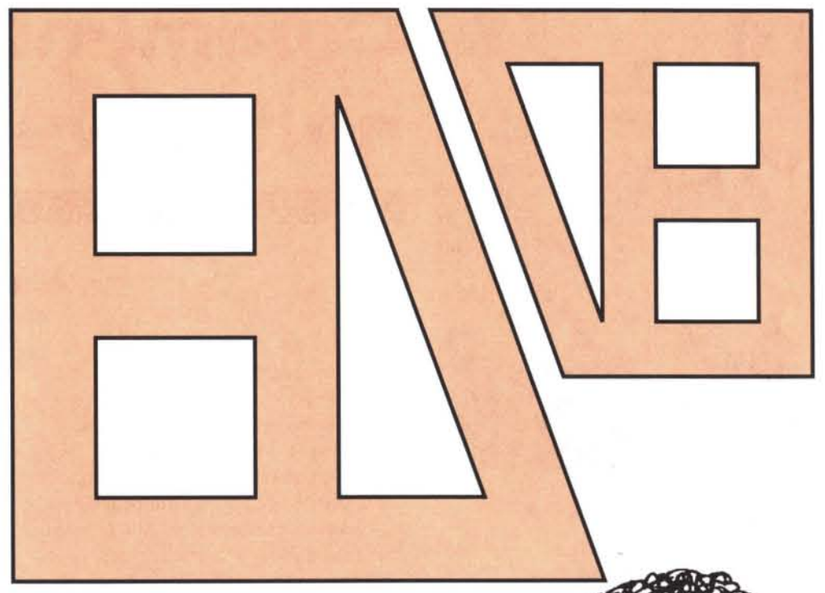
However the local people believe that the wells are haunted! A creature, apparently half man and half fish, comes at night and has indicated that any interference with the wells will lead to them drying up.

Can any readers help with ideas to solve this problem and help these communities – people whose fear of the spirit world makes them drink dirty water instead of the clear, clean water that has been offered to them?

LETTERING GUIDE FOR POSTERS

IN *FOOTSTEPS NO 8*, we looked at some ideas for producing illustrations which could be used as posters. Here is a simple idea for producing lettering for posters or banners. These are outlines of lettering guides. They will give a neat and uniform result which can be easily achieved by anyone with a little practice. They will usually be much better and easier to read than letters drawn free-hand.





THE LETTER GUIDES include ways of drawing numbers. They may also give ideas for other symbols which you may use in your community.

Before use, it would be helpful to photocopy the letter guides (or copy them using the method in Issue No 8) so that you do not need to break up your copy of *Footsteps*. Each guide should then be glued down on a sheet of thin card (waxed card is ideal). Use a sharp knife to cut around the outlines. If available, sheets of firm plastic would give an even more permanent guide. Experiment to find the right material.

