FOOTSTEPS

No.37 DECEMBER 1998

SUSTAINABLE HEALTHCARE

FROM THE EDITOR

GOOD, ACCESSIBLE HEALTHCARE is something we all need. Without it many of us would be unlikely to recover from serious diseases, infections or wounds. In an ideal world **everyone** should have access to good, affordable primary healthcare. No government would claim otherwise. However, the reality is often different…

I vividly remember a discussion about healthcare with a group of village elders in Barr Parish, northern Uganda. They told of high charges for healthcare introduced in recent years, of how local clinics had closed, of the cost of transport to Lira and the huge charges payable there for treatment and medicines. One lady turned to me with tears in her eyes, thinking of friends who had suffered and died, and said 'We have no health services now. When our people become sick, all we can do is pray for them. Please tell others how we are suffering.'

This issue looks at ideas to help healthcare become sustainable. Many governments continue to cut back funding for health services, often because of the huge debt repayments they have to make. This means that local healthcare increasingly has to raise funding from local people, who themselves may have very low incomes. In such a desperate situation, the need to share good ideas which have worked in one area becomes more and more important. Both health experts and readers from many countries have contributed good ideas for this issue.

However, health is not just freedom from disease. It concerns wellbeing in all areas of life. Improvements in sanitation, water supplies, nutrition and housing will be reflected in better health in the community. Such improvements can only be achieved by helping people to work out their own priorities and take their own action in tackling poverty.

The case studies in this issue all reflect the need to let people first establish their own health priorities. Several of these studies are from the Democratic Republic of the Congo where recent years have seen huge upheavals – including civil wars, the overthrow of the previous head of state, Mobutu, and huge movements of refugees. With virtually no government funding for healthcare, any health systems able to function well are of considerable interest.

Healthcare is something we all need. Let's work together to improve our own local situation.

Isabel Carter

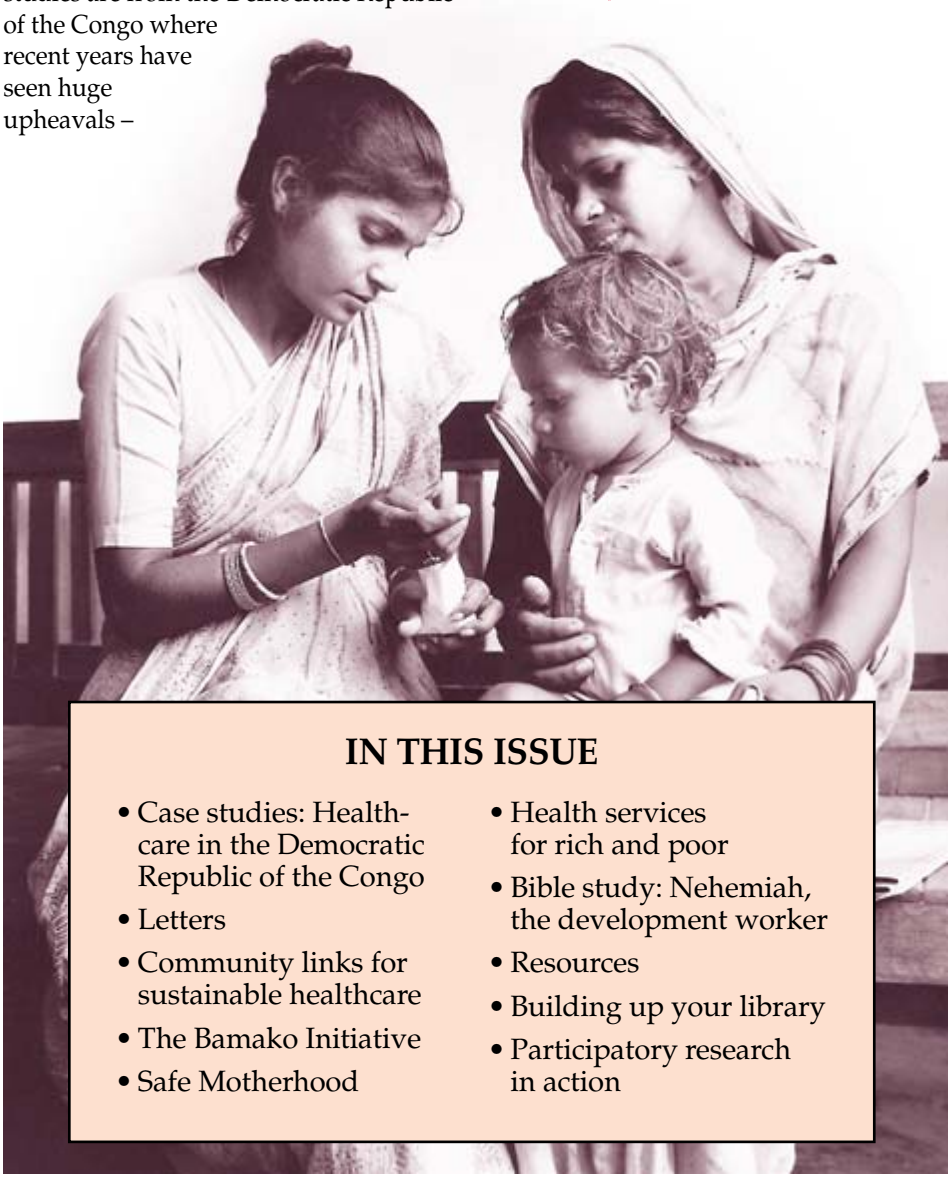

Photo: Mike Webb, Tearfund

IN THIS ISSUE

FOOTSTEPS

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Footsteps is a quarterly paper, linking health and development workers worldwide. Tearfund, 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, Portuguese and Spanish. Donations are welcomed.

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

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The Footsteps Office has moved…

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TEARFUND

CHRISTIAN ACTION WITH THE WORLD'S POOR

Healthcare in the Democratic

Two case studies of health centres – one which inherited a difficult situation and another which is a real success story

by Nyangoma Kabarole

Case Study 1

The Adranga Health Centre

The Adranga Health Centre is in Aru health district. It was built in 1970 with funding from the United Nations High Commission for Refugees (UNHCR) to help Ugandan refugees in Aru. At first this health centre was equipped both in materials and in medical supplies by the UNHCR without any assistance or support from the local population.

After the departure of the UNHCR, this health centre was handed over as a free gift to the community. Unfortunately they had no experience in managing a health centre. Materials and equipment were stolen by uncaring people, leaving the centre in chaos. A health committee was created but it soon ran into difficulties, because people were used to receiving free healthcare and did not want to pay the fees that were now demanded. Local people claimed that because the health centre had been a free gift to the community, healthcare should continue to be free of charge. Finding they were unable to manage this health centre properly, the people handed it over to the Anglican Church.

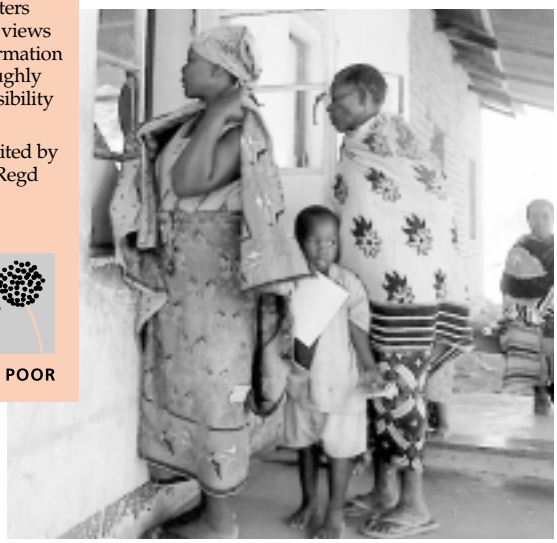


Photo: Mike Webb, Tearfund

To be sustainable, health centres must be valued by the local community.

Two responsible and well educated people from Aru took the responsibility and the initiative of closing down both the Adranga Health Centre and the old health committee and its activities. Instead they elected a new, small committee made up of three local people whose role was…

- to educate the population
- to encourage the spirit of self-financing.

Only once this is done will the Adranga Health Centre reopen with the freedom to evolve and progress.

