COMMUNITY-DETERMINED HEALTH CARE

The experience of rural Cameroon

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COMMUNITY-DETERMINED HEALTH CARE

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Most dictionaries, many writers and almost all health professionals understand health as relating to the physical state. The British Medical Dictionary introduces the idea of “wholeness” as being similar to the Hebrew shalom—a state of completeness, health and peace. To the Hindu, health means being at peace with the self, the community, God and the cosmos. Others conceptualise health as being a harmony between people and their environment.

The cultural context of health
In traditional societies, the clan or community was self-sufficient: an evolving micro-culture providing a way of living consistent with its own preservation. Health was understood as being the harmony and responsibility which existed within the clan and the wider community rather than as the well-being of the individual. Most states of disharmony (physical, social or psychological) arose within the clan and were dealt with by the clan.

Community determination in health
Most of us working in health have tried to establish primary health care programmes according to the books. But guidelines on working with village health workers or village committees seldom seem to bring the expected results. Community health professionals are left with more, rather than fewer, problems. Why? Contact's main article in this issue contrasts the early failures of the Life Abundant Programme in Cameroon with subsequent success following the introduction of a new approach. A similar radical change took place in Boga, Zaire (now the Democratic Republic of Congo) as highlighted in Contact 128. The two programmes have taken somewhat different lines but the essential similarity is that both started by asking the community about the local understanding of what health is, and about health practices and health priorities.

Posing questions concerning the local definition of health is not as straightforward as it may seem. A health professional who asks: “What is health?” may simply receive the reply: “the opposite of sickness”. This is because communities associate health professionals with curative care. By using focus group discussions, a clearer interpretation can be identified. An alternative process is explained in this issue focusing on Cameroon, bringing a response which reflects the richness of the local culture and enables the community to identify and address priority “health” needs.

The experiences in both Boga and the LAP programmes show that the community-determined approach produces a stronger impact than programmes in which the communities conform to primary health care established by health professionals. However, to ensure sustainability, the programme needs to be put into a framework (ongoing programme or civic organization) or a structure, such as district health management.

Where do we go from here? Guidelines for community-determined health care might not be appropriate since each programme must reflect the local context. However, there are principles common to Boga and LAP, and to other experiences recorded in Contact, which should not be allowed to disappear. As the health work of the World Council of Churches takes a new direction (see page 20), perhaps it is now time for a suitable response to be made to the remarkable testimony Contact has provided for primary health care over the years.

Dr Patricia Nickson
IPASC, Democratic Republic of Congo

(This issue also contains a four-page supplement on the latest findings on the effects of Pacific nuclear testing on the health and well-being of the people of Moruroa. The study was strongly supported by the World Council of Churches – Editor).
THE “BOTTOM-UP” APPROACH TO HEALTH PLANNING

Effective health planning should begin with asking people what they think health is and how they think good health can be achieved. This is why the programme in Cameroon has been such a success, according to Ruby N Eliason, education adviser of Life Abundant Programme (LAP). Here, she describes the thinking behind the project and describes the experience in the villages.

The Life Abundant Programme (LAP), a church-related primary health care organization, has been working in Cameroon for over 20 years. It is the responsibility of the Cameroon Baptist Convention Health Board and its ministry is scattered over 8,500 square miles, spanning four provinces, 30 or more tribal groups and languages, and a population of more than 100,000. Altitudes range from 1,200 to 5,500 feet, from low-lying tropical forest to high savannah grasslands.

From the beginning, LAP's philosophy of self-reliance in community financing has been followed. The community built their own health centre, paid for the training of the health promoter, and elected a health committee to manage the finances. Income was generated by sale of medicines and treatments. The LAP area coordinator taught and supervised the promoters and the committees.

However, the approach had many weaknesses. Although health needs were expressed by community members during the baseline health survey, there was very little follow-up on this information. LAP project planners developed their own goals for the communities, and decisions as to how the community should pursue health was in the hands of project planners. Communities did not implement some of the activities recommended by the project leaders, and in some communities funds were embezzled.

The main problem was that community members did not feel that the health initiatives belonged to them. How could "ownership" be achieved? LAP believes that ownership of health programmes occurs when there is community decision-making, a high degree of local programme control, satisfaction with the level of community participation in health care, and where the programmes initiated are maintained by the supervisor. It was felt that a conscientization approach...
(Freire, 1970) might be adapted for developing a sense of ownership and long-term sustainability of community health action (see figure 2).

Conscientization approach

Paulo Freire's conscientization approach was adapted for the LAP programmes to encourage a sense of ownership in community action for health. It was felt that this methodology would also contribute to the long-term sustainability of the health activities.

The process begins with interviews in the village to establish "health themes". The themes are then analyzed and grouped into topics, such as environmental sanitation, adequate nutrition and so on. The themes are then prioritized according to the number of respondents per topic and presented to the village health committee as a mini-drama (codification). Whatever the villagers said about a particular health theme was conveyed through the drama to the committee. Next, there is a discussion of the drama (decodification). The coordinator asks: "What have you seen/heard in the drama?" (reflection). Next, the coordinator asks the committee: "Is your village similar to what your villagers have described about health?" (dialogue).

Invariably, some committee members will say "Yes". However, some will say "No", and someone will spontaneously begin to name some of the village's health problems. The coordinator then asks why the problem exists, probing until the root cause of the problem is named. The final question is: "What will you do about the problem?" which leads to dialogue and some verbal commitments on action.

