COMMUNITY ACTION FOR HEALTH

Let's get organized!
INTRODUCTION

This issue of Contact features “Community Action for Health”. It was the theme chosen by World Health Organization (WHO) for this year’s technical discussions at the World Health Assembly in May 1994.

CMC - Churches’ Action for Health, as well as many other non-governmental organizations (NGOs) involved in primary health care (PHC), welcomed the choice of theme. The International NGO-PHC Group, of which CMC is a member, published a paper as a contribution to the discussion at the meeting.

The main article in this issue of Contact is a shortened version of the paper by the International NGO-PHC group. By publishing a summary of its contents, we hope to stimulate further discussion among church and other groups about community action for health.

The publication, called “Community Action for Health”, describes the three main models of community action for health. It also pinpoints what is needed in order to promote popular action for health in the future.

One of the three approaches to community action for health stresses the importance of discovering the community’s understanding of the concept of “health”. On page 2, readers are reminded of the Boga experience in which the community defined obusinga (health) to include peaceful relationships within the family, with neighbours and with the world around them.

The articles which follow the main story are case studies of community action for health. At first, the choice of these stories might surprise some readers. For example, one is a testimony from the Long Geng longhouse in Sarawak in which one of the members describes the community’s struggle for land rights. These people are not fighting for health as such, but to retain the quality of their lives. Defending their land is their only hope of retaining spiritual as well as physical health.

Another story is about a Chilean women’s group who demonstrated for clean water and a healthier environment in order to achieve better health. The third is from Uganda where a community, which is severely affected by the AIDS epidemic, has introduced a participatory action research programme. The result has been a reduction in the fear and stigma shown towards people with AIDS.

Useful Publications section provides details of some of the most useful books on the participatory approach to community-based primary health care. The list is not exhaustive, but we hope to build upon it, and to keep it available to anyone interested in receiving copies.

Last, but not least, we include an update on the campaign to promote breastfeeding (page 15). It seemed vital to share with readers an important and positive development.
COMMUNITY ACTION FOR HEALTH
THE VIEWPOINT OF NON-GOVERNMENTAL ORGANIZATIONS

Better health can only be achieved through community participation and by focusing on the root causes of ill-health. Society needs to be transformed so that everyone can enjoy a fair share of the fruits of freedom. This vision of community action for health is described in a discussion paper by International NGO-PHC Group. The following article is a summary of the paper.

Much has been written on primary health care since Alma Ata Conference in 1978. A review of both the literature and of personal experiences in primary health care shows that there is confusion about both its basic principles and how to implement it.

One difficulty has been that primary health care has often been understood and implemented in terms that have been overly medical. Not enough attention has been given to the fact that health is a political, social, and economic issue as well as a medical issue.

Health professionals, who are trained to see health problems in medical terms, tend to design and promote medical and technological solutions. Because the cause of the problems are more than medical, the prescriptions often fail to produce an adequate response.

Another source of confusion is created when health professionals define the concept of health differently from how it is understood in the community. In this case, primary health care programmes that are managed by health professionals may not be meeting many of the needs of the community.

At the Alma Ata conference, a commitment was made to the achievement of a health

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Photo: J. Wilkinson/WHO

Communities are defining for themselves how they want to achieve better health and living standards.

**Principles**
- Equity
- Socio-economic development
- Integrated and comprehensive care emphasizing health promotion and disease prevention
- Self-reliance

**Process**
- Community participation
- Inter-sectoral collaboration
- Orientation and training of personnel and others involved
THE COMMUNITY BASED HEALTH CARE MODEL

Case study of Boga
Health workers in Boga, Zaire, could not understand why mothers did not bring seriously malnourished children to the health centre. The same mothers brought their children to have them immunized, so why did they not bring children who were refusing to eat?

The introduction of a “Community-determined Health Development” programme provided the answer. The community was asked to define what they meant by “health”. The local word which came closest was “obusinge”. Obusinge meant much more than an absence of illness which is frequently the western understanding of “health”. It meant a state of peace and contentment in life. Peaceful relationships within the family, and between the family and its neighbours, were particularly valued.

The community’s concept of health was completely different from that of the health workers. When a mother saw that a child was malnourished, she did not consider him to be ill. She believed that the toddler’s problem was jealousy, due to the birth of a new baby. When asked why she had not taken the malnourished, little boy to the hospital, the mother replied: “He was not sick, he had lost his peace. Misery cannot be cured by foreign medicine.”

The health workers had discovered another definition of health. Their next step was therefore to encourage the community to set their priorities for achieving obusinge. Rather than identifying extra health services, the village communities chose activities which would promote peaceful relationships and contentment with their living conditions. For example, one village planned to improve relations between elders and undisciplined youths, another to allocate land for vegetable growing, and a third to build a road.

