COMMUNITY-BASED or ORIENTED

The Vital Difference
INTRODUCTION

THE CHRISTIAN MEDICAL COMMISSION celebrates this year its twentieth anniversary. One of the major concerns of CMC from its beginning in November, 1968 was the issue of justice and health. The churches involved in health care around the world were beginning to recognize the injustice of sophisticated health care services for a relatively few, while the great majority of the world's people had access to none. So CMC staff and commissioners scattered over the globe began, 10 years before Alma Ata, to promote primary health care as a means of making basic health care available to all.

Another major injustice in health is the way Western technological medicine, no matter how well-meaning, creates dependency. Its orientation to curative services “delivered” by persons with technical training promotes dependence on these services for health. Careful studies have shown, however, that health is not created primarily by curing disease. Furthermore, experience teaches that the great majority of early health interventions can be done by mothers and other community members with a little training. For example, a simple sugar/salt solution or cereal water for diarrhoeal dehydration, often considered as the number one cause of death in the world. Medical technology adds bicarbonate and potassium and seals the “product” in water proof packets which must be delivered. On this complicated process; the beneficiaries come to depend for their survival. Home made solutions, though perhaps not quite as effective, free the people have not participated as expected.

the number one cause of illness and death in the world today is poverty.

persons from that dependency and enable them to solve, with human dignity, one of their most serious health problems. This is NOT SECOND-RATE HEALTH CARE for poor people until something better is available. It is to be the best anywhere in the world.

Perhaps the greatest injustice in health is the fact that the number one cause of illness and death in the world today is poverty. How do we deal with this problem? How can we assist children, not only to survive, but to truly live with the well-being we define as health? Years and pages of words have resulted only in a widening gap between rich and poor. Massive loans from wealthy nations have left poor nations in hopeless debt. Concrete recommendations made ten years ago by the United Nations-sponsored Brandt Commission to restructure the economic order in favour of the poor have been almost totally ignored. It seems clear that the minority in the world with power and money will not voluntarily use it to change significantly the plight of the poor.

How then to address the injustice of poor health due to poverty? Examples have shown that the poor can be empowered to bring changes in social and economic structures to improve their lot. The Alma Ata conference declared “participation” by people in their own health to be an important element of PHC. But this idea is the least understood and the most overlooked in the whole primary health care movement. Most of the world’s governments and not a few of its churches have committed themselves at Alma Ata to provide the material and management structures to “deliver” PHC in their territories, but alas, the people have not participated as expected.

Evidence is available, however, that they can and will. Using methods developed in the 1920s for community organizing and in the 1940s for conscientizing, communities on all continents are discovering ways to bring about improvement in their conditions by creating change in economic and social realities. Sometimes health is the entry point, other times a side effect of community organizing. In this issue of CONTACT we want to emphasize the difference between dependency creating health “delivery” schemes and empowerment of people for their own health, which we believe is the best hope for Health for All by the year 2000 (HFA 2000).

David Hilton
COMMUNITY-BASED or COMMUNITY-ORIENTED
THE VITAL DIFFERENCE

COMMUNITY-ORIENTED HEALTH CARE

Here is a composite of letters received by CMC from many district hospitals in a wide variety of developing countries:

"We have heard about primary health care and have a sincere desire to do something about the lack of even simple health care in the area surrounding the hospital".

"Our hospital staff is overworked treating cases of malaria, dehydration, and malnutrition that could be prevented or treated locally. Therefore we are going to build a clinic in some villages 30 miles from the hospital. We will give an employment exam to the district secondary school leavers and select the best to train as health workers to be sent to the clinics. They will learn how to treat malaria, respiratory infections, malnutrition and other common diseases."

"We have done a survey and find very poor conditions of sanitation, hygiene, and nutrition in all of the villages. Therefore we will train the health workers to do health education. They will teach the people that they should construct latrines and dig wells in order to prevent disease. They will have classes in nutrition for the women so that they will learn how to properly feed their children."

"The nurses will go out from the hospital to the villages in a mobile clinic, when they get time and the weather allows, to give immunizations and examine pregnant women. Women who are within six weeks of their delivery time will be brought to the hospital to wait."

"We will visit the village chief and elders to make sure that they understand our plan so that they will encourage the people to participate."

Here we have described community-orientated health care (COHC), in which plans are made by outsiders and people are asked to participate. The programme is centred around medical staff who dispense their knowledge to people. There are thousands of health programmes operating on this model around the world and their concerned staff is to be highly commended for their enduring commitment to bringing medical care to those around them.

But years of experience with this model have raised some serious questions:

1. If the political will existed, would there be enough money to provide this kind of service to every community in the world?

