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A bimonthly publication of the
Christian Medical Commission World Council of Churches
150, route de Ferney 1211 Geneva 20 Switzerland

No 96
April
1987

ENHANCING MENTAL HEALTH



Care in the community

FOREWORD

Do you think it's time we simplify approaches to mental health care? To truly bring out the best in each other, to **enhance mental health**, do we still need to think of establishing more and larger specialized facilities? No! In fact, by recognizing that services to people with mental problems have literally grown out of hand and therefore beyond our direct control, we can now focus our energies on the question of how to bring them home. How do we start to nurture mental health services in our own communities?

Whether you are reading these words sitting inside an air-conditioned multi-floored glass and steel building or lying in the shade of a tree with nothing in sight but land and a few thatched roofs, your need for personal confirmation is much the same. Regardless of whether we contribute to our fellow humans by trading fresh corn cakes for a neighbour's dairy products or by directing financial transactions for a giant supermarket chain, our feelings of self-worth are very similar.

Everyone experiences stress: Searching the sky for rain, day after day, watching crops and cattle fall to the ground can break one's spirit. Staying up all night reporting on an international event, racing to get it to press before any other newspaper, can also create tremendous anxiety. And what about the desperate anguish of being forced from one's native soil, and the doubts about the new country and its welcome?

Depression, fears, extreme anger can and do strike us all. And for events of far less consequence. Some of us have phobias that we will never share with another human. We know intellectually that they are perhaps unfounded. They embarrass us. But they plague us just the same.

Our mental health is a precious and delicate state of well-being. It gets tossed around by the individual circumstances of our lives. And let us remember that mental illness knows no racial, national or religious boundaries. (See "United in Pain", page 12.) So, if it is something common to us all, let us take care of it as close to home as we can. Why have we so readily handed over responsibility to distant specialists in unfamiliar institutions? The brain sometimes malfunctions, but so do many other organs. They are all supported by the same bloodstream. They are all different parts of the greater whole – the person.

In 2 major articles, we are pleased to tell you of the progress being made in Nigeria and Botswana. In our sections "Worthy Mentions" and "Useful Publications", you will find additional studies, projects and evaluations of programmes over the last 10 years that reflect a healthy universal trend to re-humanize our mental health services and re-turn to the original meaning of the word 'care'. We recognize that there are many other facets of mental well-being not covered here, and hope to cover more in a not-too-distant future issue.

In this issue, we feel you will have plenty to ponder.

The Editors

Progressive action takes a willingness to disregard tradition and a talent for using locally available resources in better ways.

THERE IS A GREAT MOVEMENT IN MENTAL HEALTH SERVICES TODAY . . .

...toward local handling – in developing and industrialized countries alike. DE-institutionalizing and DE-specializing (keeping people home or returning them to their homes) are drives rapidly gaining world-wide support, and notably from the World Health Organization (WHO). Endorsement is also coming from many respected publications such as, "World Hospitals", the official journal of The International Hospital Federation, and the "American Journal of Public Health":

This return to a more humane, (w)holistic approach to caring for people received a significant boost back in 1973, when a report on the European situation by a WHO Working Group asserted that, "The crucial question is not how the general practitioners can fit into the mental health services but rather how the psychiatrist can collaborate most effectively with primary medical services and reinforce the effectiveness of the primary physician as a member of the mental health team."

Shortly thereafter, studies conducted in the United States reflected a situation similar to that described in Europe. In 1975, it was estimated that the prevalence of all mental disorders covered at least 15% of the American population. It was therefore concluded that, "mental disorder represents a major US health problem which... is beyond that which can be managed by the specialty mental health sector alone. Hence, there is a need for further integration of the general health and mental health care sectors and for a greater attention to an appropriate division of responsibility that will maximize the availability and appropriateness of services for persons with mental disorders..."

This call for integrated service was reinforced at a major conference held in 1980 on Mental Health Services in Primary Care Settings, organized by the Institute of Medicine with support from the National Institute of Mental Health. Julius Richmond, then Assistant Secretary for Health in the US Department of Health and Human Services, affirmed that, "After years of persistent, largely independent efforts to pro-



WHO Photo / P. Almesy

... taking care of mental health problems close to home (Tanzania)

mote the integration of mental health concepts and programs with general health care in particular, it appears that finally the time is ripe for broader acceptance of and formal commitment to this concept."

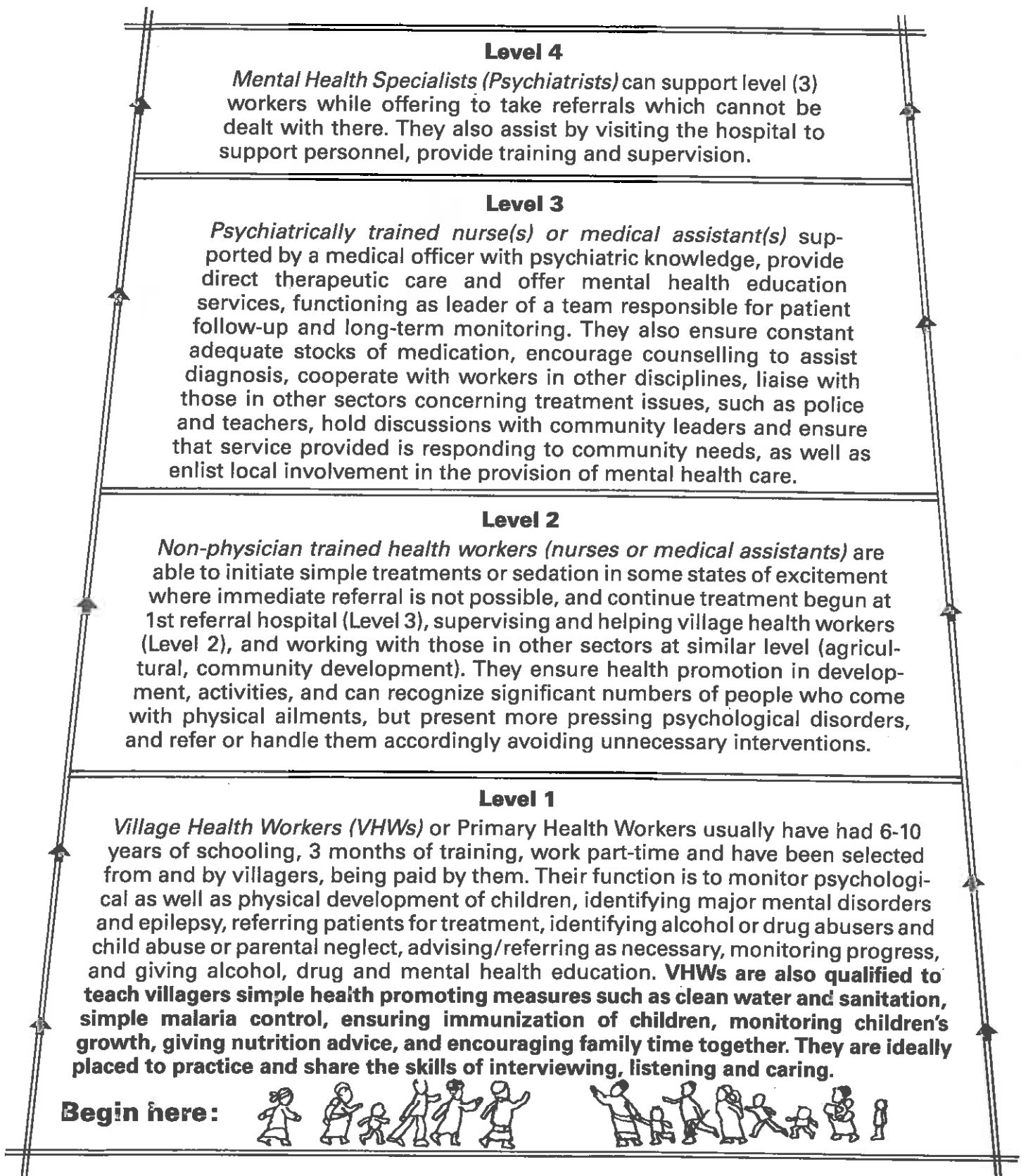
One practical outcome of this commitment has been the Epidemiologic Catchment Area (ECA) launched by NIMH in the late 1970s. Over the last decade, it has provided useful large-scale and much needed information on the public health dimensions of mental disorder in America. These findings are probably an accurate reflection of the dimensions of mental disorder in most industrialized nations. A report of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) utilized ECA data in 1986, and boldly mirrored emerging truths as it stated that, "the general medical care sector is a major component of the de facto treatment system for substance abuse and mental disorders in the United States. Clearly, primary care medicine has the patient access to play a major role in the diagnosis, care and prevention of these disorders..."