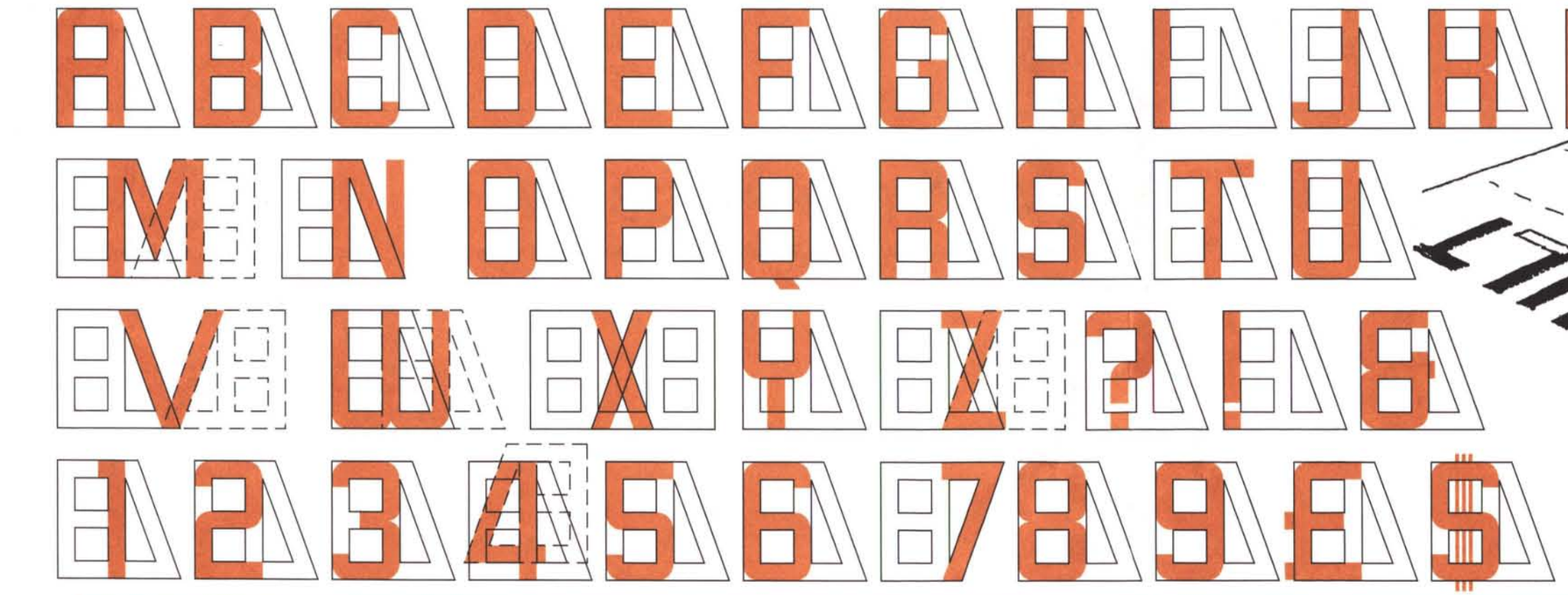
It would be helpful to draw in faint lines across the poster to show where you want to place the letters. Use these lines as markers when placing the letter guides. Draw the outline of the letters required with pencil or charcoal. You can then fill in the outlines and round off the corners using a more permanent marker – coloured pens, ink or paint.

If even larger letters are required, simply measure all the sides of the letter guide and multiply the measurements by 2 or 3.

When dotted lines are shown, it means that the letter guide has to be moved to a second position in order to complete the letter.

You will get a better result if you use the same distance in between each letter. Try this out. As a rough guide, the width of one of the vertical strokes in the letter guide would probably give good results. However, when the letter L is followed by T,V or Y you will need to reduce the spacing to avoid an ugly gap in the word. (Look at the word 'BUILT' in the illustration below.)

Again, try and use the same distance in between each word – the width of the letter A would probably be about right.



The information is adapted with kind permission of BASICS – produced by Rural Communications, Somerset.

Community health and development:

AN INTEGRATED APPROACH

by Stan Rowland

MANY CHRISTIAN organisations are concerned with meeting either people's spiritual needs or their physical needs. Too often, Christians separate the needs of people.

Some church groups feel that they solve the problem by developing two parallel ministries using different people: an evangelist will minister spiritually, while a nurse or agriculturalist helps physically. However, to follow God's command (see Bible study on page 5), Christians should not separate the spiritual ministry from the practical and physical help that they give.

A few Christian organisations understand this and develop an **integrated** ministry. This is where one person has both a spiritual and practical ministry to those around.

We are told in 2 Timothy 2:2 to find faithful people whom we can teach who, in turn, will teach others. For lasting change, we need to meet the physical and spiritual needs of people in such a way that the process will be shared, multiplied and will be ongoing.

These principles are used in the work of LIFE Ministries in many countries throughout Africa, in the training of health workers.

God is in the business of changing lives. True and lasting development cannot take place unless individual lives are transformed. Our Christian community health work is therefore concerned with individuals whose lives are changed and who are involved in changing others' lives. **We measure success, not with projects, but with people putting what they have learnt into practice and then teaching others.** We believe that the basis for all health care should be a blend of curative and preventative care balanced with biblical instruction.

Community health evangelism

How can we begin to establish an integrated physical and spiritual ministry? LIFE Ministry in Africa has developed the training of community health evangelists (CHEs). This is a Christian community health programme that is concerned with individuals whose lives are changed and who are involved in changing others' lives.

On the page opposite are some of the key stages we use in establishing community health evangelism in an area.

Our results

By January 1992 Medical Ambassadors and LIFE Ministry had 39 projects, having trained over 1,500 CHEs in 13 African countries. Since 1984 we have worked with over 160 other African Christian groups, sharing the principles of community health evangelism so that they could integrate these principles into their work. They in turn have trained over 10,000 CHEs in many African countries.

As an example, let us look at the work in Buhugu, Uganda. The twelve people chosen by the community here to undergo training have been very effective in passing on their training and beliefs.

