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NURSES: A RESOURCE TO THE COMMUNITY



Foreword

Dr. Ruth Harnar, author of our main article, "Nurses: A Resource to the Community", writes out of many years' experience as a nurse and nurse trainer in India. She has served as director of the School of Nursing and Nursing Superintendent in Jackman Memorial Hospital in Bilaspur and Director of the Mid-India Board of Examiners Graduate School for Nurses in Indore.

Ruth is now part of CMC's team with the title of Consultant in Nursing. Immediately before joining us at the CMC, she worked with the Voluntary Health Association of India (VHAI) and was very much involved in workshops, short courses and writing which helped influence health workers toward community involvement. As well as giving lively illustrations of the ways nurses can help prevent disease in communities, her article illustrates vividly the patience and inspiration required in changing

nursing curricula to make nurses real resources for health.

We believe her article may be particularly valuable for our readers as it shows how a voluntary agency can work in cooperation with government bodies to bring real change for the benefit of those most in need.

In commenting on her article, Ruth says, "If I had to summarize what I have written here, I think I could truthfully say that I have learned to believe in people. I have been forced to believe by experience and observation. I have had to learn not to approach *anyone* thinking that they are ignorant and helpless and can contribute nothing to my knowledge, welfare or happiness. I consider myself fortunate to have had the opportunities which have taught me this." Ruth's long career in missionary nursing was recently capped by an honorary Doctor of Divinity degree from the Christian Theological Seminary in Indianapolis, USA.

NURSES: A RESOURCE TO THE COMMUNITY

By Ruth Harnar, RN, EdD

Introduction

In 1977, nurses from all over the world enjoyed the warm hospitality of the Japanese nurses at the Congress of the International Council of Nurses (ICN) in Tokyo. At this International gathering of nurses, very little was said about community nursing or primary health care. As a member of the Indian delegation, I took part in a panel discussion titled, "New Horizons in the Delivery of Nursing Care". Each of us on the panel talked of new developments in a particular level of nursing. I talked about the local community health worker and the opportunity nurses have to give supportive supervision and continuing education to women and men of the community. Although there was lively discussion with many questions from the audience, this seemed to be almost the only panel or seminar in the whole conference which said much about community nursing, and the term "primary health care" had not even been popularized at that time. Nurses seemed to be more interested in economic welfare and higher education for nurses, or in gaining recognition as nurse practitioners—and this was despite the report of the WHO Expert Committee made three years earlier on Community Health Nursing⁽¹⁾ which listed areas requiring urgent action and challenged nursing to bring about the required change.

By 1985, the picture had changed dramatically. The International Council of Nurses (ICN) Congress in Tel Aviv had the theme "Nurses: Agents of Social Change" and a good percentage of the workshops, seminars and panels were on primary health care related subjects. The profession seemed much more concerned with this aspect of health care and what nurses *should be* or *are* doing about it.

What had happened to bring about this change? The ICN became an active member (as is the Christian Medical Commission) of the Non-governmental Organizations' (NGO) Group on Primary Health Care, beginning in 1976. The nursing organization presented a statement on PHC at the WHO/UNICEF Alma Ata conference in 1978 and collaborated with WHO on a workshop in 1979 in Nairobi on "The role of nursing in primary health care".

National Associations of nurses were asked to report on follow-up of this conference, and they were again urged in 1981 at the ICN Congress in Los Angeles (where the theme was "Health for All—A Challenge for Nursing") to help in the preparation of nurses as participants in primary health care.⁽²⁾

Since 1981, the ICN has made PHC a priority and has held a number of regional workshops on this topic. The role of nursing in PHC has been the favourite subject for conferences, workshops and refresher courses for nurses all over the world. Finally, Dr. Halfdan Mahler, Director of WHO, was able to say in 1985, "Millions of nurses throughout the world hold the key to an acceptance and expansion of primary health care because they work closely with people..."⁽³⁾ He foresees that nurses will move from hospital to everyday life of the community, becoming resources to people rather than resources to physicians.

Mahler realizes that many changes must take place before that becomes a reality. Constance Holleran, the Executive Director of the ICN says, "Nursing has, over the years, contributed in many ways to the improvement of health care. Yet often we seem not to be able to move forward fast enough to keep up with all the changes needed."⁽⁴⁾

Change *is* occurring in the profession of nursing, in health care systems, in nursing education programmes and in the goals of nursing and health care. I would like to share, in the pages that follow, some personal experiences which show the new directions that nursing is taking.

Functions of Hospitals and Health Professionals

"Hospital and medical professional" orientation tends to perpetuate health problems and needs of the individual person, and it does this at too great a cost. Doctors and nurses are prepared to study and develop skills in a one-to-one care relationship, care of the acutely ill and severely disabled, secondary/tertiary prevention and specialization in clinical fields.⁽⁵⁾ This means that, as a general rule, the



WHO/Afghan Health Ministry

"Nurses hold the key..."

patient has to come to the hospital before he or she is cared for. Although most hospitals do an excellent job in trying to prevent the person from becoming worse or becoming permanently disabled, the *primary* prevention needed to keep the patient out of the hospital is neglected.

Under these circumstances, in fact, many of our church-related hospitals in India have experienced the necessity of increasing the number of patients, perhaps in competition with a government hospital or even another mission hospital, in order to earn the fees so the hospital could remain open. We improved the facilities, got more specialized equipment and finally employed specialists (or trained some of our own doctors) in order to attract more paying patients—the rich who could pay more. We built private wards to care for this kind of patient, hoping we would earn enough to take care of poor patients. But this did not happen. We found that private patients demanded more facilities, more nursing care and more time; and the specialists had to have more "modern" and costly equipment to work with. Costs and the proportion of the budget spent on salaries increased. One outstanding hospital carried out a survey only to find that they were caring for the elite; less than two percent of the budget went to caring for the

poor which was the original purpose of the hospital.

We nurses went through one stage of trying to give "comprehensive nursing care". This meant that we considered the patient as a whole, were concerned about his mental and spiritual health as well as the physical. We tried to find out the home conditions from the patient's family, and plan with them for care on discharge, and even tried to prevent the condition that sent them to the hospital in the first place.

But it was *patients*, individuals, we were caring for, rather than trying to help *communities* find a way of getting rid of the cause of an illness. We were dismayed to find the same patients returning again and again to the hospital, and we were inclined to be impatient because obviously the patient's family did not do what we told them to.

