"We have done it ourselves!"

A community-based health care programme in the Machakos District of Kenya
INTRODUCTION

The Machakos story as it is told here is about two things: a training method and the structure necessary to support the young training programme.

Machakos is a story told in government, church, and World Health Organization publications of a successful training programme for community health care workers. Here, as in the original report on which this article is based, Machakos illustrates a training method and how it worked to empower community health care workers and provide them the skills and understanding they needed to do their job.

The training method used in the Machakos community-based health care programme is known by a variety of names: the psycho-social method for adult learning, the problem-posing approach, training for transformation, participatory learning, and lifelong learning for change, to name a few. In this issue of Contact, we present this method in the Machakos context. The fundamental principle of the approach—empowerment through participation of the people—remains universal. But the training needs, the training content, criteria for the selection of trainees, and so on are specific to the early years of the Machakos community-based health care programme.

However valid a training method may prove to be, its application in the community requires structural support. In the case of Machakos, support was at three levels: national, diocesan, and community (comprising that of both formal and informal leadership sectors).

Enthusiasm over the community-based approach to health development can sometimes obscure the importance of the support network behind it all. We hope that the place and necessity of both is clear in the pages to come.

Cover design: Terry Hirst
"We have done it ourselves!"—

a community-based health care programme
in the Machakos District of Kenya

When I first met with this approach to learning, I felt as if a new world had opened up, a process of liberation had begun.

—former coordinator of the Machakos programme

Before I was nothing. Now I am a community health worker.

—a woman in Kaumoni village

The woman of Kaumoni has voiced not only her own feeling of empowerment, but that of people awakening to empowerment the world over. Empowerment is liberation. Liberation from oppression by poverty, disease, ignorance, isolation, or by cultural and political systems which sustain that oppression.

Sociologist Paulo Freire maintains that people who are oppressed see themselves as objects controlled by outside forces—the cultural or religious norms, the pressures of a political system, unknown economic forces, fate, destiny, luck, the "will of God." They do not have, nor do they expect to have, significant control over their lives, their livelihood, their place in society, their access to land or education, their health. Freire regards such oppression as a fundamental condition of modern times. Its opposite, liberation or empowerment, must therefore be the supreme human objective. The great task facing oppressed people everywhere, then, is to humanize their existence, to become self-determining individuals.

"Before I was nothing. Now I am a community health worker." The woman of Kaumoni could also be saying, "Now I have some status in the community. I have become a person of some significance. I now understand something about our bodies, what keeps them healthy and what makes them ill. I have acquired new knowledge and new skills, and the confidence to share them. Now I am somebody, and I am having an effect on my community."

A process of transformation
To achieve such a change in consciousness both for the individual and for society, the process that Freire termed conscientization is necessary. Four aspects distinguish conscientization from other approaches to development or social change:

• The transforming process is on-going and ever-deepening. It is never completed. There is no "final revolution." It begins with the raising of awareness, leads to action, and is followed by reflection. This process leads to increased awareness, which in turn leads to further action.

• The process of conscientization takes place within a group. The communal raising of awareness empowers community action.

• Conscientization enables people to truly understand their situation and to look deep into the social conventions that affect them.

• Although the process of conscientization may begin with efforts to relieve hunger, increase income, or improve health, its ultimate aim is to change unjust social, economic and decision-making structures which are the root causes of poverty and oppression.

Promoting self-responsibility
In the Machakos Diocese, the newly established Development Office of the Kenya Catholic Secretariat had, since 1974, been promoting a variety
of self-reliant approaches to development, based on the awareness-creating methodology elaborated by Paulo Freire in Brazil.

The general goal of the Development Office programmes, Machakos among them, was defined as follows: "Our goal is to be catalysts, helping people to take an active share in shaping their own lives. This incorporates dignity, justice, freedom, caring, sharing, building community, building a kingdom of right relationships based on our Christian values." Such a vision meant that a health care programme looked "not only at the sicknesses but also at the whole person, at the person’s environment and community. The sick person must not simply come to you, but you must go out to where the person comes from and help that community to recognize and overcome its own problems."

The need for primary health care

The government of Kenya, in its 1984-1988 Development Plan, recognized the need for primary health care as a practical and cost-effective way to reach rural populations, such as the Kamba. In addition, "to reduce pressure on existing static health facilities in rural areas, the approach of Community-Based Health Care (CBHC) will be strengthened and expanded. Existing rural health units will be the centre of operation for these community-based health care programmes."