The next step is to develop a community-determined health care plan. Working with the coordinator, community members prepare a statement (see page 6) describing what they consider "health" to be, and "a prescription for achieving health" (ie health goals and strategies). Action is initiated by posing the following question to the health committee: "If this is what your villagers believe about health and how to attain it, what will you do about the lack of health during the coming year?"

After some more dialogue, the village committee sets goals for the year. At the end of the year the committee evaluates progress which leads to a continuing cycle of action and reflection each year. The statement on the definition of health and how to attain it is reviewed and changed if necessary. New actions are planned taking into consideration the additional information on health problems made available at the end-of-year evaluation.

The experience

At the time of the study, LAP was active in eight villages of the Yamba in Northwest Province of Cameroon. As the
researcher, I selected three villages named Jator, Nkot, and Bom. Each of these villages had their own chief, were predominantly Christian and each was accessible partly by four-wheel-drive vehicle and partly by foot. All three had a functioning village health committee (organized after the arrival of LAP in the village) and access to primary health care services at the local LAP centre. Each village also had its own trained health promoters. The villages differed in population size (Jator 454, Nkot 1,407, Bom 821), altitude (Jator 2,800 feet, Nkot 4,300 feet, Bom 3,400 feet), and educational facilities (Jator had no school, Nkot had one, Bom had two).

Work began with a discussion of what “health” meant to the people of these villages. Yamba people use the word gugun, which means “strong” to convey the meaning of “healthy”. To study the concept more deeply, four questions were asked:

1) Describe a healthy village
2) How can you get a healthy village?
3) Describe a healthy family, and
4) How can you get a healthy family?

In a trial run, five Yamba villagers were asked to answer the above questions. Fortunately, the responses seemed appropriate. Therefore, after approval by the village health committee, two participant observers (a well-oriented college student and an interpreter-companion-cook) arrived in each village to follow the project during a period of six weeks. The committee members supported the study because they were concerned about health. In addition, there was a good rapport between the villagers and the LAP team.

Phase 1: In Nkot, 50 men and 50 women and students were interviewed. In the first group, ten male village leaders (including the chief, a trader, a teacher and so on) were asked about health themes as “key informants”. Each leader was then asked to name four other men who knew the village well and were interested in its development. This means of identifying interviewees is known as the snowball method. The same procedure was used for the second group including eight women leaders and two class-seven students, the top level of primary school.

Fifteen main topics, or “health themes”, arose from the interviews. These were prioritized by the number of respondents per topic. For example, 90 interviewees said cleanliness was the way to achieve health, while 71 people talked about adequate food, and 64 said it was through the treatment of sickness.

Phase 2: The six topics, or themes, which were most often chosen were presented to the committee through six dramas (codification). The first was on cleanliness. The scene opened with a fictitious village health committee awaiting the arrival of a primary health care coordinator. After the usual greetings and introductions, the coordinator asked the committee to describe a healthy village. Each person playing the role of a committee member had been given a slip of paper on which the comments of villagers about cleanliness were written. The actors therefore repeated the villagers own words to answer the question about cleanliness.

In the next scene, the coordinator asked: “How can you achieve a healthy village?” The actors responded from notes repeating the responses of Nkot villagers to this question. The same procedure continued through questions three and four. After expressing his appreciation for their good participation, the coordinator concluded his visit.
Ngang definition and prescription for health

**Description of health**
To be healthy means:
- To stay strong physically
- To be fine psycho-socially
- To be well in the whole body and spirit.

Healthy people display the following qualities:
(50 people were interviewed, the number and percentage of respondents for each quality is given in brackets).

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage (%)</th>
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<tr>
<td>Psycho-social health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unity</td>
<td>36</td>
<td>72</td>
</tr>
<tr>
<td>Loves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is obedient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welcomes strangers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not vexed, not angry,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no quarrelling, no fighting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is happy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has good &quot;fashion&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is peaceful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not steal</td>
<td></td>
<td></td>
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<tr>
<td>Respects others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not gossip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical health</td>
<td>29</td>
<td>58</td>
</tr>
<tr>
<td>Looks clean, neat and fresh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has no physical sickness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is hardworking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is strong</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has power</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual health</td>
<td>19</td>
<td>38</td>
</tr>
<tr>
<td>Prays to God</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepts and loves Christ, knows and believes in God, grows in Christ</td>
<td></td>
<td></td>
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<tr>
<td>Likes to do God's work</td>
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</table>

**Prescription for health**
How to achieve health is summarized, giving the number and percentage of respondents for each topic.

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>49</td>
<td>98</td>
</tr>
<tr>
<td>Spiritual care</td>
<td>48</td>
<td>96</td>
</tr>
<tr>
<td>General development</td>
<td>44</td>
<td>88</td>
</tr>
<tr>
<td>Care of children</td>
<td>42</td>
<td>84</td>
</tr>
<tr>
<td>Food</td>
<td>42</td>
<td>84</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>36</td>
<td>72</td>
</tr>
<tr>
<td>Treatment for sickness</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Vaccination</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Care of pregnant women</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
This completed the first of six short plays.