It was *years*, much too long a time, before I began to *see* the constant presence of family members in Indian hospitals as more than an inconvenience to the doctors and nurses who were trying to take care of the patients. When it became an accepted practice in the USA to have the mother rooming in with the paediatric patient, I laughed because we had been doing that for years in India. What we had not done was to recognize the "inconvenience" as an



WHO/E. Rice

Nursing is moving out of the hospital

opportunity to get to know the family and to find relevant health education as a part of primary prevention.

One unforgettable experience confirmed this last conclusion very strongly in my mind. A very worried father brought his newborn child to us some days after his wife died at the birth of the child. He wanted so badly to keep her that he bought a tin of powdered milk which he had heard should be given to children who had no mother. But he couldn't read and had no one to ask, so he tried to feed the child with the dry powder. She was very close to dying when he left her with us promising to come to see her and to pay for her care. He kept the promise, paying as much as he could. We were as happy as he was when she was in her second year and he came one day to say that his mother had come to live with him from a distant town, so he could take the happy, healthy child home. About nine months later he came back with the grandmother and little girl. The child had "bad eyes" which we found to be far advanced xerophthalmia. She was blind because the grandmother and the loving father did not know that they could prevent this by making sure she had enough greens and yellow fruits and vegetables, the cheapest available foods in India. *Whose fault was it that she was blind?*

Nursing or Nurses

Nursing is more than caring for sick patients through the nursing process, which is des-

cribed as including: 1) assessment of needs 2) planning and implementation of a plan or intervention, and 3) evaluation of the effectiveness of the care provided. In Community Nursing, the nurse must work *with* people in communities, giving them a chance to become active in deciding what they need, planning and providing for their own care.⁽⁶⁾ But if she teaches a woman to care for her husband who has returned from the hospital or how to give a nutritious diet to her weak child, she is sharing her nursing responsibilities with another person. The mother will be giving nursing care even though she is not technically a "nurse". That nursing responsibilities must be shared with others is sometimes a difficult concept for nurses to accept; but neither can we deny that these are nursing tasks performed by others.

Village health workers who have been taught and are given the supportive supervision they need by nurses have learned to do safe deliveries in the home. Before VHWs were well accepted by the villagers for this task, one of these women arrived just after a woman had been delivered by members of the family. She



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Teaching nutrition in India

looked for the baby and found that they had just put it in the corner thinking it was dead. She immediately gave it resuscitation including rescue breathing, and it began to cry. The family were amazed, and the health worker's fame spread through her village and others nearby. She is the favourite VHW whom villagers try to have deliver babies in the whole area. Surely we must accept that she is giving nursing care to her neighbours.

People as Resources for Health

People are the most important resources we have for preventing illness, making health care available early when it is most needed. Nurses cannot do this alone, especially in developing countries where health services do not reach into the remote rural areas, where it is impossible to have them close enough for emergencies, for common illnesses or to provide the services necessary for prevention to the entire population; or where health personnel are unfairly distributed, or where there are not enough medical and nursing professionals for the population. In these circumstances, there is ample evidence that trusted members of the community can learn to do what is necessary. In fact, in some situations the result of organizing the community members to do something about their own problems has a greater and more long lasting effect than when professionals who are strangers to the situation try to accomplish results without the community workers.

The government of Maharashtra State in India carried out a survey to discover leprosy cases. This was followed by a second survey by the rural health project at Jamkhed which found a higher number of cases. Then one of the women, Anjana Bai, in the village was trained as a village health worker, with recognition of leprosy as part of her training. She brought in 25 new cases from her village to the leprosy paramedical worker who confirmed that they all had leprosy. When we asked her how she did it, she told us that there was a local healer who treated numbness and tingling feelings. She realized that these were early symptoms of leprosy, so she asked him to let her share in the healing sessions. He agreed to this and also that the patients should take off their clothes and walk three times around a fire. During this rite, she studied their skin carefully for white spots which might be leprosy, testing them later to find whether there was a loss of feeling. No one except a local person whom people

trusted could have accomplished this. Now she makes sure that her patients take the required treatment regularly.

In Kenya I spent a day with 13 young women and two old ones who were also traditional birth attendants. We spent some time talking about their work as volunteers to try to prevent common ailments, as well as treatment of early illnesses. Then we visited homesteads, where they introduced me to families, parents and their sons and daughters-in-law living in homes in the same compound. We saw the separate houses for kitchens, some with raised fireplaces (to prevent the children from falling into the fire and being burned), raised platforms near the kitchen used to dry dishes in the sunlight. They had persuaded many families to make outside latrines and use them, and to make kitchen gardens. The provision of safe drinking water was still a problem. Some of the women had joined together to make and fire clay pots which were sold in the market, the income being divided among the group.

Another example of a resource for community health is the traditional birth attendant, Mrs. Nayele Kumwembe, whom I was taken to visit



R. Harnar

Traditional birth attendant N. Kumwembe (rt.) and clients

in Malawi. She is a truly amazing woman. She first learned her work from her mother, and she later took a one-month course from the government nurses. She now has her own very busy practice some miles from Lilongwe and has trained her own assistant. She holds an ante-natal clinic three times a week when, I was told, the mud and thatch houses of the area are surrounded by cars from the city. She has built a brick building with a porch, a small office, a post-natal room (where there were five patients with their babies), a labour room with mattresses and blankets for patients on the floor. The delivery room had a bed and a higher table each covered by a rubber sheet. Tins held sterilized cotton and cloth.

The records she presented to the government health services public health nurse, Mrs. Kawonga, who visits regularly, showed that she had ninety patients in three months, 15 of whom she had referred or taken herself to the maternity hospital in Lilongwe. It was interesting to learn that most of her patients came from the city where there were doctors and several hospitals. Many waiting cases were chatting under the trees or cooking their food in the kitchens at the back. There was also a separate small building for a herbal medicine practice where a dozen or more clients waited patiently. Mrs. Kumwembe prepares herbal medicines for preventing pregnancy, although if a woman wants a permanent measure, it will not be offered until she has brought the whole family, including the husband, to discuss it. This practitioner is illiterate, but many nurses could learn a lot from her.

The people of a village in west Kenya, high on a ridge with beautiful views in every direction, were asking for help in beginning a small dispensary and health centre for their village which was many kilometres from the nearest dispensary. They had already organized and spent several days rebuilding a road. They were giving the land and a beautiful grove of trees for the centre and would help in building the new clinic. The tiny one-room building already there was being used for a nursery school which the women had organized, hiring their own teacher. The men had located a spring and had plans to pipe the water to a tank they would build above the clinic so there would be running water for the clinic and the village as well. They had also helped the school to find and store a source of water for the children's use.