For a full report of “Community-Determined Health Development - A vision for the future from Zaire”, see Contact 12B, December 1992.

status for everyone which would be consistent with a socially and economically productive life: It was recognized that improving health was not about delivering “health” as a commodity, but about nurturing the quality of life. It was agreed that the most practical approach to achieving this goal was through the promotion of primary health care.

The “primary” in primary health care implied community involvement. Communities, families and individuals would form partnerships in which they would take responsibility for their own health. People, especially the most vulnerable, would achieve “empowerment” by working together to increase their control over the events influencing their health and well-being.

Professionals in health and other sectors would provide appropriate support and guidance. They would facilitate the process while respecting the principles of self-reliance and self-determination.

Differences in the understanding of primary health care have produced different approaches
to community participation in action for health. Three distinct approaches can be identified:

1. Primary health care as an extension of health services
This type of programme is based at the health facility or institution. It often has volunteer community health workers operating as extension workers. The planning and operational process is dominated by health professionals using a "top-down" approach. The activities are often biased towards the selective primary health care approach. The use of "appropriate medical technology" such as growth monitoring, oral rehydration and immunization is central.

Community participation tends to be limited to contributions in cash or labour, and to the consumption of services. Community members follow the instructions and advice given by health professionals. There is usually little opportunity for the communities to contribute their own ideas, knowledge, skills, experience and opinions. The agenda is set by health professionals.

2. The community-based health care model
In the second approach, health issues are addressed on the basis of a broader understanding of what health is, and how to take care of it. These community-based health programmes are developed in the context of human dignity, development and total well-being. Action for health may therefore lead to plans for social action and holistic development.

The community-based programmes recognize that people are already taking care of their own health. All are facing daily challenges with what they know and what they have. The community of people involved in community-based health care programmes contribute their knowledge and skills rather than only their resources and labour. Power and decision-making within the programme is shared between the community and the resource people.

The community-based process involves the community and the resource people in discussions about their beliefs, behaviour and actions for health. Working as a partnership, the group is more likely to produce ideas which are both appropriate and effective. The community leads the way in analysing the problems and seeking solutions. The resource people support the necessary individual and collective action. The role of the resource people, including the health professionals, is not to take over responsibility but to help people achieve their planned action. Health workers have to remind themselves that they cannot be responsible for providing health; they can only enable the people to pursue their own community action for health.

This approach respects the community's concept of health which often goes beyond the western view. (See Case Study in Boga). It is more likely to produce lasting changes in behaviour and life-style because people have discussed the issues for themselves. They have defined their own priorities and come to their own conclusions as to what is needed. Health professionals have to persuade people that empowerment may be preferable to being given health services as charity.
3. Popular action for social change
In the second approach to community participation in action for health, the people become aware of the injustices that cause ill-health. They also plan their own programmes. In the third approach, this new awareness may move them a stage further. It may lead people to recognize that they need to plan and organize popular action for social change.

This type of participatory action has come about as a result of a progressive change in the understanding of the concept of health. Health has come to be understood from the point of view of the community rather than of the individual. The struggle for health becomes a struggle for social justice. Collective action undertaken by disadvantaged people challenges the unjust structures that perpetuate ill-health. For example, demonstrations against structural adjustment programmes remind the authorities of the effects of cuts in health and education budgets on the lives of the people. Collective action puts pressure on local and national authorities and industry to address the health needs of the people.

For local efforts to succeed, international groups also need to be active, raising awareness of the issues and gathering information at the international level. Some international lobbying has been particularly supportive, for example, campaign groups supporting breastfeeding and essential drugs programmes.

As David Werner puts it:

"The social transformation needed to bring about ‘Health for All’ requires a worldwide coalition of grassroots groups and concerned world citizens to bring the present global structure under control".

The three approaches to community participation in action for health are not alternatives. All three are needed and complementary. The challenge is to combine the approaches in a way which helps increase people’s capacity to harmoniously bring about change.

How can we support community action for health?

Principles:
First, there needs to be an acceptance that an improvement in health status is not related to health services alone.

Second, it needs to be understood that improvements in health are linked to general improvements in the level of basic education, living conditions and lifestyle.

Third, health professionals need to recognize that their role should be supportive not directive: to develop partnerships, to equip partners for effective action, to enhance networks for advocacy and collective action, and to provide technical support.

Fourthly, it is important to recognize the need for partnerships of inter-sectoral collaboration. These are needed to achieve organized demand for justice in health, service distribution and social security and to establish guarantees that basic needs are met.

Finally, and most important of all, is the need to recognize that community action is only
meaningful when the people themselves have determined their own priorities and designed their own responsive action.

Processes:
Develop leadership: recognize and support current and potential leaders at the community, district, national and international level.