2. If the money were available, would this model bring about a significant change in the health of the people included?

Experience teaches us otherwise. Then what is the alternative?

* Dr. Hilton is an Associate Director of CMC.
COMMUNITY- BASED HEALTH CARE
A Different Story

In a small town in India called Aske lives Samuel. He grew up in a similar area nearby and was a primary school teacher until he entered a course for community organizers. There he spent long hours learning to work with community groups. An important part of his training was how to listen and really hear what people are saying and feeling.

When he finished his training Samuel moved with his wife and children to Aske. He got a job on the large farm of the mayor. When he was not working he was in the town listening. He made many friends in the community and joined in discussion with individuals and groups wherever he found them. He was listening for "generative themes", topics that people have strong feelings about. As is usually the case in poor communities, people seemed apathetic and most had lost hope that anything would change. But Samuel had learned how to ask "open" questions to encourage people to discuss and develop their ideas. In groups he called people by their first names and often repeated their comments back to them so that they knew they were being heard. They began to develop confidence in themselves. He was soon being invited to meetings of women, youth, churches, farmers, workers, etc.

When he had identified several generative themes, Samuel prepared some "codes" on these themes; sometimes pictures, sometimes stories or drama about the themes. Then he would ask the people to tell what they saw in the code, and try to determine why. He would ask if the depicted situation was found in their community and if so what could be done about it. People began to think about ways to solve their problems instead of just complaining.

One of the themes which a men's group had strong feelings about was the lack of money to buy vegetables from the wealthy landowner for whom they worked, making it impossible to feed themselves and their children properly. As Samuel encouraged them to seek solutions they recalled that there was a small plot of unused land near the river. They decided to pool their small savings and rented the land from the owner. They saved seeds from vegetables that they had been able to buy and when the time was right they all worked together to plant the garden. When harvest time came they ate some and sold the rest to buy better seed for the next planting. The best product from the garden, however, was the discovery that they could work together to solve a problem. As time went on they were able to buy the plot of land and then use the profits to improve their living conditions.

A problem that the women wanted to solve was the long, hard walk to carry water from the river twice a day. There was a spring in a nearby swamp but the animals kept it too dirty to use. With the help of Samuel's gentle but persistent questioning they decided to dig out the spring and line it with rocks. They put a wooden cover on it and made a spout for water to run into a trough for the animals. When they finished it they had a little celebration and said to Samuel, "We did it ourselves!"

WCC Photo: Peter Williams
A women's informal community meeting in Bolivia
Soon the women were asking Samuel to help them learn more about how to keep their children healthy. He arranged for a health educator from the district hospital to come to their meeting. The health educator had heard about participatory learning methods from his friend Samuel. He quickly discovered that when he was answering questions the women were asking, they listened carefully and put into practice what they learned. Samuel looked for answers to some of the women's health questions in books like "Where There Is No Doctor". The women gained confidence when they discovered that they could learn and could improve their conditions of living.

In a few years they discovered that the women, who had always been dominated by the men, were now working as equal partners in the community. The poor and uneducated were also making just as important contributions to the meetings and activities as anybody else. As they all gained confidence they began to include the mayor in their meetings and, with the help of Samuel using drama and pictures as discussion starters, were able to raise many questions about his control of their community. He came to realize that what was good for the whole community was also good for him.

As time went on, the leaders of Aske talked with the leaders of other towns in their district and together they elected members to the governing council who knew first hand the importance of people controlling their own destiny. Together they continue to work, even today, for the transformation of their society into a more healthful place.

Here we see described community-based health care (CBHC), originated by and from the people with the aid of an "animator" whose only task is to facilitate this process.

Participatory learning and community organization are the keys to CBHC.

Participatory Learning

In the 1960s, Paulo Freire, a Brazilian educator developed a method of adult education for literacy which had as its ultimate goal enabling people to "read" their reality and thereby empowering them to transform it. By training "animators" to facilitate this process, Freire, who sees most educational systems to be oppressive, made significant changes in the social system in Brazil before he was expelled by the wealthy power structure.

Community Organization

The roots of the modern community organization movement are in Northeastern Canada where, in the 1920s the Antigonish movement began at St. Francis Xavier University. The movement's principles state that:

1. Each person is endowed by God with intellectual, volitional (act of will), and physical faculties which must be developed to obtain full and abundant life for all.

2. Major social institutions of society must be transformed to guarantee equal opportunity and full development of all persons.

3. Adult education and group action are the most effective means whereby the common people themselves will be able to transform social institutions. This will be done by defining
and controlling the nature and direction of social change.

4. The process begins when common people use adult education and group action to solve their immediate social and economic problems.

Through its training organization, Coady Institute in Antigonish, Nova Scotia, the movement spread throughout Canada and then to the whole world.

