BASE CHRISTIAN COMMUNITIES and HEALTH

NANGINA CBHC PROJECT
INTRODUCTION

In a small upstairs room in Jerusalem almost 2000 years ago twelve men were endowed with the Spirit of God, and went out to change the whole world.

In the 1980s many Christians are rediscovering, as they gather in homes to study the Bible and reflect on its meaning for their daily lives, the power of that same Spirit. Often referred to as Base Christian Communities, they are to be found throughout the world and are changing the fabric of social and political life, not only of their own communities, but in ever widening circles.

Many of these Christian Communities have taken on the challenge of health care, directing very effectively their zeal and commitment to the eradication of many needless forms of suffering and death. As grass roots peasant organisations, peoples participation and self reliance are a natural part of their operational style. This month CONTACT presents an example of how CBHC can be effectively implemented through these communities.

Often experts in PHC discount programmes that rely on the charisma of a leader or a group. Perhaps that is why PHC is often not as effective as we think it should be. Perhaps it is time to recognize the power of personal commitment to the God who created this vast universe. Perhaps we should find ways to identify and encourage charismatic leadership to champion the PHC cause, rather than discount it.

Twelve uneducated but committed men changed the world for all time. Why shouldn't we?

Dave Hilton
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THE LAND AND PEOPLE OF SAMIA
Extending from the north-eastern shores of Lake Victoria in the middle of East Africa’s great Lake Basin lies Samia Location. Settlements and villages are found in the midst of bush and lightly wooded grassland covering low green hills between 3000-4000 feet above the sea. A subdivision of Busia District in the Western province of Kenya, it measures 30 x 15 sq. kilometres.

Although there is no certain data on the present population, a census in 1979 recorded 47,384 people. With an estimated annual growth rate of at least 3%, the population is now likely to be more than 62,000. More than half would be below the age of 15.

Samia Location belongs to the less developed areas of Western province. With the total absence of industrial development except for a seasonally operating cotton ginnery, opportunities for salaried employment are few except for those working in government service, schools or Nangina Hospital. In many families the women are at home while the men live and work in Nairobi or other industrial centres.

Most people are small-scale subsistence farmers. The soil is not very fertile — Nangina is called “the place of stones”. Rainfall is unreliable. The people usually grow maize, cassava, millet, beans and groundnuts, mainly for their own consumption. Cotton is the only cash crop. Most families keep some chickens and goats, but few cattle.

FALTERING STEPS TOWARD PHC
In 1973, Nangina Hospital in Samia Location opened a Nutritional Rehabilitation Unit for mothers and children with severe malnutrition. Mothers were admitted together with their children and learned through practical experience how to prepare a healthy diet for their children using local foods. This nutrition unit was modeled after a local homestead and mothers learned the nutrition value of local foods as they observed the health of their children improve. A need was recognized to follow-up the mothers and children after they had been discharged, to give nutrition classes to other mothers, and identify cases of malnutrition in the community. For this purpose a Nutrition Aide Field Worker was trained in 1974 and proved to be effective.

The positive response to the Nutrition Aide led to the idea of broadening the function to include other aspects of health promotion and disease prevention. Nangina Hospital approached the leaders and clan elders in the different locations with the proposal to select and send candidates for training as “field health workers”. After an interview a group of 8 young married mothers with a minimum of seven years of education, were given 6 weeks training. They were expected to promote health in their own communities, give health and nutrition education during mobile clinic visits and home visits, and refer cases to the hospital. They were part-time workers and received a salary from the hospital. These workers answered a great need in the community by providing health education at grass roots level. However their ever increasing demands for a raise in salary, transport, etc. could not be met by the hospital and the project was abandoned.

An evaluation of the experience showed that there existed an obvious need for health education at the grass-roots levels, but that the answer to this need was not hospital employees who, by virtue of their salary, were set apart from other mothers and associated with the institution. It was clear that the people involved in the programme should be volunteers and thus remain part of the local community.

Another aspect was the enormous costs involved in employing yet another cadre of workers. It became obvious that a different approach had to be found, namely involving the community in identifying their own needs and resources. The person in charge of the programme looked for a stable and supportive infrastructure of which the proposed health programme could be part.

* Based on a history of Nangina CBHC programme written by Sr. Gertrude Dedrichs in May, 1988.
DEVELOPING SPIRITUAL COMMUNITIES

Socio-economic development of Kenya has brought education, increasing mobility and other social changes which have led to a general weakening of the traditional social organization and group solidarity. Expectations raised by education coupled with lack of possibilities for salaried employment in the area has caused many men to leave in search of work far away in one of the industrial centres, leaving a vacuum in leadership roles traditionally assumed by men. Communal action and cooperation is weak except for sporadic efforts for specific projects, the so-called "Harambee". Looking for a stable social infrastructure to support its planned community-based health care (CBHC) programme, Nangina Hospital turned to the Catholic church which in recent years had promoted new forms of communal action, cooperation, leadership and organization.

Forty to forty-five percent of the people of Samia are members of the Roman Catholic church. Since 1974, significant changes have taken place in the Roman Catholic parish. There has been a move away from a centralized structure, making every Christian and his/her local community an active part of the Church. Seeing the community as the Body of Christ, Christians became aware of their dignity, giftedness and responsibility as a member of that body. They realized that Christ is alive and active in each Christian and wants to extend His love and offer His salvation to people through those who are members of His body. Each person was understood to be gifted by the Lord to make Christ's life and love a reality in a specific way.

Not only the ordained minister or the salaried church workers are in mission, but every Christian in his/her own environment. It is recognized that it is not only the "professionals" who are able to understand the Word of God and proclaim it authentically, but every Christian is given God's Spirit for this task.