Enhance commitment: cultivate the skills and attitudes of individuals who are strategically placed to mobilize others in community action for health.

Build on people's capacity: equip people for participation by expanding what they know, feel and are able to do. Health workers and those in related sectors need to learn how to become partners facilitating primary health care.

Build networks: develop a network of collaboration of interested representatives in government sectors, non-governmental organizations and district offices. A network provides support and encouragement and a mechanism with which to collaborate and foster political will and commitment.

Create a “critical mass”: initiate and support a programme aimed at mobilizing groups which are large enough to change opinion. Every community, district or nation needs leaders who can generate the collective force needed to achieve “Health for All”.

Facilitators need to remember that change often happens as a result of crisis and problems, though it can happen at any time. It may not happen through the first group of people who risk becoming involved because they may not be the most needy. These people soon discover that the programme will not address their individual concerns. Some leave as a result, others show true commitment. At all times, facilitators need to have patience and commitment.

Evaluation
Community action for health programmes should always include regular sessions for assessment and reflection. All partners in the programme should be involved in deciding when, how, and what to evaluate, and what to do with the results. The people have defined the priorities for themselves and they must therefore be the final judges of whether the programme has succeeded or failed.

There is often a need for a resource person to help guide the evaluation, and to enable the partners to “see” their progress. His or her preoccupation should not be what is done to evaluate the programme but how it is done. It should be a process which promotes self-reliance and empowerment.

The style of the evaluation reflects the approach of all successful community action for health. Programmes emphasize people’s dignity and recognize that the people involved are the key partners in the process of achieving better health. The people uncover the root causes of ill-health, and make their own plans for regaining their share of the fruits of freedom.

Discussion paper
This article is based on “Community Action for Health, a discussion paper by International NGO-PHC Group”.

The International NGO-PHC Group is made up of approximately 60 non-governmental organizations (NGOs) most of which have official relations with World Health Organization (WHO). The purpose of the group is for members to have an opportunity to share experiences of the promotion and implementation of primary health care in their own countries. It also allows them to share and coordinate with each other, and with other NGOs, as well as with WHO and UNICEF.

Copies of the discussion paper are available in English, French and Spanish (Price: SFr 5 per copy) from CMC - Churches’ Action for Health, PO Box 2100, CH-1211 Geneva 2, Switzerland.
CHILEAN WOMEN STAND UP FOR THEIR RIGHTS ... AND WIN

A street demonstration can sometimes prove enough to push the authorities into action. This article describes how a group of Chilean women discovered the power of collective action. With the help of EPES, Popular Education for Health, the women identified drinking water and sanitation as a priority need. Then, after initial hesitation, they pushed ahead with a programme of action which eventually won them what they wanted.

Two years ago, the EPES office in Concepción, southern Chile, was contacted by a women’s group called Domo Ayllarehue. EPES or Educación Popular en Salud promotes popular education for health. The women wanted help with “capacity-building” - a training programme which would equip and strengthen them in their efforts to improve the quality of their lives.

Staff at EPES were well-aware of the difficult conditions in which the women were living. The Domo Ayllarehue women’s group was based in La Granja, a poor neighbourhood comprised of families who had been forced to move from peasant farms into poor areas of the town of Hualqui.

For the past 10 years, the women living in La Granja had been forced to cope with both a poor water supply and a decaying sanitation system. Running water was only available for a few hours every other day. The sanitation system was poorly maintained and some septic tanks regularly overflowed. The smell of the sewerage had become an accepted characteristic of the neighbourhood.

There was a constant fear that an epidemic might break out. The rate of infectious disease among children was always high. According to reports from the local clinic, 70% of the children had intestinal parasites. However, despite the environmental conditions, the health services continued to pay no attention to the causes of the infectious disease.

Most of the people were too demoralized to consider a response in terms of community action. Few had any feeling of belonging to a “community”. They lacked a common history. Some had only recently been forced to migrate into the town. These were not people who believed in collective action.

Taking the chance
Given this low level of expectation, EPES was surprised to receive a request for support from the Domo Ayllarehue women’s group. EPES staff welcomed the opportunity to work with the women, and helped them plan a series of workshops. The women would discuss their hopes and decide on which were their most pressing needs. Next, a programme of action would be planned, the implementation of which
should bring the desired results. Finally, there would be an evaluation workshop.

During the first workshop sessions, the women identified the water and sanitation problems as their main priority. The lack of regular drinking water supply and the deteriorating condition of the septic tanks caused much frustration and ill-health. The municipal authorities were supposed to clean the septic tanks every month. However, the authorities had told the Domo Ayllarehue women's group that it was a regulation that they were unable to respect "in the short term".