Another analysis of ECA data conducted in early 1987 stressed the importance of recognizing the emotional component of medical consultations. This directly acknowledged the findings of an earlier study which found that patients with mental disorder made greater use of general medical services than those without such disorder.

THE LADDER OF CARE

Mental health should be included as an essential element of primary health care everywhere, "but only providing it is broadened to include the promotion of psychological well-being generally, and does not concern itself only with the prevention and treatment of mental disorders."

Whenever possible, decisions should be made at the level of the people they concern and affect. This referral ladder illustrates the "chain of command", and responsibilities in accordance with capabilities:



Adapted by S.J. Freeman from WORLD HOSPITALS, Vol. XXII, No. 3, September 1986, from an article by The Division of Mental Health, WHO, Geneva, Switzerland, "First referral hospitals in support of mental health".

TREATING MENTAL ILLNESS IN THE COMMUNITY

Psychiatric service beyond the hospital to the doorsteps of the people

by Dr. Akolawole Ayonrinde*

THE CHALLENGE OF CHANGE

Innovators in any field are often confronted with reticence, scepticism and marked resistance when attempting to implement or even introduce progressive ideas. We were no exception.

In reporting on our experimental programme called the Community Mental Health Service in Ogun State, Nigeria, we hope to clarify the definitions of community psychiatry, community mental health, social psychiatry and preventive psychiatry. At the same time, we shall attempt to highlight the value of treatment which actively includes family and other community members in the recovery process of a patient.

Our Community Mental Health Service:

1. is based within town limits.
2. emphasizes day and out-patient care, engaging in home and office visits rather than hospitalization.
3. attempts in every way possible to involve relatives, employers, co-workers, fellow students, religious bodies and other agencies, as appropriate, in the treatment of each patient.
4. seeks to extend its service to health centres as well as hospitals throughout Ogun State.

REACHING OUT

We have learned through observing and approaching the WESTERN HEALTH SERVICE in Nigeria that:

* Dr. Ayonrinde, Director of the Community Mental Health Service in Ogun State, is a community psychiatrist from Abekuta, Nigeria.

1. HEALTH ADMINISTRATORS have major misconceptions about the work and role of enterprising psychiatrists.
2. HEALTH PROFESSIONALS of established medical facilities appreciate the need for psychiatric services, but prefer to keep them separate from other services.
3. Both ADMINISTRATORS and PROFESSIONALS feel a threat to the existence and growth of their own conventional psychiatric service. They are willing to discuss preventive practices, while actually continuing to train medical professionals for hospital service. Admission into hospital beds continues to be the symbol of health care.

Diviners and herbalists comprise the major types of TRADITIONAL HEALERS, although some combine both divining and herbalism in treating their patients. According to the Ogun State Ministry of Health, herbalists are also recognized as general practitioners. Our attempts to associate with traditional healers have taught us that:

1. until they gain official recognition, including their own council, accredited colleges, etc., they do not feel it is in their best interests to share their knowledge.
2. they feel threatened by Western-trained health practitioners to whom society has accorded a higher status and greater earning power.

We also observed certain factors common to RELIGIOUS GROUPS, POLITICIANS, LEGAL PROFESSIONALS and CIVIL SERVANTS, which sensitized us in our efforts to evolve a new delivery system in psychiatry.

As with Western health services, we felt some distrust – that we psychiatrists would infringe

on their established territory, taking away members of the congregation, the public or their clientele. We found that clergymen, politicians, judges, lawyers and civil servants also become preoccupied with their work routines. There is great hesitation to investigate new practices which requires re-examining the old.

BUILDING BRIDGES

Fortunately, innovators also meet with representatives from most groups who are receptive to new ideas and express a willingness to change for the sake of the people they serve. Comprising the WESTERN HEALTH SERVICE are numerous branches and areas of expertise. Our experience has shown:

1. general practice nurses and doctors are the most open and flexible. The more specialized a health professional, the less motivated he might be to undertake additional training.
2. a possible starting point to make psychiatric care more available to the community could be to attach the service to Public Health Departments. In this way, Public Health Psychiatry would be offered through existing centres.

TRADITIONAL HEALERS, who for centuries have enjoyed the respect of their patients, also deserve recognition from modern medical professionals. Patients undergoing Western treatment often frequent a traditional healer "on the side", owing to the tried-and-true value of the power of faith and herbs. Realizing this, it would be advantageous for the Western trained psychiatrist to complement his methods through a cooperating relationship with the traditional healer. Not only would a team approach be mutually strengthening, but with open communication, it would also eliminate the risk of uncontrollable side-effects from over-sedating patients due to duplication of efforts.

RELIGIOUS LEADERS may be an invaluable source of guidance to troubled members of their congregations. A psychiatrist could assist here by offering his services to the spiritual healer as a consultant. As such, the patient would be reached indirectly through this supplementary role, while safeguarding that the clergy remains the primary source of help to the person who seeks it. In time, with

growing trust and confidence, perhaps the goodwill of the clergy would allow the community psychiatrist to work directly with the congregation.