In conclusion, I believe that the evolution of a successful health centre depends particularly upon…

- the initiative of the local community
- a leader who believes a health centre is necessary, important and valuable for the people
- nurses with training in community health, who know how to work well with the community
- good supervision and advice from experienced medical personnel.

Nyangoma Kabarole is Director of the Medical Service of the Anglican Church in Boga Diocese.

Republic of the Congo

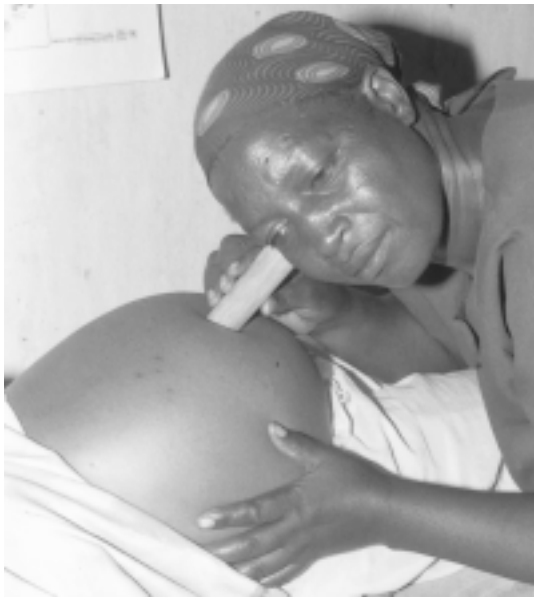


Photo: Ken Pattinson

Case Study 2

The Mabuku Health Centre

Until five years ago, the Mabuku Health Centre in North Kivu province was just another rural health centre, struggling financially and depending on outside funding for major needs. They averaged 5–10 consultations a day, and 20 deliveries a month. Today it is very successful, both with curative care and in reaching out to the population with an effective community health programme.

There are now 25–30 consultations each day, 130–150 deliveries a month and a team of 28 community health workers, locally trained and based in the 14 surrounding villages, as well as a programme for over 100 malnourished children. It is hard to pinpoint the causes exactly, but a combination of factors seem to have come together so that today the busy curative side of the work is now able to support almost fully an expanding community health programme to the 25,000 people in its 'catchment area'.

Factors for change...

- A head nurse with a vision for integrated healthcare, keeping a good balance between the immediate and pressing demands for curative care and the more long-term vision of preventative care and community issues.
- The allocation of a community health nurse (helped by Tearfund), with sole responsibility for getting out into the community and establishing and expanding various community health programmes. This nurse has no responsibility for curative work.
- A population which has real confidence in its nurses because they provide a quality curative service, with the result that people will listen to advice from these same nurses when they give health education or help people explore some of the underlying causes of ill health in their community.
- An active health committee that meets regularly with good representation from all levels of the population. This committee has a certain degree of creativity that has encouraged community involvement (see box).
- Building maternity waiting homes where up to 50 mothers who either live far from the health centre or have 'high risk pregnancies' can wait for delivery.
- Accepting that people who don't have cash, can pay their bills in produce or livestock which is either sold or given as part of staff salaries.
- Some outside assistance from Tearfund was used to establish different nutritional projects in the community. This focused on families with malnourished children. For example, there is a soya bean project which gives practical food demonstrations to mothers and provides seeds for each family with a malnourished child, for planting in their own fields.
- A policy to keep costs down and encourage patients to come to the centre. As prices were reduced, the number of patients increased and so the income increased. As income grew, the centre was able to add another full-time community nurse and to buy a second-hand motor bike for the health staff, particularly to collect vaccines.

More than a dream

All of this has resulted in a high degree of ownership by the population, both of the health centre and the community health programme. When local people finished building a new brick maternity ward (completely on their own and with health centre receipts) they insisted on calling it *Maternité Wetu* (Our Maternity)!

Needless to say, there are still plenty of problems to overcome, but we have been greatly encouraged by this integrated approach and see that a project like this – with well trained community health nurses and an initial helping hand to get it off the ground – can make the word 'sustainability' a bit more of a reality than a dream, even in one of the world's poorest countries.

Compiled by Maggie Crewes, Co-ordinator of North Kivu Medical Service, CAZ Boga, PB 21285, Nairobi, Kenya.

Creative community involvement

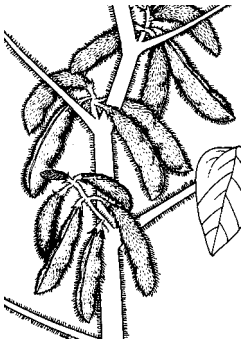
- Each baby born in the Centre is given a set of 'free' clothes which is included in the cost of the delivery. This has been very popular and now more women are coming for delivery. This has reduced the overall cost per delivery. In addition, women at risk of complicated births are now more likely to come to the Centre.
- People who participate in community work (such as carrying stones or sand to help a construction project or water source protection project) are all given a small reduction in their medicine bill. This has maintained a high level of community participation in all the projects.

LETTERS

Market for soya beans

RABEMAR (Research and Action for the Wellbeing of the Rural People) has initiated a project to promote the cultivation of soya beans instead of cotton which has damaging effects on the environment. However we are faced today with a lack of markets for the soya. Our groups produce more than 100 tons of soya beans per year. We are looking for partners either to export the soya beans, or to establish a soya oil press. Any partner able to help us reach our aims would be welcome.

Lucien E Akpinfa
Rabemar
BP 46
Glazoue
Benin Republic



Advice for smokers

I WOULD LIKE TO SHARE with other readers this method of giving up smoking, having experienced it myself in South Africa. Take some seeds of *Ricinus* (castor oil plant) and grind them up. Then leave them for two or three days in the sun. Mix them with tobacco, and then take two or three puffs of it. It makes such an awful smell, that you will never consider smoking again! This is a typical traditional way of dealing with smoking, and I hope it will help those brothers and sisters in Christ who are addicted to smoking and who cannot give it up!

Quenan Crispo
So Said – So Done
Box No 99
Lichinga, Niassa
Mozambique

Generating income for health clinics

I FIND YOUR NEWSLETTER rich in informative and useful articles. Here are a few ideas for raising income for health clinics:

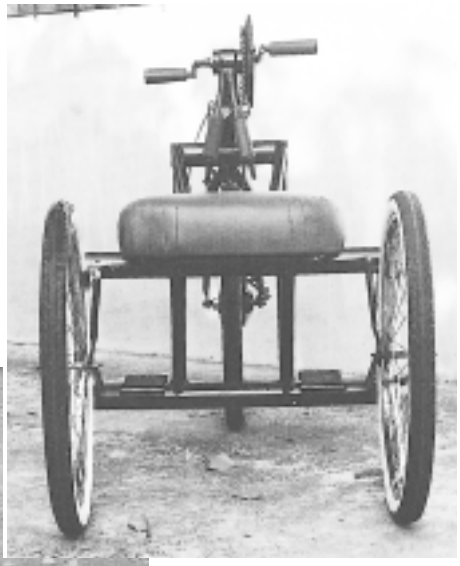
- Use only quality drugs so that patients will have trust in the treatment.
- Develop a specialised service for example in eyecare or providing laboratory services.
- Avoid unnecessary administrators.
- Set up ventures such as canteens, bike repair services or small business centres with telephones and photocopiers.
- Produce small brochures or newsletters to share information about the activities of the health clinic. This may sometimes move a kindly spirited individual to assist the clinic.

Musa Goyol
Mangu Leprosy and Rehabilitation Centre
Church of Christ in Nigeria
PMB 2127
Jos, Plateau State
Nigeria

Tricycle for disabled people

WE HAVE DEVELOPED A TRICYCLE here in Beraca Vocational School in Haiti. This is made by cutting up two old bikes (available very cheaply here) and welding the parts together. The design is lightweight with brakes and gears, so more fun to use than a wheelchair. It is completely hand-powered and can be ridden by anyone who has lost the use of their legs.

It has transformed the life of Benita, who has TB in her legs and was confined to an old wheelchair and dependent on others to push her. Now she can travel alone up to 2 miles even on rough tracks and roads without help.



Benita and her hand-powered, lightweight tricycle.