The women decided that they needed to bring the problem to the attention of the people of Hualqui. They decided to involve as wide a range of community groups as possible. The groups would be invited to join a coordinating committee which would organize "communitywide mobilization". Various Christian groups, the Boy Scouts, sports clubs, youth dance groups, neighbourhood groups, orators, singers and humorists were contacted. The "Day of Dignity for Hualqui" was planned for 29 November 1992.

Four days before the event was supposed to take place, one of the leaders announced to EPES that the women had decided not to go ahead with the action plan after all. There had been rumours circulating that the police were planning to bring in reinforcements from the regional capital. The women had lost their courage. Some women also said that they wanted the event cancelled because their husbands disapproved.

Someone had the idea that they should all sit down and talk about their fears. The women began to unload their burdens. They spoke about their sense of frustration and hopelessness. Some revealed that they had even attempted suicide. Many had been out of work for a long time. They said that they felt neglected and ignored, as if their opinions and needs were of no importance at all to the authorities.

Change of plan
The effect of this meeting was to restore the women's courage and determination. The next day, two of the leaders came to the EPES office to announce that plans had changed. They
now wanted to organize the "Day of Dignity for Hualqui", and asked whether an EPES staff member could attend a planning meeting.

During the planning meeting, the women worked on their slogans and created a range of colourful posters. They also wrote a petition to present to the municipal authorities, and made a leaflet for general distribution.

When the "Day of Dignity for Hualqui" came, the women assembled in La Granja. To their delight, they were joined by supporters from many other community groups. As the demonstration moved off towards the centre of town, marchers held the posters high and hundreds of leaflets were handed out to those who had come onto the streets to watch. The march ended in front of the municipal buildings. There, the petition was read out by one of the women as she stood on the principal plaza facing the municipal offices.

The municipal authorities responded to the women's demands. Now, there is clean, running water everyday in La Granja. The septic tanks are emptied and cleaned every month as required by the municipal regulations.

In the evaluation, the women marvelled at their success. A municipal councillor had joined the march to show his support, and some of the newest migrants to La Granja had also joined in. Above all, the women were happy that there had been no repression.

In the process of organizing the action, the women of Domo Ayllarehue had become convinced that they could bring about change. They now knew that they could do something about their needs if they worked collectively.

The women are now embarked on a second action programme: to defend themselves and other women against domestic violence. For the members of Domo Ayllarehue, this is the next step in the struggle for healthier and more dignified lives.

Source: Educación Popular en Salud (EPES), Iglesia Evangélica Luterana en Chile, Casilla 15167 - Santiago, and Casilla 3144, Concepción, Chile.
MALAYSIA: LAND RIGHTS AND HEALTH

"IF DEFENDING OUR LAND AND LIVELIHOOD IS WRONG, WHAT IS RIGHT?"

Ever since commercial logging companies began encroaching on their land, the Kenyah people living in Long Geng longhouse in Sarawak, Malaysia, found that their sources of food and clean water were disappearing. Forests were being destroyed and rivers becoming polluted. They started to take action.

We are the Kenyah longhouse community from Long Geng, Belaga. Logging companies began work in our area in 1988. They agreed, in writing, to compensate us. But they never did.

In 1989, they continued logging and made more empty promises. They logged near Sungai Geng, a major catchment and watershed area for the Geng and Keluan rivers. These rivers feed onto our lands.

Soon, we found that the water in the river was beginning to look like "Milo", the brown-coloured, commercial drink made of cocoa and malt. After that, the water from the river needed to be filtered before we could drink it. The fish began
to disappear. The animals had already disappeared from the forests. They had been frightened away as soon as the logging began. Food became more and more difficult to find.

In June 1990, when negotiations with the companies failed to produce results, we decided to set up a road block. We formed the first human barricade at the point where the road crosses onto our land. The barricade would prevent the companies from taking their machinery into the area, and from dragging felled trees out. The aim was to halt all logging of the trees on our land.

News of the barricade travelled fast. Company representatives came to argue and threaten us. The company’s lawyers said that we had no claim to the land, whereas they had. They said that the company had a licence from the government to log the land, and that therefore they had the right to work in the area. Our response was to stand firm. We had a right to the land. It was our land, the land of our forefathers and the land of our children.

When the company realized that their threats were failing to frighten us, they brought in the police. In July, eight of us were arrested. We were held at Kapit police station for 10 days. There, we were punched and threatened by the police even though there was no case against us. Nine days later, at the magistrate’s court, no formal charges were made and we were released after signing bonds committing us to “good behaviour and keeping the peace”.

The barricade continued to prevent anything other than food entering the area. Its success led to another group of us involved in the barricade being arrested in August. These 14 men did receive jail sentences of six weeks, but only because they refused to sign the bonds of good behaviour. Three months later, they were also acquitted, this time by the High Court in Sibu, Sarawak’s capital.