With appropriate community pressure, POLITICIANS can be made to see the wisdom of actively contributing to the development of psychiatry. The community psychiatrist should approach these officials only through community groups, agencies and leaders, rather than affiliate himself with the party in power. When rulers change, so do the programmes which enjoyed their favour, and like the politician, the community psychiatrist's power must come from the people.

Public outcry changes laws more easily than official comments from JUDGES or LAWYERS. The community psychiatrist could write and circulate a book about the inadequacies of mental health care. If there is no Mental Health Society in the community, efforts should be made to establish one. Through this enlightened body, pressure may be exerted to gain the necessary improvements.

In working with CIVIL SERVANTS, the most efficient means we have discovered for the community psychiatrist to develop programmes are:

1. to allow the community to appeal to the government or agency on his behalf and then have the government appoint a civil servant to cooperate in the project's implementation.
2. to establish a good working rapport with the civil servant assigned to the project. It is worth bearing in mind that while carrying out the orders of superiors, the civil servant would appreciate being considered an integral part of the growth process and receiving due recognition for his efforts.
3. to offer his services as a consultant to the civil servant's department.

OTHER SOURCES OF SUPPORT

Some sources of support lend themselves more readily to cooperate in our community-based psychiatric endeavours:

The POLICE, as law enforcement and social



WHO Photo / P. Almasy

Patients gardening in Mwera, Tanzania – a village they built themselves using local materials at low cost. One way of relieving overcrowded conditions in psychiatric hospitals.

service agents, already provide valuable assistance in some communities. Since they are often the first to see behaviour problems associated with epilepsy, drug abuse, attempted suicide, etc., it could soon become routine for them to act additionally as referring agents to community psychiatrists.

The MEDIA – radio, television and the press – are powerful tools for reshaping people's attitudes. Two approaches that have proved successful are offering lectures and workshops to media personnel, and helping to prepare manuscripts for publication or broadcast.

The FAMILY is, of course, our most valuable resource. When member comes for help, it is usually the family as a whole that is in crisis. If they choose to get involved in finding solutions, the family shares the responsibility for and can take pride in the recovery of their loved one.

It is doubtful whether a psychiatrist can be an effective community mental health leader if he does not feel a strong sense of belonging to that COMMUNITY. He is responsible to his

people not only as a doctor, teacher and parent, but also as a fellow citizen, child and friend. This quality of identification with the community is essential to reaching and promoting the well-being of its families.

LOOKING FORWARD

In Ogun State, our Community Health Service co-exists with the Psychiatric Hospital at Aro, Abeokuta – just a few kilometres away. The Hospital is fee-paying and belongs to the Federal Government, while the Health Service belongs to the Ogun State Government and provides treatment free of charge. This, coupled with basic philosophical differences, provides a challenge to our relations, which we strive continually to improve.

The need to hospitalize patients is declining, thanks to the increase of health services, including expanded sanitary and immunization programmes, and a wider range of available antibiotics throughout the country. The advantages of decentralized psychiatric care are many:

1. High quality mental health care is more evenly distributed to outlying areas rather than concentrated in one part of the State.
2. Transportation and time costs to the patient are reduced considerably.
3. Early referral, diagnosis and treatment can reduce the risk of more serious mental illness developing.
4. The staff-patient ratio remains small and the treatment personalized.
5. Psychotic patients, who normally constitute the highest percentage of admissions, are able to receive the intensive out-patient and home treatment that they need through psychiatric units spread around the State.
6. A small, local centre is more approachable. Consequently, the support of the community is more accessible and readily offered. The generosity and involvement of family and other community members is forthcoming, because they know it is **their** centre.
7. Mental health education and preventive care programmes are given the attention they deserve and become a natural extension of services – to the benefit of the entire community.

“A human being is a part of the whole, called by us ‘Universe’, a part limited in time and space. He experiences himself, his thoughts and feelings as something separated from the rest – a kind of optical delusion of his consciousness. This delusion is a kind of prison for us, restricting us to our personal desires and to affection for a few persons nearest to us.

“Our task must be to free ourselves from this prison by widening our circle of compassion to embrace all living creatures and the whole nature in its beauty.”

Albert Einstein

COMMUNITY-BASED CARE

by David I. Ben-Tovim*

Botswana has undertaken a "quiet revolution" in mental health. Part of its dynamic and forward-looking programme has involved introducing community-based psychiatric care; as a result, many patients can live normal lives at home.

Health has been defined in the WHO Constitution as a state of complete physical, mental and social well-being. Yet the provision of adequate psychiatric care has usually been given a low priority in developing countries.

Botswana, however, is one African country that has recently given particular attention to the development of an appropriate psychiatric service, one that is not institutionally-based, but rather is located in the community and integrated with a primary care system.

At the time of political independence in 1966, Botswana inherited a large curative, hospital-based service to which the majority of the population had limited access. The country has a very low population density, with its 1 million people spread throughout a land mass the same size as France and Switzerland combined. Indeed, much of the country, the inhospitable scrubland of the Kalahari Desert, is virtually uninhabited.

An isolated mental hospital was in effect the only source of psychiatric care. Over the years this 140-bed institution gradually became seriously overcrowded, until at times it had up to 500 in-patients. During the last decade, the government has made a major effort to deliver health care to the whole of this dispersed population through the establishment of an extensive primary care system.

At the village level, there are now over 300 village health workers, called Family Welfare Educators (FWEs) who are chosen from the village by the village. After their 11-week training, they work essentially as health educators and motivators, promoting preventive activities and giving First Aid and treat-

ment for minor ailments. Supervision of each group of FWEs is undertaken from clinics which are staffed by nurses, whose task is to provide curative and further preventive services throughout their areas. Secondary and tertiary referrals are made to health centres and district hospitals. Estimates suggest that 90% of the population now live within 15 kilometres of a health facility.

When Botswana decided to give more adequate attention to mental health programmes, it set up a Community Psychiatric Care Programme. This programme sought to enable the majority of all patients identified as suffering from psychiatric disorders to receive treatment within their own communities, to increase the availability of services, and to initiate preventive activities.

Clinical priorities were established by community assessment, by personal experience, and by the evaluation of a pilot community care project that began in 1977. As has been the case elsewhere, the health authorities felt that the management of psychiatric emergencies and an active approach to continuing care in the psychoses and convulsive disorders were the most important activities; there was also pressing need for strategies of brief intervention for patients with physical complaints of unknown origin.

One problem was that no new staff were going to be available to initiate the programme. So, with only 1 psychiatrist in the country until recently, it was decided to build the service around the existing group of psychiatric nurses. After a period of preparation to ready them for the move, 5 of the country's 8 available psychiatric nurses were transferred from the mental hospital to strategically located hospitals and health centres around the country. As well as starting an out-patient service in the base facility, each nurse was given a

* Dr. Ben-Tovim, an English psychiatrist, trained and supervised Family Welfare Educators as part of his assignment in Botswana.

specified catchment area, and encouraged to visit homes and health facilities within his or her area. The nurses were to provide direct clinical and educative services throughout the primary health care system. Supervision of the nurses was through monthly visits from the psychiatrist – each visit to coincide with a work session so that clinical problems could be reviewed. The nurses could directly refer cases to the mental hospital if the need arose.