Such people can contribute more through their own resources than any outsiders. Any health

care project they are helped to begin will belong to them and will be continued by them.

The Nurse's Role in the Community

Nurses must be prepared to play a much wider role in community health nursing and primary health care than is offered by their work in hospitals. There is a much greater element of decision making in all kinds of different circumstances. Management skills, administration of programmes, teaching and acting as the leader, as well as a member, of the health team—all these will be important. But it is perhaps most crucial that the nurse be able to trust people, to learn from them, to share leadership with them when it is appropriate and to plan with them.

I listened in on a meeting of a parish development committee and the local Arombo village health committee in the Kisumu Archdeaconry in Kenya. It began with refreshments and broke for lunch, finishing late in the afternoon. There were reports from the health workers' section and the agricultural section, followed by questions. Then the main business of the day was discussed. Some who had seen a project where there was a permanent health centre as the base for community health and development wanted to start such a centre in their own village. There was much discussion about this point. Did they really need a health centre when the volunteer health workers were making a good impact on health, especially the health of children? Did they have enough



R. Harnar

Village health workers in Kenya, PHN Esther Aruwa, left

resources to do this? What were the resources they could spare or expand? Finally, the Secretary said that he had been worried about it because it would be a very big project; but now he realized that they did not have to *start* big. They could do it a step at a time. Someone suggested that they should choose more women as volunteer health workers and ask that they be trained. This would lessen the heavy load the present VHWs carried and would give them more time to talk with people to show them the advantages of having their own centre for health and development.

Only at this point did the people ask the Health Coordinator of the whole project for the diocese, Public Health Nurse Esther Aruwa, what she thought about their plan. And only then did she speak to agree that it was a big step to take, and to comment that the suggestion made was a good idea. She said she would be glad to arrange for the training of new health workers. This project would belong to the village, because they had planned it, but they could count on her to back them up.

Once I asked some senior village health workers who were helping to train new community health workers (CHWs) what they felt was most important in this new work they were doing. Two of them answered in parables, as they often do. One said, "Do you see this house we are standing in?" (It was a round house with mud plastered mat walls and a thatch roof.) "We village health workers are like the roof. We can protect our people from many dangers, as the roof does. But if this central pole should break, or the walls give way, the roof would fall and many people would be hurt or killed. We need someone to whom we are responsible and someone who is responsible for us."

The second VHW answered, saying, "In our village we have a pond which the whole village uses for water. We use it to wash clothes and dishes, we take it for cooking and drinking, we wash the animals and bathe there ourselves. One side is the place we use for a toilet, because water is near. It fills up in the monsoon, but in a few months, there is very little water left; and what there is, is very dirty and dangerous to use. In the neighbouring village there is a river which keeps flowing constantly, and it is therefore much safer to use. These new health workers are being trained now. But unless they have more regular teaching to review and learn new things they need to

know, they will forget and make mistakes which can be harmful to people."

There can hardly be a simpler and clearer picture of the need for supportive supervision and continuing education as these women recognized it. Nurses are and will be the ones who are given a large part of the responsibility for this kind of continuing support.

The nurse, along with other health team members and the community, must identify groups and areas where health care is especially needed, make arrangements to extend basic health care to all, especially the vulnerable or neglected. She must be able to help improve prevention, follow-up, monitoring and control of common health problems; to train and use community workers in planning, providing and evaluating health care services; to help develop referral and support systems; and to stimulate community and intersectoral action improving social conditions affecting health—for example, housing, work conditions, economic status and education.⁽⁷⁾

Nurses are already carrying out these roles in many places in the world: Mary Constancy Barrameda, a nurse on a college faculty in the Philippines, works with her students in a Barangay on the edge of Manila, teaching the volunteer health workers to use traditional medicines prepared from plants in the primary school garden which she helped the teacher plant. She has organized leadership training workshops for all of the group leaders in the community. Nurses in Indonesia work with other development workers and community leaders to provide adequate food for children with malnutrition, teaching for mothers and immunizations for everyone. Nurses in Malawi regularly visit the TBAs for teaching and supervision. Nurses on the West Bank of the Jordan River in the Middle East volunteer their free time to join the mobile teaching team visiting the refugee camps, remote villages and health centres they have helped the communities set up. A nurse in India stimulated village communities to organize and helped them in their implementation of income generating schemes and non-formal education for adults and drop-outs from school.

In the Philippines nurses work with other health team members to help people organize in areas where the need is greatest, to use every available means, including traditional remedies, acupuncture and acupressure, to overcome health problems. They work in slum areas, training local health workers about the

need for safe drinking water, proper diet and how to treat diseases without the help of doctors who are not available to them. In some countries where there are economic injustices and oppression, it is said that even to talk about health can be unhealthy for the nurses and health team. It takes courage to work with people under these circumstances, but nurses are doing this in many countries.⁽⁸⁾

Sometimes because of the particular situation that exists in a country, nurses have the opportunity to give unusual service. When Botswana became a Republic, there were no local physicians and only a handful of expatriate doctors. Nurses had already been in the position of having to make decisions on the wards. Since they were the most numerous and also the best trained, it was decided that they were the most appropriate cadre to carry out the Government's commitment to provide primary health care for the country. So nurses were posted to rural clinics and health posts throughout the country, bringing health care within reach of most of the people.⁽⁹⁾

What Nurses Must Learn to Work in the Community

Graduates of traditional nursing schools usually have little ability to take on this new role outside the hospital setting. Often the training the nurse receives has little or no relevance to the required contribution of nursing in the development of health of individuals, families and communities. She will need new knowledge and new skills, particularly skills in problem-solving, communicating and working with people. This will mean a shift in the educational focus of programmes preparing nurses to work in the communities.

Perhaps we can be more specific if we look at the examples in the last section. Public Health Nurse Esther Aruwa had been able to accept the fact that people are able to decide what their own problems are and to find solutions for them. She knew the custom of the "baraza", the meeting of community members in which a discussion is carried on until everyone can come to agreement about what should be done, even if it takes all day. She supported their ideas and agreed to play her part in carrying out what they wanted to do, thus strengthening the organization in the community.



WHO/D. Whitney

Traditional midwives trained as village health workers

The village health workers' stories indicate the need for the nurse not only to teach health workers in the community, but to give them continuing education required for them to meet the problems they face. PHN Mary Barrameda made sure her student nurses had the kind of experiences which would help them work with communities in meeting their problems, finding local resources and providing for other needs which would make a stronger community. Nurses had to find ways of helping people recognize the symptoms of common disorders and how to treat them so that they could care for their own families when other alternatives were not available.