Over the next 18 months, our barricade continued with only one major disturbance. In November 1990, nine policemen arrived at the site. The sergeant among them shouted to those manning the barricade that he wanted it dismantled. He said that the men had no right to block entry to the land and should return home. Our Kenyah men replied that they disagreed. They said that they wanted to meet the company manager, and asked why it was only the police who spoke to them. After a while, the police fired warning shots into the air and left. The barricade was left to continue its work.

The peace was next broken more than a year later on 12 January 1992. A plain-clothes policeman with a gun, accompanied by 50 police field officers, walked into the area firing warning shots. They arrested the two residents of the Long Geng longhouse who were forming the human barricade that day. Kayang Kesah and Jabu Lawan were taken to Kapit police station even though the police had no warrant for the arrests.

Two weeks later, they were charged with “wilfully obstructing” a forest officer who was trying to execute his duty. Kayang, the elder of the two, was treated the most harshly. He was sentenced to five months imprisonment, and to pay a fine of 1,000 Malaysian Ringgit (US$ 385). Afterwards, he told a local newspaper reporter that his family could not even raise 50 Ringgit. “That is why we want to defend our farm and the surrounding jungle. It gives us rice and food.
We hope that the people will continue defending our land. If we lose our land, we have lost everything," he said.

During the time that Kayang and Jabu were in jail we looked after their families. This practice is part of our tradition known as "maap". All the villagers contribute rice and food. They also take care of the small children, and help look after the farms of those who are absent from our community.

During their absence, we organized a two-day celebration in Long Geng for our Bujang Berani. We gave them this name, which means "brave warriors", because they have defended our land for us like our ancestors before them. About 800 people came to celebrate with us. Most were from tribal communities in Sarawak and West Malaysia. The highlight of the event was the welcome we gave to ceremonial "brave warriors" who returned home having defended the ancestral lands. These men were all dressed in traditional costume.

The celebration lifted our spirits. It increased our commitment towards the next step in our struggle for our rights and to maintain our lifestyle. Since then, there have been more arrests but our action continues. Our livelihood depends on our land and we will continue to defend it for our children and our grandchildren. As one of our community leaders said recently: "If defending our land and livelihood is wrong, what is right?"

Source: Information provided by Doreen Teo, Institute for Community Education (IPK), PO Box 8, 96007 Sibu, Sarawak, Malaysia.

Bakun Dam
Today, the Kenyah people are facing another threat. It may prove to be an even greater onslaught to their rights and lifestyle. The proposed hydro-electric power project, the Bakun Dam, would mean that the Kenyah people would be forced to move from their homeland. The project, which is supported by the World Bank, would flood a huge area in Sarawak, destroying the Kenyah community and culture.

The community has responded by organizing a press conference, and by sending a leaders' delegation to present a signed petition to state ministers. Nevertheless, latest reports reveal that more and more pressure is being put on Kenyah people to agree to the proposed project.
AIDS IN UGANDA:
COMMUNITY RESEARCH FOR COMMUNITY ACTION

Participatory action research (PAR) is a means of encouraging community discussion and action on AIDS. Christopher Tusubira, the author of this article, was the research coordinator who introduced the method at All Saints Primary Health Care (PHC) Programme in Uganda. He describes how the families living in this area of high HIV/AIDS incidence are responding.

All Saints PHC programme covers a 21 square mile area just outside Jinja, south-east Uganda. Most of the population of 36,000 are involved in agriculture, though a small number run kiosks (shops) and a few are involved in brick making, horticulture and pig farming. Each of the 26 villages in the area is affected by HIV/AIDS and many people have died. Seven in every 1,000 in the community are people living with AIDS (PWAs).

Health services are very limited. Fifteen of the 26 villages have Village Health Committees but there are only four trainers available to teach and support Community Health Workers. Basic maternal and child health services exist, as do basic treatment facilities, and programmes for health education and control of communicable disease. There are also efforts taking place to improve water, sanitation and home environments.

However, a particularly important growth area has come about over the past three years. The PHC programme has been able to strengthen HIV/AIDS activities following the introduction of participatory action research (PAR) in June 1991.

Defining PAR
Participatory action research means communities finding their own solutions to their own problems. It begins when community members acknowledge that a particular problem or issue requires some close attention. Once this has happened, the community feels the need to
organize itself to look more carefully into the problem. They start to gather information, share ideas and experiences and discuss the issue. They identify the causes of the problem and begin to think about possible solutions. They create plans of action which are eventually implemented to solve the problem and transform their situation.

**Process**

In 1991, the community involved in the All Saints Primary Health Care programme in Jinja, had already recognized that AIDS was an important problem. The research process began with a small group of people identifying which topics might be the most important for group discussion. Having consulted various groups, the research team at All Saints decided that harmful, cultural beliefs and practices should be the key topics for discussion.