This country-wide service began in 1980, without any new transport or accommodation being available for the nurses at the 5 new bases. Everyone managed with existing resources. Mental health units providing a small number of in-patient beds were constructed. A visit by a psychiatric nurse to an outlying clinic usually took the following form:

In the days before the visit, the FWEs would go to the homes of all the patients in the village known to be suffering from psychiatric disorders. They would gather information from the families, and remind those patients scheduled to be available on the day of the psychiatric nurse's visit. The FWEs would also tell the other villagers that the nurse was coming.

On the morning of the nurse's visit, the FWEs helped to bring patients **and their families** to the clinic. There, the psychiatric nurse conducted the clinic together with the FWEs and other members of the staff. Interviews emphasized the joint responsibilities of the primary care teams and the visiting nurse, and enabled them to discuss patient identification and management and to share information. A patient would be seen alone if he or she requested, or if it seemed appropriate, but this was rare. Family and personal problems in Botswana are traditionally solved by meetings with various members of the extended family. The patient, the family, the clinic staff, the psychiatric nurse and the psychiatrist (if available) formed natural and comfortable groups.

It would be usual for patients with many different types of problems to be seen together, such as those who had received treatment for psychiatric emergencies since the nurse's last visit, chronic psychotics and epileptics. The treatment of epilepsy has received considerable emphasis not only because of the physical handicaps that it leads to especially from burns incurred by falling into open cooking fires during fits, but also because of the marked stigma attached to the illness.

Though this stigma has a complex basis, including belief in the infectious nature of the illness or in its origin in the eating of a taboo bird, one of its most serious companion beliefs is that the illness is incurable if a patient has suffered a burn during a fit. Traditional healers often refuse to treat burnt epileptics, possibly because they recognise that such patients tend to have an established illness which will not spontaneously remit.

All self-referred patients who have requested treatment from the psychiatric nurse will also be seen at the time of the joint clinic. Pharmacotherapy forms an important part of patient management, and nurses prescribe those drugs that are available to them, at their own discretion. Chlorpromazine and phenobarbitone are available at all clinics, and the psychiatric nurses also have certain basic drugs available. FWEs do not usually have access to active medication.

After the session at the clinic, those patients who would not, or could not, come to the clinic receive home visits.

An additional feature which appears to be unique to Botswana deserves mention. This is the part played in the rehabilitation and readaptation of patients in the community by the *Khotla*, or Council of Elders. The psychiatric nurse arranges for a patient to appear before the Khotla, where she presents the problem to the village elders, asking for their help. This direct appeal rarely fails to have a positive result and most patients, even after a long absence from their village, have been accepted back to their communities.

Since the programme began, all the country's hospitals and health centres have had regular visits, as have the majority of the clinics. A smaller proportion of the health posts (about 15 per cent) have been systematically included so far, though it is the practice for the clinic staff to bring patients in from the smaller villages at the time of the nurse's visits. In all, over 100 health facilities currently receive visits each month. Since 1980, when the service began, an estimated 70 per cent of the population live no more than 30 kilometres from a consultative psychiatric service. This high rate of coverage compares with two and a half per cent of the population who had similar access before the service began.

The overall population density of Botswana is very uneven, since over 80 per cent of the

population live in a relatively developed and fairly narrow strip running down the eastern border of the country. Although distances are still large within this strip, at least travel is straightforward. That cannot be said of the 32 clinics which are more than 100 kilometres away from the margins of the strip, and which consequently have very rudimentary services. Mostly they can only be reached by four-wheel drive vehicles. Nevertheless by combining with other health workers and by using both air and road transport, 27 of the 32 do have visits either every second month.

As accessibility of the psychiatric services has increased, so has utilisation. Figures from the registers kept in all the centres show that whilst first referrals increased only modestly during the first year of service, the number of repeat consultations increased sixfold. When services were only provided at the mental hospital, patient follow-up was very poor, which was especially unfortunate in the case of chronic problems presented by schizophrenia and epilepsy. Those two conditions together accounted for 80 per cent of first consultations, and over 90 per cent of repeat visits, since service has improved.

Being able to show that a service is geographically dispersed and well used by patients and other health workers is an indication of its acceptability, but not of its effectiveness. No formal studies have been done in Botswana, but if inpatient statistics for the country's only mental hospital are indicative, then the impact of the programme is clear. Since the programme began, admissions to the mental hospital have halved (from 950 to 450 annually) and in-patient numbers have fallen from a peak of over 500 in the late 1970s to a steady level of about 100 to 120. Closer collaboration with the police, patients' families and other community services has raised the number of voluntary admissions from 64 per cent in 1978, before the programme began, to over 90 per cent at present.

Not only were there no additional costs involved in this programme, but in fact substantial net savings were made – in the order of one-tenth of the entire drug expenditure for the country. Rehabilitative activities are gaining ground too; those who work with mentally retarded and other disabled children are finding the Training Manual for the Disabled, first published by WHO in 1981, particularly useful.

Of course many deficiencies remain. Alcohol abuse is still a massive problem, but no national policy on prevention or the development of adequate services has yet emerged. Health workers still tend to identify mental illness with severely disturbed behaviour, and to neglect those depressed patients who may be equally ill, but are less socially disruptive. **Our contacts with the traditional healers and healing churches that abound throughout the country are still rudimentary, though the national policy of encouraging their contribution to health care is beginning to bear fruit in the shape of joint educational activities.** Preventive and promotional activities have still much ground to gain before they get the attention they deserve. Finally, so long as the numbers of staff remain small and limited, any further extension of services to small communities of between 500 and 1,000 people will prove difficult.

Several factors have made this community care programme possible.

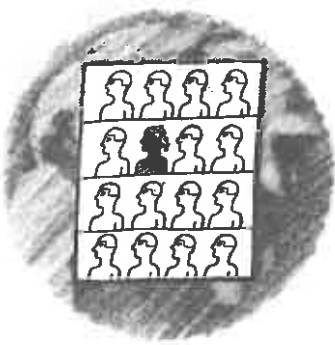
1. There has been a sustained commitment to the new-style programme – of which community care for the sick forms a part – on the part of senior decision-makers at the Ministry of Health. These persons made sure that a clear plan of work was developed and established a powerful action group on mental health, with representatives from the different sectors concerned. The latter's members include the Permanent Secretary to the Ministry, as well as the Chief Nursing Officer.
2. There already existed a widespread and effective primary health care system within which the psychiatric services could work.
3. There was timely stimulation and consultative advice from WHO, under a programme of technical co-operation. Nevertheless, the desire for change and improvement in the Mental Health Services has always been internal to Botswana, and has never been imposed from outside.