Konde Pambu Yemba, a male nurse in Zaire, found it was necessary to begin health education with his own family and home surroundings as an example. He talked with the chiefs, held village meetings, worked with villagers to make latrines and drinking water supplies available. He found himself setting up development committees in each village, making them responsible for development activities; he started antenatal clinics and maternal and child care. He and his dispensary staff made kitchen gardens, showing how these could be used to

improve nutrition of children and others. They persuaded people that they could take more responsibility for their own health—teaching them how to recognize and prevent contagious diseases, and to eliminate insects. Finally, the committees decided to start raising rabbits and ducks, and also to make adobe bricks for housing. Many of the committees now locate children that need to be helped and refer pregnant mothers to the clinics. Most of these activities which Mr. Yemba originated were not included in his original nurse's training under the responsibilities of a nurse; but in the community he had to do them in order to reach his goal of health care for the people.⁽¹⁰⁾

The need for nurses to be sensitive to the problems and feeling of community members and to motivate them to take action is well illustrated in the "Story of Baby Wafa" (see box).

"I shall try to describe to you a case who is registered in the ICC Family Service Centre in Bidia village. It is about a child named Wafa who was born in September 1984. The child's mother sustained fatal injuries during her last stage of pregnancy as a result of a gas bottle explosion. She was rushed to the nearest hospital which is 25 kilometres from her village. The hospital induced labour, but sadly the mother died after giving birth to child Wafa whose weight was 2.3 kilos. Wafa was left to the care of her ignorant old grandmother. On hearing this, the Centre's nurses visited the grandmother to offer their condolences and to help the grandmother take care of the child. The grandmother proved receptive. Ten days after her daughter's death and the ending of the funeral ceremonies, the grandmother reported with the child Wafa to the Centre in order to seek further advice and to learn how to take good care of her. Breastfeeding is, of course, ideal for the normal growth of any child. The ICC nurses brought this case to the attention of the nursing mothers who happened to be in the Centre. Fortunately, one of the Centre's nurses was breastfeeding her 3-month-old son. This nurse breastfed Wafa, setting the example to other mothers who expressed their sympathy and also volunteered to help nurse Wafa. Wafa went home, and neighbouring mothers went to the grandmother's house to feed her. Child Wafa thrived on breastfeeding, and she now weighs 7.5 kilos. Nurses advised the grandmother to start supplementary feeding when Wafa was four months old; they also placed her on the supplementary feeding programme to help her and further educate the grandmother. It was a tragedy for Wafa to lose her mother. But now, when she becomes old enough, she will understand that she has several mothers who love her as much as their own children. Traditionally women who have nursed children consider these children as their own, and they forbid their own children to marry these 'brothers and sisters'."

(Reported by Sumayye Khoury)

In 1983 I helped with a research study in India which considered the relevance of nursing education to primary health care. Twelve major health problems contributing to high child mortality and birth rates had been identified. We developed a set of specific nursing tasks related to each of these key health problems. (See Table 1 on pg. 8). Most of the tasks in the list begin with the action verbs *inform, motivate, educate, plan and carry out, identify, make available, recognize, train and support, demonstrate and teach, advise, assist, take an active part, report*. It is clear that these skills would be useful in the hospital with patients and families, but they are essential for a nurse in the community.

Table 1
**NURSING TASKS RELATED
TO KEY HEALTH PROBLEMS**

Key Health Problems	Nursing Tasks
A. Related to FERTILITY	INFORM AND MOTIVATE PARENTS to:
Early age of first legal pregnancy	<ul style="list-style-type: none"> — delay marriage of girls till after the age (18), and if possible, after 20. — encourage newly-married couples to use contraceptives.
Short birth intervals	<ul style="list-style-type: none"> — use temporary contraceptives, or natural family planning — request MTP (Medical Termination of Pregnancy) if necessary. — request sterilization.
Large completed family size	MAKE AVAILABLE various contraceptive methods. <ul style="list-style-type: none"> — through depot holders. — through self. — by assisting in planning Family camps and with surgical procedures. — by IUD insertion.
B. Related to ANTENATAL CARE	EDUCATE AND MOTIVATE families and mothers for:
Low birth weight	<ul style="list-style-type: none"> — appropriate diet for pregnant women.
Malnutrition (in mothers)	<ul style="list-style-type: none"> — low-cost supplements for mothers. — taking iron & folic acid to prevent anaemia. — developing kitchen gardens, — recognizing possible abnormalities in pregnant women and obtaining appropriate aid. — acceptance of ante-natal care and examinations so need for referral can be recognized.
Neonatal and Maternal Tetanus	<ul style="list-style-type: none"> — acceptance of tetanus toxoid immunization during pregnancy.
	PLAN AND CARRY OUT ante-natal clinics, home visits and care, including tetanus immunization.
	IDENTIFY HIGH RISK PREGNANCY and take appropriate action.
	— prepare for home deliveries.

Key Health Problems	Nursing Tasks
C. Related to MIDWIFERY High incidence of birth injury and asphyxia Septicaemia	EDUCATE AND MOTIVATE mothers and family members to: <ul style="list-style-type: none"> — obtain a trained person for management of delivery. CARRY OUT skilful/and safe delivery, RECOGNIZE complications in mother and child, and take appropriate action, TRAIN AND SUPPORT dais (traditional midwives) in doing deliveries, recognizing need for referral or assistance.
D. Related to POST-NATAL mother period and CARE OF THE INFANT Septicaemia Low Birth Weight	DEMONSTRATE AND TEACH family members how to <ul style="list-style-type: none"> — do a safe cord dressing for the infant, — give hygienic perineal care to the mother, — recognize weakness or abnormalities in the newborn and take appropriate action, — keep the newborn turned on its side when lying down, — prevent colds and chilling by keeping the child warm, — put the infant to breast soon after delivery for feeding. ADVISE mother and family on appropriate measures to prevent, an unwanted, or too early, pregnancy.
E. Related to CARE OF CHILDREN. 0-3 years Respiratory Infections	DEMONSTRATE AND TEACH mothers how to <ul style="list-style-type: none"> — prevent colds and chilling, — prevent pneumonia with steam inhalations, — give fluids to drink, — feed the sick child, — care for a child with measles, especially concerning: <ul style="list-style-type: none"> ● adequate nutrition and ● prevention of exposure to cold.
Diarrhoea	TEACH AND MOTIVATE mothers, families and village leaders to <ul style="list-style-type: none"> — carry out home sanitation, — plan for safe drinking water supply, and provide it, — plan and provide for appropriate sanitary measures in home and village, — maintain personal hygiene for cleanliness, — avoid use of bottle feedings, — use Oral Rehydration Solution <i>early</i> in diarrhoea to prevent and treat dehydration. DISTINGUISH between simple and dangerous diarrhoea, GIVE ORS and other appropriate management.
Malaria	TEACH and MOTIVATE families and community about preventive measures for malaria, IDENTIFY malaria patients, MAKE malaria slides, GIVE presumptive treatment, and