Community members were then called upon to discuss their ideas and experiences in small groups. They were asked to focus on such practices as polygamy and the inheritance of widows.

In the course of the discussions, it became clear that some cultural practices were contributing to the spread of HIV/AIDS. Polygamy increased the risk of HIV transmission because men could legitimately take on new partners. Widows were vulnerable because they were often expected to marry a male relative of their dead husband. Poverty amongst those who refused to be "inherited" in this way often led them to prostitution.

People also became aware that socio-economic difficulties contributed in a major way to problems. They identified many positive cultural beliefs that helped the situation. For example, couples would often adopt AIDS orphans within the extended family. However, lack of income made it difficult for families to cope with too many sick or orphaned additions.

**Response**

Two years later, the community experience of participatory action research has produced definite change in behaviour. There is less fear and less stigma shown. People have become more willing to share the responsibility of home-care of people with AIDS. Marriages seem to become more stable and polygamy less popular. There has also been an effort to promote family planning. In this way, the number of children likely to end up as AIDS orphans should fall. Some youth groups for drama, sport and income-generation have been formed to keep young people busy.

A particularly powerful response expressed by both men and women during the discussions was the need to look at gender relations. People felt that the fact that women were often denied their rights contributed to instability in relations between the sexes. For example, wife beating sometimes forced women to find new partners. Changes in partnerships increased the potential risk of HIV transmission.

The "Gender Relation Forum" was set up in response to this expressed need. Focus group discussions were organized for groups both of women and of men. The women concentrated on their problems and the strategies that might help them live more dignified lives. The men looked at the root causes of patriarchy (male dominance). They tried to work out whether the problems are connected with religion, politics, race or ethnicity. They analyzed the factors that contribute to the subordination of women, both socio-culturally and economically. They also discussed how women could be "empowered" by gaining more skills and resources.
The result of the Forum has been to boost women’s morale and to give them an opportunity to set their own priorities. Most of the women involved have formed cooperative groups to generate income for their families. Many men taking part in the Forum have begun to offer their wives a share in the income from cash crops. The result appears to have been greater marital stability. Discussion about equality has also led to a greater acceptance of the need for the education of girls. Some young women have already started at university.

There has also been more discussion about family planning. Couples are more likely to agree to choose longer intervals between the births of their children. They are also more likely to plan how many children they want. Men are still likely to refuse to have a vasectomy. But this will come about in time.

Christopher Tusubira is currently writing a manual on how to introduce participatory action research in the community.

Repeating the success
Participatory action research was presented to a meeting in Kampala, Uganda, in June 1991 by Uganda Protestant Medical Bureau, Christian Medical Board of Tanzania and Medical Bureau of the Eglise du Christ in Zaire, and CMC - Churches’ Action for Health. The meeting was attended by a number of African churches, many of whom showed great interest in the approach.

Since then, a programme in Nigeria has used the participatory action research approach, and health workers in many other countries are talking about the idea. During a meeting to share the results achieved in Africa, Marion Morgan, executive secretary of Christian Health Association of Sierra Leone, called on the World Council of Churches to help implement participatory action research on a worldwide basis.
UPDATE: Triumph for breastfeeding campaign

The US government has officially joined the worldwide consensus on infant feeding policies. At the 1994 World Health Assembly (WHA) in May, US delegates voted to reverse their country's 13-year opposition to WHO's International Code of Marketing of Breastmilk Substitutes. The Code sets down provisions which effectively ban all promotion of bottle-feeding.

The move followed a showing of united resistance from health ministers from developing countries - including 52 African countries voting together as a block. Although the US delegation had initially proposed changes to the Code, the pressure on them during the WHA, supreme governing body of the World Health Organization (WHO), ultimately swayed their decision. They withdrew the amendments and agreed to support the resolution with no changes.

Consumer, health and breastfeeding advocates have expressed delight with the result. Many have been campaigning intensely on this issue for many years. US campaign organization, Action for Corporate Accountability, said that they had been lobbying particularly hard for this decision since the Clinton Administration came into office last year. They intend to initiate a domestic campaign in favour of breastfeeding. "Only when the US government restricts the formula industry's deceptive promotional practices here in this country, will it have truly reversed its regressive infant feeding policies of the past 13 years," a spokesperson said.

Negative reaction at Nestlé

In June, a month after the WHA decision, campaign groups demonstrated outside the Nestlé shareholders meeting in Lausanne, Switzerland. They wanted Nestlé's response to the strengthening of international commitment to WHO's Code. Chief Executive Officer, Helmut Maucher, made it clear to the shareholders that there would be no change in Nestlé's worldwide policy of promoting powdered baby milk.