Local trainees and workers from the ten villages involved in the Buhugu project have protected 40 springs and built a 13 km gravity-feed water system that provides clean water for more than 10,000 people. The incidence of measles in the area has been reduced by 40% and deaths due to diarrhoea have been reduced by 30%.

Several individual projects have also been successfully carried out by groups within the community. These include bee-keeping, seedling tree nurseries, ponds for fish raising and improvements in many home garden plots.

Conclusion

We have found that it is easy to say, 'Let us have a programme that combines both physical and spiritual truths.' However, careful planning is needed to put this into practice.

It is important to spend as much time in discipleship as in physical subjects. This shows that both are equally important. If we are not careful, CHEs may spend all their time meeting physical needs, which are so visible. This is the main reason why we do not

True and lasting development cannot take place unless individual lives are transformed.

encourage CHEs to be involved in curative medicine, as it takes up so much of their time and resources.

Community health evangelism needs to be thought about, talked about, planned, practised, expected and evaluated if it is really to take place.

Some of the material in this article is adapted from Stan Rowland's book on community health evangelism which is reviewed on page 12.

Phase 1 INITIATION

Up to a year should to be allowed for this phase. This will depend on whether the training team is made up of local people or of outsiders.

STEP 1
Get to know the area and the health needs and resources.

STEP 2
Meet with government and church leaders in the most likely areas, to discuss their needs and resources. The aim is to begin in areas that are likely to succeed, not necessarily in areas of greatest need.

STEP 3
Choose the area in which to begin. Work with the local chief to organise a large community meeting. Help the community to identify their problems and needs and encourage discussion about ways of solving these problems.

At follow-up meetings, discuss ways of solving one or two of their most important problems. Discuss ways in which an outside team could help as well as the role of the community and the team. The community then chooses a community health committee with 25% – 30% of its members from the supporting church.

Phase 2 TRAINING

The length of this phase will vary greatly. We believe that the key to success is for the programme to be community based, and for the community leaders – the committee – to first receive training.

The training of the community health committee is as important as the training of the health workers.

STEP 1
Train the committee members. Help the committee to finalise its members, make plans and organise the community. They need to work out the expected roles of the community health evangelists and then choose a team of CHE volunteers – which the team will train.

They also need to identify the main health concerns of their own area – which will form the basis of the training.

STEP 2
The training of the CHEs begins with a community survey to discover the main needs. Training is given in spiritual truths and then in the identified problem areas. Initial training takes between 30 to 50 days and can be arranged as convenient. Each training day includes one physical and one spiritual subject. Home visits are begun early on during the training. Local churches are encouraged with discipleship training to be prepared to welcome new members. After completion of training, the CHEs are officially commissioned by the community.

Phase 3 EVALUATION

Many projects consider their programmes complete at the end of Phase 2, but we believe that the evaluation of the programme is very important.

STEP 1
Continue training the CHEs for two or three days each month for a further year and then four times a year afterwards. Evaluate their progress with them. The committee and community should choose a second team of CHE volunteers to receive training.

STEP 2
Select CHEs to be trained as trainers and to begin training programmes on their own. Continue training until a ratio of one CHE for every 50 to 75 families is reached. The original training team will move to a new area, while the local teams continue their expansion into neighbouring areas.

Stan Rowland has a business background in marketing and the development of new medical products. He spent 13 years with Campus Crusade for Christ (LIFE Ministry) in Africa, working in management and giving training in community health. Here he developed the concept of 'community health evangelism'. He is now Director of Community Health Evangelism for Medical Ambassadors International in the USA.

Community health evangelism trains people who train others how to live a healthy physical and spiritual life.

TALC has recently brought out two new developments which would be very helpful to community health workers...

TALC Baby

This consists of a large (A3) sheet of paper with the drawing of a mother's pelvis and of a baby. The sheet is glued onto a large sheet of paper and then carefully cut out. The head of the baby is then connected to its body with a paper clip in such a way that it will rotate freely. This model can play an important part in helping TBAs, midwives and other workers to understand the birth process. Single copies are available free of charge in English, Spanish and Portuguese if other books or materials are being ordered. Otherwise a contribution of 50p ($1) is requested to cover postage.