Probably the greatest asset for a community-based psychiatric service is a strong and effective extended family system, such as still exists in Botswana. Admission to a distant mental hospital will tend to sever those family bonds. Community psychiatric care is a realizable goal in Botswana, and not just an empty slogan – a fact which has been noted by the African Mental Health Action Group, of which Botswana is a member. This country's experience undoubtedly holds valuable lessons for many other developing countries.

UNITED IN PAIN

More than 40 million people in the world suffer from severe forms of mental disorder, such as schizophrenia and dementia.

A least 20 million suffer from epilepsy. And a further 200 million are affected by less serious mental conditions.



This means that today

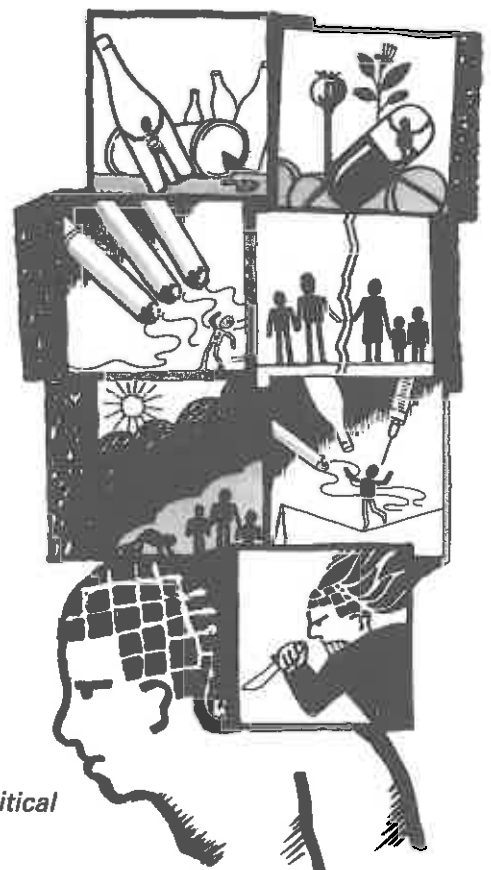
260 MILLION

PEOPLE

are suffering from some kind of mental disorder, which is largely left untreated:

**1 out of every
16 people in
the world.**

It is a universal problem.



*Adapted from WHO "Mental health care in developing countries: a critical appraisal of research findings", Technical Report Series 698, 1984.
Drawings by Arne Boström.*

HEALTH DAMAGING BEHAVIOURS

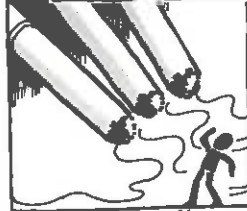
ALCOHOL-RELATED PROBLEMS, including death from poisoning, crime and accidents, have increased considerably in most parts of the world over the last few decades, even in countries with long traditions of abstinence from alcohol. One very sad result of drinking during pregnancy is the effect on the unborn child.



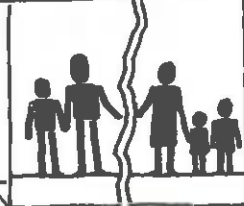
DRUG ABUSE has increased in frequency and severity to some 48 million drug abusers worldwide. Parallel to this is the increasing availability of drugs on legal and illegal markets, which adds to the difficulty of implementing control measures: As market expands, large regions become more dependent on income derived from growing cannabis (marijuana), opium poppy and coca shrub (cocaine).



TOBACCO smoking is a social habit maintained by dependence on nicotine. 1/3 of all cancers, at least 80% of lung cancer, 75% of chronic bronchitis and 25% of heart attacks in the US are traced to cigarette smoking. While yearly rate of consumption was down by 1.1% in industrialized countries, it rose by 2.1% in developing countries (1976-1980). Premature deaths, estimated at over 1 million each year, are also due to smoking. Evidence shows health risks for those inhaling smoke produced by smokers ("passive smoking").



FAMILY BREAKDOWN throughout the world begins a chain of stressed links. Increasing rates of divorce put mothers into the work market, but usually earn them a lower income, interfering with time formerly devoted to raising children and increasing pressures of maintaining the standard of living. Weakened family units also contribute to community disorganization which results in psychosocial and other health problems.



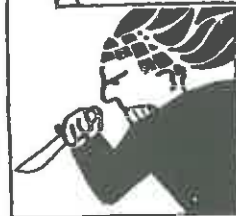
CONDITIONS OF LIFE that lead to disease often from factors beyond the individual's control: homelessness, unemployment, lack of access to health and social services, loss of social cohesion (slum areas), forced idleness (refugee settlements), forced migration, racial and other discrimination, "conventional" wars, and the threat of nuclear war. Personal life-styles concerning patterns of eating and exercise also play an important role.



RISK BEHAVIOUR AMONG YOUTH, such as experimenting with alcohol and drugs, sexual activity without precautions against sexually transmitted diseases, adolescent pregnancy, driving at excessive speed, and generally challenging established guidelines for health and safety, results in serious morbidity and mortality. Pregnancy in young teenagers leads to a cycle of disadvantages.



VIOLENCE (accidents, homicide, suicide) is one of the leading causes of death in most countries. Psychosocial factors and mental disturbance play important roles in the occurrence of violence, which in turn causes neuro-psychiatric morbidity following damage to the central nervous system. Dealing with consequences of violence for victims of child abuse and wife battering (for example) can be eased significantly if mental health care skills are used.



ACTION taken through the primary health care system, schools and media to confront any of these challenges to our well-being needs the support of government policy to be effective.

SUCCESS in carrying out preventive and therapeutic measures in the health sector depends on the psychosocial skills of PHC workers – sensitivity, empathy and ability to communicate – as well as a thorough knowledge of the community, its culture and its resources. In the absence of such skills in practice, the health facility will fail.



October 20, 1986

Dear World Council of Churches:

*Understanding suicide may be difficult, but **preventing** suicide is not a complicated social problem.*

Prevention depends mainly on recognizing the depressive illness which usually comes first, and it's time ... we all learned how.

I hope you will publish this article or use it in some way toward that goal ...

Sincerely, 

George P. Nichols, M.D.

IT'S NOT HARD TO PREVENT SUICIDE

by George Nichols, M.D.

My son Bill killed himself last summer. A year later, we still miss him, and the sorrow is slow to disappear. We hear a lot in the news about the tragedy of suicide, but not nearly enough about prevention. As a doctor, and as a father, I am very concerned that the topic of suicide be presented properly, because I think we now know enough to look at it with more understanding, and this can save some of these precious lives.

WHAT TO KNOW

Most suicides are due to an underlying depression. **Depression is an illness**, and it is **very common**. It affects about 10-15% of all men, and 20-30% of all women at some time during their lives. It hurts families and careers; it destroys people. Yet, surprisingly and sadly, most people fail to recognize it either in themselves or in their loved ones. What makes this especially tragic is that depression is so curable.