Based on this understanding the parish priest has tried to make the Christians aware of their dignity and mission, thus making the faith more alive and relevant to their daily life situation.

WCC Photo: Michael Dominguez
The outstanding characteristic of the Christian Communities is a shared spiritual motivation.
Ceremonies such as the blessing of seeds, infant baptisms, and the celebration of the Holy Communion are now conducted in the respective communities. Furthermore, the Christians started coming together informally to pray and to read the Bible and apply it to their own life situation. This fostered a new sense of unity and purpose among the Christians, who joined together for communal action, assisting each other, especially the old and poor members of the community. Similar groups, often called Base Christian Communities, are found throughout the world.

The people became more actively involved in the planning and implementing of church activities through their own elected delegates who form the central Parish Council and 6 sub-Parish Councils in the various areas. By mid-1976, 43 Christian Community Groups were established and had proved themselves viable organizations on the grassroots level, having much experience in such social activities as raising communal gardens and building houses for poor and aged community members. The outstanding characteristic of these Christian Communities (CCs) is a shared strong spiritual motivation.

MOBILIZING THE COMMUNITY FOR HEALTH

Arising from reflection on their own life experience, the communities shared a holistic understanding of health which includes physical, psychological, social and spiritual realities. The parish organization and its CC appeared to be the most suitable social structure on which to build the hospital's CBHC programme.

Through the parish priest the hospital approached the leaders of the Christian Community groups and explained the new programme to them. It was made clear that the persons trained would go back to their own communities, their work would be completely a voluntary service rendered to the community, and any support for the voluntary health workers must come from the community they serve. There was an enthusiastic response from the CCs who were very eager to incorporate health into their sphere of activities.

At that point the following goals and objectives were developed:

(a) to improve the health and nutritional status of the community, especially the children and lactating mothers;
(b) to make available a basic minimum of health and nutrition education to a maximum number of people;
(c) to provide health and services that are relevant to the community in terms of effectiveness and acceptability;
(d) to improve environmental sanitation;
(e) to create a better understanding and a cooperative relationship between the hospital and members of the community;
(f) to make every father and mother a health educator in their own homes.

This was to be done by training Community Health Workers (CHWs) who could encourage community involvement in health and facilitate open discussion of their health problems, leading to solutions. The CHWs would provide a liaison between the hospital and members of the community.

COMMUNITY HEALTH WORKERS

Whereas the "field health workers" had been proposed by the local leaders and selected according to criteria set by the hospital, the selection of the Community Health Workers was done by the local Christian Communities according to their own criteria.

The goals and ideas of the CBHC programme were explained to the Christian Communities. People were then free to volunteer, knowing the sacrifices this would mean in terms of time and energy, to be a CHW. Screening was done by the CCs, who required any volunteer to have the personal spirit (gift) of caring — she/he had to be a spiritually-minded person who is also community-minded. Also considered were traditional attributes of a leader such as patience, trustworthiness, approachability, and the love for peace and wisdom which is often associated with advanced age. Heavy drinkers were excluded.

Because the Communities had been involved in self help projects for some time they knew those who were dedicated, reliable, and selfless and willing to assist others. Some had shown an interest in the work of CHWs and had assisted them with their work.
Nearly half of the first groups of Community Health Workers were illiterate. Whereas the first group trained comprised mainly mature senior women in the community, later groups consisted of both men and women of all age groups. CHWs are average rural villagers with no more or less socio-economic or educational status than others.

Being aware that the training does not entitle them to salaried employment, the main source of motivation for CHWs springs from the meaning which their activity/service has in their own life and in the life of the group. At first the health workers were called ‘Clan Health Workers’ following the initial terminology and organization of the CCs according to clan lines. The name changed later, because people living in one neighbourhood do not necessarily belong to the same clan, yet form a community. Thus the term “Community Health Worker” was introduced.

**BASIC TRAINING**

The two-week basic training is conducted in the vernacular language by a member of the Public Health Team using the psycho-social method developed by Paulo Freire to teach adults (see Contact 106). It focuses on topics and issues relevant to people’s lives and draws on their life experience and expertise in solving their own problems rather than considering them helpless and ignorant. The method involves people actively in the process of learning through discussions and group work. The goal is not simply transmitting knowledge but also mobilizing for action. The “teacher” is more a facilitator of discussions than an expert who knows everything; she/he supplements the knowledge present in the group and provides additional information only where needed.

The training sessions begin by eliciting the trainees’ own perception of their pressing needs and problems. These initial sessions have revealed how deeply rooted the traditional views of illness are. The local people, the trainees included, consider witchcraft the most common cause of illness. In this situation, information or knowledge will be unlikely to change their attitudes towards health and disease. It has become clear in the training sessions that in this context personal conversion and transformation are effective in overcoming the deep-seated fear. Communal prayer and consideration of the spiritual aspects of illness play, therefore, an important role in the training sessions. This leads to the sharing of experiences where the effects of witchcraft and the resulting fear have been overcome through the power of Christ. This process enables the trainees to be more receptive to medical knowledge.

Subjects introduced are the basic elements of health and nutrition, mother and child care, hygiene, and sanitation as well as basic information regarding pregnancy, delivery, and antenatal and post-natal care. Details and sequence of the syllabus were determined by both the felt need of the community/participants and the needs seen by the trainer.

The primary goal of training is to create awareness about health in the CHWs and thus enable and motivate them to become health educators in their own homes. By giving a good example in their own homes they would gain the ‘authority’ to approach others about health promotion and disease prevention. The CHWs appreciate gaining the additional knowledge about a part of their life often regarded as secret and accessible to experts only (in both the traditional and modern approaches to illness the patient is often passive in the treatment). The CHWs feel empowered by the newly acquired insights and are eager to share them with their communities, using the psycho-social approach.