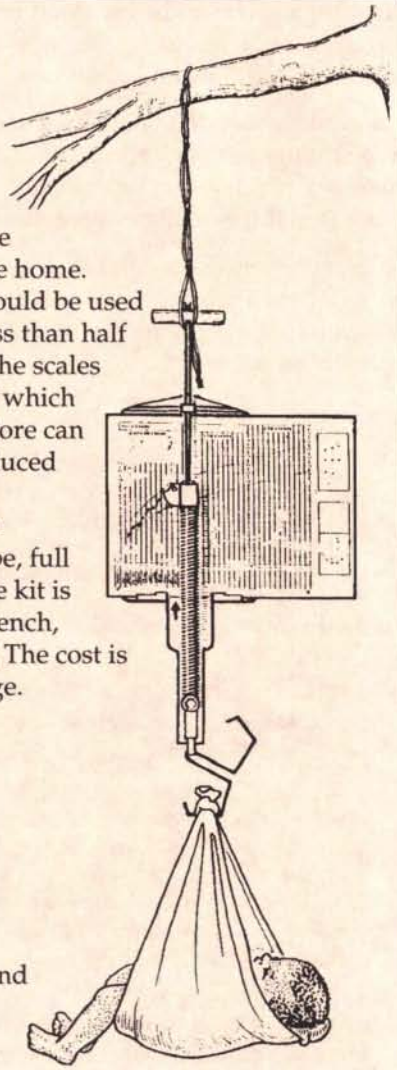
TALC Direct Recording Scale

This scale is designed to be used in the home or community. Unlike other scales, the chart is fitted into the scale and the mother herself places the next dot on the child's growth curve. Early experience suggests that mothers are pleased to be involved in doing this. Other members of the family are involved and the baby rarely cries. There is a much greater understanding of the growth curve. As a result, the family often becomes involved in a discussion on how the child's nutrition may be improved.

The scales can be hung from the branch of a tree or a hook in the home. They are strongly made (and could be used to weigh goods, etc) and are less than half the cost of a traditional scale. The scales are used with A4 charts – 30 of which are supplied with the scales. More can be ordered from TALC or produced locally as long as the lines are correctly placed. The scales are supplied with strong nylon rope, full instructions and wall chart. The kit is available in English, Arabic, French, Spanish, Portuguese and Zulu. The cost is £19.50 including surface postage.

Please write to...
TALC
PO Box 49
St Albans
Herts
AL1 4AX
England.

They have many other books and resources.



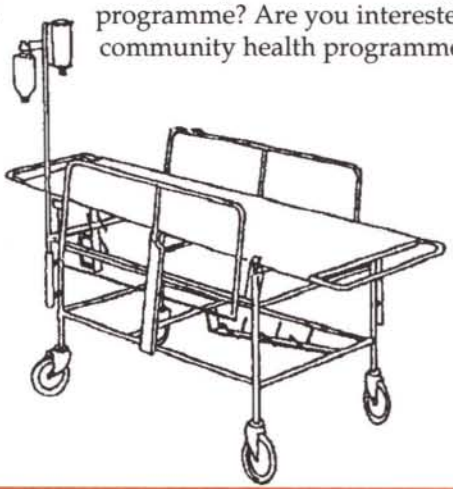
Making Health Care Equipment – Ideas for local design and production

ISBN 1 85339 067 4

This practical book contains illustrated step-by-step instructions for making items such as folding beds, ward screens, wheelchairs and mobility aids. It gives guidelines for adapting the designs for particular circumstances. Ideas and designs are included for laboratory equipment, maternity and child care equipment and many other items of hospital furniture.

Price £7.45 including postage.

Order from...
Sales Office
I T Publications Ltd
103-105 Southampton Row
London
WC1B 4HH
England.



Multiplying Light and Truth: through Community Health Evangelism

by Stan Rowland

Are you concerned that Christian community health programmes are no different from secular ones? Are you interested in integrating evangelism, follow-up and discipleship into a community health programme? Are you interested in a community health programme which lasts after the initial trainers have left the area? If so, this book is for you and gives the background and answers to these questions.

Available for $9.95 from...
Medical Ambassadors International
PO Box 6645
Modesto
CA 95357 – 6645
USA.

Plantation Forestry in the Tropics

by Julian Evans

400 pages
ISBN 0 19 854257 7 (paper covers)

This is a second edition of this forestry manual. It has been thoroughly revised and concentrates much more on small-scale and social forestry issues. The British Government have funded a softback ELBS edition which costs only £6. (Usual softback edition is £30 and hardback £60). This should now be

available in large book shops in many countries or through the British Council.