Key Health Problems	Nursing Tasks
Malnutrition	CARRY OUT complete treatment for malaria. TEACH and MOTIVATE mothers about <ul style="list-style-type: none"> — breast feeding immediately after birth of the infant, — giving boiled water to infants, if necessary, — beginning weaning foods from 6th month: mixed cereal foods, green leafy vegetables, yellow fruits and vegetables, etc. — diet supplements for lactating mothers and under-5 children (including vitamin A2 and anaemia prevention), — how to feed sick children adequately. TEACH MOTHERS, DAIS, VILLAGE TEACHERS, BALWADI TEACHERS AND SUPERVISORS about nutrition needs, and recognition of symptoms of malnutrition in children, by use of arm circumference measurement, etc. DEMONSTRATE preparation of a nutritious diet with available foods; for children, and mothers, showing how to feed children of various ages. IDENTIFY high-risk children and give special care required. TEACH AND ASSIST MOTHERS in beginning a kitchen garden. TAKE AN ACTIVE PART in women's organizations to plan for <ul style="list-style-type: none"> — adequate feeding of children, — income generating schemes, and — women's literacy. ASSIST IN PLANNING AND CARRYING OUT nutritional status surveys <ul style="list-style-type: none"> — by taking weights of children — using arm circumference band — working with Balwadi teachers and others in feeding programmes.
Immunizable Diseases	EDUCATE AND MOTIVATE mothers and families to have all children immunized for childhood diseases. (Include measles particularly if vaccine is available) PLAN AND CARRY OUT immunization campaigns. (Include school children) REPORT communicable diseases identified.

Changing the curriculum to community-oriented nursing

How these requirements can be organized into a curriculum for community-oriented nursing education will differ from country to country according to who does the planning. In Bangladesh, I worked as a WHO short-term consultant with the Directorate of Nursing which was able to have many of the nurse leaders and tutors from almost all of the

schools of nursing develop a new curriculum through a series of workshops. They now have a WHO nurse-consultant with them finalizing and implementing the new syllabus. The Kenyan nurses in the Ministry of Health and the Nursing Council decided some years ago that all of the Enrolled Nurse schools should prepare Enrolled *Community* nurses. They worked out a syllabus from which each school developed its own curriculum. Only a few schools remain which have not made the change. Now they are beginning the same process for a similar change in the registered nurse schools. Malawi nurses are working with consultants from Howard University to prepare a Registered Community Nurse curriculum which will be tried out soon. India has begun the process at the national level in a workshop called by the Indian Nursing Council. But here it is a very complicated process because every state is responsible for health, and each one must accept any changes made. Many consultations and seminars will be necessary before effective change can be agreed upon.

I believe that to be truly successful, any curriculum change needs to follow the "AITEAI" model for change, otherwise sudden changes will be met with resistance. The AITEAI model moves by phases, with the initial letters standing for AWARENESS, INTEREST, TRIAL, EVALUATION, ACCEPTANCE and INTEGRATION. Nurses, professional organizations and decision-makers must become aware of the need for change, their interest in various possibilities and ways of changing must be aroused, and suggested change must then be tried on a small scale—perhaps in just one or two schools of nursing. These experiments should then be evaluated, accepted by more schools and finally integrated into the system as a whole. This process is time-consuming and it is often by-passed with less than satisfactory acceptance and implementation.

Any changes are difficult to bring about and there are several factors in nursing in India which exaggerate the difficulty. Nurses have had a very low status in a country where women working outside the home, with all castes and groups (including both sexes) is unacceptable to most people. Nurses in their struggle for status have found that higher levels of education, including a degree and specialization in teaching or administration, helped them to win respect. On the other hand, as in medical education, "public health" nursing had no appeal at all, especially as it required young women to live in villages unprotected,

as strangers. In many places, to visit in people's homes is almost a taboo.

When I joined the staff of the Voluntary Health Association of India in 1975, my first responsibility related to curriculum change was "helping to revise the present educational programmes for nursing personnel at all levels". Other related tasks had to do with improving present courses for nurses and health team members and finding ways of motivating nursing personnel for work in the communities and primary health care. We decided to begin by trying the AITEAI model.

Awareness Grows

Since 1975, and indeed up to the present, we at the Voluntary Health Association of India (VHAI) have taken every possible opportunity to inform nurses at all levels of the present health situation in India and other developing countries; of the failure of the health systems and health professionals to reach the people with adequate health care; and about the trends and changes in health delivery systems in the country. We pointed out the danger of nurses being completely absorbed in the care



WHO/A.S. Kochar

Working as members of a team

of the sick, warning that active efforts should be made to find the most appropriate role for nurses in primary health care, including the role as members of a team along with village people.

VHAI implemented a plan which involved several types of workshops and courses in 1976-79. In about three and a half years, we planned and participated in about 50 workshops, seminars and short courses related to Community Health and Development. Most of these were deliberately planned to give information and experience that would help to motivate nurses and others to take action in their work and in teaching nursing students to increase interest in and knowledge of community health. In addition, six two-week workshops in various areas of India were held for Nursing Tutors on "increasing the community health content in the present nursing curriculum".

Two major occurrences in 1977 influenced the process of change in nursing curricula. First, I accepted a 10-week assignment as a short-term consultant with the SEARO WHO to direct a Regional Workshop of "Community Oriented Nursing Education" and to prepare guidelines on bringing this change about. The second influence was a new curriculum for ANM (Auxiliary Nurse Midwife) schools brought out by the Indian Nursing Council (INC). This was intended to prepare "Health Workers" (male and female) to fit into the Primary Health Centres and sub-centres under the multi-purpose health workers' scheme. A real attempt was made to increase the community health-related content in the course, including more weeks of experience in the field practice. However, a political decision forced the shortening of this course from two years to 18 months.

Moving Toward Community Nursing

There began to be evidence of greater awareness and more interest in community nursing among nurses. For example, in 1977, a long series of continuing education short courses were held in RAK College of Nursing, and only one or two were related to community health. By 1978, five short courses were held in this field. More and more requests came to us for help in planning experience for nursing students in the rural field, for teaching in how to work with the community, in how to motivate nurses for community health, and what to teach.