The initial learning is reinforced by a guided survey of the CHWs’ neighbourhood and its health needs. The results are discussed with a member of the Nangina Hospital Public Health Team in a monthly gathering of all CHWs at the hospital. These discussions as well as annual refresher courses and workshops serve as a means of on-going education.

**SECOND COURSE**

After the first course the CHWs work for a period of at least one year during which they do their basic Health Survey and practice what they have learned. If they prove active and committed, the CC may recommend them for the second course which includes First Aid, Oral Rehydration, simple treatment of common diseases such as fever, malaria, diarrhoea and vomiting, and the dressing of wounds. In 1980/1981 the first five groups of 15 CHWs went through the one week’s training. The content for each group was somewhat different as it depended also on
the expressed needs and interest of the participants. After finishing both trainings and having been actively involved in the work the person receives a Certificate of Attendance. CHWs who prove very dedicated are rewarded by the CC with a badge which identifies them as trained health workers.

ACTIVITIES
The activities of the CHWs are mainly health promotive and disease preventive. While their activities promote awareness about health in the community, they also involve an understanding of which problems can be solved within the community and which need referral to professionals.

Each CHW was supposed to serve 60-80 families; some covered many more during the initial years. The work includes:
(a) visiting the assigned homes to give education on health and nutrition (balanced diet, proper food for small children of pregnant or lactating mothers, food growing), immunization, ante-natal and under-five clinics, and hygiene (dish racks, latrines, compost pits, smearing of houses, etc.). CHWs choose to do much of their home visiting in small groups rather than alone, allowing mutual encouragement and increasing self-confidence;
(b) helping sick members of the community to go to the clinic or hospital;
(c) following-up cases referred by the Public Health Team and the Nutrition Rehabilitation Unit;
(d) health education during mobile clinic visits in their home areas;
(e) assisting with home deliveries;
(f) helping with MCH clinics (preparing the site, assisting with registration and weighing, and giving health education);
(g) giving health education at celebrations, parish meetings, primary school and catechism classes, etc.
(h) keeping a record of all activities and monthly health happenings in one's own area (with the help of the local secretaries if needed) and forwarding these data to the supervisors;
(i) Other activities: agriculture (planning what to grow and cultivate together); building homes cooperatively for the aged, poor and disabled members of the community; literacy classes (involved either as teachers or pupils); homecraft (making of brooms, baskets, mats ropes, etc. to raise funds for the community); and helping create safe water supplies for the community.

THE PROGRAMME GROWS

DISPENSING CHWS
SINCE 1982 selected groups of reliable CHWs have been trained to dispense medicines such as aspirin and chloroquine. Special attention is given to diagnosis by symptoms, e.g., fever, diarrhoea, and vomiting, and to treatment — including age adjusted dosage of chloroquine. Appropriate referral to a professional is stressed.

At the end of the course an exam is given and the whole group determines together who is qualified to be given medicine for dispensing.

Medicines are bought from the hospital pharmacy at cost price and resold with a small profit. The profit margin is determined by the community leaders. Part of the profit is for the CHW and the remainder is kept in a community fund.

Each dispensing CHW has a tally sheet to record what she/he dispenses. Before being
supplied with new medicines she/he has to hand in the tally sheet to the supervisors who again examine him/her on correct dosage and indications for treatment. Only if records are correct and the exam is satisfactory is the medicine supply renewed.

Originally it was hoped to have at least one CHW dispensing medicine in each of the 60 Christian Communities. Although many were trained in dispensing, today only 33 CHWs in 26 Christian Communities are actually dispensing. This is due to the fact that some CHWs and their Christian Communities had difficulties with the funds involved and were unable to pay for the medicines which had been supplied. The hospital decided not to replenish the supply unless the debts were paid. The Christian Communities still express interest in having CHWs dispensing, but 34 have not yet settled their debts.

TRADITIONAL BIRTH ATTENDANTS

Beginning in 1980, selected CHWs were trained in safe delivery and care of the newborn-child. They also learn to recognize potential complications of pregnancy and refer mothers early to the hospital. The Traditional Birth Attendants (TBAs) help at the ante-natal clinics and follow-up post-natal cases which are referred to them from the hospital. In keeping with the local tradition of the Samia, the TBAs are allowed to ask for a small remuneration if they assist a delivery. They are also willing to help people who are unable to pay the small fee.

Of the 35 TBAs trained to date, all but one who died are still active. In 1987 they assisted in 298 home deliveries.

IMMUNIZING ASSISTANTS

Starting in 1983, literate CHWs from each sub-parish were trained to help with immunizations. Training included immunization procedures and handling of vaccines. Today 16 out of the 24 trained are still assisting the supervisors with vaccinations. Originally it was planned that these CHWs would eventually be able to be responsible for the immunizations of children in their own areas but this has not yet been implemented.

TRAINERS

As the training of CHWs escalated there was a need to involve capable and dedicated health workers in the training. In 1981, twelve CHWs who had proved themselves in the field were introduced to the principles of the psycho-social method of teaching and involved in the basic training of CHWs. In the first year these trainers instructed 52 new CHWs under the supervision of the full-time staff.

Since that time the basic training of the CHWs and most of their refresher courses have been conducted by these trainers in their local communities. They teach in their own sub-parishes and, on request, other sub-parishes. The supervisors from the hospital only assist with the planning and selected topics and giving the final examination. Of the 25 CHWs trained as trainers, 10 are active.