Nevertheless, campaigners kept their spirits high. Two British supporters of Baby Milk Action had cycled on a tandem (bicycle for two) from Nestlé UK head office through Luxembourg and Strasbourg to Lausanne. One, dressed as the "Grim Reaper", the symbol of death, aroused much media interest.

Shareholder Philippe Ammann, a Swiss pastor, presented Nestlé with a petition signed by 50,200 people who boycott Nestlé products in 19 countries. He reminded shareholders that the Church of England may soon decide to disinvest in Nestlé shares. At the next General Synod meeting, the Church of England will be called upon to disinvest its £1.4 million (US$2.1 m) shares in Nestlé. Following the Church's endorsement of the Nestlé boycott in 1991, sales of Nescafé fell by 3% in the UK. Nescafé accounts for approximately one eighth of Nestlé world sales.

Preliminary results of recent monitoring by IBFAN (International Baby Food Action Network) show that although many countries are now attempting to control the free supplies, the problem continues. In Pakistan, 60 facilities reported receiving free supplies and many health workers were passing these on to mothers. Nestlé, which is estimated to control 35-50% of world market sales of infant formula, was responsible for 25% of donations recorded in 11 countries.

Resources

Please note that Contact 133, October 1993, featured "Campaigning for breastfeeding: Church and community action". In that issue, we launched a CMC Code monitoring project. Please write to us for a copy if you would like to become involved in the worldwide campaign to promote breastfeeding.

An international resource list of organizations involved in promoting breastfeeding, with a section on publications and audio-visual materials, will be available soon from AHRTAG. It will be free to readers in developing countries. Details: AHRTAG, 1 London Bridge Street, London SE1 9SG, UK.
USEFUL PUBLICATIONS

This list includes some of the most useful books on the participatory approach to promoting primary health care. Unless otherwise stated, these publications are available in English only. Addresses of the distributors are provided in the Address box on the next page. Please send us your suggestions for additions to this list of books and manuals.

AIDS home care handbook
The aim of this book is to enable health care workers to help individuals, families and communities to manage AIDS-related problems, particularly safe and compassionate AIDS care at home. It costs SFr 20.- and is available from WHO. Please quote WHO/GPA/HCS/93.2. Also available in French.

Beyond the dispensary
This book describes how a well-trained community health worker can motivate the community. It is published by AMREF and available at price US$3.60 plus postage and packing. It is also available at a price of £3.25 plus p & p from TALC.

Child-to-child resource book
This extensive guide to the child-to-child approach includes activity sheets as well as an action guide, an evaluation guide, and a workshop guide. It is edited by G Bonati and H Hawes (1991) and is available at a price of £5.00 plus p & p from TALC.

Community health
This publication from AMREF looks beyond the individual to the health of the community as a whole. It is available from AMREF, price US$5.70 plus p & p, and at £4.00 plus p & p from TALC.

Community involvement in health development
An examination of critical issues
This book presents an overview of both the theory and practice of community involvement in health. It costs SFr 16.- and is available in English, French and Spanish from WHO. (ISBN 92 4 156126 2).

Education for health
A manual for health education in primary health care
This book is designed to give health workers the insight and skills needed to help individuals and communities learn how to improve their own health. It is available in English, French and Spanish from WHO. Order number 1150297. Price: SFr 34.- (US$30.60); SFr 23.80 for readers in developing countries.

Health care together
Training exercises for health workers in community based programmes
Edited by M P Johnstone and S B Rifkin, this publication includes training exercises for health workers in community based programmes. It is available at a price of £3.60 plus p & p from TALC.

Helping health workers learn
This manual by David Werner is full of practical ideas and advice on how to teach village health workers. It is available in English and Spanish at a price of £5.90 plus p & p from TALC.

Participatory action research on AIDS and the community as a source of care and healing
This manual introduces participatory action research on AIDS. It is available in English at a price of US$5, including surface-mail postage, from UPMB; and in French for US$5, including surface-mail postage, from CMC.

Partners in evaluation
Evaluating development and community programmes with participants
This publication by M-T Feuerstein is both a practical field handbook and a textbook. It is designed for those who want to know more about monitoring and evaluating their own work. It is available in English (£2.80 plus p & p) and Portuguese (£4.80 plus p & p) from TALC.

Setting up community health programmes
This practical manual by Ted Lankester follows a logical progression from before the programme starts through to running particular programmes and subsequent evaluation. It is available at a cost of £5.95 from TALC.
Training for transformation  
A handbook for community workers  
This three-part manual provides the methodology and a practical guide to introducing health personnel to the participatory approach. It is available from: Mambo Press, PO Box 779, Gweru, Zimbabwe; MAP International, PO Box 50, Brunswick, GA 31521-0050, USA; CAFO, 2 Romero Close, Stockwell Road, London SW9 9TY, United Kingdom; Graalville Art and Book Shop, 932 O'Bannoville Road, Loveland, OH 45104-9705, USA. Spanish translation is available and French translation is in process.