In 1974, Anne Hope and Sally Timmel, two members of the International Grail Movement, started DELTA (Development Education and Leadership Teams in Action) in Kenya to do human relations training programmes using Freire's ideas of participatory education in literacy classes, women's and youth groups, community health groups, agricultural programmes, Basic Christian Communities for Action and Reflection, and many others. The training has since expanded to Zimbabwe, Nigeria, Gujerat, India, and the United States.

The two Sisters of the Grail have written a training manual, called "Training for Transformation - A Handbook for Community Workers", based on their experience. Part one is basically the theory of Paulo Freire on developing critical awareness and how to put it into practice. Part two is focussed on the skills necessary for participatory education. Part three deals with the social analysis necessary to develop critical awareness and long-term planning and with the steps needed for building solidarity in peoples' movements. Since we believe true peoples' participation to be the key to HFA 2000, we are printing here some important paragraphs from their publication. We also strongly encourage you to obtain it, study it, and above all, put it into practice.

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TRAINING FOR TRANSFORMATION

By Anne Hope and Sally Timmel

The Need for Transformation

All of us are involved in community, and are immediately confronted with the real life problems of people — people who are caught in a never ending struggle for survival; with unsafe water, too little food, little education, and no voice or power in decision making.

Development and education are first of all about liberating people from all that holds them back from a full human life. Ultimately development and education are about transforming society.

Development, liberation, and transformation are all aspects of the same process. It is not a marginal activity. It is at the core of all creative human living.

Because the bonds of poverty and oppression make the lives of vast numbers of people increasingly inhuman, it is amongst the poor and oppressed that development programmes and adult education must start.

Any human view must focus on those whose well-being is denied by others. Progress cannot be measured only by the increase in the total production of a country, because often a privileged minority take for themselves the fruits of the labour of a hard working majority. Millions of people are the victims of a vicious system of exploitation managed by a small powerful group which controls the economic and political life, not only of their own country but of other countries as well.

This system sets up a process which leads inevitably to the rich getting richer and the poor, poorer.

It creates poverty and underdevelopment, establishes classes with conflicting interests, and destroys human dignity in the process.

All people of faith need to focus their attention first on the liberation of the victims of an unjust society, a total liberation which is personal and social, economic and political. At the same time they need to be building a new society.
Critical Awareness

Paulo Freire provides us with a philosophy of education and development, and a very practical method of:

- getting groups actively involved,
- breaking through apathy, and
- developing critical awareness of the causes of problems.

"Some of the dominant class join the oppressed in their struggle for liberation. Theirs is a fundamental role and has been so throughout the history of this struggle. However as they move to the side of the exploited they almost always bring with them the marks of their origin. Their prejudices include a lack of confidence in the people's ability to think, to want, and to know. So they run the risk of falling into a type of generosity as harmful as that of the oppressors. Though they truly desire to transform the unjust order, they believe that they must be the executors of the transformation.

They talk about the people but they do not trust them; and trusting the people is the indispensable precondition for revolutionary change. A real humanist can be identified more by his trust in the people, which engages him in their struggle, than by a thousand actions in their favour, without that trust."

"To substitute monologues, slogans, and communiqués for dialogue is to try to liberate the oppressed with the instruments of domestication."

Paulo Freire,
Pedagogy of the Oppressed

He has given us insights into:

- the different levels of consciousness,
- the direct link between emotion and motivation to act,
- the importance of having the participants themselves choose the content of their education rather than having "experts" develop curricula for them, and
- the fact that all real liberation and development must rise from the grassroots up. Transformation is not something that one person can do for somebody else.

All these insights have helped turn education and development programmes upside down in the last twenty years.

Key Principles of Freire

1. No education is ever neutral, it is either domesticating or liberating.
2. People will act on issues on which they have strong feelings (generative themes).

This can be contrasted to the old 'banking approach':

Banking Approach
- Teacher knows all
- Pupils seen as empty vessels needing to be filled with knowledge
- Teacher talks
- Pupils listen.

Problem Posing Approach
- Animator provides for creative thinking, activates participants to consider a common problem
- Animator raises questions: why, how, who?
- Participants describe, analyze, decide, plan.

3. The whole of education and development are seen as a common search for solutions to problems (problem posing). From the beginning all participants are recognized as thinking, creative people with the capacity for action. The aim of the animator is to help them identify the aspects of their lives which they wish to change, to identify the problems, find the root causes of these problems, and work out practical ways in which they can set about changing the situation.
4. Genuine dialogue is important—a real learning community where each shares their experience, listens to, learns from the others. No one has all the answers, and no one is totally ignorant. Each person has different perceptions based on their own experience. The so-called educated, who have been trained mainly through the institutions of the dominant class, have a lot to learn from the people. To discover solutions everyone must be teacher and learner.