The professional staff conduct supplementary training such as dispensing, giving immunizations, attending births, and new areas of interest such as TB, leprosy, etc. They also give refresher courses at parish level for the trainers and CHWs with special functions.
SUPERVISION SECRETARIES
From among CHWs who are literate and active, secretaries are chosen to assist their illiterate colleagues with the recording of activities in their area. They meet once a month with the General Secretaries of their sub-parish to hand on the data collected and report on any problem. Supervisors provide notebooks and a form published by AMREF (African Medical Research Foundation, Nairobi) which illustrates the major "health happenings" in a community. This form provides semi-literate CHWs a way to record their data accurately, allowing on going diagnosis of the health status of a community. The secretaries are accountable to their CC and the General Secretary of their area. They are provided a bicycle, a motorbike, and a monthly stipend by the parish council.

GENERAL SECRETARIES
Each sub-parish has 2 General Secretaries whose function is to assist the supervisors in their follow-up and support of the CHWs in the field. The tasks of the General Secretaries are as follows:

- being responsible for half the CHWs of a sub-parish;
- collecting and collating health statistics and activity reports;
- noting and forwarding information about significant developments or problems in the sub-parish;
- attending the monthly meeting with CHWs and assisting them with any problems;
- participating in the large group home visiting, recording the results and forwarding them to the HC, sub-parish and Parish council and the full-time supervisor;
- attending the monthly Health Committee meeting and reporting on the CHWs' activities;
- attending the sub-parish council;
- meeting once a month with the full-time supervisor and other General Secretaries in order to report, discuss issues and plan for necessary follow-up; and
- being accountable to the sub-parish council and the full-time supervisor/trainer.

AREA SUPERVISORS
Nangina Parish has 2 supervisors, each responsible for 3 sub-parishes. They receive a small stipend (KSH120, US$2) from the parish council. They have a motorbike and a bicycle at their disposal. The maintenance of the motorbike and the petrol are being provided for by the hospital, whereas the parish council pays for their driver's license and the maintenance of the bicycle. The tasks of these supervisors are:

- supporting and stimulating the work of the General Secretaries;
- assisting the full-time supervisor in her work;
- ensuring support for CHWs by following-up cases where problems have arisen;
- supervising the training and on going education;
- evaluating record of CHWs so as to identify progress and the degree of their effectiveness;
- attending the Health Committee meetings of the 3 sub-parishes (see below);
- attending the large group visiting in 3 sub-parishes;
- attending and reporting at the parish council meeting;
- meeting once per month with the full-time supervisor and area supervisors of neighbouring parishes;
- meeting with local government officials and informing them about relevant activities and problems and
- being accountable to the parish council and the full-time supervisor and trainer.
## Programme Staff Role

In 1983 the Hospital allocated two members of the Maternal Child Health staff for full-time supervision, follow-up and on going education of the CHWs. A Kenya Enrolled Community Nurse (KECN) and a Public Health Aide, facilitated the further development of the programme under the supervision of the medical doctor, who remained the over all project director. They are assisted in their work by the General Secretaries with whom they meet once a month to receive reports, discuss issues and plan follow-up according to the needs arising. In mid-1986 the KECN terminated her involvement with the CHWs in order to concentrate her efforts on Natural Family Planning and the Family Life Programme. This has left the Public Health Aide as the only full-time supervisor. Her tasks are:

- supervising, following-up, stimulating and supporting CHWs;
- ensuring support for the CHWs from the side of the CCFs, sub-parish, parish and hospital, by facilitating good communication and calling upon resource persons as needed;
- assisting in any area where problems have arisen;
- meeting once per month with the area supervisors of 3 parishes to receive reports and plan for follow-up;
- meeting once per month with the General Secretaries;

- assisting with and supervising training sessions conducted in the local communities;
- conducting the specified training for TBAs, HC members, secretaries, etc.,
- calling on professional staff as needed;
- attending the parish council meetings;
- attending the programme committee;
- being accountable to hospital and parish.

The affiliation of Nangina Hospital with the programme raised questions within the communities and among the CHWs regarding whether or not the hospital would eventually support them financially. This question was dealt with in the context of the Christian Communities and their understanding of Christian service rendered freely to one another.

Even so, since community autonomy was encouraged, the hospital’s role of clinical supervision appeared somewhat ambiguous to the CHWs and CCFs.

Unquestionably, however, on going education, support and stimulation from both the parish and the hospital proved to be essential for the motivation of the CHWs. The support and appreciation experienced both from the community and the hospital has been a vital factor for the function of the programme.
CHRISTIAN COMMUNITIES’ ROLE
In order to promote a better understanding of the work and role of the CHWs in their respective communities, frequent meetings have been held at different levels between the hospital staff, parish leaders, leaders of sub-parishes and CCs. These discussions highlight the fact that the CHWs are meant to serve the community, but also need the community’s support. Thus the community is expected to fulfill part of the supervisory role — help assess the quantity and quality of the work done by CHWs — but also to support them in their training and activities.

Once a month all the CHWs of one CC gather to visit the 10 homes of one of their fellow CHWs. The gatherings serve the same purpose as the other home visiting, while the work of the CHWs is acknowledged in front of local community members.

SUB-PARISH ROLE
The deliberations about the mutual responsibilities of CHWs and the CCs led to a general reorganization of the programme. In 1982, the CHWs were regrouped according to sub-parishes and began holding their monthly meetings in the sub-parish centres rather than in the hospital.

Training
Since 1982 all the basic training and refresher courses for CHWs have been conducted in the sub-parish centres. That means that the responsibility for the selection of trainees, the organization and support of training, etc. rests with the sub-parish and the respective CCs.