The national political climate was clearly favourable to the primary health care/community-based health care approach, but the Machakos programme was actually born of an immediate need rather than a statement of political will or even Christian values.

Machakos District and Diocese

The District of Machakos, which embraces the Catholic diocese of the same name, lies at the southern edge of Kenya’s Eastern Province, covering an area of some 14,000 sq km (see map).

The Kamba of Machakos

The Machakos District is the homeland of the Kamba people, a Bantu ethnic group believed to have migrated to the area some 400 years ago. The Kamba first settled in the more fertile, better-watered hills, but with time and population increase, they were forced to move into the surrounding semi-arid lands. As a result, the ecology of the area has become increasingly fragile. More fertile areas also suffer from intensive cultivation, over-stocking, and the destruction of tree cover.

Despite the fragility of its environment, the Machakos region is supporting increasing numbers of people. With its population growing at the national rate of about 4% per year, by the year 2000 Machakos will have over 2 million people.

A mobile people

Traditionally, the Kamba were farmers, pastoralists, and hunters. Modernization and the legal protection of wildlife, however, have virtually eliminated their hunting role. At the same time, the population increase and the resulting pressure on usable land have given rise to a new mobility, especially among Kamba men. In areas where land is very poor and there are no employment opportunities, over 30% of the men have left home to seek work in the towns—often outside the district or even outside the country.

Changing role for women

Modernization and male migration to the towns has also meant a change in the role of women. The loss or limitation of traditional male roles, such as hunting or herding, and the lack of alternative occupations have left many men with a lack of purpose. As men, they retain their leadership status, but with limited effectiveness. The net result is that women now have more work to do than ever before.

Social organization

Another outcome of mobility and modernization has been the breakdown of traditional social organization. Traditional Kamba society did not have a stratified political structure, no single chief or king. The family homestead, where a man lived with his wives and children—and perhaps the families of his sons—was the focus of life. Neighbouring homesteads (perhaps 100 or more) were grouped into a village, where communal issues were settled by a council of elders. This flexible form of leadership survives today, but in the shadow of the modern, political-administrative system of appointed chiefs and assistant chiefs. Any attempt to promote social change at village level, for example the introduction of a health care programme, invariably needs the support of both groups of leaders.
The district/diocese is shaped like a long, narrow triangle. At its nearest point, the triangle is only 20 kilometres from Nairobi.

The beginnings of the Machakos CBHC programme

1975 and 1976 were years of severe drought and consequent famine in the dry lands of the Kamba people. In the face of the widespread malnutrition that followed, the Kenya Catholic Secretariat felt the need to promote better medical services in the poorer, more remote, and neglected areas of the region. It was Machakos’ arid, sparsely-populated administrative division of Yatta that, in 1978, was chosen by the Diocese of Machakos as the site for a pilot PHC project.

Yatta Division is one the district’s most remote and poorly-serviced areas. The land is mainly poor and dry. The main food crops are maize, pigeon peas, cowpeas, and beans. The only cash crops are cotton, tobacco, and sunflower seeds. Most families own cattle and goats. Several Catholic mission hospitals and clinics existed in the diocese and some operated mobile clinics, but, as was the case with government services, the coverage was uneven and did not extend to the most needy areas. A survey of needs was undertaken, and a Dutch woman with long experience in Uganda as a nurse and nursing tutor was recruited to launch the Machakos community-based primary health care programme.

Programme objectives

The precise objectives of the Machakos CBHC programme were defined as follows:

- To initiate community-based efforts towards self-reliance in achieving improved health for the whole community.
- To develop cadres of community health workers who would:
  - create awareness of preventable diseases
  - improve environmental health
  - teach recognition and simple cures for most common illnesses
  - improve child-feeding practices
  - stimulate interest and self-reliance in health practices at village level
  - provide links between the community and static health facilities
  - encourage existing women’s groups to include health on their agenda.

Getting things going

To announce the programme, a meeting was held with the chief of Kenyatta Location (the site selected for the first training course), the three assistant chiefs of sub-locations within the area, the local county councillor, and a representative of K.A.N.U. (the ruling political party). It was intended to have a baraza (public meeting) to publicize the programme, but the death of Kenya’s first president, Mzee Jomo Kenyatta, on 22 August 1978 meant that all such meetings were temporarily suspended.