Andrew Lewis
c/o MFI/UFM Haiti
PO Box 15665
West Palm Beach
FL 33416
USA

EDITOR
If you want to build one of these tricycles and would like full details of the design, please write to the Footsteps *Editor.*

Palm oil soap production

I READ ISSUE 26 and was very interested in the subject of self-financing projects. In my work as a community health nurse I visit many homes. One successful example of a self-financing project I have observed is soap-making. Here is the method they use:

- **Soap-making uses dangerous chemicals. First keep children away and protect your hands with rubber gloves or plastic bags.**
- Weigh 1.5kg of caustic soda.
- Measure 4 litres of cold water and pour into a large plastic or wooden bowl.

- Pour the soda into the water very carefully and allow it to dissolve and cool. **(Be very careful. This mixture can burn the skin – wash off immediately. Avoid breathing the fumes.)**
- Pour 16 litres of palm oil into a pan (22 measures using a standard 720ml bottle) and heat until the oil changes colour from red to yellow or white and then allow to cool.
- Pour the oil very carefully into the caustic soda solution, always stirring in the same direction to avoid splashes, until a thick blue paste forms.
- Pour the paste into a wooden frame (100cm x 65cm x 3cm in height) lined with cloth on a level surface.
- Level off the soap and allow it to harden before cutting into bars (wire is useful).
- Allow to harden for seven days before handling and using.

Nzangya Hussa
Infirmier C S – Boneleko
Communauté Baptiste du Zaire Nord
BP 63
Bangassou
Central African Republic

Rice banks

A MAJOR PROBLEM for our region is that of drought each year between January and June. The region produces enough rice – the main food – to last the year but unfortunately, because of their need for cash, people sell much of what they produce to buy goods and to pay school fees. This means that there is then a period of hunger each year. I plan to establish a rice bank in order to build up a stock of rice which will be available during the time of annual hunger. Rice will be made available as a loan which will then be paid back during harvest time. I would like to receive ideas and advice from readers who have experience with this sort of project.

M Abale A Lucien
BP 36
Niambézaria
S/P de Lakota
Ivory Coast

AIDS testing

I WORK AS A SOCIAL WORKER with a concern for sexual health education in the AIDS Information Centre. We provide teaching about AIDS and carry out tests to check if people have either AIDS or any other sexually transmitted disease. We used to do this free of charge. However, we found that when we began charging a small fee for these tests, many more people began using them. This is because when somebody pays for something, they value it more. Since 1990 we have tested 350,000 people and set up clubs all over Uganda.

Turyatemba B Eddy
Mengo Institute of Technology
PO Box 14060
Kampala
Uganda

Save the planet!

FORMED LONG AGO from craters and volcanoes, over millions of years our planet became covered in greenery and water. But if we 'waste' the fertile covering through our unreasonable economic activities, our planet will once again be without life.

Nohoune Leye
Senegal

Anniversary issue

In 1999 *Footsteps* will celebrate its tenth anniversary. We're planning a special anniversary issue and are looking for short examples of how *Footsteps* has helped in people's work, or helped to change situations. If you can send a short story, with a photo if possible, we'd be pleased to hear from you. Please note that we want practical examples that might inspire others – not just nice comments about *Footsteps!*

GLARP

GLARP – The Latin-American Group for Vocational Rehabilitation – has workshops, symposia and conferences on offer throughout 1999. These cover a number of different disabilities and are held in various countries. For full details, write to Nohora Elena Diaz U, GLARP, Carrera 53 A No. 122-02, Santa Fe de Bogota, Colombia. Fax: 613-51-24. E-mail: glarp@cable.net.co

Harvest for health

THE MOST POPULAR WAY of running clinics with villagers here in Afghanistan is *ohshur*, meaning *one out of ten*. Villagers give a tenth of their harvest to the clinic every year. In return for this donation, all health treatment for their whole family will be free until the next harvest time.

This system was started in Bambai in Wardok province two years ago. Now there are many successful clinics in this province. This donation of crops is affordable by the farmers and covers all the expenses of primary healthcare services.

Abdul Hafiz Ahmadi
Kabul Medical Institute
H No232, Str 44, D2
Phase I, Hayat Abad
Peshawar
Pakistan

AIDS education project

OUR ORGANISATION initiated a project called 'Everyone against AIDS'. This consists of a tour to raise awareness in the towns and villages of Togo. Since it began in December 1997, we have already been to several colleges in Lomé and the surrounding towns, raising the awareness of young people to oppose AIDS and HIV. Debates have attracted as many as 900 people! The project is now facing some material and financial difficulties. We would welcome support from anybody wanting to help the project reach its aim.

Amouzouvi E Blewoussi
Association Brimax
BP 13182
Lomé
Togo

Case Study 3

Healthcare priorities in Marabo village

OUR THIRD CASE STUDY from the Democratic Republic of Congo comes from Marabo, a village of 5,000 people. Though near Nyankunde Christian Centre – a 250 bed hospital – health activities were limited to a poorly attended private health post. There was little support for primary healthcare and only 23% of children were fully immunised.

Often the people of Marabo were described as 'difficult.' (This could mean health professionals have failed to understand the population's difficulties!) Even with patients paying full costs, there was no way in which the health post could be self-financing.

In July 1997, following the war and a long dry season, students from the Institut Panafricain de Santé Communautaire (IPASC) did a health survey of Marabo. They found that over half the children under five were malnourished, and that many people were tired and demotivated.

Puzzling attention

IPASC's principle is to listen to a community and then facilitate their response to key problems. So IPASC staff and students visited the village several times a week to meet the people and hear their problems. The community was puzzled by this attention since they had felt abandoned for many years – but within ten days they formed a committee to consider their problems logically. The urgent need was that of the mal-nourished children. The villagers asked for work, so that earnings would provide a communal meal for the children. A few weeks later, with full stomachs, many of the pathetic children had turned into cheerful toddlers. Now the villagers asked for spades for digging. The IPASC agriculturalist went out with students to give advice on what could be effectively and economically grown. Soon, gardens started to sprout soya beans and other nutritious foods.

The next need expressed was for a protected water source. A student spent several weeks working with the community to clear vegetation from a spring site and to put in a pipe and cement surround to protect the spring. This protected water source later meant Marabo was one of the few local villages spared from a serious cholera epidemic.

Only when improvements in nutrition, agriculture and water had been achieved did the community turn its attention to the health centre. A dilapidated hut which previously served as a health post could be rebuilt – but they needed a nurse and an initial stock of essential drugs. They purchased a few important drugs, and sent a male student community nurse, Jean, from Burundi. Another nurse looked after the curative care, while Jean was responsible for working closely with the community. His caring attitude quickly won a warm response. As a result, the primary healthcare activities came alive. In six months the immunisation coverage of under-fives had risen from 23% to 90%. Around ten patients attended the health centre each day.

The newest initiative is to upgrade the health post to a centre with a maternity ward. A community member gave 8,000 bricks towards this, while others dug up large rocks for the foundations. IPASC helped with their transport.

Conclusions

■ Establishing a health post without first defining the target community may mean there are too few people to make the post self-financing. In this area a population of 4,000–5,000 is needed for a health post and 8,500–12,000 for a health centre.

■ A health post may not be a priority need. In Marabo, nutrition, agriculture and water were thought to be far more important to the community than medicines. Until these needs were met, it was unlikely that patients would attend the health post. No patients means no income.

■ We found that a nurse who places curative care before community involvement will seldom have sufficient patients to be self-financing. Nurses are much more likely to win people's confidence if they…

- mix with the community
- visit handicapped, chronic and high risk patients
- associate themselves with daily concerns
- are available to all sectors of the community.

■ If people have confidence in their community nurse, that's who they will turn to when they fall sick. This automatically increases the number of patients, and thus the income of the health post.

■ Marabo health post is run by a committee which examines activities, income and expenditure. This ensures the community's involvement and enables them to understand and control the level of self-financing. A partner programme (in this case, IPASC) should facilitate, rather than impose development and encourage dependency.

Self-financing has more to do with an approach to a community than with the financial management of a health post.

Compiled by Pat Nickson, who is the Director of IPASC, c/o PO Box 21285, Nairobi, Kenya.