Now it was the turn of the field coordinator for Nkot to ask questions of the committee. The questions, summarized by the acronym SHOWD, were as follows:
1) What did you See?
2) What was Happening?
3) Does this happen in Our village?
4) Why does it happen?
5) What will you Do about the problem?

In the theory of Paulo Freire, questions 1 and 2 stimulate an experience of reflection (decoding). Question 3, "Does this happen in Nkot?" then encourages dialogue. Nkot committee members contrasted what the villagers considered to be "healthy" with the actual situation in Nkot. They identified existing health problems, such as dirty compounds. They also discussed the consequences of dirty living conditions, such as the problem of scabies. The coordinator asked the committee members why Nkot villagers were not keeping their compounds clean. They pressed and pressed with the question "Why?" until the committee came up with the root cause, namely poor sanitation. The committee was then asked what they would do about the sanitation problem. Committee members decided that they would make visits to the compounds to teach what they knew about environmental sanitation. The process was repeated for each of the other five drama dialogues, and other verbal commitments were made.

The same process was followed in Jator and Bom. Fifty people were interviewed at Jator and 70 at Bom, reflecting the smaller population size of these two villages. After this, the researchers brought together the information from the 220 respondents in all three villages and summarized it in "A Yamba Description of Health and Prescription for Health". The intention then was to give members of each of the three village health committees an opportunity to discuss the statement, and then to set goals for the coming year.

The committees in Jator and Nkot readily agreed to the statement. The Nkot committee then set its targets and has since moved towards the attainment of some of its goals. For example, one aim was to improve road access to the village. This was accomplished by village members working voluntarily. Another was to send the female health promoter to Trained Birth Attendant (TBA) training. This was achieved by the end of the year. During the following two years the newly-qualified TBA conducted 68% of village deliveries, all of which took place without problems.

Implementation in Jator and Bom faced setbacks. Financial problems, inactive committee members, and disharmony between the village chief and his people were the main difficulties. However, the Jator committee has now agreed the following goals:

1) Repair and maintain village roads,
2) Repair and improve the LAP centre building,
3) Begin building a primary school (the village has already obtained government permission for a school, and cleared a land site), and
4) Strengthen love for all. This fourth goal would be evaluated by attend-
ance at committee meetings, cooperation with the chief, attendance at church and visiting the helpless.

Things have developed less well in Bom. The meeting to discuss the statement had to be delayed due to internal problems, though the health centre reopened in November 1997. The committee intends to review its prescription for health and goals during the course of 1998.

Other study villages
LAP area coordinators wanted to know whether the process tested in Nkot, Jator and Bom could be simplified and shortened, while still resulting in villages implementing their own plans for achieving health. If villages were implementing their own plans, there was more "ownership" of health programmes. LAP therefore decided to test the conscientization approach in Ngang (1996), a Christian community, and Makoup (1997), a Muslim community.

Christian community
Most of Ngang’s population of 468 were professing Christians (93%). After completion of a baseline quantitative health survey in 1996, a primary health centre was opened with a newly-trained male health promoter. For eight days during 1996 the researcher and area coordinator lived in Ngang to test the conscientization approach to community-determined health care. Several changes to the process were made.

First, there were two interview teams in Ngang instead of one, each of which was led by a LAP project leader and joined by an educated villager. Second, the target number of interviews was set at 50: 25 men, and 25 women and students. Third, instead of doing dramas on the six most popular topics, only the three top themes were selected for drama. In addition, separate drama, reflection and dialogue sessions were held with women’s groups.

To simplify the interviewing, the researcher recommended that the questions should be changed to:

1) Describe the people of a healthy village.
2) How can you get a healthy village?
3) Describe the people of a healthy family, and
4) How can you get a healthy family?

A final meeting with the community was very encouraging. The coordinator gave a report on the Ngang baseline survey, and the health promoter read to the people the “Ngang Description of Health and Prescription for Health” (see page 6). After both reports, the audience had an opportunity to reflect on the health status of their village. Then the coordinator asked if anyone wished to make any changes to the health statement. Two suggestions were incorporated. One was that parents should teach their children cultural arts such as making clay pots and weaving baskets, and the other that if children were not able to go to school, parents should send them to learn a trade such as carpentry, bricklaying and so on.

After much discussion, all agreed on three goals: to lay the foundation for the primary health centre building, to build a new primary schoolhouse to replace the present crumbling building, and to begin an adult literacy school with classes twice a week. The villagers agreed that the health centre foundations were the responsibility of the health committee and that it should be completed by November 1996; the school building was the responsibility of school committee and was to be reburied by November 1997, and the literacy school was charged to the Baptist Church for action by June 1998.

One year later, the Ngang committee reported that the school building was on target, and the committee chairman proudly presented 20 mostly-female literacy students who sang in Pidgin, “We go learn”. The health building foundation had not been accomplished because of the unsuitability of the original site chosen.

Muslim community
Makoup was a Muslim community of the Bamoun ethnic group. The conscientization approach was introduced there in February 1997.