Lessons learned from the pilot project (the omission of the baraza mentioned above, for example, was later considered a great drawback) and later difficulties in sustaining the activities of the CHWs led to more careful launching of CBHC programmes and to a deeper involvement of the community from the very beginning. In fact, a training programme is now started only in response to requests from the local community.

At first, the selection of suitable participants was left to the local assistant chief, the village elders, the parish council, and women’s groups. Trainees were required to:

1. be married women, preferably with children (later training courses included men);
2. belong to the area and live within two hours walking distance of the training centre;
3. be educated up to Standard 6 level and, for the initial courses where the trainers spoke only English, be able to read and speak English;
Traditionally, the Kamba were farmers and hunters. In the Machakos District, in areas where land is poor and hunting now prohibited, over 50% of the men have left home to seek work elsewhere, such as at this Coca Cola plant in Kisumu. The women are left with direct responsibility for the well-being of their families.

4. be willing to work in the village on a voluntary basis;

5. have written permission from their husbands to participate in the course and to act as voluntary health workers.

Equipment and resources
A set of basic equipment was bought for the programme, including cooking equipment, eating utensils, sleeping gear, and teaching materials. From the beginning, training courses were held in the location where CHWs were to work. Thus the community took responsibility for finding accommodation and a classroom, and helped build shelters for cooking and bathing. Funding for the programme (covering vehicle, staff salaries, workshop expenses, and office equipment) was provided by CEBEMO, a Dutch funding agency. The Diocese of Machakos provided a furnished house for the expatriate coordinator.

The process and content of the training, or “When are you going to teach us?”
“The method we used is revolutionary,” explains the former programme coordinator. “According to Kamba custom, a woman sits and listens when the men talk. So, in the beginning, when we started using this method, the women were puzzled. They kept silent, even though no men were present, and wondered what it was all about. So it happened that after the first week, during the evaluation, the question came, ‘When are the teachers going to teach us?’”

Even now, years after these first workshops of the Machakos programme—after scores of training courses, follow-up workshops, awareness-raising sessions and training-of-trainers seminars—there is still no fixed syllabus for training workshops. This can be disconcerting, not only for passive participants who expect to be “taught” but also for interested visitors who want to “see,” development journalists who want a basic script to “write up,” public health professionals who want to be sure that the training is “relevant,” and funding-agency representatives who want to see evidence of how the money is spent.

Start with what the people know
“We bought locally-made stools and sat in a circle. No one stood in front as a teacher,” said the former coordinator, speaking of the first workshops undertaken as part of the Machakos programme.

Then as now, courses begin with discussion to find out:
- what problems the women face in their homes and immediate environment, particularly in regard to health;
- what the women already know about sickness and health;
- what are their expectations for the training course.

In the course of discussion, participants themselves outline the issues that interest them and those they wish to address. The issues that usually emerge are
common to most rural areas: nutrition, hygiene, water, common illnesses, pregnancy and child care, and women’s diseases. Through a process of ongoing evaluation, particular interests and local needs become more sharply defined. If, however, the course leaders realize that some major and common health problem has not been raised, they feel free to draw attention to it by saying, for example, “When we were in the training course at Milimani, the women there told us that many people were suffering from such-and-such. Have you ever seen this in your own village?” And very often they have.

Setting the agenda and “housekeeping”

When course participants have listed their main concerns, the task of the trainers is to group these concerns in a logical order and then devise ways to promote participatory discussion on the major topics that emerge. Normally, only one topic is dealt with each day, so that a weekly schedule might look like this: Monday—nutrition, Tuesday—child care, Wednesday—common diseases, Thursday—hygiene, Friday—women’s problems and evaluation. The time-table for the week is worked out by common consent and adjusted when necessary.

The trainees themselves are responsible for keeping the training centre clean—classroom, “dormitory,” cooking area, latrine, and the surroundings. If a task is not done properly, it is mentioned in the group or during the weekly evaluation. The participants also schedule household duties, assigning tasks among themselves, such as budgeting, buying of food, menu-making, cooking, dishwashing, sweeping, and time-keeping.