Teaching Health Care Workers

by Fred Abbatt and Rosemary McMahon

A simply written, well illustrated, detailed guide for the teachers of health care workers. This is available from TALC (address above) for £6.25 including postage.

Courses on health work

The Pan African Institute of Community Health opened at Nyankunde, North Eastern Zaire on 1st June 1992. It has the academic support of the Liverpool School of Tropical Medicine in the UK and will provide training that is aimed at church-related programmes in French-speaking Africa.

Their objectives are to train French-speaking health programme leaders, to research the causes of poor health care and to offer a consultancy service in community health. In addition to basic courses in community health, it is expected to offer diploma, master and doctoral degree courses.

For more details write to...
Pan African Institute of Community Health
PO Box 21285
Nairobi
Kenya.

NEWS

Control of bean weevils

A recent study in Michigan University, USA has found that common bean weevils, which cause much damage and loss of stored food crops, can be controlled in a very simple way. Apparently the larvae of the bean weevils take one or two days to bore their way into a bean seed.

Simply turning sacks of stored beans (and probably other crops) upside down twice a day will prevent nearly all damage. If this is maintained for several weeks virtually all the larvae should either die of exhaustion or be crushed during the moving.

Let us know if you find this successful.

FRENCH NEWSLETTERS

La Lettre du CIPRE

This is a new French newsletter looking at environmental concerns from a Christian viewpoint. The June 1992 issue looks at the implications of the Summit in Rio, what it means to be a Christian environmentalist, women and their environment, methods of mosquito control and urban pollution.

For more details, write to...
Pasteur Jean-Blaise Kenmogne
BP 1256
Bafoussam
Cameroon
W Africa.

Agripromo

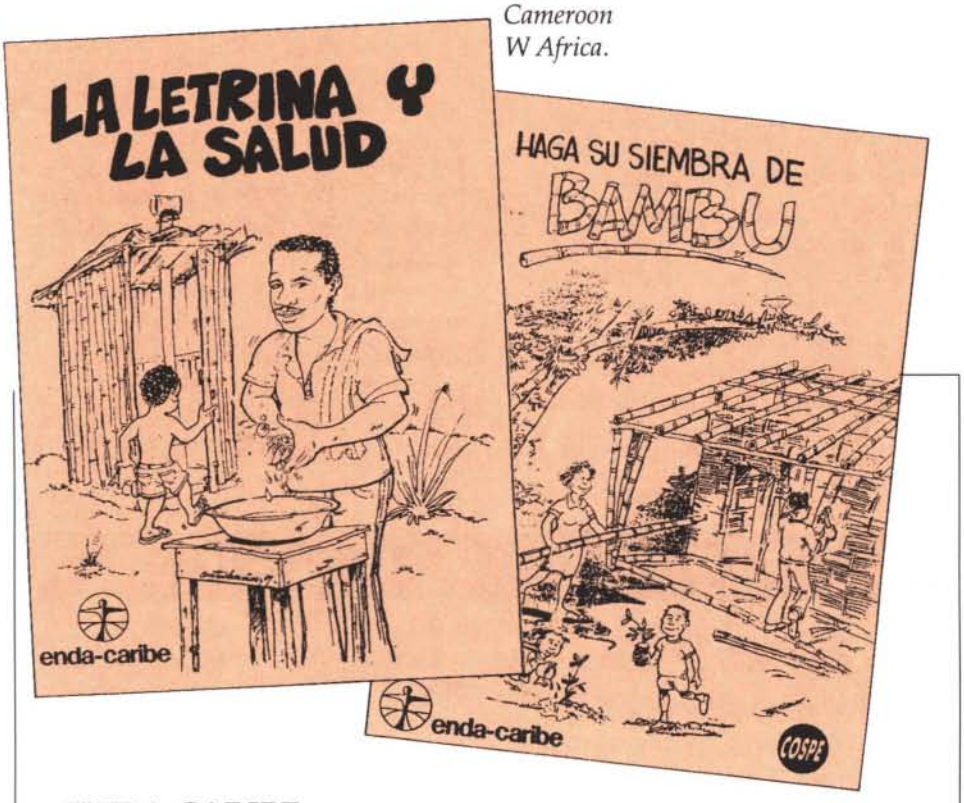
Each issue of this free newsletter looks at a particular development or agricultural issue. It gives practical information of help to farmers.

Write for information to...
Inades Formation
08 B.P. 8 – Abijan 08
15 Av Jean-Mermoz
Ivory Coast.