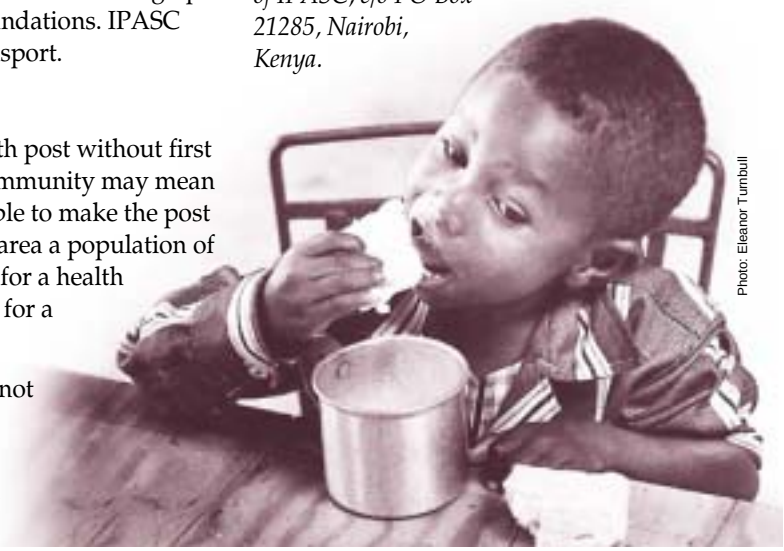
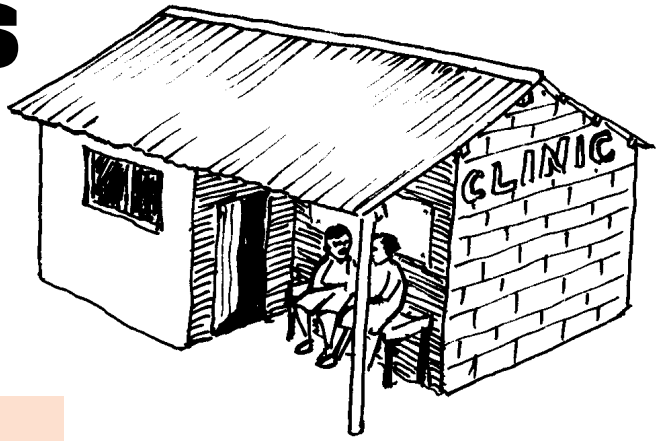


Photo: Eleanor Turnbull

A health post may not be a priority need…

Community links for sustainable healthcare



by Dr Shobha Arole

THE IMPACT of sustainable, community-based healthcare has been studied recently at the Comprehensive Rural Health Project in Jamkhed, North India, through a one-year study in three villages nearby. The findings are shown in the diagrams on pages 8 and 9. The first diagram indicates the pattern of access to healthcare and other facilities in villages before community health staff began work. The second shows the impact of effective community health work three to five years later.

A typical village

The first diagram (page 8) shows a village divided by economic and social barriers. It is made up of the following groups of people…

A few wealthy people with easy access to all the necessary services – such as schools, doctor, government officials, bank and credit facilities, clean water and transport.

Poor, marginalised people (the majority), who are…

- dependent on home remedies, herbalists and local healers
- dependent on the rich for employment
- without power to make decisions
- without access to outside knowledge, government or NGOs
- without good access to health facilities
- without access to safe drinking water.

People with leprosy, AIDS and TB, who are driven out of the village and live nearby.

Women, who are marginalised both within their family and within the community, receive less food than others and no money for healthcare.

Case Study

In Ghodegaon, Madhu was found to have HIV/AIDS. When members of the community organisation were given information about AIDS they lost their fear of infection and took care of him, provided work for his wife and helped look after his children.

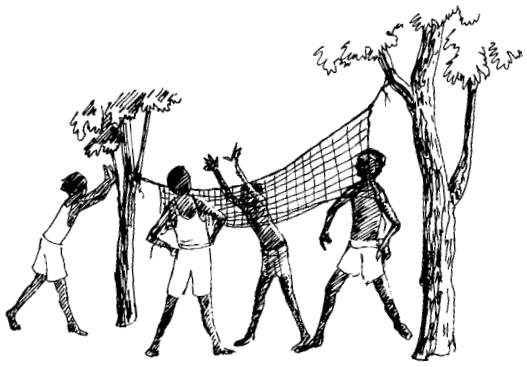
Sri, a leprosy patient, had been driven out of the same village. After understanding the causes and treatment of leprosy, members brought him back home, made sure he had proper treatment and rehabilitation and today he is an active member of the men's group in his village.

Effects of community-based healthcare

When Jamkhed staff first begin work in a community, they aim to build up relationships, and to build and strengthen community organisations. This takes much time. Games such as volleyball are good ways of bringing people together and relaxing with them. Jamkhed has found that effective organisations of women, men and children are vital to successful community healthcare. Motivated organisations can help cut across caste barriers, religious and other differences. They often include a few socially minded rich people. When both caring health staff and effective community organisations are present, various results may occur…

- A community health worker (CHW) will be chosen and supported.
- The CHW and community organisations can work in partnership to make sure good health services are available.
- If community organisations are provided with good health information, they can assess the local health situation, analyse the causes and take action.
- People may also become aware of harmful cultural practices such as discrimination against women, and act.
- They may also understand the real causes and treatment of TB, AIDS and leprosy so that sufferers can be cared for within the community.
- Community organisations may improve the access to micro-credit for poor families.

The effects of these changes on the life of the village community are indicated in the second diagram (page 9).



Community links for sustainable healthcare

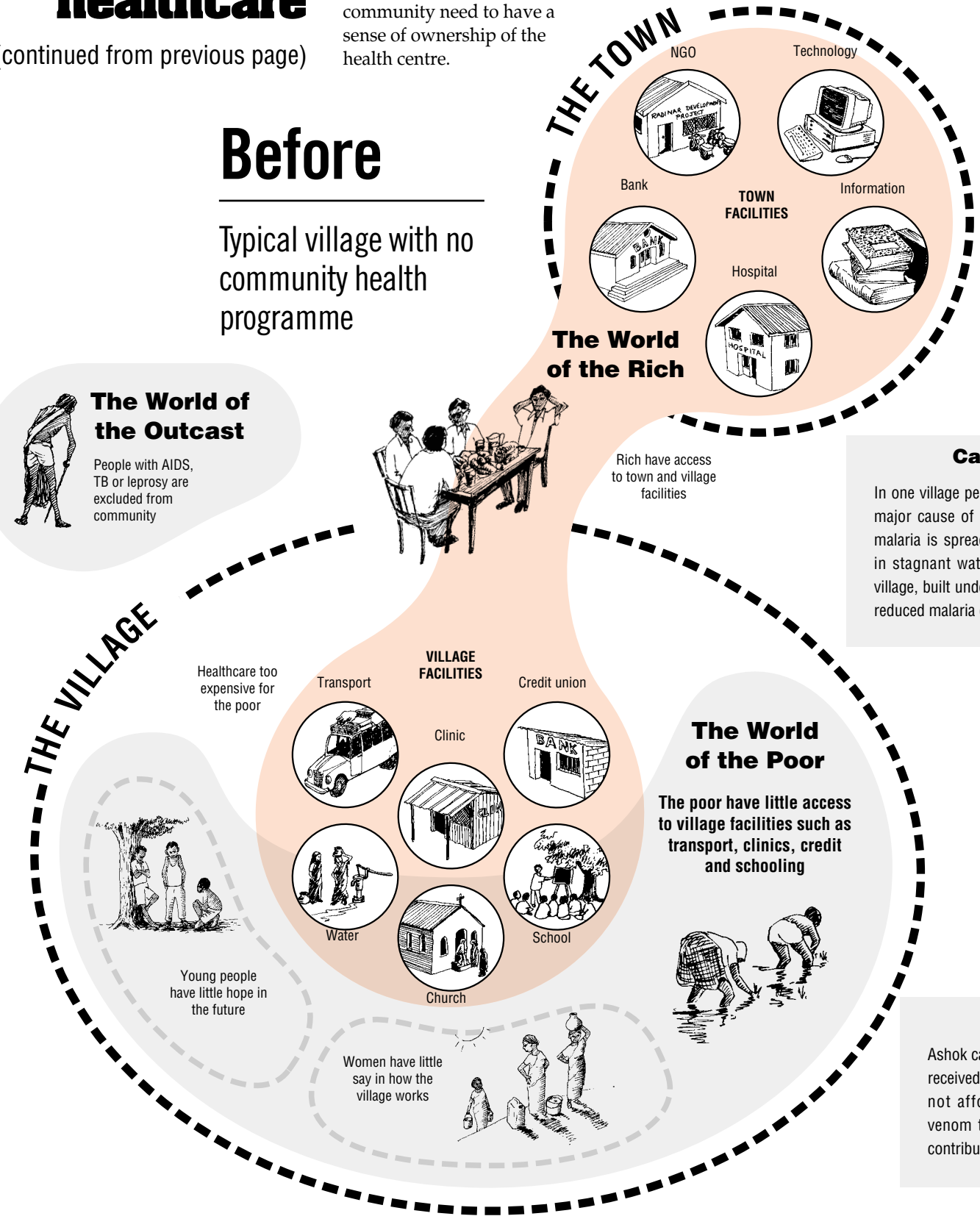
(continued from previous page)

Sustainable healthcare involves working with the community in an integrated way, promoting good health and dealing with preventative, curative and rehabilitation services. Staff from the health centre need to act as facilitators with real sensitivity and ability to bring people together. People within the community need to have a sense of ownership of the health centre.