The workshops for Nursing Tutors also resulted in increased interest and willingness to try something new—even though many problems seemed too difficult to solve. Participants wrote articles and shared with other nurses. One result of the workshops was a draft pamphlet listing different kinds of practical experiences which nursing schools could plan for providing community health experience in the present general nursing course.

The WHO-UNICEF emphasis on primary health care and an Indian endorsement of this as a goal for health services gave further push to the interest in primary health care. Perhaps the most immediate interest was aroused by a sudden imposition of the INC's new Health Worker's ANM curriculum in 1977. Serious problems arose: some states have not yet accepted or implemented this curriculum, and in other places schools closed down because they felt the change was not possible for them.

In response to appeals for help from some schools, VHAI set up a small project to see what could be done. Five ANM schools indicated an interest in participating in a workshop held in the second half of 1978, and in 1979 a refresher course for tutors from these schools was held. New methods of teaching were tried out, discussion and field observation followed. The major effort of the tutors was to reorganize the nursing syllabus of the INC, incorporating all content under five major concepts as integrated subjects: Keeping the Body Healthy, Understanding Ourselves and Relating to Others, Keeping the Family Healthy, Introduction to Community Health and Development and Restoration of Health.

Midwifery was a more or less unchanged sixth subject. For each of these integrated subjects, the participants stated behavioural objectives and listed competencies needed to accomplish each objective. Content covered all that was included in the INC syllabus. It was felt that the duration of the course should remain at two years. The Mid-India Board of Examiners of Nurses (MIBE) obtained permission from the INC Secretary to experiment with the revised course. They tried to follow the outlines for the next year and found that there were many repetitions of content under various subjects. The subject "Understanding Ourselves and Relation to Others" was most difficult because it was mostly new material and very theoretical. They are now working on a complete rewriting of this section. The MIBE now use these subjects for final examinations, with

many questions (now all multiple choice) on community health and preventive nursing.

The most recent step in revising the Health Workers' Curriculum has been to simplify the outlines and to share the progress made with the MIBE and the Board of Nursing Education, CMAI-South India Branch. This board has also accepted the recognized syllabus of six integrated subjects. The next step was a textbook written for this course with the Government Health Workers' manuals and VHAI's adaptation of *Where There Is No Doctor* as companion textbooks. This work is under way.

General Nursing Curriculum

In addition to the change in ANM curriculum described above, the General Nursing Curriculum is also under revision. Following my consultancy with WHO, the MIBE members have developed a "Community Health Oriented Curriculum" including a new philosophy and objectives (accepted by board members). Subjects have been designed to prepare the nurse for 'preventive' care at various levels in various settings (see Table 2). The organization of the subjects is based on the steps in the nursing process (assessment, planning and implementation of nursing interventions and evaluation). Defining subject objectives and competences and writing outlines is now in process following a workshop for tutors of all MIBE schools.

In addition to work on revision of the general nursing course, the MIBE has studied the relationship between general education patterns (10+2+3) the vocational "+2" subjects and the "Health Workers and Nursing courses". They have made several recommendations including recognition of the new Health Worker two-year course (ANM, described above) as equivalent to the 10+2 required for admission to nursing schools. The board also recommends that this course become, as soon as practical, a pre-requisite for general nursing, thus creating a nursing career ladder with several points where the nurse could leave the educational programme to work.

All of these recommendations and proposals are under consideration by the India Nursing Council. WHO has assigned an Indian nurse as a short-term consultant to work on the Health Workers Curriculum Guide. The INC called a workshop in 1982 to revise the General Nursing Curriculum, which resulted in a revised syllabus which is now undergoing the process necessary to be accepted by all State Nursing

Councils. The workshop strongly recommended that the INC sponsor workshops to prepare all nursing tutors for the change. It will take time to make the new curriculum a reality, but the first necessary steps have been taken.

Table 2
AN EXAMPLE OF A NEW APPROACH TO CURRICULUM

MIBE NEW CURRICULUM (PROPOSED)

I. ASSESSMENT

1. Health and Life Process (Normal and Abnormal) Physical and Health Assessment
2. Basic Science Concepts
3. Hygiene: Personal and Environmental Health Teaching on Hygiene and Sanitation, etc.
4. Applied Psychology and Mental Hygiene
5. Philosophy of Health Care Development and Social Justice
6. Sociology and Economics Survey and study methods, Use of data and records, Problem solving
7. Major Health Problems
8. Language and Communication Skills
9. Searching for and Using Information