Communautes Africaines

This free three-monthly newsletter contains articles on agriculture and appropriate technology, with some good practical hints.

Write to...
Revue Trimestrielle Africaine de Formation d'Information et d'Action pour le Developpment
BP 5946
Douala-Akwa
Cameroon
W Africa.



ENDA-CARIBE

This is a group based in the Dominican Republic who produce a range of Spanish booklets and materials to help those working in health and development.

The booklets – all available only in Spanish, are simple, practical and well illustrated. Examples of subjects include: Control of Diarrhoea, Cultivating Bamboo, Building with Bamboo, Clay (Lorena) Stoves, AIDS and Sanitation.

Write for details to...
ENDA-CARIBE
Aptdo 3370
Santo Domingo
Dominican Republic.

Bele – a little known vegetable with huge potential

by Nicky Davison

Bele (*Hibiscus manihot*) – which is also known as slippery cabbage, aibika and sunset hibiscus – is a plant whose leaves are often used in cooking in the South Pacific. Recently it has spread throughout the Pacific and its popularity and many uses could mean it may be useful in other countries.

What makes it so popular? One of the reasons may be that it is so easy to grow. It is propagated by cuttings which are 15 to 30 cm long. The new plant is ready to harvest just 2–3 months after planting. A healthy plant will produce for 1–2 years. The leaves vary in size and shape, depending on the variety. They are very tasty to eat, apart from a slightly slippery texture which some people do not like. Nutritionally they are very rich.

Its high nutritional value may also be responsible for its popularity. The protein content of the leaves is very high – 5%. It also contains high levels of vitamin A, vitamin C and calcium, as well as significant amounts of iron. So it will make a valuable addition to any diet. The World Health Organisation recommends it as a good first vegetable for babies. This is, because the young shoots and leaves contain very little fibre, so it is easy to digest. There are also records from Papua New Guinea which show that bele medicines are used for rashes, constipation, colds and sore throats and childbirth fertility medicines.

Bele can be recognized by its dark shiny leaves and beautiful yellow flowers. It grows 1–1½ m high.

The areas where bele is found are tropical or sub-tropical. It is ideal as a vegetable for home gardens in these areas since it needs very little care – though it does better with some manure and weeding. It produces a high yield – 0.36 tons/hectare/year. It is susceptible to insect damage, but in the home garden, this can be easily overcome by picking the insects off by hand.

A popular recipe for bele is to wrap pieces of fish in bele leaves and cook in coconut cream. Another is to mix bele with mackerel and onions and lightly fry. Almost any vegetable recipe can be adapted to include bele – and it can even be eaten raw in salads.

Are there varieties of this useful plant in your area? Ask your extension officer for advice about how you could obtain cuttings.

If you have problems, try writing to...
Laloki Research Station
PO Box 417, Konedobu
Papua New Guinea.

Nicky Davison sent in this article from Pohnpei, Micronesia where she is encouraging gardening for improved nutrition.

AGRICULTURAL TIPS

Deworming with papaya seeds

by G Arthur Kaye, Ghana

This is a home-made medicine that is used in Ghana against certain internal worms in livestock.

- Cut open a fully ripe papaya and scrape out the seeds.
- Soak them in water to remove the soft covering around the seeds.
- Strain and dry them in the sun until they are very dry.
- Grind the dried seeds into powder and keep in an airtight container.

A teaspoon of this powder in four litres (one gallon) of water, will give protection against roundworms and other worms in livestock and poultry.

Rat control

by Peter Afekoro, Nigeria

Rice farmers in the north of Nigeria have found an easy, low-cost method of rat control. They dig holes around their farms. The holes are 30–40 cm wide and 50–60 cm deep. The farmers fill the bottom of each hole with water. They rub the sides of the holes with a mixture of dry, ground fish and red palm oil which provides an attractive smell around the hole. If these are not available, try some other strong-smelling food.

The smell of the oil mixed with the fish attracts the rats. When they try to eat the food, they fall into the water at the bottom of the hole. They will be trapped in the hole until the farmers get rid of them.

Adapted from DCFRN Notes.

The 'Diarrhoea Doll'!

Jean-Pierre, Toussaint, Patrice and Raphael supervise a group of health workers in Rafai, Central Africa Republic. Their task is to teach how to avoid some diseases. One of the commonest diseases in the area is diarrhoea. To make the teaching more effective, a 'diarrhoea doll' is used! Toussaint tells us how it works...