(continued on p.133)
In 1996, Contact 151 announced that the World Council of Churches (WCC) was supporting a study on the possible consequences of French nuclear tests on the health and well-being of the people of French Polynesia. The study, published as a book entitled "Moruroa and Us", represents the first ever comprehensive, independent survey of those working in the French nuclear testing site in Moruroa, French Polynesia. It details interviews undertaken by a team from the Protestant Church of French Polynesia (Eglise Evangélique) and Hiti Tau (a national non-governmental organization). The research was coordinated by Dutch sociologists at the University of Wageningen. The findings reveal the extent to which the French authorities neglected the protection of those working at the test sites.
testing programme. Many employees considered that before and during their recruitment they had not been informed sufficiently about the character and purpose of their work nor about the possible risks to which they would be exposed. Johnson, who had worked 20 years for the Centre d'Expérimentation du Pacifique (CEP), said: 'I was asked to work in contaminated zones. I was wearing special clothing. But when I was asked to sign my contract, I didn’t know I was supposed to do that kind of work. They never told us. No, they never explained anything.'

Most former employees interviewed said they had taken the work because of the money. In some cases this had resulted in a feeling of guilt. They told the interviewers that they blamed themselves for damaging their health and the environment by accepting this work. They were often distressed that they had put at risk their lives and those of their society.

**Protective clothing**
Forty-one per cent said they had worked in "possibly contaminated zones", and 30% among them claimed they had worked with no protective clothing. Many employees had belonged to one or other of the trade unions. However, union representatives put little energy into monitoring working conditions. They were convinced that plenty of effort was put into informing workers about regulations and risks. Nevertheless, the trade unions admitted that even they were not formally informed when leaks and accidents took place.

Very few of the former employees interviewed trusted the health system that had been set up for them at the test site. A major shortcoming was the lack of a rigorous system of health control. Although a large majority (94%) of the test site workers underwent a medical examination before they arrived, only 48.5% were examined at the end of their stay at the sites.

**Results lost or withheld**
Many of those interviewed also complained about the laxness and secrecy...
of the health system. “Often we did not get the results of medical tests. In 1984, I had blood in my urine and I was sent to Jean-Prince hospital in Papeete to be examined. I am still waiting for the results.” Forty-seven per cent of those workers who had worn a dosimeter to measure radioactivity had never been given any analysis results. Many said questions about whether a certain disease from which they were suffering could be related to activities at the test sites were often ignored or not taken seriously.

The inadequacy of the service had serious implications for medical records. While the French government says that there is no evidence of a relationship between the nuclear tests and the occurrence of certain types of cancer in French Polynesia, the researchers concluded that on the basis of official statistics it was impossible to provide scientific proof of whether there was a relationship or not.

The authorities also say that there is no reason to believe that the nuclear tests harmed the health of the Polynesians. They have not collected the relevant data because they believe that the cost of setting up an adequate health control system for former workers would exceed the benefits of heightened knowledge. However, such costs would be minor compared with the huge amounts of money invested in nuclear testing.

The survey interviews revealed numerous fears of the adverse consequences of nuclear testing for the health of former workers. One former employee was convinced that his sickness was related to work at the nuclear test site. “I am ill now, I have been analyzed by the doctor. I scratch my nose and blood comes out, I have been examined by a female doctor. She asked me whether I had worked at Moruroa. I said yes. She told me that all former test site workers have the same disease, that it is due to certain microbes. I then responded that it was radioactive contamination. I have seen a film made in Japan. After the nuclear explosions there, the children had the same symptoms as I have.”

Whether or not beliefs about the relationship between illness and nuclear contamination are well-founded, such fears need to be expelled by information. This has been seriously lacking. The authors of the survey say that it is difficult to escape the impression that French medical experts in Polynesia systematically ignore the anxieties and doubts of former workers.

However, collaborated information cannot be provided because it is not available. “Although the French authorities have always presented the test sites as a scientific laboratory, research on the long-term effects of the nuclear

**Child test site workers**

A startling finding of the survey was that even children were employed at the nuclear test site. The study estimates that 10% of the 10,000-15,000 Polynesians employed from 1963 onwards were under 16 years of age when they began working at the site. Six per cent were 16 years of age or younger. The French authorities strenuously deny this claim. However, the study interviews reveal that national regulations could be circumvented through informal agreements between parents, chiefs of district and either subcontracting companies or the CEP. The issue needs detailed investigation.
Further epidemiological research should be undertaken about the consequences of nuclear testing on the health of the population. Testing programme on the health of the test site workers was not contemplated" according to authors Pieter de Vries and Han Seur. "From the answers given by the former test site workers, it can be concluded that the French authorities did not even bother to collect relevant data on this subject."

Time to forget?
The French government called a halt to nuclear testing in the Pacific in 1996. Is it now time to forgive and forget? Asked whether it was important to continue the discussion about the possible consequences of nuclear testing, 83% of respondents answered "yes". An even higher percentage (91.3%) said further epidemiological research should be undertaken about the consequences of nuclear testing on the health of the population.

Archives reveal evidence of risks withheld
French leaders knew that local Polynesians were being exposed to exceptionally dangerous levels of radioactive fallout during nuclear testing in the 1960s but they publicly described the tests as "innocuous", according to a report in the French weekly magazine Le Nouvel Observateur in February 1998. The magazine quoted from defence documents which it said were now sealed because of its probe.

The report said that the radiological service, (SMR), had recommended evacuating the islands of Reao, Tureia, Pukaua and Mangareva before the first test on 2 July 1966. SMR believed that "the genetic risk is higher than for a European population of the same size" because of the population's isolation, and the high percentage of under 15s, pregnant women and old people. But the archives report simply said that "the hypothesis of an evacuation was excluded for political and psychological reasons." An evacuation would raise fears and might provoke demonstrations.