People need to become aware that good health comes through their own actions, both as individuals and as a community. The more information they receive, the more they can make changes for their own good.

Before

Typical village with no community health programme



Case Study

In one village people identified m
major cause of illness. After lear
malaria is spread by mosquitoes
in stagnant water, they cleaned
village, built underground drainag
reduced malaria cases significantly

Case Stu

Ashok came from a poor
received a serious snake
not afford the expensi
venom to save his life.
contributed the cost of th

Villagers' suggestions

- Common minor illnesses can be treated by the village people with scientifically sound remedies and advice from health workers.
- Provide more information and training for health workers. Give them a supply of simple medicines which are available over the counter, to treat certain common diseases.
- Use effective measures to treat preventable diseases.
- Certain basic health services should be the right of every citizen through state health services.
- Community groups should work in partnership with health services to make sure that there is equality in health care.
- Community organisations should set apart a fund for the few people who need curative health services in either clinic or hospital.

Dr Shobha Arole is a graduate of Christian Medical College, Vellore. After gaining medical experience elsewhere, she returned as Associate Director of CRHP, joining her parents who established this work in Jamkhed. In addition to sustainable community-based healthcare, her interests are in developing viable secondary healthcare and, in particular, low-cost surgery and exploring the use of endoscopic surgery. CRHP Jamkhed, Ahmednagar District, Maharashtra 413 201, India.

After

Village with effective community health programme

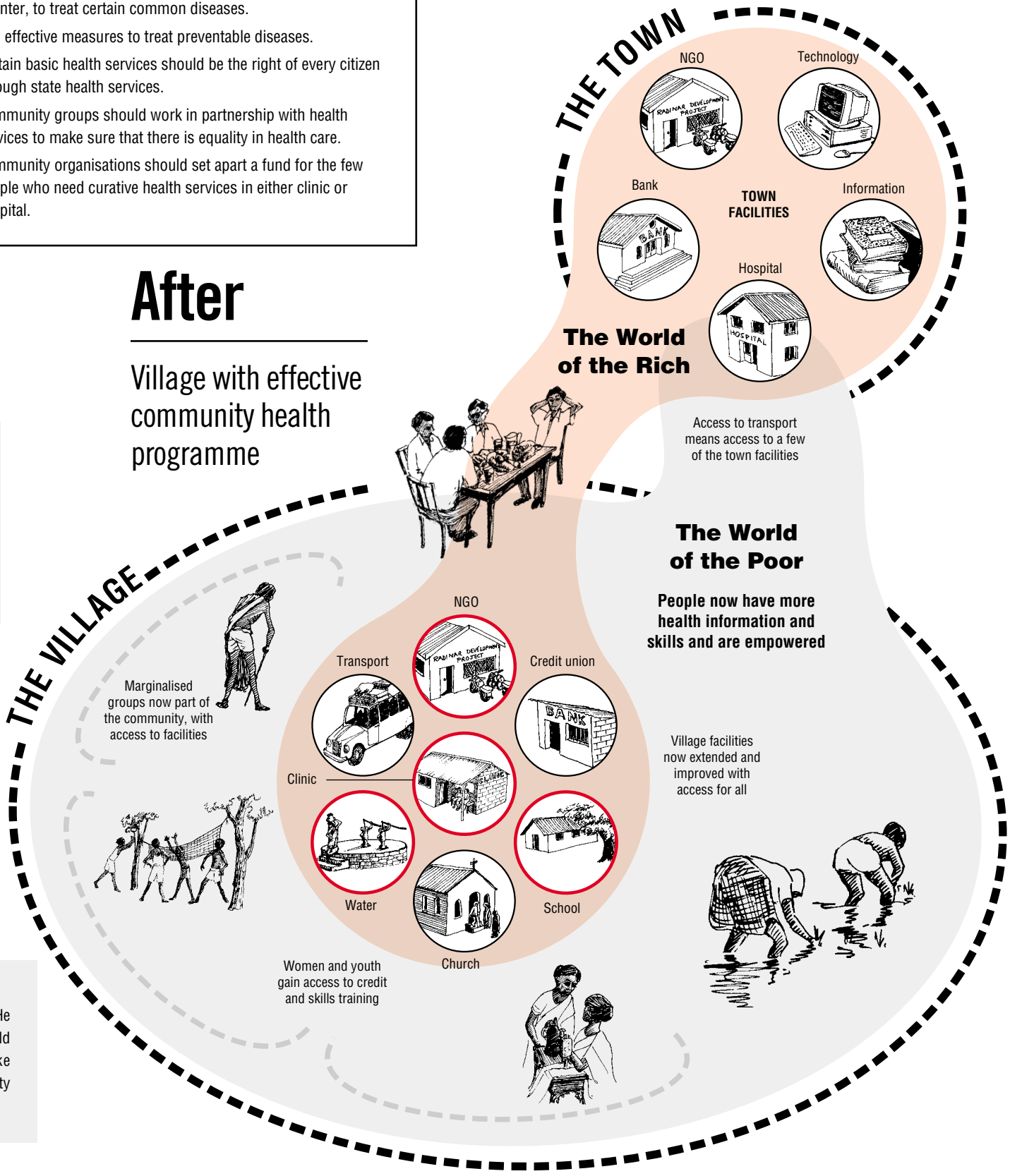


Photo: Tearfund

Providing essential drugs:

The Bamako Initiative

The eight principles

- Improving primary healthcare services for all
- Decentralising the management of primary health services to district level
- Decentralising the management of locally collected patient fees to community level
- Ensuring consistent fees are charged at all levels for health services – whether in hospitals, clinics or health centres
- High commitment from governments to maintain and, if possible, expand primary healthcare services
- National policy on essential drugs should be complementary to primary healthcare
- Ensuring the poorest have access to primary health care
- Monitoring clear objectives for curative health services

THERE ARE MANY REASONS for drug shortages. Many countries, particularly in Africa, have not adopted an essential drugs list to ensure good supplies of the most commonly used drugs. There may not be enough foreign exchange to import the necessary raw materials to produce the drugs within country. Drugs can be lost due to theft, poor storage and wastage through expiry. When drugs are prescribed to patients there may be further losses due to over-prescription, unnecessary injections or incorrect prescriptions. Finally, patients may also waste drugs they have been prescribed if they are not sure of the correct dosage, lack confidence in the health staff or fail to complete a course of treatment because they feel better.

Making the patient pay

As funding for health services continues to be cut (often through the effects of third world debt), there is great pressure to maintain salaries for staff and, as a result, available funds for drugs are reduced even more. All these difficulties mean that both governments and health programmes are increasingly trying to raise funding for drugs directly from the patients.

The Bamako Initiative was agreed by African Ministers of Health in 1987 with WHO and UNICEF, calling for community participation in managing and funding supplies of essential drugs. It is based around the eight principles listed at the top of this page (see box). Countries have varied considerably in the ways they have tried to put these principles into action.

Kenya

Here the government has encouraged the setting up of 'community pharmacies' run by CHWs (community health workers). The pharmacies stock between nine and twelve essential drugs and these are charged at prices which not only cover their cost but also include a profit kept by the CHWs. In addition, insecticide-treated mosquito nets are sold at subsidised prices. Local people have been positive and feel that prices are fair, though many struggle to find the necessary funds. CHWs are positive because they can earn a small income – but there are dangers in this, particularly with the over-prescribing of unnecessary drugs to earn more money.