OUR BODY has been made in a very wonderful way, but if we introduce dirty things into it then it won't function very well anymore. Water is a good example. Often **we can't see** that the water is dirty, but if the water is boiled for long enough, we can see on the sides a grey deposit that is not clean. If this dirt enters the body, it may cause diarrhoea. The diarrhoea, in turn, may cause dehydration and sometimes even death.

The 'diarrhoea doll' is used to show what happens when we replace dirty drinking water with clean boiled water. It also shows the effects of dehydration. This is how you can make the doll:

- Cut the doll shape out of a piece of thin wood. Cut out a hole for the tummy and make two small holes just above this.
- Cut both ends from a small tin (or use a hollow piece of bamboo). Place a clear plastic bag inside the tin and fold the top over the tin. Tie this behind the doll firmly with string, using the two small holes to attach it. Water can then be poured into the doll.
- Make a very small hole in the bottom of the bag to let the water run out and to show the effects of diarrhoea.

You will also need containers of clean water and dirty, muddy water.

The cause of diarrhoea

Pour dirty water into the bag until it bulges like a real baby's tummy, filling up the hole in the doll. Let the water run out of the doll. This shows what happens when a baby gets diarrhoea from dirty water.

If we block the hole at the bottom of the plastic the dirty water stays inside. This is similar to what happens when we give a drug to stop diarrhoea. The dirty water stays inside – which is not good.

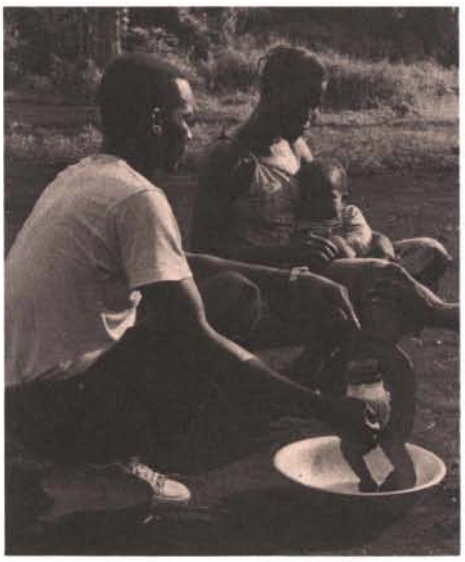
As the dirty water runs out, the bag deflates – the baby becomes dehydrated. The water that is lost through diarrhoea must be replaced or the baby may die. Should it be replaced with dirty or clean water? Encourage people to participate so that they will understand better.

The cure for diarrhoea

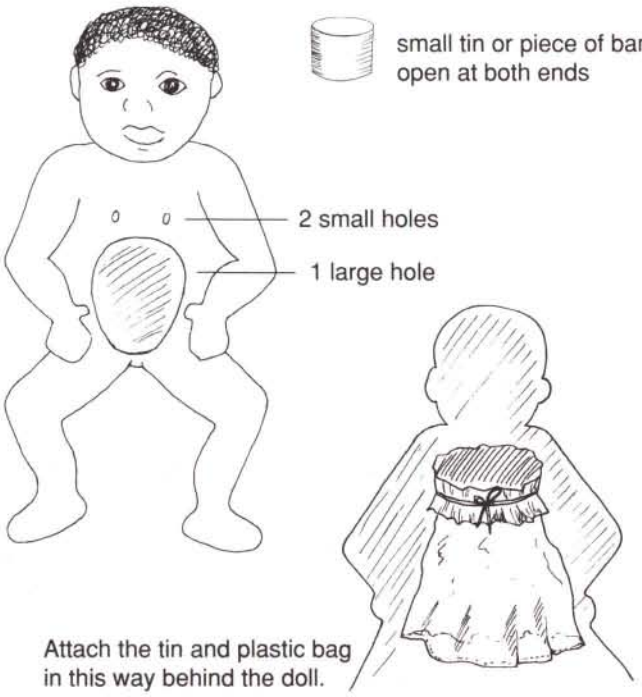
The dirty water must be replaced by the clean water in oral rehydration solution or breast milk. Pour in clean water slowly so that people can see the water inside the baby's stomach becoming cleaner until all the water inside is clean – the diarrhoea has gone.

We teach this in the form of a question and answer system with people to make sure they have really understood. Here in Rafai, people now know how to reduce the dangers of diarrhoea – may God help us now to put it into practice!