Problem-posing approach

In the psycho-social method described here, discussion of any particular topic usually begins with a code. A code is a thought-provoking “starter.” It can be a brief role-play, a story, a song or mime, a poster or photograph, or a flannel-graph. But to be a code it must pose a problem or stimulate a new way of looking at familiar situations. For example, to start a discussion on malnutrition, a drawing like the one on page 6 is put up. It shows a young woman leaving the compound with a basket of food to sell in the market, while a sickly child is being fed by a sad and weary grandmother. Members of the group are given time to study the picture carefully, in silence. The facilitator then asks the whole group:

- What problems result from this?

Everyone is free to offer an answer and the facilitator repeats each answer to make sure that every opinion has been heard and understood. This is particularly necessary at the start of a training course when participants may hesitate to speak.

Next, the participants are divided into small “buzz” groups of three or four people to discuss two further questions:

- What causes such a situation to happen?
- What can we ourselves do about such a problem?

A chance to speak

The use of small discussion groups gives quiet participants a chance to speak and ensures that everyone’s opinion can be heard. Usually, one person from each small group is chosen to report back to the group, while the facilitators record the various opinions or recommendations on large sheets of paper. This simple process begins to transform passive learners into active participants. In response to the opinions and concerns of the trainees, the course leaders then offer appropriate input on a particular topic—how to recognize measles, how to treat infant diarrhoea, or how to ensure a balanced diet for a family, for example.

For every major topic raised and discussed in this way, the facilitators try to prepare for the discussion by carrying out a local survey.

Appropriate surveys

In the psycho-social method, a survey is not something done by an outsider with a pad of paper and a set of pre-determined questions. It is best done by members of the community who have been trained to observe what is happening in their own community and to “hear” in a variety of informal, unstructured ways what the community’s real concerns may be. During the course, participants undertake surveys on issues such as:

- **Hygiene/water.** The group visits local water sources and raises the following questions: What did we see at the water source? How can good water become bad? What disease can we get from bad water? How can we prevent these diseases? What can we do in this community to improve the water source?
- **Food/diet.** The group visits the local market and answers questions about what they see: What vegetables are sold? What are the prices? Can you bargain? The women then create a balanced
menu for their meals, based on what food can be obtained at the market.

- **The dispensary.** The group investigates the dispensary. They ask, Who comes to the dispensary? What illnesses do they have? How are they received by the staff? What kind of medical treatment do they receive?

- **Drugs in the dukas (Kiswahili for shop).** At the duka, the group asks What medicines are available for what illnesses? What advice (if any) do the shopkeepers give to those who buy? This often leads to discussion with the shopkeepers and among the trainees themselves about the correct use of drugs.

- **Home visits.** Before the first one-week break in a training course, the trainees (in groups of three or four) visit homes in the neighbourhood. They report back on what they hear and see. The trainers then advise on how to act and what to look for when the trainees begin visiting homes in their own villages.

- **Schools.** The group checks for scabies, ringworm, and roundworm in several local schools, to learn what kind of health instruction may be most needed amongst school children.

Every survey is intended to lead to discussion and practical action.

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**Practical daily demonstration**

When an important topic has been thoroughly discussed (either in response to a code or as a result of a local survey), the knowledge is made practical in the daily running of the course, for example,

- **Food/diet.** Once the trainees know what to look for in the local market, they make a menu for the whole week, budget for the food, and buy it. Then they cook it themselves. The quality of diet and level of nutrition of these meals invariably improves during a training course.

- **Water.** When there is no clean water source near the training location, participants draw water from a river or dam and boil it for drinking and cooking.

- **Cooking.** One afternoon per week (after a morning discussing nutrition) is devoted to practical lessons in cooking. Depending on the morning’s topic, the demonstration involves the preparation of food especially for a pregnant woman, an anaemic person, or a child with kwashiorkor, for example.

- **Pregnancy and childbirth.** If there is a maternal and child health and antenatal clinic near the training site, the trainees see how to palpate a pregnant mother, assess the lie of the baby, and weigh infants. A doll is used to practise delivery.
techniques and resuscitation, for example, so that later they can assist at deliveries when necessary. On the day devoted to child-care, the afternoon is spent repairing torn clothes or making clothes for children.

After training, what?
As from the beginning of the Machakos programme, home visiting has been a major activity for all CHWs. Most spend two or three afternoons per week either visiting homes or with women’s groups. The number of homes a CHW is responsible for varies. In the first areas chosen in Yatta, the areas covered were large, with one CHW responsible for up to 200 homes. Experience showed that this was impractical, so training later became more localized and the size of the areas reduced.