Many who suffer don't come to the doctor for an official diagnosis. They look quite normal as they walk about in public, among friends and family, **displaying** the classic signs of depression, but usually meeting no one who

understands what they mean. So their illness remains unrecognized. Many recover, but some die. Families and friends could save them by just **suspecting** the disorder.

HOW TO RECOGNIZE THE SIGNS OF DEPRESSION

Since we have no reliable tests for depression, we depend on symptoms and signs. Any symptom by itself may be normal; and almost all of us have "the blues" now and then; but when these symptoms occur in combinations and when they persist, **real depression** may be indicated.

ONE DOZEN SIGNS OF DEPRESSIVE ILLNESS

The person:

1. has recurrent thoughts of death and suicide.
2. has mood swings from sad to irritable and anxious, and denies such mood changes.
3. has feelings of hopelessness, worthlessness, and self-reproach.
4. cries (often), or forces back tears.

5. is frequently withdrawn.
6. loses interest and pleasure in things.
7. neglects personal grooming and appearance.
8. has trouble thinking and concentrating.
9. has difficulty sleeping – may have trouble falling asleep, awakening too early, or sleeping too much.
10. experiences change in appetite or weight.
11. feels tired and slow, or agitated and restless.
12. complains of physical ill health, such as fast heart beat, headache, constipation, constant pain.

Symptoms like these are common but misleading, and disguise an underlying sadness; they probably mean that the person is worried about himself and is asking for help in approved – non-emotional – ways.

Some depressed people, especially youths, may not appear sad and hopeless, but may act rebellious instead, becoming involved with alcohol or other drugs, failing subjects in school, or not going altogether.

Sometimes your first suspicion that someone is seriously depressed occurs when you feel a little gloomy yourself after talking with him. It IS contagious. And it IS always possible to ask a person directly how he feels. Trust your instinct and follow through on that concern.

Life's problems are especially difficult for someone who is depressed. Depression, therefore, can easily mimic a normal reaction to trouble. Even a pastor may not always realize that he is dealing with a serious depressive illness when one of his congregation asks for help with a personal problem.

MORE SERIOUS SIGNS

Suicide becomes even more of a threat with these danger signs:

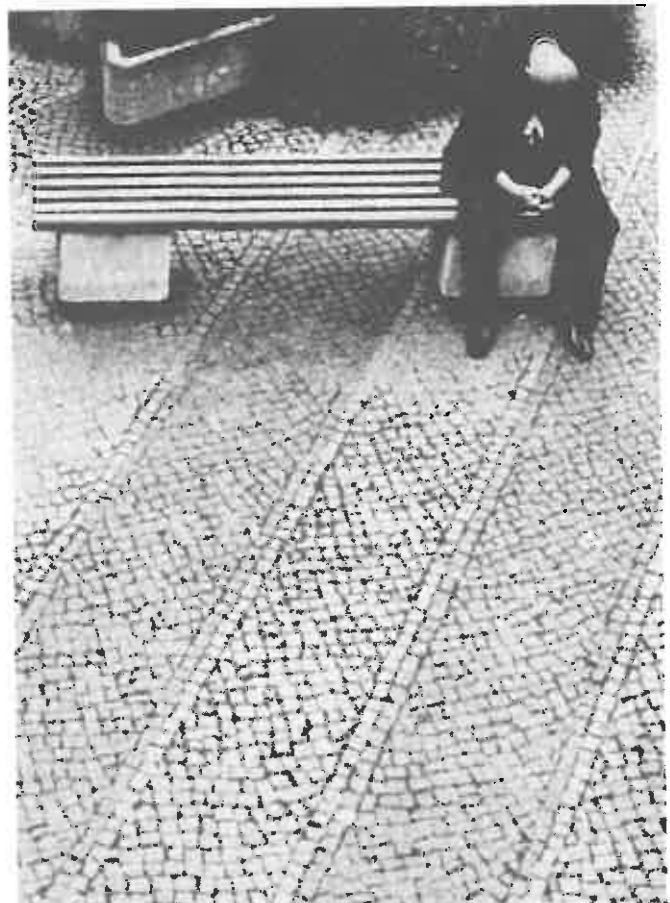
1. Increasing distance and withdrawal from family and friends
2. Absence of hope
3. Hearing voices and other disordered thinking
4. Talking of suicide
5. Giving away prized possessions – "I won't be needing these any more."
6. Putting affairs in order, such as returning long-borrowed items, final contact

(unspoken goodbyes) with important friends and relatives

7. Sudden improvement (no longer painfully undecided)

Having counsellors, ministers, crisis centres, social programmes, and people available when we are troubled are wonderful resources for many people, **but not for those who are chronically depressed.** It is not enough. We can't stop there.

Serious depression is not primarily a social or a counselling problem. It is an illness whose sadness has grown beyond words and beyond self-control.



PFR. HS. DOMENIG Photo

If you suspect depression, if you wonder whether suicide is on his mind, don't wait and see...

WHAT TO DO

If you suspect depression, or if you are concerned that someone is suicidal, don't decide to wait and see. We can't leave the treatment up to the one who is depressed, because he is not himself. His thinking and judgment are impaired. This is not the time for sympathizing, or listening, or trying to restore hope. It is not the time to lecture and tell him to "shape

up". He is not able. Delaying treatment is risky. He needs your help desperately.

Step right in and take him to his doctor or a psychiatrist, who can verify your amateur diagnosis, and begin appropriate treatment.

SUICIDE PREVENTION IS A PUBLIC MATTER...

... but public recognition of depression is almost nonexistent at present. Society has not failed these people – we just haven't seen them clearly before. Shame and stigma have held us back. We publicize the signs of cancer, and we even teach the public "CPR" (cardiopulmonary resuscitation) to re-activate the heart and lungs. Why not a simple programme to show **everyone** how to recognize depression? I think

your own doctor might be willing to help. I am one doctor who has learned from personal experience. That's why I have written this for you.

For more information on depression, contact your local mental health service or ask your doctor or a psychiatrist. Or write the lady in Minneapolis who talks and writes on suicide. Her booklet, "Your Child Has Died", is the best immediate solace and treatment I have found for families who are left behind after this tragedy: Adina Wroblewski, 5124 Grove St., Minneapolis, Minnesota, 55436, USA.

* * *

"MENTAL DISORDERS CAN BE PREVENTED", according to the World Health Organization

"Mental, neurological and psychosocial disorders constitute an enormous public health burden for both developing and developed nations. A review of the evidence demonstrates that the implementation of a comprehensive programme of prevention, based on currently available methods, could produce a significant reduction of suffering, destruction of human potential and of the consequent economic loss they produce."

WHO Doc. 34/1986, IN POINT OF FACT.

HOW YOU CAN IMPROVE THE MENTAL WELL-BEING OF PEOPLE CLOSE TO YOU – JUST LISTEN

Tragedies such as suicide can be avoided. Many heartaches can be averted. To do so requires your commitment as a practitioner, that is, a **healer** who actively **practices** his or her life's work. And the most important part of ministering as a doctor, nurse or other health worker may well be LISTENING.