The role of the animator is to set up a situation in which genuine dialogue can take place.

5. Reflection and action are essential. Most real learning and radical change takes place when a community experiences dissatisfaction with some aspect of its present life. An animator can provide a situation in which the community can stop, reflect critically upon what they are doing, identify any new information or skills that they need, get this information and training, and then plan action.

Often the first plan of action will solve some aspects of the problem, but not deal deeply enough with the root causes of the problem. By setting a regular cycle of reflection and action in which a group is constantly celebrating their successes, and analyzing critically the causes of mistakes and failures, they can become more and more capable of effectively transforming their daily life.

6. Radical transformation of life is for each person, the environment, the community, and the whole society. It is not an individualistic academic exercise, but a dynamic process in which education and development are totally interwoven. It recognizes that each person has a contribution to make in building a new society, and tries to help each person and each community become more and more capable of, and committed to, the service of the people and national transformation.

Listening for Generative Themes

In the Freire method people listen with a clear idea of what they are listening for—issues about which people have such strong feelings (generative themes) that they will break through apathy and stimulate initiative in the community. Emotion is linked to motivation.

The whole approach is different from that of traditional surveys in which the research worker prepares beforehand a questionnaire of facts he is going to find out about. In this method he listens to unstructured conversations in such places as markets, buses, homes, washing places, etc., where people feel relaxed and talk about the things they are most concerned about. He listens especially for feelings about meeting basic needs, relationships between people, community decision making processes, education and socialization, recreation, and beliefs and values.

Problem Posing Materials

Problem posing education is much easier if one uses codes which have been specifically prepared for a group on the basis of the generative
themes which have emerged through listening. A code is a concrete presentation of a familiar problem. It may be a picture, a play, a poem, etc. The important thing is that it raises questions, it does not provide solutions.

![A problem posing picture ("code").](image)

We recognize that a generative theme has been tapped when a group suddenly comes to life. The room is alive with emotion, whether it be excitement, anger, worry or joy. Nearly everyone wants to express their feelings — there is no longer apathy or boredom. There is energy that could lead to action. But of course, many discussions filled with feeling do not lead to action. They waste away in fruitless grumbling unless the energy is channelled and directed. This is the role of the animator, ‘to present to the community in a challenging way those topics which they already have been talking about in a confused way’, and then to lead the group, step by step, through a process leading to transformative action.

The animator leads the group through a series of steps in the discussion of the code, asking what do you see happening, why is it happening, does this happen in real life, what problems does it lead to? To help them discover the root causes of these problems he or she will use what David Werner calls the ‘But why method’.

‘The child has a septic foot.’
‘But why?’
‘Because she stepped on a thorn.’
‘But why?’
‘Because she has no shoes’
‘But why?’
‘Because her father cannot afford to buy her any.
‘But why?’
‘Because he is paid very little as a farm worker.’
‘But why?’ etc., etc., etc.

How People Learn
Tests have shown that people remember
20% of what they hear,
40% of what they hear and see, and
80% of what they discover for themselves.

Conclusion
These theories, codes, and exercises have been used effectively with groups in Africa and India over the past 14 years. There is no short cut to effective leadership of groups. Sensitivity to the needs of the group and quick, sure judgements on what will be most helpful at any given moment, can only be developed through constant practice, complete openness to feedback from participants, critical reflection, analysis, and years of experience.

Again we emphasize that development and education are first of all about liberating people from all that holds them back from a full human life. Ultimately development and education are about transforming society.

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2. David Werner and Bill Bower, Helping Health Workers Learn. The Hesperian Foundation, USA (see USEFUL PUBLICATIONS).

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The fatal pedagogical error is to throw answers, like stones, at the heads of those who have not yet asked the questions.

Paul Tillich
CBHC IN EUROPE

It is not only Third World people who suffer from dependency on technology for health. In North America and Europe about 40% of all deaths in the middle age population are from heart and blood vessel (cardio-vascular) disease, making it one of the worst world- wide epidemics of all times. Surgery on the heart for blocked arteries is increasingly advertised as the ultimate in high quality health care and thousands are having it done. Mostly ignored is the overwhelming evidence that it is not necessary, with some changes in lifestyle, to get blocked arteries. Truly high quality health care would be facilitating and enabling people to make these lifestyle changes.

In Eastern Finland the population of North Karelia became concerned when they learned they had the highest incidence of heart attacks in the world. Among the county’s total population of 180,000 some 1000 heart attacks took place every year, about half of them in men under 65 years of age and about 40% of them caused death.