Guinea

In Guinea, W Africa, the government supports comprehensive primary health services. They have a nationally agreed set of charges for the more common diagnoses. These include drugs for treatment and after-care.

Ghana

Discussion groups were set up (by Waddington and Enyimayew) in the Volta region of Ghana to examine people's attitudes to paying for health services. The actual charges for health services were not the only issue people considered. Equally important were the attitude of health staff, the availability of drugs, whether payments could be made by instalments or in kind and whether credit was available.

Dominican Republic

Research here (by Bitran) found that people would prefer to pay for good quality private healthcare, rather than use government health facilities which were free or low cost but were believed to offer poor healthcare and often lacked drugs.

This information was summarised from in-depth research and analysis carried out by Dr Barbara McPake and others in the Health Policy Unit, London School of Hygiene and Tropical Medicine, Keppel St, London, WC1E 7HT, UK.

THE IPASC PROGRAMME FOR Safe Motherhood

by Kaswera Vulere

THE SAFE MOTHERHOOD Programme at IPASC (Institut Panafricain de Santé Communautaire), Nyankunde in the Democratic Republic of the Congo recently extended its work in the local communities. Mothers join small groups where they can discuss problems and find their own solutions, according to local culture and the available local resources. We also hope to start discussions and workshops for young people, couples and women who have reached the menopause.

The mothers' group at Komanda

This group provides an interesting example of the benefits of our work. Following each training seminar at IPASC, midwives produce an action plan for improvements in their work. A midwife in Komanda was concerned about the risks run by mothers giving birth at home without medical back-up. She discussed this with the mothers in the Komanda safe motherhood programme and they decided to start a fund, with each mother contributing a small monthly payment. 25 mothers joined immediately. After two months they chose leaders, and later formed a committee composed of a member of the health centre staff, some advisers and some representatives of the mothers.

This committee has taken part in several training sessions on safe motherhood. They considered the following concerns…

- Most mothers do not attend an ante-natal clinic.
- Many mothers give birth at home without any trained help.
- Mothers who have no money may need urgent medical help.
- Many children under five suffer from anaemia and malnutrition.

All present insurance systems in the area are simply concerned with burying the dead and make no effort to save lives.

The committee undertook the task of making mothers in their area aware of these problems. They are working to meet the needs of mothers who have complications in childbirth and to help children under five whose families can no longer provide for them.

'Safe Motherhood' will help a mother in need even if she is not a member. Later, when she is better, she is encouraged to join. The association will pay for the transport of a member from any health centre in the town to the recommended hospital and then for their medical care. They help mothers with complications in childbirth or pregnancy and also with cases of anaemia, malnutrition and other serious illnesses in children. At present there are 270 members in 13 different groups, each one paying a monthly contribution. Twice a week, leading members visit local communities.

Education

Following a Bible study, community activity and health education is given every Monday at ante-natal classes and at all members' meetings. A sketch entitled *When Home Delivery is a Mistake* has been prepared, taped and broadcast for local radio. It compares a woman with a narrow pelvis, who did not attend an ante-natal clinic and dies at home with her baby, with a second woman who has a bleeding placenta and who is transferred to hospital, where both she and her baby survive. Two songs about safe motherhood are sung during the drama.

Benefits

So far, eight mothers have needed hospital treatment. One mother was in a state of shock following a ruptured extra-uterine pregnancy, but the group provided and paid for the mother's transport, with a further US $3 for hospital admission. Another woman had been married for more than ten years without conceiving. When she became pregnant, the baby was particularly precious to the family so at 38 weeks she was transferred to hospital to await the birth and avoid any risks. After a week's wait, she needed a Caesarean but they were able to save the baby for which she had waited so long. The mother came back to the committee saying, 'Thanks to "Safe Motherhood", my precious baby has been saved.'

In addition to the women needing hospital transfers, 60 serious cases were looked after with a subsidy from the 'Safe Motherhood' groups.

Financial situation

During this year over US $400 has been entered in the books. So far, US $200 has already been used to help members, US $3 has been used for administrative costs, US $80 for buying a cow and just over US $100 remains.

The cow was bought to raise income through the sale of calves and milk. A soya field has been planted and a manioc field is being prepared – again to raise funds. Future plans include raising goats, planting community fields in each village and buying and installing a mill to lessen the burden for the mothers and to increase the cash in the fund.

Kaswera Vulere established The Safe Motherhood and Family Health Programme at IPASC, Nyankunde, DR of Congo.

Health services for rich and poor

Photo: Mike Webb, Tearfund

The demand for our health services has steadily increased.

by Dr Apolos B Landa

IN OUR SOCIETIES, healthcare often becomes a commodity. The rich few can afford good healthcare while the vast majority of people do not have the means to pay – they have no access to healthcare as a basic human right. Is it possible to make healthcare more equal?

We at the Luke Society have been struggling with this goal for a while. We work both in the urban areas of Moyobamba, central Peru, and the nearby deprived jungle areas. We found no organisation able to support us financially in subsidising healthcare. However, moved by our convictions, we committed ourselves to providing good quality, personalised health services for the poor in our communities. To make it accessible, we not only fixed subsidised fees but also began a community and school health education programme, as well as promotional and preventative healthcare programmes.

Painful truths

After seven years, however, we were dismayed to discover that…

- The majority of poor people did not use our services.
- The poor did not appreciate a first-rate service offered at very low cost, believing low cost meant poor quality.
- The rich were able to take advantage of the situation. Though a minority in the community, they overused our services and got good healthcare at low cost.
- We needed increasing donations to sustain the programme and felt unhappy, even dishonest, when those donations ended up serving the rich.
- With little finance being raised through charges, we finally faced bankruptcy and break-up.

Facing the problems

Did we give up? **NO!** Over a long period we discussed and debated. We looked back at our experiences and implemented the following practices, in order to help the poor without subsidising the rich…

- We worked out the real costs of our services and raised our fees considerably.
- We set up a sliding fee system for the poor. This is worked out on a personal basis – the staff member dealing with a patient sets the price on the patient's card. The rich pay the full cost.
- We set apart 10% of our total income for a poor relief fund. Through this fund we are able to help those who are unable to pay even the basic costs.
- We still apply for donations to supplement the needs of poorer patients, but we no longer depend on these.
- We had meetings with key leaders from the civil and religious communities, to explain how our new system would operate. Our motto was 'Everything has a price, even our salvation.' (Even though we ourselves do not pay for it, it is still of priceless value.)
- Community health workers, volunteers, religious leaders and their immediate families were given a type of insurance.
- We keep a register of all the fees paid, to avoid accusations of religious bias or tax evasion.

Photo: Mike Webb, Tearfund

Many people struggle to pay for healthcare.

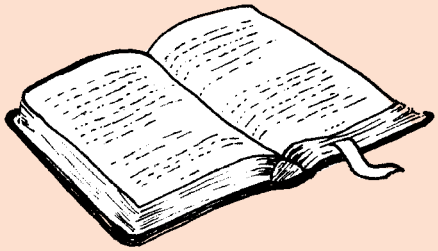
Positive outcomes

Now we are seeing the following results…

- The demand for health services has steadily increased. We maintained the attendance of the rich and we increased the number of poor patients as they became aware of the subsidy system.
- The rich grumbled about paying more but were satisfied because we offered high quality services.
- The poor became our best promoters and their increased numbers made up the surplus income. We had to start limiting appointments to allow space for patients from remote villages.
- An awareness that 'what is expensive must be worth paying for' spread without us making any effort. And we committed ourselves to live up to that!

BIBLE STUDY

Nehemiah, the development worker



by Dangako Wango

Nehemiah is one of the men of the Bible whose working methods must inspire every Christian development worker. As we read the book of Nehemiah, we can learn much to improve our own work strategy to obtain better results. If possible, try to read the whole book before making this study.

Chapter 1:1-11 Prayer. We must ask for God's help before undertaking any development work (Proverbs 16:1-3, Psalms 127:1)

Chapter 2:1-8 Nehemiah sought permission from the King before beginning work. The development worker must not disregard people in authority such as the chief, community leaders or local government of the State.