The archives also reported that three days after the first blast, tests on unwashed lettuces on Mangareva were showing contamination levels equivalent to those of crops around the Chernobyl disaster site. No decontamination measures were taken and residents were not told of a risk, the magazine said.
The 14-member health committee included three Mullahs, the Islamic teachers of the Koran, one Imam (preacher at Friday mosque prayers) and three El Hadjis (men who had made the pilgrimage to Mecca). One of the three women on the committee had also visited Mecca, gracing her with the title of Adja. The changes indicated from the Ngang experience were followed in Makoup. Interviewers asked the respondents to describe the people of a healthy village and the people of a healthy family. This helped to produce more useful and appropriate responses.

The Makoup people decided on three goals for the coming year: to clean the seven water sources of the village, to make 12 new latrines in the village, and to complete their primary health centre. When the coordinator asked who would dig the latrines, 12 people, including two committee members, volunteered. The committee gave the responsibility of monitoring progress to three committee members and the area coordinator.

Discussion
The study supports the idea that effective planning of community-determined health care should begin with discovering people's definition of health. People's "health beliefs" are based on how they describe healthy people. This provides a definition of "health". Next, villagers develop their ideas on how "health" can be achieved. Many villagers decided that health had more to do with promotional activities that kept people well than with the use of medicine when people are ill. In Ngang, respondents considered psycho-social health more important than physical health. This understanding led to the realization that only self-action could fulfill the community's health needs. Plans for how "health" could be achieved followed easily.

Why is this a desirable approach to community health? First, the approach is positive. Too often, project leaders encourage communities to talk about health problems rather than discussing concepts of good health. Second, the project captures people's interest because it is built on their own ideas and plans. Third, by first discovering the health beliefs in communities, project leaders begin to understand people's values in relation to health before discussing health problems. This is important because it reinforces the public health principle "Start where the people are," in other words, begin with what people believe and know. Fourth, the people themselves put into words a baseline from which levels of health can be measured. When community members realize that health conditions do not measure up to their own standards, they begin to identify the problems. Finally, the process is desirable because it takes a bottom-up approach to primary health care. It begins by identifying community beliefs about health rather than implementing top-down primary health care through health centres. The bottom-up approach fosters community participation, self-reliance, job satisfaction and ownership by the people - all factors necessary for sustainability of the health programmes.

By adapting Freire's conscientization theory to primary health care, another approach to "Community-Determined Health Development" (defined by Dr Patricia Nickson in describing her work with a community in Boga, Zaire, see Contact 128) has been devised.
Dr Nickson’s approach also began with developing the community definition of health, but it did not involve the coding and decoding of themes, and the “action, reflection on action and revised action” processes developed from Freire’s conscientization theory.

The original study at Jator, Nkot and Born had three limitations: the length of time it took to complete the study, the possibility that villagers responded in ways to please the interviewers, and low input from village women during dialogue sessions. Only the older women among the small number of female committee members had been willing to speak out. This was probably due to the presence of the village head (chief) and other traditional leaders. The study took six years (1986-1992) and this may have weakened its impact.

The Ngang and Makoup experiences provided three distinct advantages. First, separate drama (codification), reflection (decoding) and dialogue sessions were held with women’s groups in both villages, making it possible to hear more views from village women. Second, the process was completed within a two-week period because only 50 people were interviewed in each village. Third, the intensity of the experience over a short period produced a growing momentum of interest and involvement of the village people. As a result, many village people attended the committee sessions and participated in dialogue and goal-setting. Asking for a description of the people of a healthy village and a health family produced more appropriate responses.

The follow-up studies in Ngang and Makoup simplified the process and stimulated “community empowerment” in the sense that a community plan has been implemented. In Ngang, villagers have implemented their own “prescription for health”; in Makoup, the committee is working towards achievement of its goal.

Conclusion
To what extent does “conscientization” empower villagers to define health and to plan and implement an appropriate health care system? In all five villages the communities defined their own meaning of “health” and identified how they might attain it. Certain conditions were associated with success. First and foremost, success depends on harmony between the village head and his people. It also requires that the health committee has the active support of the village head and other traditional community leaders. A third factor is the committee’s integrity in money management. Fourth, the committee must hold regular meetings and produce regular reports which should be collected by the supervising coordinator. Fifth, there must be an urgent sense of the need to mobilize village and committee members on action for health care. Finally, the health promoters must be trustworthy in their management of money and drugs. Their good behaviour reinforces the value of the health programme.

Community-determined health care, using the conscientization approach, calls for a continuing cycle of action, reflection, new action and so on (praxis). This continuing praxis is based on the community definition of health and prescription for health. The process is a dynamic one, for as the community’s views on health expand, their description of health and their prescription for health will change. The area coordinator acts as a facilitator for the ongoing process.
Impact update
Following the research in the five villages mentioned here, the process had been implemented in five more villages by February 1998. Statements of health beliefs (Description of health and prescription for health) were developed in each village. Treatment for sickness was ranked anywhere between 5th and 9th in Importance. Considered more important were the health promotion activities which villages could undertake themselves. Four of the villages have set goals for the coming year, and one has already achieved some of its goals. There, enthusiasm led to mass participation in the cleaning of all nine of the village water sources.

The following is a list of useful publications relating to health planning based on community planning.