Alarmed by newspaper reports of these statistics, the residents asked the government to help them solve the problem. A major community-based preventive cardio-vascular study was launched. With the community pressing for action, WHO and other experts were called in to do a baseline survey of behavioural and medical information.

The project was based on the following premises:

- Major success in controlling a chronic disease can be based only on primary prevention.
- Major control of cardio-vascular disease is possible with existing knowledge if it can be effectively applied to the population.
- It is more effective to attempt to lower the risk for the entire population than to intervene only in those with high risk.
- Merely informing people of the behavioural factors causing a disease is usually not enough to change the behaviour.

- Since the problem relates closely to lifestyle, the population itself has to make the decision to organize itself to solve the problem, with the help of project experts.

Organizing themselves for action, and with appropriate input from the experts, the people stopped smoking, reduced their intake of fat, and exercised more. Deaths from heart disease among middle-aged men in North Karelia declined 22% in five years.

1 From Annual Reviews of Public Health, 1985. 6:147-93

WCC Photo: Peter Williams
Exercising for Improved health in Holland.
PROBLEMS IN CBHC

△ Community-based health care takes time, lots of time. It is a difficult process to overcome the apathy and despair of generations of poverty. It may take years for a trained animator to see significant changes and perhaps even longer for significant health problems to be addressed adequately by the people. But the quick, easy fix from the outside has been applied long enough to see that the results are not significant.

△ Animators are often seen as a threat in certain political climates. Indeed large numbers have been killed in the countries of Central America, Southern Africa and the Philippines. These facts must be openly discussed in the training of animators and the communities they serve. But we must not forget that it has always been those who were willing to risk that have empowered others to determine their own destiny locally, nationally and globally. The goal is not anarchy but transformation of social institutions which oppress into those who recognize the rights of all to a share in the benefits of society.

△ Will it work in the city? Yes. People everywhere are in community. It may not be geographic, but everyone has a group of friends with common interests. Successful urban community organizers have made use of this fact.

△ What role is there for medical professionals and institutions? We must say emphatically that there is always a need for doctors and hospitals in the total health care system. Where they exist, may they continue the important function of treating those with complicated sickness. But let them recognize that disease is not eliminated by treating the sick. Let them encourage and support that part of the system that seeks to facilitate health. A majority of illnesses can and should be handled by mothers and others in the community. The medical professionals and institutions can help by giving them training and logistical support and be ready to provide information when they are asked. Then the hospitals can be free to do that which they are trained and equipped to do — take care of complex medical problems. Then the patient, not the doctor, is at the centre of the health care system. Above all, let all interested in health recognize that for most of the people in the world health is

"Listen until the whole cultural arrogance of your mind has been exhausted, and you really begin to hear the voice of the people."

Illustration from Crelando Unido, CINDE, Medellin Colombia
not a medical problem but a social one, and actively support them in the appropriate political arenas in their quest for the basic necessities of life that are required for health.

Medical schools must be reoriented from focussing on curative medicine to looking at health problems of communities in totality. Students must be taught the whys and hows of community participation in health so that they can be intelligently supportive.

Δ Most people have been taught in various ways and for various reasons to believe that what they need is injections, medicines, a doctor or a hospital. Often governments reinforce this by promising free health care to all. Only participatory education with the community focussing, not on needs but on problems and their appropriate solution, will overcome this barrier.

Δ Donor agencies unfortunately, are reluctant to support such unstructured CBHC activities. But money invested in training animators is clearly the most cost effective in the long run for improving health.

The Challenge

We are aware of health projects and programmes using the principles of community organizing through participatory education in many parts of the world. We do not list them here because we know from experience that development tourism can destroy the very principles which are so important for their success.

Going far beyond the mere patching up of sick people, community-based health care builds a caring, supporting, community which seeks the best for all. We believe that HFA 2000 is most likely to happen through the massive training of animators to empower communities to regain responsibility for their lives and health.

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**BRINGING PEOPLE TOGETHER**

Awareness or consciousness about a problem can be classified broadly into three levels: magical, naive and critical. The quality or nature of any action depends on the kind of consciousness one has. A magical consciousness leads one to a magical action.

For example if a person believes that diarrhoea is caused by evil spirits he will recourse to magical actions like rituals to appease the evil spirit.

To believe that root causes of diarrhoea are germs/polluted water is naive. Hence medicine and boiled water are naive solutions. But to see that the root causes of diarrhoea are the lack of good drinking water, lack of food, unjust distribution of land and unjust wages suggests that the root causes need to be tackled.

A village animator tells the story of his work:

We belong to a small village named Bodo Khoni, in Mohana Block of Ganjam District in Orissa.