Chapter 2:11-15 Listen to and observe the situation before taking action. Nehemiah began by looking and he certainly listened to his fellow countrymen before doing anything. It takes time for a development worker to be accepted by the community.

Chapter 2:16-18 Make use of meetings. The development worker doesn't see problems in the same way as local people. Nehemiah brought his fellow countrymen together so that they could understand what he saw. A meeting helps all those concerned to identify their problems and to recommend solutions.

Chapter 3 The community must participate. Sound development must eventually become truly self-supporting and independent. This is the aim of community development. People who are confronted by misery organise themselves and set to work.

Chapter 4:7-15 Even when confronted by the attacks of his enemies, Nehemiah didn't stop work. He worked on with courage, perseverance and self-control. Development work must not be abandoned unfinished, no matter what price has to be paid. Development work is difficult and long-term.

Chapter 7:1-2 The work must be followed up. Measures were taken for the protection of the walls. If we do not think about the follow-up or maintenance, some time later the work will collapse.

Chapter 7:73-8:8 We should plan for a time of prayer and praise at the end of the project, in order to thank the Lord for his working with us in our task.

Dangako Wango is Director of BDC/CBZN, Bangassou, Central African Republic, and teaches at FATEB on the Church and development.

- Our total income multiplied ten-fold, so we were able to pay our staff an appropriate salary and maintain our clinics to a high standard.
- We no longer have problems with other local medical services through under-cutting local clinics.
- Finally, most people are much happier and more fulfilled.

In this way we are able to be financially sustainable and, at the same time, to serve the poor. Like the covenant of grace where both rich and poor benefit from the Lord's gift, by working together we can provide quality healthcare for all (Isaiah 65:17-24). Explaining the gospel is closely linked to all our health services and there are many opportunities to share the love of Christ.

Dr Apolos Landa is Latin American and Caribbean Co-ordinator for the Luke Society Inc, with wide experience of primary healthcare. His address is: Asociación San Lucas, Apdo 421, Trujillo, Peru. E-mail: panluk@inglenet.lima.net.pe

Some development guidelines

by Dangako Wango

In order to achieve a sound approach to development, we need to bring together the following elements…

- Needs must be expressed by those concerned. Don't do anything either on behalf of or instead of local people without being asked.
- Those concerned must participate themselves at every stage of the project.
- Take into account the capabilities of the local population when looking for solutions to the problems which have been raised. We make a serious mistake in our development work if we do not believe in the ability of local people to bring about the change they want to see.
- Take into account whatever local resources may be available. The solutions to the problems which have been raised must not come from elsewhere. But if a little help is given from outside we should simply thank God for it.
- Take into account past experiences. It is said that there is nothing new under the sun (Ecclesiastes 1:9-10).
- We must learn how to evaluate our work.

Photo: Isabel Carter

A good development worker uses local resources and builds up the confidence of local people.

District Laboratory Practice in Tropical Countries

This detailed book (464 pages) is aimed at medical staff working in district laboratories and those who train them. It contains details of managing and equipping laboratories, health and safety aspects and numerous clinical and parasitological tests (with a large section of colour photos). It emphasises the need for integration with community health services. Details are available on planning a training curriculum for laboratory staff.

Normal price is £33.30 but the book is available at £10.90 (including surface postage and packing) for medical staff in developing countries (or £19.00 with airmail postage). Send payment with order to:

Tropical Health Technology
14 Bevills Close
Doddington, March
PE15 0TT
UK

Women's Health Library

This is a special offer of a library pack of six books which will provide community health workers with the latest information on a wide variety of women's health problems. They include

Where Women have no Doctor – recently published and providing a health guide to identify common medical problems and treatments

Helping Mothers to Breastfeed

Setting up Community Health Programmes

Nutrition Handbook for Community Workers

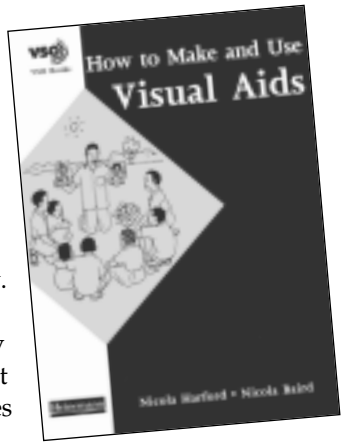
Training Manual for Traditional Birth Attendants

Freda Doesn't get Pregnant – an easy to read book for young girls, to help them understand the risks of becoming pregnant.

The set of six books is available at a special low price of £30, including postage, from :

TALC
PO Box 49
St Albans
Herts
AL1 5TX
UK

How to Make and Use Visual Aids



Visual aids are important all over the world to help teachers, trainers and development workers to communicate effectively. This book shows how to make visual aids quickly and easily using low cost materials. The techniques described have all been well tried and tested by volunteers with VSO, the publishers. The ideas are easy to use with plenty of practical hints and tips. The book encourages the use of local materials and techniques. Among the ideas included are card games, puppets, masks, models and toys. There is a useful list of contacts for advice, free catalogues and other materials.

Available from TALC for £7.15 (including surface postage) or £8.15 (including airmail postage). Address above.

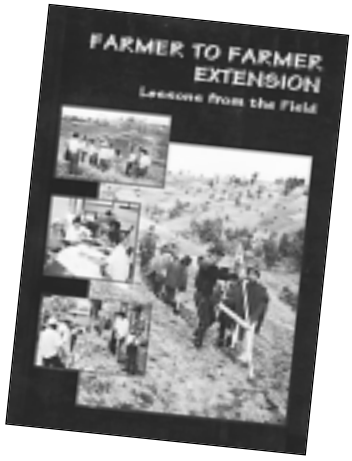
New books on livestock and their care

The Christian Veterinary Mission have just published two new books called *Raising Healthy Sheep* and *Drugs and their Usage* as additions to their useful series on raising healthy animals. This brings the total to nine (including pigs, cattle, sheep, goats, fish and rabbits). They cost US $10 each and $15 for *Drugs and their Usage* (with 300 pages) including postage. CVM will consider making books available to mission agencies, agricultural libraries and development agencies in developing countries. Requests for the books should be typed on letterheaded paper from the organisation.

CVM also publishes an *International Animal Health Newsletter* quarterly. *Raising Healthy Poultry, Rabbits* and *Goats* are also available in Spanish. For further information, please contact:

Dr Leroy Dorminy
Christian Veterinary Mission
19303 Fremont Ave N
Seattle
WA 98133
USA

E-mail: missionvet@aol.com



Farmer to Farmer Extension: Lessons from the field

by D Selener, J Chenier and R Zelaya

Published in 1997, 150 pages

This book is the result of two workshops in Honduras and Ecuador, held to document and analyse the experiences of several rural development projects. Most of the information comes from the point of view of farmer promoters, based on their many years of experience. Part One looks at many aspects of the work of farmer promoters (extension workers). Part Two looks at five case studies from Mexico, Nicaragua and Ecuador. The book would be of interest to development workers using participatory approaches to development. It is available in Spanish and English, costs US $15 including postage, and can be ordered from:

IIRR
AP 17-08-8494
Quito
Ecuador

E-mail: daniel@iirr.ecuanex.net.ec

Resolviendo Conflictos en Pareja

(Resolving Conflicts as a Couple)

This short, straight-talking booklet in Spanish, written by a Brazilian psychologist, goes directly to the heart of marital difficulties. It identifies the main source of conflict as the refusal to accept each other as different. It describes how easily couples can retreat into hurt silence and grow apart. It gives practical advice on how couples can appreciate their differences, learn from conflict and grow stronger through it. This 11-page booklet is one of a series produced by EIRENE and included free for subscribers

to their quarterly bulletin, which costs US $20 a year. Single booklets cost US $3, including postage.