During a home visit, the CHW discusses a number of health-related subjects with the mother: the health of her children, problems of hygiene or nutrition, or
practical ways to improve the home environment, for example. When the CHW returns home, he or she records the visit in a book and notes any improvements made since the previous visit. Nothing is written during the visit itself, since this actually proved to be a block to communication. The records are given to the local coordinator during regular monthly meetings of the CHWs. The figures for the month are then tabulated and sent to the Diocesan office in Machakos.

The distribution of first-aid boxes to CHWs was not envisaged at the beginning of the programme. But many CHWs said they felt helpless only giving advice to people far from a hospital or dispensary. Later, it was decided to give a certificate and a first-aid box to each CHW who remained active for a period of six months. These visible and practical forms of recognition of work done by the CHWs help motivate them to continue serving their community. A set of basic remedies are supplied for the common ailments. The CHW charges the patient for any medicine given and must account for the money every time the supply needs to be replenished. So far, among scores of CHWs and thousands of clients, only one case has been reported of the wrong medicine being given.

**Follow-up and support**

The kind of follow-up and support system planned for the Machakos CHWs called for an immense commitment of time and energy on the part of the training team. The basics of follow-up, laid down at the start of the programme, included three main elements:

- an annual refresher workshop for all CHWs trained;
- monthly or bi-monthly visits by the training team to meet with the group of CHWs from a particular area.
- yearly visits by team members to the community (including the women’s group, local school, and village elders) of every CHW.

During the first three years of the programme, in the context of follow-up the training team made numerous individual and group visits, and conducted two one-week refresher workshops attended by about three-quarters of the CHWs. As the programme expanded, however, intensive follow-up by the core training team became less feasible. When Area Coordinators were appointed, the tasks of follow-up and continuing motivation were increasingly left to them.

This is how the training team summarized their observations after a series of home visits to the CHWs:

*The local people know most of the CHWs and come for advice. We noticed this in the way people responded to them and the way they were welcomed and talked to.*

*The elder of the village would walk with us and visit homes. Cooperation between the CHWs and the elders was good.*

*We got to know the CHWs better in their own surroundings. They had implemented what they had learned. All of them had a latrine, a dish-wash stand, a clean home; and their children were well-dressed, well-fed and clean.*

*We have seen the difficult circumstances under which they have to work such as the heat, the long distances they go on foot, and the frustration of finding no one at home; the lack of food and water during the dry season.*

*When testing the knowledge of the women in the women’s groups, we discovered that they had already learned many things regarding health.*
Several health plays were performed. This meant that these topics had been taught by the CHWs.

After the survey in the primary schools at Ekarakara, we saw that the number of cases of scabies dropped from 1110 to 198.

New women’s groups were started.

Mothers have been taught about rehydration fluid when children have diarrhoea, and the CHWs report no more deaths due to dehydration.

New latrine has been built and others are being built.

Some have built dish racks.

Children who suffered from kwashiorkor and marasmus were improved due to the teaching of the CHWs and greater use of the milk provided by CRS at the dispensary.

Vegetable nurseries were tried. Some succeeded, and some failed due to the lack of rain.

One women’s group had been invited several times to perform health plays in another village at the invitation of the District Development Officer.

One women’s group started to make water jars.

Encouragement for the trainers

These visits served both to up-date and encourage the CHWs but also to convince the trainers that their work was effective.

The coordinator reported, “In Ekarakara we visited eight primary schools, with a total of 2112 children. The CHWs had conducted a campaign against scabies in the schools. We examined all the children and found that only 198 still had scabies, whereas six months earlier the number was 1110! From visual assessment we estimated that 478 children probably had roundworms. We found that only 391 children had a latrine at home, so we launched a new campaign to get rid of roundworms by building latrines in the homes and boiling drinking water for the small children. Every child took this message home. The headmasters and teachers were very helpful and encouraged the CHWs to continue teaching, as they had seen the result of the campaign to eradicate scabies.”

The support element of the Machakos programme was key in motivating both trainers and CHWs, as it will be for any successful CBHC programme. Everyone needs encouragement—particularly when attempting something new.
The training content

The Machakos programme has no pre-determined syllabus. Instead, the trainers use the problem-posing method to discover topics of particular interest to trainees. The issues usually dealt with in the Machakos courses are given below, with the recognition that each CBHC programme will have its own training needs.