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1. Adapted from *Medical Service*, vol. 43, #2 (Feb. - March 1986), Catholic Health Association of India (CHAI)

* Fr. Chacko Paruvani is a member of CHAI/CHD team. He is involved in adult education programmes in Orissa.
People in our neighbouring village took a different decision to solve their water problem. They marched together to the block development office to demand a well because they realised that good drinking water was their right as citizens of India and that it was denied to them unjustly. They too got a new well.

The role of the health animator is to enable the people to exercise collectively their responsibility to maintain their health and to demand health as their right.

I realised that most of us, including me, were spending money and time unnecessarily going to the doctor for any ache, while most of the cases could have been treated by any one of us and many cases were self curing.

The money thus wasted could have been used to buy food. Health is in our hands and we need not buy it from specialists for the price they arbitrarily fix. We are already poor. Why should we allow ourselves to become poorer through medical exploitation?

Though I started to treat some common diseases in the village, I soon realized that they could not be got rid of unless the root causes of these diseases were tackled and this could be done only through the collective effort of the villagers.

So I thought of bringing all the people together to reflect on their village problems. People were very enthusiastic to discuss their health and development-related problems.

The non-formal get together became a regular feature. Sometimes people from CHAI and other organizations gave us some guidelines.

As a result of these non formal gatherings for discussion we felt the need for more organised bodies in the village to take concrete decisions on action programmes.

Thus we formed ourselves into two village organizations: Mahila Sangho (Womens's organization) and Gramya Sangho (Men's organization).

In our Mahila Sangho we discuss mainly problems relating to women and the education and health of the children. Now we realize that health is not only an absence of illness. It means ability to express our opinions and to take effective decisions concerning health, development, cultural life and also to elect representatives for the panchayath. It means physical, mental and spiritual well-being.

Here are our Mahila Sangho members.

Both the Mahila Sangho and Gramya Sangho have elected office bearers like President, Vice-president, Secretary and Treasurer and have a meeting at least once a month. Both these sanghos meet together whenever a common action is to be undertaken.

Now we are confident to tackle the problems of our village one by one in a very organized way. For example:

Our village shop

We were depending on the merchants who came from outside for our essential commodities like rice, salt, kerosene etc. These merchants made enormous profits because they fixed the price arbitrarily and we had to pay.

So, we discussed this matter in our regular meetings and decided to put an end to this exploitation which really affects our health. Unless we get good food items, regularly, at a price affordable we will always have the diseases arising out of malnutrition. But to initiate a shop we needed money. So we started a saving scheme. Now we have a shop and the merchants cannot come to exploit us. This same shop is used as a grain bank so that we always have some food grain even in lean seasons.

In order to improve our purchasing power and the unity of the village community we decided to make use of the government resources. Thus we started to have a community goat rearing
programme subsidized by the Integrated Rural Development Programme (IRDP) of the government. The goats are looked after by families on turn, and the profit is used to initiate similar programmes.

In our regular evening meetings we have initiated a functional literacy programme for those who cannot read and write. Now most of us can read and write whatever we really need to in our day to day life. We are proud of it.

We have also started a non-formal school for our children. Our children learn about the village problems and they too have begun to contribute their share to building a healthy community.

We are poor but we have our own dignity and our own cultural talents. We want to develop all our talents. Till now, we, with our culture, were kept suppressed by the rich and the powerful. Now we are rising up from a culture of silence and oppression to a culture of enlightenment and self-dignity.

The role of the village level animator is to enable the unorganized and the marginalized to get organized so that they can be craftsmen of their health and development and creators of their own culture and history.
SUMMARY: COMMUNITY- BASED PROGRAMME

Inside community:
Animator listens to unconstructed conversation to find out what people have strong feelings about!

An open attitude encourages people to speak freely

Acceptance will build peoples confidence in themselves and increase their faculty to organize.

Generative Themes, reflected through 'codes' will generate energy to break through apathy and will stimulate initiative.

Confidence and success:
leads to other tasks being taken on.

Managing the problem alone stimulates credibility and confidence in the community

Reflection and action
When causes are found, the solutions must be discussed and undertaken by the community.

Find causes of problems:
Find the root or roots of the problem by asking "WHY?"

Asking "WHY?"
reveals three possible causes of problems:
- natural
- social
- political

Flowchart by Monika Witak-Venulet
USEFUL PUBLICATIONS

Training for Transformation by Anne Hope and Sally Timmel is the best publication we have seen on the "How to" of community participation. Using Freire's liberating principles of participatory education and insights from many development agencies around the world, the authors' twelve years experience is a solid background for their excellent step by step advice on methods of empowering communities. The series of three workbooks is published by Mambo Press, PO Box 779, Gweru, Zimbabwe. It is also available from MAP International, PO Box 50, Brunswick, GA 31521-0050, USA for US$ 18 plus postage.