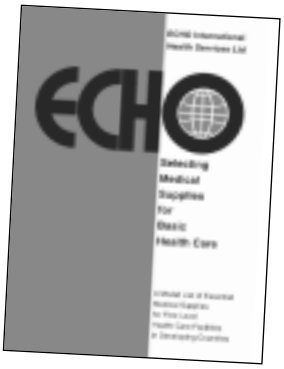
EIRENE Internacional – ALAPF
Casilla 17-08-85-72
Quito
Ecuador

Selecting Medical Supplies for Basic Health Care

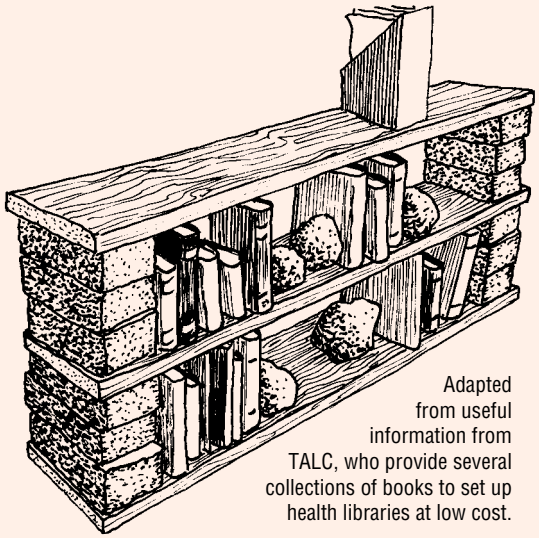
A list of essential drugs has provided a useful guideline for many health personnel in deciding priorities when ordering drugs. However, no similar list is available for medical supplies to complement that for drugs. ECHO are just reprinting these guidelines to help medical personnel make practical decisions when ordering supplies with a limited budget. The booklet costs £3 (including postage), but a copy is available free of charge to health personnel in third world countries who have no access to foreign exchange. A second booklet in the series called *Basic Technical Maintenance of Medical Equipment* will also soon be available.

ECHO are a leading supplier of low-cost medical drugs and supplies to clinics and hospitals around the world. Write to:

ECHO
Ullswater Cres
Coulsdon
Surrey
CR5 2HR
UK



Building up your library



Adapted from useful information from TALC, who provide several collections of books to set up health libraries at low cost.

Fixtures and fittings

Make shelves, using wooden boards and bricks. You can use blocks of wood held up with stones as bookends until a carpenter can make wooden ones. Instead of stones, you could use painted pebbles. If a number of people will be using the library, make sure it is open at regular times for people who want to come and read. Keep some chairs or mats for people to sit on. If space is limited, a cupboard can be used for the library books and locked up when not in use.

Divide the library into sections

This will make books easier to find. Use letters and a colour code to indicate each subject. For example, if your library is on health issues, you could use the following sections:

MCH	Mother and child health	Red
IND	Infectious diseases	Blue
DAT	Disability and appropriate technology	Purple
HAE	HIV/AIDS education	Orange
NCG	Nutrition and child growth	Green
MSO	Medicine, surgery and obstetrics	White
HCS	Healthcare services	Yellow
EC	Education and communication	Brown

Divide the sections with wooden blocks, marked and painted with the correct colours. Mark the books on the outside cover and inside. Give each book a section number and write this after the letters. For example: MSO 2. If you have several copies of the same book mark them as: MSO 2A, MSO 2B and MSO 2C.

Keep a register

Divide an exercise book into sections and write down all the books you have. If people borrow copies, write their name down as well as the date they should return the book. Decide together on a borrowing policy for books. Maybe one person can borrow two books at a time and keep them for up to three weeks. Decide if you will use penalties if people do not return books on time.

Use a box for people to place their returned books. Mark them into the record book and then place back in the right section.

Finally

Keep a lookout for interesting books you can add to the library. Charging a small contribution for the use of the library may enable you to buy a few really useful books each year. Some organisations will also support groups building up small libraries.

Community Viewpoint

by Boureima Kabre

Participatory research in action

IT IS ESSENTIAL when beginning a new community project to have the full involvement of all the layers of society which make up this community. Each society has its own particular knowledge and ability which enables it to function, however poor its members may be.

Here in GRAAP (Groupe de Recherche et d'Appui a l'Auto-promotion Paysanne), we have developed a process to help allow all groups within a society to express their views, including women and children.

The structure

Each neighbourhood area is represented by a delegation which consists of members of all the social groups – including leaders, adults (both men and women) and young people. These are then formed into sub-groups as follows…

- Leaders' group
- Men's group
- Women's group
- Girls' group
- Boys' group

Sometimes more groups may be necessary to include minority groups such as tribal groups, refugees, disabled people or migrant workers. In order to get a balanced result it is helpful to make sure that numbers in each group reflect the actual numbers in the population.

Areas of concern

Each of these sub-groups chooses a spokesperson and an organiser to lead the discussions. The same subject is discussed by all the sub-groups, who make a list of all their ideas and rank them in order of importance. Their three main concerns are then brought to the General Assembly of all sub-groups. The reporters present the three priorities selected by their sub-group, using everyday symbols to represent these (for example: a twig to represent timber, a shoe to represent transport, beans to represent seeds).

Priorities

When all the sub-groups have put forward their views, all delegates are able to decide on their overall priorities as a community. Each person takes the same number of pebbles (this can be based on the number of priorities listed, but between 5 and 10 is a good number). They place their pebbles alongside the symbols representing their own priorities. At the end of the session, people who are not members of the sub-groups add up the pebbles. By using this method, the views of accepted leaders and the issues they see as priorities do not automatically get pushed forward. The views of each sub-group can be expressed and heard by all sections of the community, ensuring that women and young people have the opportunity to share their points of view. Priorities receiving most votes (pebbles) are thus seen to be the main priorities for most of the community, and discussion can move on to how to improve and tackle these priorities.

When to keep quiet

I have found that the best method of leading discussions is not to express your own opinions and knowledge, but instead to enable people to discover the situation for themselves and then think about it and act accordingly. This can be achieved by using the art of questioning skillfully, just as Jesus did (Luke 7:36-43). Sometimes, however, there are difficult or embarrassing situations which people will avoid tackling, and there may be no alternative but – with sensitivity – to express our opinions and encourage action (Matthew 12:9-13, Luke 14:1-6).

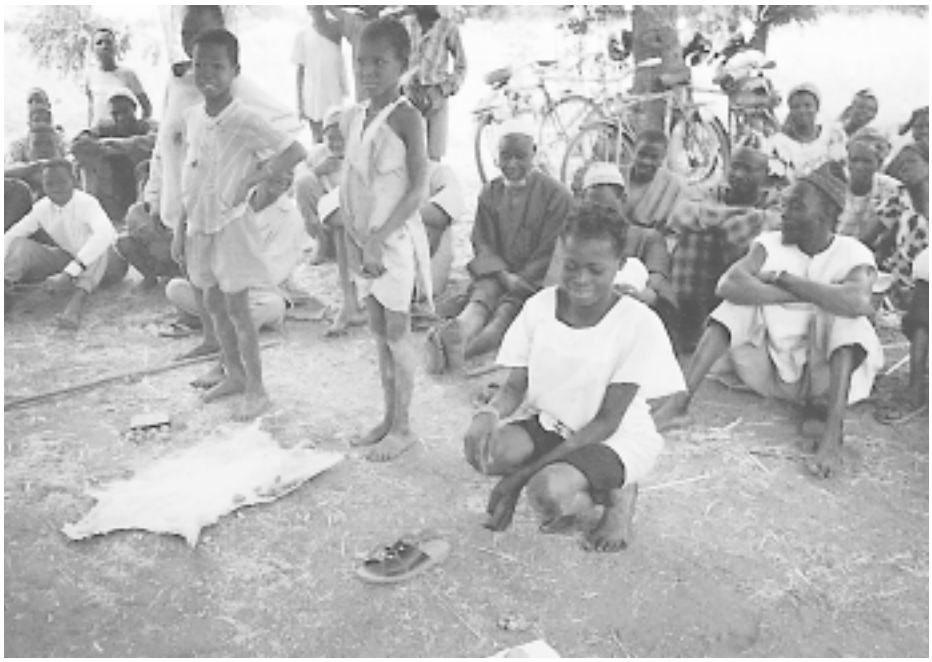


Photo: Boureima Kabre

Children in Burkina Faso using pebbles to indicate their priorities for community development.

We should not hesitate to share the truth if necessary, as we are the salt and light of the world (Matthew 5:13-16).

Boureima Kabre is a facilitator working with GRAAP. His address is BP 143, Koujiela, Burkina Faso, West Africa.

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