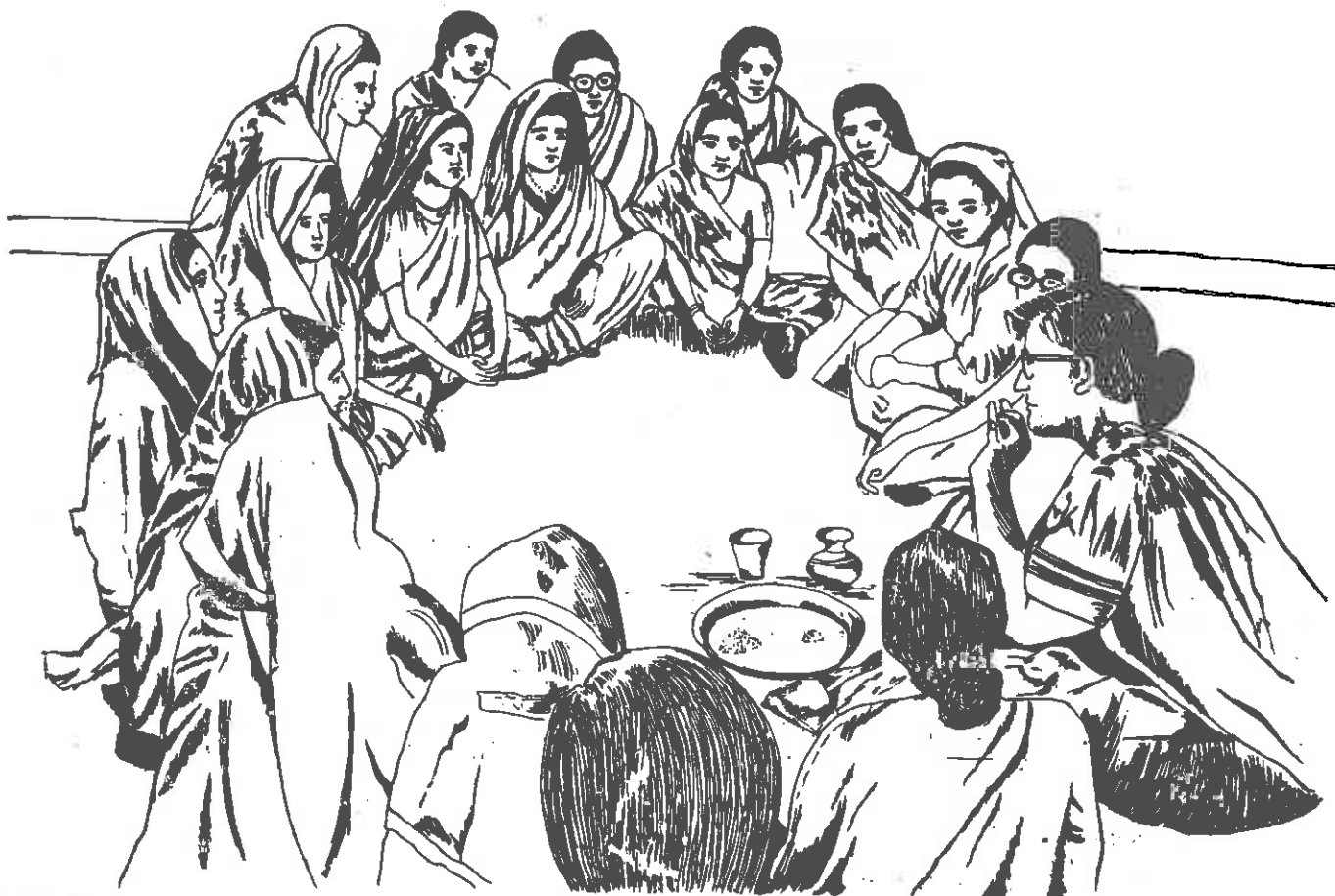
II. INTERVENTIONS

10. Early Diagnosis and Treatment of Common Disorders
11. Maternal and Child Care
12. Assessing, Planning and Implementation of care of patients and children
13. Health Care and Education
14. Understanding the needs and problems of patients with Medical-Surgical conditions

III. EVALUATION

15. Technique of evaluation of patients' responses to nursing care. Assessing, Planning and implementing care of patients in home and village
16. Evaluation of patient care (on ward and community)
17. Rehabilitation Methods and work of Social Agencies
18. Working with the Health Team and Community Organization
19. Evaluation and Measurement in Learning
20. Determination of Patients' response to care
21. Research or Study/project on nursing care problems in hospital or community health care programme
22. Professional adjustments

This new syllabus will be for hospital-related general nursing courses. Earlier, the INC made a revision of the B.Sc. nursing course, and most nursing colleges have implemented these changes. Post certificate nursing is also revising its content to stress communication skills, interpersonal relationships, assessment of people's needs, etc.



Health for Millions

Another kind of nurses—another kind of training

Awareness and interest in community orientation for nursing education has certainly increased greatly as compared to ten years ago, due to efforts such as this with impetus from WHO, international and national nursing organizations and other interested groups, including the Christian Medical Commission. Nurses who want to take the next steps are recommended to make use of *A Guide to Curriculum Review for Basic Nursing Education: Orientation to Primary Health Care and Community Health*, published in 1985 by WHO.

Ways of Teaching

A necessary part of bringing about a changed curriculum is the re-orientation of the nurse instructors. For community nursing, it is also important to prepare the instructors to use more effective teaching-learning methods. The knowledge and skills required for community nursing will be learned only through active, participative learning methods. Even attitudes can be learned, not only from examples the students observe, but through simulations and educational games.

In the courses and workshops we carried out at VHAJ, we found that small group work was

very useful in many kinds of learning experiences. Practice in listening to others, in problem solving and group decision making was possible in these small groups. Case studies bringing out certain problems were usually marked as very useful in learning. A bingo game for learning the meaning of various terms in family planning education, a snakes and ladders type of board game called the "District Nutrition Game" are examples of educational games. Another method is that of simulation exercises such as the "Jobhiho Village" which increases understanding of the plight of landless labourers in a community where they have little chance of overcoming their economic problems unless there is some group organization and cooperation. "Choosing a Village" brings out principles which are useful in choosing the village where community health work is likely to succeed. There are many kinds of role playing learning exercises which are especially successful in understanding reasons for customs followed by people in the communities. While lectures are useful for giving new information not available elsewhere, especially if there are supporting visual aids, more participative methods are necessary in all nursing education, but particularly in preparation for community nursing.⁽¹²⁾

Field experiences which are appropriate and relevant to the future responsibilities of the nurses are absolutely necessary, but not always easy to arrange. In a workshop for nurse instructors in Irianjaya (Indonesia), we found that the participants had never worked in, or indeed visited the remote health centres where the graduates of their courses would be given posts. When we planned a four-day experience working with nurses in the field, we found the participants were very apprehensive. One of the teachers (all but one of the participants were men) once happened to have been kidnapped by a local tribe of rebels and held captive for months. No wonder the participants were worried. We persisted with our plan, however, visiting some of them in the centres. When they returned they were full of new ideas about the problems nurses in the field would face and how they could be prepared for them.

We have found that a dialogue type of teaching is most effective for community health workers, giving opportunities for mutual learning, aiding mutual searching for solutions to recognized problems and avoiding trying to teach what people already know. I feel that this kind of learning could be much more widely used in the education of professional nurses, even doctors. It makes possible the use of problem-solving techniques on relevant and important issues and questions in a way that is not possible in the commonly used lecture methods. Health professionals are fortunate in having a "living laboratory" for learning experience both in the hospital and community. We need to learn to make the best use of these.

It has been found that student nurses who have their experience in community nursing early in their training and who *live* in the community during this experience are much more motivated to work in community health positions. This must be taken into account when planning the curriculum for community-oriented nursing.

THE NURSE IN THE COMMUNITY

There are endless problems, challenges and satisfactions in community nursing.

Not long ago in India, I was delighted to meet a Sister Tutor who had been a student of mine, with ten of her student health workers. But as they waved me goodbye from the place where they left the bus in a remote rural area, I was struck with a feeling of concern as I looked down into their sweet faces. What would hap-

pen to them in another year or two? They were very young, most of them, single girls from poor families. Like the Auxiliary Nurse Midwives they would be assigned to remote subcentres, where they are likely to have to live alone. Most often the centre would be far from the new health worker's original home. She might not know the local language, the customs of the people; she would be a stranger. The people of the village will not accept her as one of themselves, and unless she is very fortunate, no one will care what happens to her. The social traditions in most areas of India do not accept the idea of a young girl living without her family in a village, and certainly she is not considered as someone capable of teaching older women and men!