Back issues of Contact on Community-Determined Health Development: the Experience of Boga, and Contact 127 on Leadership, Training and Community Development.

Community ownership and program continuation following a health demonstration project by Neil Bracht and others is a paper included in the journal Health Education Research, 1994, 9(2):243-255. It describes the conditions under which “ownership” of health programmes is more likely to occur, such as when there is community decision-making, a high degree of local programme control, satisfaction with the level of community participation in health care, and where the programmes initiated are maintained.

Pedagogy of the Oppressed by Paulo Freire, one of the most significant figures in education of the twentieth century. His work helped liberate education from being a process which is confining and controlling to one which has the possibility of setting people free. This book was published in New York in 1970 by The Seabury Press, New York, USA. ISBN 0 8164 9132 1.

Evaluation, A Systematic Approach by P Rossi and others introduces the snowballing method of interviewing using key informants mentioned in the main article of this issue. The book was published in 1979 by Sage Publications, London, UK.

MULTIPLYING LIGHT AND TRUTH THROUGH COMMUNITY HEALTH EVANGELISM by Stan Rowland introduces the SHOWD technique of stimulating reflection and discussion as described in page 7.

WCC Bookshop
World Council of Churches
PO Box 2100
1211 Geneva 2
Switzerland
CREATING A HEALTHY COMMUNITY

I PETER 3.8-11

The following reflection has been prepared by
Rev Simon Oxley,
WCC executive secretary for education.

The Life Abundant Programme in Cameroon, described in the article on pages 3-15 makes use of Paulo Freire’s conscientization approach. This enables people together to come to a new awareness of their situation and their ability to transform it. It is more than a change in what they know. It is a change in attitude as well.

Spend a few moments thinking why this kind of change was important for the Life Abundant Programme. Have you seen similar effects of a conscientization approach from your own observation or experience?

Changed attitudes in the life of a community can have powerful effects. This is a recurring theme throughout the Bible. The first few books of the Old Testament contain laws and good advice about the creation of a healthy community for the people of Israel in the promised land. There are passages about good and just relationships between people and about measures for promoting physical health. These “everyday” things are regarded as religious issues because the change in attitude to make them possible comes out of the people’s relationship with God.

1 Peter was written to Christian communities who were being persecuted for their faith. The letter did not offer them the hope that their suffering would be miraculously prevented or ended. They were offered a hope which would enable them to accept the reality, to live in it and so change their situation.

Read I Peter 3.8-11
What do you think “unity of spirit, sympathy, love for one another, a tender heart and a humble mind” (verse 8 NRSV) meant for the original readers? Do Christian communities still need to pay attention to this advice?

The article on the Life Abundant Programme describes one of the goals of the committee in Jator as “Strengthen love for all”. Are the values expressed in verse 8 important for the health of all communities?

Some attitudes and behaviour can be destructive. The passage concentrates on ways of talking which are deceitful and malicious. This was obviously a problem in the churches which received the letter. Think about your own experiences of communities which have been broken by this kind of talk. What other attitudes and ways of behaving can be destructive?

The passage talks about the people who “desire life”, “desire to see good days” “seek peace and pursue it” (verses 10 &11 NRSV). Sometimes Christians think of words like “life”, “good days” and “peace” only in spiritual terms. They do, of course, relate to the spiritual dimension of a person. However, life is whole and peace is present when all aspects of life for the individual and community are healthily integrated.

How does a positive spirit within a community contribute to the physical and mental health of all those who are part of that community? Can you think of examples where you have seen this happen?

How can we create the kind of attitudes and positive spirit which will enable the development of a healthy community? How valuable are approaches like that of Paulo Freire? What part can or should Christian faith play in this kind of process?
Dr Rakiya Booth of the Christian Health Association of Nigeria has been asked to talk about public health effects of globalization.

Yohanna Samari is a 42 year-old teacher married living in Bwoi, a rural area in the state of Bauchi, Nigeria. He is married with five children – the eldest of which is 14 years and the youngest is two years. His eldest son is working on the farm because Yohanna, despite being a school teacher, cannot afford to pay secondary school fees.

In October 1997, the dispensary and maternal and child health clinic in Bwoi was forced to close down. Established by the Church of Christ in Nigeria (CCCN), the centre could no longer afford to maintain the revolving drug fund which supplied the drugs to the clinic and which covered the costs of the staff. Previously, the facility had served a community of 2,000-2,500 people and was the only health centre in the locality. I asked Yohanna what he thought about its closure.

"The clinic was a tremendous help to us here in Bwoi. I, myself, and my family benefited a lot from it. My wife received prenatal care at the clinic and my last two children were born there. Now, when any one of us falls ill, we have to look for a nearby clinic or go to one of the hospitals in Jos (70 km). But this is not even feasible as I cannot afford the cost of hospital bills."

Curious, I asked him whether this was the only development that had adversely affected him. "No," he said. "For the past two years, there has been very poor yield from my farm. This is because the subsidy on fertiliser has been removed. Whereas before we farmers could afford to buy bags of fertiliser, now we don’t even see them, let alone buy them. As a result, the yield from the farm is very low and I cannot sell farm produce any more to supplement my income."

To get an idea of family income, I asked him how much he received from his teaching job. "N2,652.00 (US$ 31.20) per month," he said, "and sometimes it takes six months before we are paid."