Health Committees
Health Committees (HCs) are formed in each sub-parish in order to assume the supervision and support of their CHWs. These committees consist of one annually elected delegate from the CC, the 2 General Secretaries of the sub-parish, and the 3 leaders of the sub-parish council who chair the monthly meetings. The role of the HCs is:
• ensuring the community support for the CHWs’ activities;
• helping to generate the necessary resources;
• making and supervising the implementation of the over all annual plan of all activities and trainings;
• receiving monthly reports about all activities;
• assisting in areas of difficulties;
• evaluating progress and identifying areas of need;
• approving and finalizing the list of new trainees and organizing the training including the necessary support;
• providing means for maintenance of bicycles of General Secretaries through the help of the sub-parish and
• linking with local government officials.

Some HCs have been functioning well in these tasks whereas the others have been weak. The latter have only held sporadic meetings. The reasons given are that many of the HC members are already overburdened with responsibilities or that the chairpersons are not very active. It is interesting to note that an active HC seems not necessarily to guarantee active CHWs and vice versa.

Sub-Parish Council
Each sub-parish has a council which meets monthly. Tasks of the sub-parish council are:
• receiving monthly reports about CHWs’ activities;
• providing means for these activities as needed (food during training sessions and group home visiting, transport to training sessions or seminars held at the pastoral centre, remuneration for outside trainers, maintenance for the 2 bicycles of the General Secretaries);
• chairing the HC meetings and

WCC Photo: Michael Dominguez
The communities are expected to support the CHWs in their training and activities.
• maintaining a savings account, part of which is for CHWs' activities.

**Group Home Visiting**

Group home visiting brings together all CHWs of one sub-parish on a set date to divide into small groups and visit all homes in that area (including homes that are not covered by CHWs). During the home visiting they record health data and invite the people whom they visit to gather at a particular centre. While the people gather, the returning groups of CHWs collate their findings about the sanitation and health status of the community. Role plays and health songs are used to educate people and create awareness about common problems.

Finally, the collated results — a kind of community diagnosis — are communicated to the people, and the most burning issues of their cause, effect and possible solution are discussed. The results of the previous year's home visiting are used as a reference and any progress or the lack of it can be easily identified. Local leaders (ligurus) and Assistant Chief(s) are invited to these gatherings and called upon to assist with the solution of problems. These large group home visits take place about once a year in each of the CCs. They serve as both support and supervision of the work of the local CHWs.

**ROLE OF THE PARISH**

In spite of the decentralization, certain specialized training sessions (for TBA's, HC members, secretaries, trainers and CHWs with specific functions), workshops and seminars continue to be conducted at the Pastoral Centre of the parish as these involve only a few members from each area. Since the courses are residential they provide an opportunity for in-depth motivation, e.g., informal evening sessions offer opportunities for spiritual growth.

**CHW Day**

Each year a CHW day is designated on which all CHWs gather at the Parish Pastoral Centre, compete in performing role plays and health songs and listen to the reports from each sub-parish. The parish council awards a prize for the sub-parish which has been the most active. The prize initially consisted of books but since 1987 a trophy is being given. This annual gathering is a very joyful event and expresses the community's appreciation for the services rendered by the CHWs. Those CHWs who have proved active and dedicated may be given a CHW badge by their local CC.

**Parish Council**

The parish council also shoulders part of the community responsibility for the CHWs with such activities as:

• receiving regular reports through the supervisors;
• paying for food and accommodation during training sessions conducted at the Parish Pastoral Centre;
• providing food during the meeting of General Secretaries;
• organizing the annual CHW Day and providing the trophy;
• giving a monthly stipend to the 2 area supervisors; and
• paying for the driver's license of the area supervisors and the maintenance of their bicycles.

**The Parish Priest**

The parish priest has played an important role in stimulating and sustaining the spiritual motivation of the CHWs and their CCs. He has encouraged the development of self-reliance and ensured the active participation at all parish levels. He has also taken part in the training sessions, pointing to the deeper spiritual and social dimensions of the activities. Without ongoing interest and support from the parish priest, the programme could not be sustained.

**ROLE OF THE HOSPITAL**

From the very beginning the Nangina CBHC programme has been a joint venture of the Parish and the Public Health Department of the hospital, each side taking an active interest in the CHWs and supporting them. Increased community participation and a more prominent role for the sub-parish level and the local CCs changed the task of the full-time workers in both parish and hospital. Now their task is to stimulate, encourage, support and assist in areas of need and provide on-going education. From the beginning good communication and cooperation between the parish and the hospital staff who were involved with the CHWs was crucial. Since 1982 annual meetings have been held at sub-parish level between the full-time
supervisor(s) of the CBHC programme and the leaders of the Christian Communities to evaluate and identify areas of common concern and formulate common goals and priorities. Furthermore, until the end of 1987, monthly meetings took place between the General Secretaries and the MCH staff, to discuss issues pertaining to the running of the Nangina Hospital mobile clinics.

**Outreach Programme Committee**

In 1985 an Outreach Programme Committee was formed which meets monthly to co-ordinate the work and generate the necessary support for the further development of the MCH clinics, the CBHC programme and the Family Life programme. The committee ensures communication between different levels, identifies common goals and concerns, and prepares the over all work plan. These meetings are attended by the parish priest, the full-time supervisor of the CBHC programme, the sister-in-charge of the MCH department, the Family Life co-ordinator and the hospital administrator.

**FINANCING**

During the programme's initial phase, 1976-1982, the hospital and parish financed training — provision of trainers, teaching aids, stationary, food and accommodation in the Pastoral Centre and a large share of the transport costs — while local communities helped their CHWs with part of the transport and the initial registration fee. During this period a total of KSH 114,930 was spent from hospital and parish funds on the various courses, seminars, and monthly meetings. This figure does not include the salaries for the staff members of the MCH team who were involved in these activities.