Training in the community for people with disabilities  
This manual has been developed for use in community-based rehabilitation programmes and is written primarily for people with disabilities and members of their families. It is available in English and French from WHO. Price: SFr 80.- or SFr 56.- for readers in developing countries. Order number 1150330.

Turning the Tide  
A Safe Motherhood action manual for those whose aim is to reduce maternal morbidity and mortality. It is available from TALC in English or Portuguese (£3.00 plus p & p).

Where there is no dentist  
This book is useful for health workers who look into patients mouths! say TALC who distribute it in English and Portuguese (£3.00 plus p & p).

Where there is no doctor  
This highly practical book with many illustrations was written by David Werner. It is particularly useful for those developing village health programmes. It is available from TALC in English (£4.00), English for Africa (£4.00), Arabic (£5.50), Portuguese (£5.50) or Spanish (£5.20). Price of postage and packing not included.

"Bought" by Nestlé  
Dear Editor,

Reading through a friend's copy of Contact on "Campaigning for Breastfeeding", I became indignant when I discovered how I am being "bought" by Nestlé.

As a final year medical student specializing in paediatrics at the Federal University of Rio de Janeiro, I receive special treatment from Nestlé representatives. For example, last week, I received free samples of Cerelac (Nestlé product), booklets on drugs used in paediatrics, and Nestlé publicity and advertising material. I am sending these to you as I find them misleading and would like to speak out strongly against them.

Nestlé samples are given to paediatricians and to students in their final year. Meanwhile, there is no official component on breastfeeding in our education programme. Any training we receive depends upon the conscience of the health professional involved.

Elizabeth Pereira  
Instituto de Puericultura e Pediatria MG,  
Universidade Federal do Rio de Janeiro,  
Rio de Janeiro, Brasil.

Better language  
Dear Editor,

Usually I much enjoy your journal and find it has many useful ideas which we can apply to our situation. The recent issue (Contact 136 April 94) entitled "Writing about Health" was interesting and I heartily agree about the need for

Address box  
AMREF, Book Distribution Unit, African Medical and Research Foundation, Wilson Airport, PO Box 30125, Nairobi, Kenya.  
CMC - Churches' Action for Health, World Council of Churches, PO Box 2100, 1211 Geneva 2, Switzerland.  
TALC, PO Box 49, St Albans, Herts AL1 4AX, United Kingdom.  
UPMB, Uganda Protestant Medical Bureau, PO Box 4127, Kampala, Uganda.  
WHO, World Health Organization, 1211 Geneva 27, Switzerland.
our written - and spoken - words to be clear, precise and also non-judgemental in teaching situations. The article "Words can hurt" rightly drew attention to the damage which can be caused by casual use of words which have a tendency to "reinforce prejudice or to confirm negative attitudes".

Unfortunately, in the next article ("Health professionals and the AIDS epidemic"), the author was allowed to do precisely this. On page 12, she writes "today, all over the world, people with AIDS are being treated much as 'lepers' were treated at the time of Christ"! The author was concerned that health workers should "...avoid terminology that is incorrect, misleading or even subtly judgemental in nature". If this is important in speaking to, or about, AIDS-afflicted people, is it not reasonable to extend the same courtesy to those afflicted by leprosy?

On account of its derogatory overtones, the term "leper" was proscribed (condemned) by the Leprosy Mission, by the World Health Organization and by many other institutions, a long time ago. We speak of "leprosy patients" or "leprosy affected people"; in my experience in UK, India and Nepal, these terms are not offensive. In some parts of the world (notably USA) even the word "leprosy" as the name of the disease is unacceptable and "Hansen's disease" is preferred.

Could you please request the author of the article to avoid in future using the word "leper" as she will unwittingly hurt many innocent sufferers and also anger many of those who care for them.

Dr C Ruth Butlin
The Aranabar Leprosy Hospital
Kathmandu, Nepal.

Thank you to Ruth Butlin for bringing this matter to our attention. It provides a valuable reminder that even those with the best intentions can slip up from time to time - Editor.

ANNOUNCEMENTS

WHO Award for Health Education and Promotion in Primary Health Care, 1994

A WHO annual award for health education in primary health care was established in 1985. The purpose of this award is to reward outstanding contributions made by any person(s), institution(s) or nongovernmental organization(s) towards strengthening Health Education/Promotion in primary health care. The award consists of 1st, 2nd and 3rd prizes of US$5,000, $3,000 and $2,000 respectively.


For more details, please write to Division of Health Promotion and Education, World Health Organization, Avenue Appia, 20, 1211 Geneva 27, Switzerland.