Yohanna said many others were also facing increasingly difficult times. "For example, the staff at the clinic lost their jobs so some joined us to work on the farm. They needed to subsist and earn a living. Others have gone to different places to look for jobs. All the farmers are also affected because of the scarcity of fertiliser and because the price is beyond their reach."

The Bwoi clinic was one of 86 rural health clinics run by Church of Christ in Nigeria. Many health services in Nigeria are church run. The Christian Health Association of Nigeria (CHAN) represents organizations which provide 40% of health care delivery within the country. Many church-related health facilities are suffering because the Nigerian government has withdrawn or reduced grants in recent years.

In the late 1980s, Nigeria succumbed to the demands of the World Bank and IMF and introduced a structural adjustment programme (SAP). There were massive retrenchments and many people lost their jobs. Subsidies were either reduced or withdrawn. Consequently, many people were thrown into hardship. Some government enterprises did not survive either. Although it is at least 10 years since the introduction of the structural adjustment programme, things have not yet returned to normal and many people are still suffering.

Dr Rakiya Booth, Primary Health Care Coordinator, Christian Health Association of Nigeria (CHAN), PO Box 69244 Jos, Plateau State, Nigeria. Tel: 234 73 457 308. Fax: 234 73 457 429. E-mail: postmaster@hisern.gn.apc.org

This article arrived too late for inclusion in Contact 159 on Globalization.
USEFUL PUBLICATIONS

Where women have no doctor combines self-help medical information with an understanding of the ways that poverty, discrimination and cultural beliefs limit women’s health and access to care. Developed with community-based groups and medical experts from more than 30 countries, this book can help anyone understand, treat and prevent many of the health problems that affect women. Clearly written and illustrated with over 1,000 drawings, this book is an essential resource for any woman who wants to improve her health. It is also invaluable for health workers who want more information about the problems that affect only women, or that affect women differently from men. Finally, the book helps women to identify obstacles to good health in their communities and share ideas on how to overcome them. Published by the Hesperian Foundation, ISBN 0 942364 25 2. Available at a price of £7.25 (plus £2 postage and packing) from Macmillan Education Limited, Houndmills, Basingstoke, Hampshire RG21 6XS, UK. Fax: 44 1256 819210.

Confronting AIDS together grew out of the WCC Participatory Action Research project coordinated by Dr Erlinda Senturias. Authors Anne Skjelmerud and Christopher Tusubira are convinced that the best way of addressing AIDS is through participation. The book describes the process of getting started, participatory tools and methods, and how to set up and work in groups. Two appendices deal with gender analysis and the experience of the WCC project in Kagoma, Uganda. ISBN 82 7805 005 8.

HIV/AIDS Networking Guide This comprehensive resource is for individuals and organizations who wish to build, strengthen or sustain a network. Chapters are devoted to making networking more effective; what makes networking work; lessons learned about networking. There is also a list of international HIV/AIDS related networks. It is produced by International Council of AIDS Service Organizations, Suite 400, 100 Sparks Street, Ottawa, Canada, K1P 5B7. E-mail: icaso@web.net

LETTERS

Hello Dolly! Hello Dolly! The ethics of cloning (Contact 156) made thought-provoking reading. Cloning may be an adventurous advance in science at the physical level but the question that comes to my mind is: "Can science clone the consciousness of man, too?" The answer is of course "No!". It is impossible, and this makes physical cloning a mockery. You cannot undo existence.

P S Sulochan
Library and Information Centre
National Institute of Mental Health and Neuro Sciences (NIMHANS)
Bangalore, India

Gillian Paterson, author of the article, responds
Your correspondent, Sulochan, seems to me to hit the nail on the head when he points out the limitations of human "cloning". Science may soon be in a position to produce two human beings who are genetically identical, but it cannot replicate the human spirit, or soul, or the "consciousness" as Sulochan calls it. As Christians, we believe that each of us is unique. Each of us is responsible for our own actions, and each experiences the world in a uniquely different way. We are more, therefore, than flesh and blood. We are grateful to Sulochan for his wise contribution to the debate. Have other readers had thoughts about this subject?
Contact 158 on “Sustainability” was a great inspiration. The article by Dr Kofi Asante on the findings of the WCC study on “Sustainability of church hospitals” took me back and made me analyze the challenges we had to face when I was working in a rural mission hospital in South India. The battle still continues to keep up with the glamorous private health care services. Though one tends to get discouraged by this, we can still see the need for the healing ministry by the church. The articles by Dr Sigurur Magedal and Dr Asante were an eye opener in showing what hospitals lack to sustain themselves in this great challenge. We trust that this inspiration will sustain many who face the challenge of sustainability.

Amudha Poobalan
Aberdeen, UK

I have just read with great interest the article on Globalization in Contact 159. My view of globalization is quite different. Your article renders a service to politicians in “Third World” countries to lay all the blame of development failures or shortcomings on World Bank and IMF. Corrupt governments are equally responsible. Subsidies on food are often introduced to buy goodwill, promises to the landless are rarely kept. Deregulation and liberalization of the economy, as demanded by the international monetary institutions, often poses a threat to politicians and governments: liberalization also means opening up business and job opportunities to all people and not just to a few who share the values of the ruling class in a given country.