Nutrition
1. Three basic classes of food
2. Use of pictures of different food types (for illiterate mothers)
3. Nutrition from birth to eight months, including breastfeeding and weaning
4. Ensuring a balanced diet: making a daily menu, budgeting, surveying the local market, and buying the food
5. Healthy cooking (for a balanced diet and appropriate consistency):
   - preparation of food for infants (e.g. milk with beaten raw egg; mashed beans) and children
   - food for sick and/or malnourished children and adults
   - preparation of local foods such as cabbage, cowpeas, beans, potatoes, and maize
6. Preparation of packed lunch for school children
7. Vegetable gardening

Child care
1. Immunization: types of vaccination (whooping cough, tetanus, polio, BCG, DPT, measles)
2. Child Health Clinic: explanation of “Road to Health” chart (indicating weight trend by age); how to explain vaccination and weighing charts to mothers
3. Practical experience in child clinic, including
   - weighing of babies
   - recording (using charts and books)
   - vaccination procedure
   - explanation of various medications given
   - discussions with the mothers about health and food
4. Process for weighing and taking blood pressure of adults
5. Children’s diseases (explained using posters and pictures) and the care of a sick child, including appropriate medication
6. How to prevent diseases in a small baby (including infant hygiene)
7. How to lower fever in a baby
8. Use and preparation of a baby cot
9. Knitting for babies and children’s dressmaking

Pregnancy
1. Female reproductive system, with emphasis on the menstrual period, hormone cycle, and child-spacing
2. Abnormal growths in the abdomen
3. Pregnancy: how it occurs, what happens inside the body, and signs of pregnancy
4. Ectopic pregnancy
5. AbORTIONS: causes and prevention
6. Risks during pregnancy
7. Minor and major complaints during pregnancy
8. How to stay healthy during pregnancy
9. Care of the breasts
10. Antenatal clinic: explanation of its purpose, palpating the abdomen (to determine the foetal lie and size), taking blood pressure
11. Normal delivery and resuscitation
12. Abnormal deliveries, including when to transfer the mother to hospital
13. Bleeding after delivery and how to stop it
14. Care for a newborn baby
Hygiene
1. Water: survey of local water sources, followed by discussion covering
   • what problems women in particular have in regard to water
   • diseases carried by contaminated water: their treatment and prevention
   • construction of home water purifier
2. Diseases carried by flies and their prevention
3. Hygiene of the body, including treatment of scabies
4. Hygiene of the home, including insects in the home
5. Food hygiene and preparation to prevent disease
6. Construction of latrines, rubbish pit, and dish racks

Diseases
Training courses cover the following diseases, their causes, signs, treatment (including the use of medication), and prevention.
1. Acute respiratory infections (A.R.I.) (e.g. pneumonia)
2. Anaemia
3. Broken bones
4. Burns
5. Diarrhoeal diseases (e.g. cholera, typhoid fever, and amoebic and bacillary dysentery)
6. Diseases associated with malnutrition (e.g. marasmus, kwashiorkor)
7. Fits and convulsions and unconsciousness: causes, treatment, and prevention
8. Meningitis
9. Measles
10. Malaria
11. Sexually transmitted diseases (S.T.D.)
12. Shock, choking, resuscitation
13. Skin diseases
14. Tonsillitis, ear ache, nose bleeds, eye diseases
15. Worms (threadworm, whipworm, roundworm, tapeworm, bilharzia, hookworm)

Psycho-social method
Use of the psycho-social method for adult learning and selected communication skills:
1. Devising the daily and weekly programmes
2. Use of small and large group discussions
3. Asking questions in a group
4. Theme-finding by use of brainstorming and/or discussion in small groups
5. Sharing the knowledge and skills of each participant
6. How to plan and chair group meetings
7. The use of surveys
8. Summarizing of the week’s work.
9. Report writing: what to write (what is important)
10. Evaluation of learning
11. Expectations of the group, community, and family
12. Home visiting and discussion of problems found
13. The use of learning aids/codes (e.g. pictures, posters, role plays, flannelgraph, books)
14. Leadership skills, receiving visitors
15. Feedback: good personal qualities and skills and learning from mistakes
16. Psychology: how to understand people, Johari’s window
17. Parent/adult/child (PAC) behaviour
18. Women’s issues: role of women in development, how to keep peace at home, how to help each other, self-reliance
19. Bible readings
Belonging and accountability

The question of belonging and answerability has been addressed in numerous ways in numerous PHC programmes. CHWs trained as part of the Machakos programme are not clearly identified either with the church, with existing medical services, or with the government administration. Support may be provided from these institutions, but the CHWs do not "belong" to any of them. They do not fit into their existing structures, nor are they directly answerable to them.