Sent in by Marie-Christine Lux, who works for Tear Fund in Rafai, CAR.



Using the doll to teach the dangers of drinking dirty water.



Three-pile sorting cards

THIS IS A VERY USEFUL teaching method which has been developed and used by Kumasi Health Education Unit in Ghana. It encourages community health workers to participate in discussion and to develop self confidence in thinking through the problems and needs of their community. It is also an exercise which will help trainers to assess the understanding and knowledge of their trainees.

Materials

Sets of cards are needed – usually each set has between 15 to 25 cards. Each card has a picture of a scene which could be interpreted as GOOD, BAD or NOT RELEVANT. There are many different subjects which can be used for the cards. For example, we have produced sets on family planning, water and sanitation, immunisation, food hygiene, malaria control and control of diarrhoea. Ideally, an artist could adapt ideas for the cards so that they are appropriate for the local culture and situation. Otherwise pictures could be copied (see article in *Footsteps No 8*) or cut out of newspapers and magazines. It helps if the cards are well made, so that they will last a long time. If possible, they should be covered with plastic. Below are some examples for a set of cards on malaria control.

Method

- Divide the group into small groups of between 4 to 8 participants.
- Give each group a set of cards to study.
- Ask the group members to discuss the content of each picture card and to sort them into three piles: GOOD, BAD or NOT RELEVANT.

Encourage each group to consider their choices carefully and make changes if necessary. It is important that all the group members are happy with the choice of cards in each pile.

The aim is to encourage the group to think carefully about each picture, rather than to place them quickly in piles.

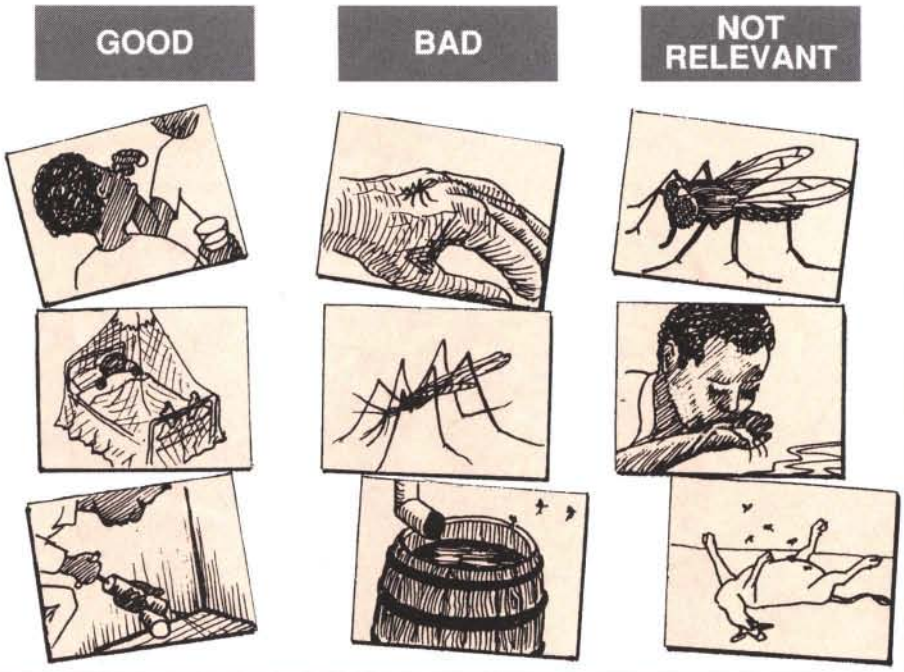
The trainer should make sure that the discussion keeps to the subject area and help with any difficult issues which are raised.

When all groups have finished, the cards in each group are displayed on a flat surface. A short presentation is made by one or two of the participants from each group to explain and, if necessary, defend their choice of cards.

The Kumasi Health Education Project has successfully used this material with teachers, school pupils and community health workers. The adaptations of this material for different subject areas are limitless. The materials have been used in clinics, classrooms, markets, compounds and church groups.

Sent in by...
The Kumasi Health Education Project
PO Box 1916
Kumasi
Ghana
West Africa.

Card set on the control of malaria



Published by
TEAR FUND
CHRISTIAN CONCERN IN A WORLD OF NEED
100 Church Road, Teddington TW11 8QE, UK
Editor: Isabel Carter 83 Market Place, South Cave, Brough, N Humberside, HU15 2AS, UK