Whether people be a part of your family, good friends, colleagues, neighbours, acquaintances, clients or patients, the moment you agree to **be there with them** when they need to talk, you have entered into a special union. And the responsibility of that bond is to **hear** what they have to say.

Reverend Claude Réverdin of Switzerland reminded participants gathered at the European Consultation on the Christian Understanding of Health, Healing and Building Community held in Budapest, Hungary, September 3-9, 1986, that:

*"Christ never told a sick person, 'Resign yourself to suffering, it's a good thing.
You will help me to save the world.'
He always strove actively against evil and against suffering,
which is never a good thing... Our task is to listen to the suffering
of others and to allow them to talk about what they are living through,
to try to enlighten this suffering by the certainty
that Christ enters into it and transfigures it."*

How can you open up communication?

Learn to listen. Listening is ninety percent of good communication. It's not just "the other half of talking." It's a skill. A skill that must be learned and practiced. All the time. Most people find it hard even to listen half the time, and then only with half of their mind.

Genuine, attentive listening has become so unusual that finding a good listener almost makes you lose your train of thought. Actually, to listen is the queen of compliments; to ignore, the chief of insults. To become human everyone needs listeners and to be human he too must learn to listen.

Do you know how to listen? Or do your eyes stray and betray your wandering interests? (A good listener listens with his eyes too, you know.)

Do you let others' words and ideas fly by while you plan your next comment, cooking up some sage word with which to stun them at the first opportunity? Do you interrupt others or, even worse, second-guess them, trying to finish the line for a friend, or coach him when he stumbles for a word? Do you probe, question, interrogate, cross-examine, thus suggesting impatience or superiority?

Or can you truly listen? Can you go beyond merely hearing words and phrases to catch the ideas? And beyond the ideas, to the feelings? Beyond the expressions to the true intent?

That's listening. With love for others. Love is a warm listener!

Haven't you experienced it? Have you ever talked with someone who listened with such abandon and attention to what you were trying to say that it drew you out? Called forth your best? Even helped clarify your thoughts by the very quality of that listening?

Or have you started out to vent your inner agonies and complain bitterly against your circumstances, but your friend's understanding love given in complete attention made you see things in a new and brighter light?

That's the power of listening love. Nothing is more needed. Particularly by people with problems, and that includes almost all of us.

Remember when you were involved in a personal tragedy? Did you want someone to talk to you? Give you a speech of sympathy? Or a little sermonette of encouragement?

No, no! You wanted someone who loved you enough to sit down and listen to your feelings, to give understanding and acceptance in spite of your problem. Right?

And the people who didn't care enough to listen hurt you deeply. No matter all the nice things they said or how well they kept up the clichés of "after-all-it-might-have-been-worse."

I'll never forget a moment of tragedy in my life when I needed help and turned to an old friend

to share a bit of my suffering. After three sentences, he interrupted to give me a flawlessly-worded, lovely little speech. But the farther he went, the more distant it became. I wanted to reach out, grasp him and say, "Come back. I don't want your beautiful bouquet of words. I want *you* !"

But who am I to criticize? How often I've given a friend in need the stone of eloquent comfort when he wanted the bread of human understanding. No matter how polished, perfect and multifaceted the stone, it offers no nourishment...

Loving is listening. Caring is hearing. Love is the opening of your life to another. Through sincere interest, simple attention, sensitive listening, compassionate understanding and honest sharing.

An open ear is the only believable sign of an open heart. You learn to understand life – you learn to live – as you learn to listen.

To love your neighbor is to listen to him as you listen to yourself. The golden rule of friendship is to listen to others as you would have them listen to you.

Listening – it's the key to true friendship, loyalty and understanding between any and all persons in all relationships: parent-child, employer-employee, and most important of all, husband-wife relationships.

Communication begins with listening. It grows with genuine understanding...

The Freedom of Forgiveness, by David Augsburger, Chapter 9, pages 85-88. Moody Press (1970) Chicago, USA.

CONCLUSION

Mental health services do not always have to be provided by specialists. You personally can often furnish the necessary care right where you are.

We selected and condensed material as wide-ranging as the aspects of mental well-being itself: from sources as varied as international organizations, to the poignant intimacy of a father's personal letter. It is our hope that by adapting these articles to your local needs, you will increase their utility, and as an individual health worker, become more empowered to serve.



WCC Photo (Vietnam)

The art of listening can be cultivated from very early days. And what this little one hears depends on the self-esteem that his elder projects. The way people with physical disabilities are treated affects not only their own mental well-being, but also that of people close to them.

MENTAL HEALTH: MORE THAN THE ABSENCE OF MENTAL DISEASE

It is generally accepted that one of the most important factors in mental health is living in a well-integrated society. With the increasing disintegration of cultures all over the world, one of the most important remaining sources of stability is the local religious community. In the book of Acts in the Bible we read how early followers of Jesus "continued together in close fellowship and shared their belongings with one another. They would sell their property and possessions, and distribute the money among all, according to what each one needed. Day after day they met as a group in the Temple, and they had their meals together in their homes, eating with glad and humble hearts, praising God, and enjoying the good will of all the people." (Acts 2:44-47 TEV) They also shared their memories of Jesus' teachings, such as:

"Happy are those who know they are spiritually in need; the Kingdom of heaven belongs to them!

"Happy are those who mourn; God will comfort them!

"Happy are those who are humble; they will receive what God has promised!

"Happy are those who are merciful to others; God will be merciful to them!

"Happy are the pure in heart; they will see God!

"Happy are those who work for peace; God will call them his children!

"Happy are those who are persecuted because they do what God requires; the Kingdom of heaven belongs to them!" (Matthew 5:3-10),

"Come to me, all of you who are tired from carrying heavy loads, and I will give you rest. Take my yoke and put it on you, and learn from me, because I am gentle and humble in spirit; and you will find rest." (Matthew 11:29-30), and

"Do not be worried and upset, believe in God and believe also in me." (John 14:1).

Anxiety, guilt, and meaninglessness are universal in human experience. Let's remember that mental health is more than the absence of mental disease, and includes an understanding of our place in the community and the universe, of who we are, and whose we are.

Dave Hilton



WCC Photo: Peter Williams

Time out for playing in a Lesotho secondary school.

WORTHY MENTIONS

The editors of CONTACT find the following efforts most heartening, as they are in keeping with the publication's goal of reporting on 'topical, innovative and courageous approaches to the promotion of health and integrated development'.

Case notes of a Salvadorean refugee from the Latin American Health Workers' Group, Mexico, which has specialized in helping Central American refugees, and offers individual and group therapy: June 1983.

Maria is very perturbed in our first interview. Her complaints are essentially physical: 'My head aches, my jaw, my stomach. I can't sleep...' She has no words to express her tension and sadness but can only identify the pain through her body.