In the case of Machakos, an attempt was made from the beginning to build up a shared identity among CHWs as a new and distinct cadre in the community—with some administrative links to the church and, wherever possible, good working relations with existing health services. In a sense, the programme is accountable only to itself, and to the values which inspired it. This means that the service of the CHWs in the villages must continue to be a direct response to the needs expressed by health-aware communities. Sooner or later the Machakos programme and other CBHC programmes in Kenya will need to become part of an integrated, more highly coordinated approach to addressing nutrition, water, hygiene, and other health-related issues. Meanwhile, institutions such as the Diocese of Machakos is in an ideal position to promote small-scale, local integration as a possible model for government structures at the district level.

Collaboration in training and reflection

Community Health Workers Support Unit (CHWSU)

As indicated earlier, since the late 1970s there has been in Kenya an increasing interest in primary health care. Church-related programmes were first in the field, and various NGOs continue to be at the forefront of CBHC expansion. A pilot project in Western Kenya between 1977-1979 (sponsored jointly by the Ministry of Health and UNICEF) has also had considerable influence on Government thinking. But it was not until 1987 that the Ministry of Health, working together with non-governmental organizations, produced guidelines for primary health care. The guidelines are, in essence, the government policy regulating all agencies involved in CBHC.

In 1979, the African Medical Research Foundation/The Flying Doctors (AMREF), which is the foremost NGO involved in health care in the East African region, organized two seminars for people involved in JKUAT:}

At Ekarakara, three CHWs work part-time with the feeding programme and use the opportunity to teach mothers about nutrition and hygiene.
in CBHC in the region. The consensus emerged that there was a need for on-going information-sharing, training (capacity building), advocacy with governments, and cooperation among organizations promoting primary health care. To this end a coordinating committee was formed at the national level, comprising representatives of the country’s key CBHC programmes, interested NGOs (e.g. AMREF, World Neighbors, the Kenya Catholic Secretariat), the Ministry of Health, the University of Nairobi Community Health Department, and UNICEF. The work of the committee was divided by region, resulting in the formation of regional and district coordinating committees. These committees took responsibility for:

- organizing Training of Trainers (TOT) courses
- standardizing CBHC approaches, strategies, and practices
- sharing information and innovations
- undertaking joint evaluation of the CBHC activities
- organizing refresher courses.

Originally, AMREF was intended to assume simply the lead role among the cooperating bodies, but by virtue of the full-time medical and support staff attached to the unit, the organization rapidly became the dominant partner, and the work of the unit an independent AMREF programme.

**Aims of the CHWSU**

The principal aims of the Community Health Workers Support Unit were:

- to develop a system for facilitating the exchange of information, ideas, and expertise amongst all groups concerned with CBHC;
- to provide advisory support to CBHC projects in Eastern Africa in planning and evaluation and in training trainers/leaders of CHWs;
- to influence health policy makers and planners (both government and NGO) to place greater emphasis on promoting prevention, through facilitating voluntary self-help activities beyond the dispensary;
- to serve as an information/promotion centre and a facilitating agency for visits (cross-fertilization) between CBHC activities;
- to promote a training and leadership system tailored to the special challenges of CBHC.

To a great extent, these objectives have been realized, but the real impact of the support unit has been in the area of training. Since its formation in 1980, the unit has conducted numerous TOT courses in Eastern Africa, graduating hundreds of trainers. In the TOT context, much thought has been given to:

- the applicability of the term CBHC to a particular programme
- the meaning of the term community health worker
- the suitability of an applicant for TOT courses
- the content of TOT courses.