Primary Health Care and Peoples Movement contains the major papers given at an international conference by that name, organized by the Coordinating Committee for Primary Health Care of NGOs (CCPN) in Thailand in 1986. CCPN, 132/14 Soi Orapin, Rama 6 Road, Bangkok 10400, Thailand.

The February/March edition of Medical Service, the journal of the Catholic Hospital Association of India is titled Health and Power to People. It contains much useful information from the grassroots on the subject. CHAI, CBO/Centre, Goldakhan, New Delhi - 110001, India.


Agriculture-Health Linkages by Lipton and de Kadt is a WHO publication outlining the impact of agriculture on health and how agriculture can be made responsive to health. It is the first publication we have seen which discusses the growing problems of overnutrition in health. WHO Book Sales, 1211 Geneva, 27, Switzerland or from booksellers around the world.

Empowerment - How to Promote Your Own Wellness by Thorsheim and Roberts is a personal workbook for understanding the importance of relationships in community for health. Social Ecology Resources, Inc., Northfield, MN 55057, USA.

PRICOR Monograph Issues Paper 3 is titled Community Organization. This scholarly look at the need for research on community organization for primary health care cites numerous references from the medical literature on the subject. Authored by Goldsmith, Pillsbury, and Nicholas. PRICOR, Center for Human Services, 5530 Wisconsin Ave., Chevy Chase, MD 20815, USA.

Community Organization and Rural Development: A Learning Process Approach is an article in Public Administration Review reprinted in 1980 by Ford Foundation. Recognizing the failure of reallocation of funds through donor projects to be effective, it supports the need for "bottom up" approaches to development. Extensive bibliography. Ford Foundation, Office of Reports, 320 E. 43rd Street, New York, NY 10017, USA.

Partners in Evaluation by Dr. Marie-Thérèse Feuerstein, published by T.A.L.C. is both a practical field handbook and a textbook. The methods, principles and examples it contains can be used in many different types of programmes but they are particularly appropriate to development and community programmes, whether in health, agriculture, adult education, rural or urban development, and craft cooperation. This book is to be used by field practitioners. See TALC address below.

Rural Development by Robert Chambers, supplied by T.A.L.C. deals with the theme of rural poverty that is often unseen or misperceived by outsiders, those who are not themselves rural and poor. That the outsiders rarely appreciate the richness and validity of rural people's knowledge, or the hidden nature of poverty. This book is for all concerned with rural development. See TALC address below.

The Struggle for Health by David Sanders and Richard Carver, supplied by T.A.L.C. argues for a radically new approach from those who want to promote health. This book traces the connection between economic development and improved health in the West and looks at the reasons for continued social inequalities in health in both developed and developing countries. It is destined for health workers and the general public.

For more information write to:
T.A.L.C. / Box 49
St. Albans/Herts, AL1 4AX/ U.K.
Once again we list *Helping Health Workers Learn* by David Werner and Bill Bower as a very useful publication, providing much information on what people can do for themselves as well as on empowerment for health (Chapter 26). *The Hesperian Foundation, P.O. Box 1692, Palo Alto, CA 94302, USA.*

Taking sides, *The Choices Before the Health Worker*, by Dr. C. Santhymala, Nirmala Sundaram. Nalini Bhanot shows how and why disease and ill health are a result of poverty and exploitation, factors which modern medicine largely ignores. The “choice” is whether a health worker in a rural village will change the focus of her work to spend a major part of her time in the village, understanding and dealing with the root causes of ill health rather than simply treating patients as they fall ill. The last seventy pages give specific advice on how a health worker can identify with the groups of people who are most oppressed and assist them, through developing an understanding of the reasons for their oppression. This book is recommended for health workers of all levels. *Voluntary Health Association of India (VHAI), 40 Institutional Area, South of IIT, New Delhi 110016, India.*

**CMC NEWS**

Associate Director Dr. Reginald Amonoo-Lartson has resigned from CMC to return to Ghana, from where he intends to work as an independent health services consultant concentrating on countries in Africa.

Reggie joined CMC as a full-time consultant in March 1984, and was appointed Associate Director in September 1985.

While with CMC, he played an important role in promoting Primary Health Care, especially in the field of district management. He was involved in planning and organizing workshops on the topic of Family Health Programmes in PHC in many parts of Africa as well as taking an active part in the life of the WCC.

Reggie says that his commitment to PHC remains strong, but he feels the time has come to return to the field where the problems emanate and where he can be in direct contact with the people facing them. His new address:

> Dr. Reginald Amonoo-Lartson,
> P.O. Box 1659, Tema, GHANA

Ms. Monika Witak-Venulet joined CMC on the 1st of October, replacing Sandra Freeman as Editorial Assistant for CONTACT.