Günter Rath
Geneva, Switzerland

Small grants for pharmaceutical projects
Are you planning an operational research project in good pharmaceutical practice? The joint World Council of Churches (WCC)/ Community Initiative Support Services (CISS) is offering small grants to support churches, church-related health institutions, agencies and groups involved in assessing, monitoring and evaluating church pharmaceutical activities. The funds available are only for specific operational research projects and will not be available for capital expenditure, eg purchase of land, property, vehicles or equipment, nor for salaries other than those directly related to the research.

Projects/research given priority include those which aim to:
1. Raise awareness of the essential drugs concept (EDC) and rational drug use (RDU), including effective drug management; or increase understanding of the effects of global policies on EDC and RDU.
2. Change behaviour eg in terms of prescribing habits, dispensing: habits, drug management; or de-mystify drugs and medical care; or which change attitudes towards drugs.
3. Promote an understanding of health beyond that of drugs, such as initiatives in support of the involvement of churches and communities in health and healing.

(This might include initiatives in the promotion of traditional methods of healing).

4. Find innovative ways to sustain health care, minimize health costs and promote self reliance.

For more information, please contact: Dr Ebe Ombaka, Director, WCCCISS Pharmaceutical Programme, PO Box 73860, Nairobi, Kenya. Tel: 254 2729066725003. Fax: 254 2711918.

Healing ministry celebration in India
The theme for Healing Ministry week in India this year was “Healing relationships – Shalom”. Many churches throughout the country invited special preachers to lead services on Healing Ministry Sunday (8 February 1998), and some initiated health care programmes in their localities. Activities included praying for the sick, team visits to hospitals and other community health programmes.

The seven-day event takes place each year during the week leading up to the second Sunday in February. It is organized jointly by the Christian Medical Association of India (CMAI) and the Catholic Health Association of India. Both organizations use the same theme. CMAI produces an order of worship, bible studies and posters for the event. CMAI's bible studies were printed in seven languages this year, and distributed to all the churches, institutions and members of the CMAI network.
Changes on the horizon
After nearly three decades of extremely significant and influential work in the area of the churches' role in health and healing, the programmes that characterized the Christian Medical Commission and its heir, the CMC-Churches' Action for Health of Unit II, will face a profound transformation. Contact readers need to be aware that such a transformation is a direct consequence of a re-definition of the vision and self-understanding of the World Council of Churches.

From now on, the WCC will put far more emphasis on strengthening the fellowship of the churches with and among themselves. In addition, the Council – aware that it is not the only organized expression of the ecumenical concern for unity, mission, education, justice and service – will limit its programmatic work to that which can only or best be done globally or with the compelling authority of a worldwide body. Naturally, the realization that there are resources for addressing these priority concerns in the churches themselves (and in numerous church-related and secular organizations, networks and programmes) has also influenced this view. So has the reality of dwindling income.

After this year's Assembly in Harare, the concern for health and healing will be located within the programme mandate of mission and evangelism. Emphasis will be placed on reflection, analysis and study of crucial issues in health, healing and wholeness from theological, ethical and biblical perspectives. In accordance with this new emphasis, the work will be carried out with and through churches, health networks, coordinating agencies and institutions. Already sensitive questions like biomedical ethics and faith healing have been identified for such ecumenical study. It is foreseen that the WCC will also continue to advocate for justice and health and work more closely with a wide range of partners and organizations in this field.

Future of Contact
The transformation signaled above will also have a direct bearing on this well-known, WCC health publication, Contact. Because it will not be possible to continue to issue it from Geneva, new arrangements are now being explored. In particular, a proposal for Contact to be published in partnership with existing agencies is being developed following strong support for continuation of the publication at a meeting of international advisers and friends at WCC in March. You, our readers, will be kept informed.

Keen to maintain its essential mandate and strengthen its unique focus in health, the WCC expects to begin recruiting for a new Executive Secretary. It will be the task of this person to develop the lines of work described, in the style that characterizes the WCC. May we count on your understanding and support as we seek to implement in new ways the vision of God’s desired wholeness for all!

Farewell
Our colleague Dr Daleep Mukarji will depart from the WCC at the end of March to become the director of Christian Aid, London. Daleep, a well-known figure in church-related health and community development work, brought his unique gifts and wide experience to bear on the WCC’s work in health and healing during this time of transformation. We salute his appointment and wish him many blessings in his challenging new position.

Rev. Ana Lagerak
Director, Unit II, World Council of Churches

Contact is a periodical publication of “CMC-Churches’ Action for Health” of Unit II, Churches in Mission: Health, Education, Witness, of the World Council of Churches (WCC). It is published six times a year in English, French, Spanish and Portuguese. Selected issues are also published in Kiswahili in Kenya. Following our recent mailing list review, present circulation is approximately 15,000.

Contact deals with varied aspects of the community’s involvement in health and seeks to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to Contact and the publication of CMC-Churches’ Action for Health, WCC. Editorial Committee: Kofi Asante Daleep Mukarji, Simon Oxley and Diana Smith; Editor: Diana Smith; Design: Michel Plassart. Printed on recycled paper by Imprimerie Arthus. Mailing list: Fernande Chandrasekharan. All correspondence should be addressed to: CMC/WCC, P.O. Box 2100, CH-1211 Geneva 2, Switzerland. Tel: 41 22 791 61 11. Fax: 41 22 791 03 61. E-mail: dgs@wcc-cos.org

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