**CHW SELF HELP**

In 1981 the CHWs - who at the time were not yet organized by sub-parishes - decided to group themselves and start 3 income-generating projects to support their own activities (transport costs, food used during meetings or group home visiting...). When evaluated at the end of the year this approach proved counter-productive in two ways:

- it separated the CHWs from their local communities and created a separate structure and
- it absorbed too much of their time, energy and attention, leading to the neglect of the health work.

**SUB-PARISH**

It appeared, therefore, more appropriate to get the local communities involved in the support of their CHWs. In order to make the CBHC programme more firmly rooted in the local commu-
nity by decentralizing the activities (monthly meetings, group home visiting) and the basic training and refresher courses, it was decided to make the sub-parishes responsible for financing all activities taking place in their area. This made it necessary to reduce the costs for transport and accommodation at the Pastoral Centre, as food and remuneration for trainers from other CCs or sub-parishes must be provided by the sub-parish from very limited resources. Parish level specialized training sessions such as training for TBAs, HC members, secretaries, trainers, etc., and workshops as well as the annual CHW day continue to be held at the Pastoral Centre. The parish council supplies food and accommodation while the sub-parishes provide transport.

In 1987 it became the responsibility of the sub-parishes to cover the costs for the maintenance of the bicycles used by the General Secretaries of their area; previously it had been the duty of the central parish council. According to parish records, the sub-parishes and CC’s support of the CHWs amounted to KSH.30,000 in 1986. This amount was mainly spent on food for the various meetings and an additional KSH.2,000 were spent on training sessions. These funds are generated through communal gardens. Each CC contributes KSH.100 annually.

COMMUNITIES

In addition to money and food support, the communities try to assist their CHWs with their farming. The communities allow the trained TBAs to charge a small fee for any delivery they assist. Dispensing CHWs also receive a part of the profit from the sale of drugs. Trainers who assist with trainings in sub-parishes other than their own are usually remunerated either in kind or money.

PROGRAMME

The hospital’s financial responsibility has been reduced to paying the salary and transport for the full-time supervisor/trainers, providing teaching aids and stationary, and assisting any CHWs who attend regional and national meetings or training sessions. The hospital received a special grant from a German donor agency, MISEREOR and the Integrated Rural Health Programme in 1983 to cover these costs and purchase the necessary motorbikes and bicycles used by the supervisors and General Secretaries. The grant from MISEREOR was renewed for a further period of 3 years in 1986 with the understanding that the CHWs would gradually be enabled to increase their skills in the curative area and in giving vaccinations. This would reduce the MCH hospital staff requirements considerably. This intended development has however not yet materialized.

EVALUATION

Up to May 1988, 798 CHWs have been trained in Nangina parish. From these 788 are still active. Others have either died or moved away from the area. Some ceased to be interested in health promotion in the wider community but continue to use personally what they have learned.

In 1979, D.G. Makuto, from the Institute of Child Health of the University of London, did a major evaluation of the Nangina programme’s effectiveness in promoting maternal and child health. He called special attention to the volunteer CHW’s high degree of motivation and dedica-

WCC Photo: Peter Williams
98% of the mothers were impressed by the quality of the work done.
tion and described the work performed by CHWs as "of a high standard" with regard to quantity, quality and effectiveness. He further reports:

(1) most of the CHWs (80%) covered all of the assigned families;
(2) 87% of the CHWs were performing the optimal amount of home visiting;
(3) of the 9 functions CHWs are supposed to perform in their communities, 5 (home visiting, teaching on types of food to grow, helping the sick to go to the hospital, health education on all topics and building homes for the poor and aged) were performed by over 95% of the CHWs; while home deliveries and home craft classes were performed by 50% of the CHWs;
(4) 95% of the mothers interviewed were impressed by the quality of work done by the CHWs and 97% of these mothers expressed a willingness to entrust CHWs with performance of further health promotive functions in their community including 93% who wanted them to add curative work to their duties;
(5) the CHWs were effective in extending health education coverage to a large section of the community, promoting nutrition knowledge — though not nutrition practice — among mothers, getting latrines built, used and maintained by a large section of the community, and bridging the gap between the community and the hospital, by actively getting the sick in the community to utilize hospital facilities and available health services such as MCH clinics;
(6) a high rate of job satisfaction was manifested by the fact that 94% remained in service and expressed willingness to continue unpaid community work. However, 38% of those continuing to volunteer found working without salary difficult.

The above successes appear to be related to two factors: (a) the spiritual motivation that characterizes the Christian Communities from which most of the CHWs were chosen; and (b) the prevailing political mood in the country which emphasized self-help ("harambee") projects, and self-reliance.

FAILURES
Among the notable failures in the CHW programme are:

(1) failure to change nutrition practice in spite of changing nutrition knowledge. Taboos and superstitions were suggested as reasons for this failure;
(2) failure by the CHWs to perform some of the functions specified in the programme, perhaps due to failure of the programme to adequately teach the necessary skills and expertise, e.g., home deliveries, protection of water supplies, etc.;
(3) inadequate supervision for CHWs, including lack of quality control checks by the hospital to validate reports made by CHWs at monthly meetings, and failure of CHWs to provide the information needed for continuing evaluation. It was recognized that in cases where the community supports their CHW with a wage, accountability for both them and the CHW is enhanced;
(4) lack of a curative service. Over 90% of mothers wanted to see CHWs perform curative work. Over 50% of the CHWs stated they would like their functions expanded to include curative work.

In 1981, D.G. Willms of the University of Waterloo further investigated social factors that influenced the Nangina CBHC programme. He pointed out that the success of the programme derives from a newly-adopted approach of reciprocity between the local community and traditional institutions such as the Catholic parish and the hospital. Going beyond usual boundaries of both medical professionalism and traditional ecclesiastical constraints favours an open dialogue and exchange of ideas with members of the local community which creates a new awareness of common needs in the social, spiritual and physical sphere. A new sense of common purpose and meaning emerges, leading to joint action.