**Content of TOT Courses**

The TOT course comprises three one-week workshops, at intervals of two to three months to enable participants to carry out practical assignments in their communities between workshops. The psychosocial method, as described on page 1, is used throughout. At least one of the three phases is held at a site where field visits to an existing CBHC programme can be arranged. Major topics covered in the course include:

- concepts of self-reliance and development as they relate to a CBHC programme
- methods of helping adults to learn
- basic skills for processing information
- planning and evaluation in CBHC programmes.

**A guiding star**

At a crucial stage in the development of the CBHC idea, the AMREF-based support unit was vital in promoting CBHC programmes such as Machakos. In return, the principles of the Machakos programme, which focussed so strongly on empowering people to take responsibility for their own health, had a major influence on the philosophy of the CHWSU. This influence accounts in part for the shift from the concept of primary health care to that of CBHC. Community-based health care is one form of primary health care, and its principles understood and put into practice constitute a far more radical approach to the issue.

In the ten years since its creation, the CHWSU has evolved significantly, for a number of reasons. CBHC in Kenya has seen rapid expansion, with a multiplication of parties involved. In addition, as a result of training there has been an increase in levels of skill and experience at the periphery, with individuals trained as part of the programme assuming greater and greater independence.
Leadership within the Machakos programme

Adapted from Public Health Paper No. 82, Leadership for primary healthcare. by D. Flahault and M.J. Roemer, World Health Organization, 1986

Since Machakos is a project sponsored by a Roman Catholic mission, leadership must be traced within the mission framework, rather than that of the government. Thus at the national level, leadership comes from the Kenya Catholic Secretariat, in which the Medical Department has responsibility for health activities. The head of this department functions as overall coordinator of primary health care projects such as Machakos. She makes periodic visits to them and consults with the project leader on plans. She is responsible for preparing reports to the foreign donor agencies, and handles the basic financing (including grant funds from the Kenyan Ministry of Health) and accounting for them.

At the diocesan level, the project leaders make 6-12 month plans and set priority goals. They coordinate the work of team members and participate in teaching courses for training the community health workers and public health aides. They evaluate the services and propose necessary changes. They cooperate with other diocesan development personnel concerned with agriculture, water supply, literacy, the role of women, etc. They also liaise with government departments in the district and handle correspondence, salaries, and other administrative matters.

Below the diocesan level, there is the area level, consisting of a group of villages. At this level there are two leaders—one for training and the other for services. The training leader plans the training programme, organizes courses and workshops (for community health workers, traditional birth attendants, health helpers, and village health workers), and makes evaluations. She meets with local political leaders, with medical and nursing personnel in government hospitals, with similar personnel in mission institutions, and with others as appropriate. She also cooperates with personnel in education and other sectors. The area leader for services organizes meetings for community health workers and public health aides, where problems are discussed and tally sheets on home visiting and other reports are collected. She visits the local workplaces of the community health workers and public health aides, discusses the programme with villagers, and refers problems to higher levels when necessary.

At the village level, the community health worker and public health aide give direct health service to families. They treat simple sicknesses with such medication as chloroquine, aspirin, eye ointment, and rehydration fluid. They give first aid for wounds and refer cases to hospitals. They teach about nutrition, improvements in latrines and water supply, and the use of rubbish pits. They keep records on all home visits. They visit schools and treat children for scabies or ringworm, meet with mothers to discuss their children's health, and also meet with village leaders.

At the village level, there are also village health workers and health helpers. These part-time PHC workers are essentially promoters of the use of health services, such as immunization of children and attendance at regular clinics by mothers with babies.
As a result of these factors, the role of the CHWSU has diminished—and possibly this could be considered a sign of success for any organization involved in promoting the community-based approach.

Nonetheless, the presence of a resource agency, or guiding star yet remains of vital importance in the beginning stages of a CBHC programme. In the case of Machakos, it happened that AMREF served in this capacity. Another country, another programme, another guiding star....

The challenge for the future

It is at the district level that a radical approach such as that of the Machakos programme—based on empowerment—can be proven practicable, economical, and effective. The challenge facing such programmes is to show conclusively, by better use of baseline data and subsequent quantitative measurement, that the work of voluntary health workers in the villages is having a sustained and measurable effect on the health and well-being of the community.

"I don't think those community health workers have made any impact on the health of the community."
—Ministry of Health official, Machakos, August 1985

"Unless we adopt the same approach as this programme, I don't think we will ever succeed in reaching the majority of the people."
—the same official, June 1987
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