Some of these problems have been solved, or lessened in various ways. In the Miraj Integrated Health Services Project, the basic health workers, the auxiliary nurse-midwives (now called multi-purpose workers or Female Health Workers), and their supervisors all had several weeks of initial training and a regular continuing education programme. The latter was found to be particularly useful in not only sustaining and improving knowledge and skills, but in developing positive attitudes and self-confidence in their new roles.⁽¹³⁾ Before any of these workers were sent to live in a village, the Director of the project visited and talked with the leaders and others. He asked that the village adopt the health worker as a "daughter" of the village and give her their help and protection. Wherever this was done, there was no problem with the safety of the nurses, and they found it much easier to do home visits, work with women's groups and motivate the village committees for health activities.⁽¹⁴⁾

In some areas in India it is becoming the practice to recruit local girls, and even married women, to train them close to their own area, and when possible, to post them to their own or nearby villages where they will be accepted, and will have the protection of their families. A few experimental schools are arranging to send students with a Tutor or Public Health nurse, to live in a village where the villagers are willing to have them come, and to help them by taking an active part in the teaching. For example, the local Village Health Worker would introduce the student to the village leaders and take her on home visits. Her "Sociology" course would include finding out from the people of the community about family patterns, religious groups, customs and ceremonies, and decision-making processes. She would find out for herself who

the formal and informal leaders are and what they do; and about the way in which people make a living. ⁽¹⁵⁾

The work of the Community Nurse is full of challenges to find ways of meeting problems and of creating networks for support for both the nursing personnel and vulnerable people in rural areas and slums. This is true everywhere, because no country is free of such problems. A Russian immigrant to New York is disillusioned. He says, "I didn't know that in New York thousands of people with bags could walk around completely abandoned, with their legs covered with sores, and not only without a place to live, but no help to hope for."⁽¹⁶⁾

But there are great satisfactions, too. One recent experience stands out in my life. I was visiting a project where the village health workers had become my friends over a period of years. As I met one of these women, poor, illiterate, but extremely successful in bringing health to her village, I expressed my pleasure in seeing her again as we embraced. Then she held me a little away from her, smiled and said, "When you come to visit us, our hearts grow big." My heart skipped; there was a lump in my throat. These are the kind of people worth working with and winning as friends in community nursing.

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USEFUL PUBLICATIONS

Nursing Education In India: Its Relevance in Provision of Primary Health Care, Ruth Harnar and Betsy Lehman, Report to USAID, Sept. 1983, 253 pages.

This study considers the role of nursing personnel in supporting the Government of India's goals of increasing child survival, reducing population growth and developing the infra-structure appropriate for rural health care. The book makes concrete suggestions to help improve existing conditions and attitudes so that nursing can have an impact on rural health.

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Available from:

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U.S. Embassy
Chanakyapur
New Delhi, India

Health for the Millions: A Bi-monthly of the Voluntary Health Association of India.

This journal talks about problems and solutions available in health work in India, but its helpful, down-to-earth approach might provide inspiration for the work of other agencies.

Write to:

Voluntary Health Association of India
C-14, Community Centre
Safdarjung Development Area
New Delhi, 110016 India

A Guide to Curriculum Review for Basic Nursing Education: Orientation to primary health care and community health. WHO, 1985, 53 pages.

Examines the implications of a commitment to primary health care for the practice of nursing and for nursing education. How can nursing most effectively meet the health needs of the population? What changes are needed in nursing education? How can the necessary changes be effected?

Available from:

World Health Organization
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Price: Sfr. 8 or equivalent in £ sterling or US dollars.

CMC NOTES

The 1986 programme for the **Ecumenical Institute at Bossey, Switzerland** features seminars and courses on subjects of ecumenical interest:

14-21 March: The Roman Catholic Church 20 Years After Vatican II. A seminar for theologians, church leaders and journalists.

21 April-4 May: Orthodox Theology and Spirituality. A seminar for students, theologians, pastors and lay people.

20-30 May: The Ecumenical Significance of the Geneva Reformation. A seminar related to the celebration of the 450th anniversary of the Geneva Reformation, with participants including theologians and lay people.

9-16 June: Women in Church Leadership. A seminar for women in church leadership.

1-10 July: Workshop on the Teaching of Ecumenics. A seminar for teachers of ecumenics, members of theological faculties and doctoral level students.

15 October-28 February 1987: The 35th session of the Graduate School of Ecumenical Studies.

For more information: Programme Secretariat
Ecumenical Institute
Château de Bossey
CH-1298 Céligny (Vaud)
Switzerland

Health Education: Focus for community health development. Map International Workshop, December 2-6, 1985.

A workshop designed to help participants understand the basic principles of community-based health promotion programmes and develop skills in health education, programme planning and evaluation.

Held at: Epworth by the Sea, Georgia, USA

Cost: \$275

Information from:

Jeannie Thiessen, MAP International
P.O. Box 50
Wheaton, IL 60189-0050, USA

NEW PUBLICATIONS

Managerial Leadership, G.D. Kunders. All India Management Association, 1983, 117 pages.

Subtitled "A design for Self-development" this booklet states that "leaders are made, not born". Its main divisions of information include: Management skills to develop; Skill in handling human resources; and Leadership qualities. In his preface, the author says that many men and women in his country have been placed in management positions without any kind of training for management tasks. His booklet should be helpful, not only for those in India, but for the large majority of managers in the world who have to learn management skills after they are promoted to positions of authority.

Available from:

Voluntary Health Association of India
C-14, Community Centre
Safdarjung Development Area
New Delhi, 110016 India

Price: Rs. 20.

The Congregation as a Healing Community,
National Council of Churches in the Philippines,
1985, 21 pages

This little brochure was used as a resource for the celebration of health week in the Philippines. It

consists of a series of Bible studies, one for each of seven days, with reflections and questions for group discussion. It might serve as a resource for other church groups who wish to run the same sort of series.

Write to: National Ecumenical Health Concerns
National Council of Churches in the
Philippines
879 EDSA, Quezon City, Philippines

The Congregation as a Healing Community,
Edited by Charles Cole and Al Murdock. Health and
Welfare Ministries Program Department, General
Board of Global Ministries, United Methodist
Church, 1985, 64 pages.

It is the conviction of the editors that the Church must act as a healing community, given its mission and its physical scope in the world today. Contributors to the volume share their thoughts about the church as a healing community, and the result is a thought-provoking, challenging collection of personal essays which give an overview of some ways the church today is promoting health.

Available from:

The Service Center
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