According to Willms "the social interventions designed by the hospital to meet the need were culturally legitimated through symbolically meaningful events provided by the mission.

...The effectiveness and self-reliance of the volunteer CHW is derived from the social participation in the training sessions, and through the cultural experience of recurring symbolic events in the community — the sacraments, the 'mass for the sick', prayer and scripture reading in the community, caring for the poor, and assisting persons who are ill.

"Formerly, religious (mission) and medical (hospital) knowledge was experienced to be mysterious and forbidden. The boundaries of spiritual and medical professionalism kept the activities of these healers from public view...Now, however, there are frequent opportunities made available to participate in both events.

"The apparent success of Nangina's CHW programme can be attributed to the integrated fashion through which the hospital, mission and

the CHWs have attended to the health care needs in the area."

The complementary and reciprocal relationships between the three are further affirmed by shared truths and meaning. For the CHWs the understanding of life in community was revitalized and the awareness is expressed in their service of others who are in need. Willms points out that "in itself, this moral universe is complete and socially satisfying." He indicated also that this understanding (especially the voluntary nature of the work) may not be shared by people outside the 'system'.

CONCLUSIONS

There are a number of characteristics of the Nangina CBHC programme from which lessons can be learned. The charisma, zeal and commitment of Base Christian Communities was found to be very useful in implementing CBHC. The role of the parish priest was clearly crucial. Close supervision, internal incentives, and the practice of asking for volunteers from whom CHWs are selected by the community seemed to combine to produce a very low attrition rate.

The programme has an elaborate information system which seems to work well. Tangible support by the community was shown to improve accountability.

On the negative side, the community based drugs programme must be considered a failure, a lesson which Bamako Initiative proponents may do well to note. In addition, the Health Committees were found to have little to do with success or failure, and income generating schemes were apparently not highly successful.
USEFUL PUBLICATIONS

Base Communities in Brazil, dynamics of a journey is the story of how "poor, simple people", gathered in small community groups whose leader is Jesus Christ, are making their mark on the socio-cultural and political history of Brazil. From ideology through process to action, this monograph shows how Christian communities are a major force behind the remarkable political change taking place in Brazil today. The author, Frances O'Gorman, writes from extensive experience in such groups in the favelas of Rio and elsewhere in Brazil. Available from: FASE-CEAR, Rua Hermenegildo de Barros, 52 - Gloria, 20241 Rio de Janeiro, Brazil.

Children of the Caribbean by Dinesh P. Sinha documents the progress made in reducing infant and child mortalities in the English speaking Caribbean countries. After reviewing global patterns of mortality it examines child survival in the region, detailing the remarkable improvement in the last 40 years. Determinants of both mortality and progress toward reducing it are comprehensively described. It discusses lessons learned which may be useful in many other places in the world. Especially interesting to CONTACT readers will be Part IV, which presents attempts by Caribbean institutions to go beyond mere survival to social, psychological, emotional and intellectual development of children. Available from: The Caribbean Food and Nutrition Institute, P.O. Box 140, Kingston, Jamaica, W.I.

From Alma Ata to the year 2000, is a WHO publication based on a meeting of PHC experts from all WHO regions which took place in Riga, USSR, in 1988, to review progress towards HFA 2000 since its launching in Alma Ata in 1978. The book, edited by John Bryant of Aga Khan University in Pakistan, not only realistically reviews problems and progress but also presents recommendations for accelerating progress towards that goal, reaffirming Primary Health Care as the most feasible strategy. It empha-

sizes that PHC is not simply provision of health services but a strategy in which individuals, families, and communities are empowered to take care of their own socio-economic and health development in the spirit of self-reliance and self determination. Available at WHO bookstores worldwide - SFr 30.

Preventing Maternal Deaths by Erica Royston and Sue Armstrong is a WHO publication comprehensively reviewing this major health problem. It starts with a discussion of social, cultural, and political factors which effect women, and then turns to questions of specific causes and prevention. After outlining changes needed in health care and family planning services, the book ends with a call for the simple, inexpensive measures which could prevent the needless death and suffering so long condoned as part of motherhood. Available at WHO bookstores world wide, or WHO Distribution and Sales, CH1211 Geneva 27, Switzerland, SFr 40.

A Training Materials Catalog which describes books, filmstrips, and flipcharts covering health, nutrition, and other development topics is available from World Neighbors free to anyone worldwide who requests it.

5116 N. Portland Ave., Oklahoma City, OK 73112, USA

CMC NOTES

WHO will offer an award again this year for an outstanding contribution towards strengthening health education in Primary Health Care. The $5,000 cash award may be given to a person, institution, or nongovernmental organization involved in a continuing activity.

Nominations, which must include the name and address of the nominee and a brief summary of the Primary Health Care project and of the health education activity, should be sent to the WHO Division of Health Education and Promotion, 1211 Geneva 27, Switzerland.
WORTHY MENTION

FACTS FOR LIFE — the most important book of the next decade?*

No problem in the world is more important than a quarter of a million children dying every week from infection and malnutrition and millions more living on with ill health and poor growth.

The world now has the knowledge to enable most parents to protect their children’s lives and growth. That knowledge — be it about timing of births, the promotion of growth, the feeding of young children, the prevention of illness, the technique of oral rehydration, or the importance of full immunization — is knowledge which should now belong to all families everywhere.

As a first step, UNICEF, WHO, and UNESCO, along with many leading international organizations concerned with child health (including CMC), are now bringing this basic knowledge together in a slim booklet called FACTS FOR LIFE.

The audience is communicators of all kinds — all those who can help to put today’s child health knowledge into the continuous channels of information flow so that it can become part of every family’s basic stock of child care knowledge.