Before joining the WCC, Monika finished her studies in Political Sciences and followed courses in Medicine, this field being of particular interest to her. Her previous professional position involved much writing of manuals. Having travelled to and sojourned in many countries, she is open to different people, cultures, traditions and is looking forward to being part of the chain that promulgates information all over the world.

**CMC 20th ANNIVERSARY**

The Christian Medical Commission was created as a part of the World Council of Churches in 1968 to

- “assist the churches in their search for an understanding of health and healing,
- promote new approaches to health care and
- encourage those involved in church-related health care programmes to join in planning and coordinating their activities for more effective service.”

The first issue of CONTACT appeared as an occasional paper in October 1970. There are now over 26,000 readers in 130 countries.

As we face CMC’s third decade it is clear that much remains to be done. We thank God for the many committed people in the CMC network around the world and pray for His guidance as we chart the course ahead.
The JPIC Process

What does JPIC, the new ecumenical buzz word mean? It is the short for Justice, Peace and the Integrity of Creation. These are three important areas of concern for people around the world, Christians and non-Christians. At the last General Assembly of the World Council of Churches in Vancouver 1983, it was decided that Christians and churches everywhere should work together on these issues seeking a common understanding and common responses.

In many congregations and church groups people are meeting to study and learn about the realities of life of other groups. They try to understand the relationship between power, wealth and injustice; between economic growth and the destruction of nature and man; finally between poverty, hunger and political unrest. They study what Jesus taught about these issues and discuss what this means for their lives today. How can they as individuals and groups actively work for justice, peace and the integrity of creation (the protection of nature and art)? For some it might mean organized civil disobedience and non-violent struggle (eg. Philippines, South Africa or Central America), for others it might be working together to improve the socio-economic situation in the community (eg. base-communities in Latin America, community health programmes in India, or planting trees in Africa). In the rich world it can mean demonstration against production and export of arms, boycott of companies with unethical marketing and sales practices deceiving consumers (pharmaceuticals, baby foods etc.), conscious choice of products, where the production does not exploit and destroy nature (reusable bottles instead of aluminium cans or paper packages, food grown with little or no chemical fertilizer etc.).

All these actions by groups or individuals may seem small and meaningless one by one, but together they are part of a global process to bring peace and justice to all and to save our earth and humanity from exploitation and destruction. To achieve this, Christians and all others of good will, have to work together to counteract the disastrous effects of greed, selfishness and hunger for power.

How can we as health workers all around the world be involved in this important process?

Write to CONTACT to tell how you are or could be involved in the process.

Birgitta Rubenson
Many projects begin by pointing out what people do wrong.

On the contrary, one should start by pointing out what people are doing correctly.

This attitude undervalues the people and makes them feel bad.

This attitude improves self-esteem and self-confidence.

Illustration from Creando Unidos, CINDE, Medellín Colombia

"In the first six months, the risk of morbidity and death from diarrhoea is respectively 15 and 25 times higher for children not receiving breastmilk, compared to those who have the immunological protection of an exclusively breastmilk diet."

UNICEF Annual Report, 1988
This month people around the world will celebrate the anniversary of the birth of Jesus of Nazareth in Palestine nearly 2000 years ago.

We believe that in Jesus, God came to live among us in human form. His life as well as his teaching showed us God’s special concern for the poor and oppressed. His execution by the authorities and subsequent resurrection demonstrated that unselfish love, although not easy or popular, is the only power that will last. He calls each of us to follow him in building a world where all creation is able to achieve the full potential given by God.

It is in this spirit that the Christian Medical Commission staff and commissioners around the world join in wishing you a

**MERRY CHRISTMAS** and a

**HAPPY, HEALTHY NEW YEAR!**

CONTACT is the periodical bulletin of the Christian Medical Commission (CMC), a sub-unit of the World Council of Churches (WCC). It is published 6 times a year in 4 languages: English, French, Spanish and Portuguese. Selected issues are also being printed in the Kiswahili language in Kenya and Tanzania and in Arabic language in Egypt. Present circulation is in excess of 28,000.

Papers presented in CONTACT deal with varied aspects of the Christian community’s involvement in health and seek to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the 1st issue of each year in each language version. Articles may be freely reproduced providing acknowledgement is made to: CONTACT, the bi-monthly bulletin of the Christian Medical Commission of the World Council of Churches.


The average cost to produce and mail each copy of CONTACT is SF2.50 (US$1.50), which totals SF15. (US$10.00) per year for 6 issues. Industrialized-country readers are strongly encouraged to subscribe to CONTACT to cover these costs. Please note that orders of back issues of CONTACT will be charged at the above rate.