THE CONTENT

FACTS FOR LIFE will present today’s vital information on child health in the form of basic messages which can be understood by all.

Those messages will come under ten headings:

- Safe Motherhood
- Breast-feeding
- Respiratory Infections
- Timing Births
- Promoting Child Growth
- Malaria
- Diarrhoea
- Immunization
- Home Hygiene
- AIDS

THE PURPOSE

The FACTS FOR LIFE booklet is a starting point for discussions with those who influence the mainstreams of continuous information flow, a way of putting to them the challenge that, as communicators, they are today potentially important health workers. It is a way of making that challenge specific and ‘do-able’. For example:

- Ministries of education, principals of schools and teacher training colleges, teachers and teaching unions, will be asked to join in the task of making sure that no child leaves school without a knowledge of today’s methods of protecting the lives and growth of children.
- Religious leaders, political parties, employers, trade unions, and health workers will be asked to promote the FACTS FOR LIFE messages at every opportunity to their congregations, constituencies, customers, employees, members, and patients.
- Journalists, broadcasters, youth movements and women’s groups will all be asked to get the information out.

FACTS FOR LIFE is a contribution to primary health care and reflects two of its most fundamental principles — that there is a need to demystify health care and empower all families with today’s health knowledge, and that health is not the responsibility of the medical profession alone but of society as a whole.

Although recognizing that poverty and poor services are major causes of ill-health which must be addressed by governments and the international community through social justice and economic development, the booklet points out that making scientific information available to families can help them protect their children by methods they can act on now.

While acknowledging that the relationship between knowledge and actual behavioural change is a complex one, the booklet affirms that promotion of knowledge is an essential part of the process of empowerment.

HOW TO GET IT

FACTS FOR LIFE is available in English, French, Spanish, Portuguese and Arabic.

One to five copies of FACTS FOR LIFE will be supplied free of charge by:

UNICEF, DIPA Attn. J. Tierney
3 UN Plaza
New York, NY 10017, USA

Be sure to indicate which language version you want, and include your complete address.

*from a brochure produced by UNICEF
CMC NEWS

STAFF
- Dr. Erlinda Senturias of the Philippines has been appointed Programme Secretary of CMC. Dr. Senturias received her MD from the University of Santo Tomas in 1973 and completed residency training in obstetrics and gynaecology at Quirino Memorial Hospital in 1977. She has been involved in training for community based health care programmes integrating traditional and Western medicine. Since 1978 she has been Programme Director for the National Ecumenical Health Concerns Committee of the National Council of Churches in the Philippines. Linda has also been very active in ecumenical and women’s issues on a national and global scale, being National Secretary for the Philippines Women’s Association, delegate to the Sixth WCC Assembly in Vancouver, Canada, participant in the celebration of the UN Decade of Women in Nairobi, and speaker at several international meetings of the Board of Global Ministries of the United Methodist Church and the United Methodist Women in the USA.

No stranger to the CMC, Linda has been moderator of the commission since 1984. She arrived in Geneva to take up her new post at the end of July. Coming with her were husband, Al, and son Al, III. The Senturias’ also have a daughter, Yasmin, studying medicine in the Philippines.

It is expected that the WCC Central Committee meeting in August will appoint a person to fill the remaining vacant post of Programme Secretary at CMC.
- After 4 months as CONTACT Editorial Assistant, Monika Witak-Venulet resigned to move with her husband to Austria.
- Candice Corey, will be joining the CMC staff in September to replace Monika. Candy, who has training and experience in journalism, comes to us from WHO.
- Valerie Medri, part time secretary at CMC for the last eight years, transferred at the end of June to Renewal and Congregational Life, another subunit of the World Council.
- Marilu Forerone has joined CMC as a full-time secretary. Marilu, a Philippina, has worked in other sub-units of the WCC.

COMMISSION MEETING

Salvador, Brazil was the meeting place for the Christian Medical Commission May 22-26. Twenty-one commissioners, 6 staff, two Roman Catholic consultants and several guests gathered to review the work of CMC over the previous eighteen months and plan for the period leading up to the Seventh Assembly of the World Council of Churches in Canberra, Australia in February, 1991.

During the week preceding the meeting, commissioners and staff divided up to visit church health projects throughout Brazil. These ranged from rural CBHC projects emphasizing traditional healing methods to community organizing for health in the urban favelas (slums) of Rio de Janeiro.

At the end of the visitation week the participants gathered in Salvador for sharing of experiences, to hear presentations on problems of indigenous peoples and blacks in Brazil and a report on a programme promoting traditional foods for good nutrition.

In business sessions, the commissioners approved an emphasis for CMC’s next few years on peoples participation and on healing and wholeness in Primary Health Care. A paper was presented on Health, Healing, and Wholeness, summarizing the results of the ten regional study meetings held over the last twelve years, and marking the end of the study and the beginning of a programme initiative based on its findings.

In other business a CONTACT Editorial Advisory Board was appointed to assist in determining policy and processing manuscripts.

CMC Photo
CMC Commissioners, staff and guests in Salvador, Brazil.
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 English, French and Spanish. Selected issues are also being published in Portuguese in Brasil, Kiswahili in Kenya and Tanzania and Arabic in Egypt. Present circulation is in excess of 35,000.

CONTACT deals with varied aspects of the Christian community’s involvement in health and seeks 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.

Editorial Committee: Dan Kaseje, Director; Dave Hilton, Editor; and Christel Albert. Editorial Advisory Board: Hildegarde Bromberg-Richter (Brazil), John Hatch (USA), Hari John (India), Deborah Raditapole (Lesotho), and the Editorial Committee.

All correspondence: CMC/WCC, PO Box 2100, CH-1211 Geneva 2, Switzerland.

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