Slowly, feelings of distress and claustrophobia (underground bus) start to emerge, which frighten her and make her feel she is losing her memory. Only after several sessions is it possible for her to link these symptoms with her experience in prison.

In our first session, Maria had mentioned that she had been in prison, but made little of it: 'I was only there five days, they only beat me, I wasn't there long.' At this stage I don't ask any questions but let her talk about her health, her worries about her children and anxiety about her relatives in El Salvador.

Only two sessions later the subject of prison comes up again. I ask her to tell me more. She tells me the story without emotion. She was held for five days but she only knows it was five days because the people who found her dumped by the roadside, unconscious, covered in blood and badly beaten, told her the date. I help her to see that if she was left in the road, it can be deduced that it was thought she was dead. She accepts that this

is true and says she hadn't thought of it like that. From this moment on, she is able to talk more about those days and particularly about other experiences related to death and dead people.

As a human rights worker, she was responsible for identifying corpses. She would memorize the person's clothing and characteristics and would then write the reports to be sent to the UN and other agencies.

She talks about how at first the proximity of these corpses frightened her and what an effort it was to look closely and have to touch them.

It is possible to link these three experiences and to show her the relation between these dead bodies which frighten her; her own experience of 'being dead' and dumped on the road and her present suffering. Her physical suffering shows that she is still alive and negates her experience of death.

From this history, we can perhaps deduce that for many refugees and political exiles, who have experienced imprisonment, their frequent psychosomatic complaints – the head or stomach aches – are, apart from being an expression of distress, a new way of 'feeling alive'. This allows to negate, forget or minimize all these traumatic experiences related to facing death in such violence and sinister conditions. Between the lines we can read a feeling of guilt at being alive when so many have died. An 'aching body' is a way of saying 'I'm alive – but only just.'

Reprinted from CENTRAL AMERICA REPORT, Issue 32, Jan/Feb 1987, "All in the Mind/Learning to Fight War's Other Wounds" (83 Margaret St., London W1N 7HB, Great Britain).

* * *

The International Commission of Health Professionals for Health and Human Rights (IHP) was inaugurated on 30 January 1985, following 4 years of preparation. It is responding to the need to oversee the situation of health professionals where they are:

- "persecuted or harassed because of following medical-ethical principles,
- hindered in bringing medical assistance to the poor and underprivileged,
- hindered in free association with other members of their profession, in order to bring medical assistance to the needy,
- used by the authorities to participate in torture procedures or other unethical conduct condemned by international conventions and declarations,
- used by government or business interests in order to promote medical products or research which is against the basic health interests of the people."

From Human Rights and Mental Patients in JAPAN, 94 pages:

Reports of serious human rights violations in mental hospitals in Japan prompted the International Commission of Jurists and the International Commission of Health Professionals to accept an invitation to send a mission to that country to review and make recommendations on the legislation and practices for the treatment of mental patients.

The members of the mission, distinguished experts of recognised competence in the field, had discussions with the Ministry of Health, psychiatrists, social workers, nurses, occupational therapists and representatives of many organizations and individuals concerned with mental patients, as well as visiting several mental hospitals.

They commented that:

"the present structure and function of the Japanese mental health services create conditions which are conducive to inappropriate forms of care and serious human rights violations on a significant scale."

This substantial report of their mission ends with 18 conclusions and recommendations which identify the major areas of concern as:

- a) a lack of legal protection for patients during admission procedures and during hospitalization, and
- b) a system of care characterized by a preponderance of long-term institutional treatment and a relative lack of community treatment and rehabilitation.

Available from:

International Commission of
Health Professionals,
15, route des Morillons,
CH-1218 Grand-Saconnex,
Geneva, Switzerland

or:

International Commission
of Jurists,
P.O. Box 120,
CH-1224 Chêne-Bougeries,
Geneva, Switzerland

Price:

SF 10 plus SF 2.50 postage in Europe.

Foreign \$9 by surface mail / \$11 by air mail.

A 2nd publication, entitled **Health and Human Rights** (1986) 149 pages, outlines the ICHP's history, and addresses issues such as torture, estimates of World War II's early casualties, ethics in prison health care, death and dying. **Available from:** ICHP's above address. **Price:** SF 15 plus SF 2.50 postage in Europe. Foreign \$12 by surface mail / \$14 by air mail.

USEFUL PUBLICATIONS

Problems of Mental Health in the African Region, Report of a Round Table, Brazzaville, 9-11 July 1986, World Health Organization, Regional Office for Africa, 40 pages.

Collective viewpoint of the participants of this round table are expressed, covering Africa's current situation, constraints to programme development, required action with detailed guidelines, and recommendations concerning formulation of national policies and their development and implementation. Also available in French.

More information from: WHO Regional Office for Africa, P.O. Box 6, Brazzaville, Rep. Pop. CONGO.

First-contact mental health care, Report on a WHO meeting, Tampere, Finland, 25-29 April 1983, EURO Reports and Studies 92, 74 pages. The working group's purpose was to examine the nature and consequences of the 1st contact made with mentally disordered people as well as the management of this 1st contact in relation to the promotion of mental health within the community (Finland, Italy, Yugoslavia, Bulgaria, Spain, USSR, Denmark, Federal Republic of Germany, Sweden, Nor-

way, Netherlands, Greece, Morocco). Participants were asked to identify tasks and responsibilities of general practitioners, exploring self-help groups, voluntary organizations and specialist mental health services as supportive or referral systems within the context of primary health care. A work plan was proposed to develop mental health care as an essential component of primary health care. Summaries in French, German and Russian included.

Available from: Akateeminen Kirjakauppa, Keskuskatu 2, 00101 Helsinki 10, FINLAND.

Psychiatric Annals, "Psychiatry in Rural-Agrarian Societies", by T.W. Harding, M.D., June 1978 (reprint), 9 pages. Three major points covered: urban, industrial origins of modern psychiatry; unsuccessful and counterproductive attempts to transfer these technologies and concepts to less developed countries; the kind of action through which basic mental health care could be provided to communities that are in greatest need.

Available from: Insight Publishing Co., Inc., 501 Madison Avenue, New York, N.Y. 10022, USA.

Tropical Doctor, October 1983, No.13, pages 149-152, "**Mental health care in the developing world**", a review of the 1st phase of the WHO Collaborative Study on Strategies for Extending Mental Health Care by H.G. Egdell, FRCP MRCPsych, Royal Liverpool Hospital, Liverpool L7 8XP, United Kingdom.

WHO research centres were established in rural or urban areas of Brazil, Colombia, Egypt, India, the Philippines, Senegal and Sudan to test whether the *recommendation of a WHO Expert Committee that the detection and management of priority mental disorders should form part of the regular tasks of primary health workers* was feasible. This article briefly assesses progress made by citing findings in the detailed reports of Harding, Climent, Wig, Beigel, Giel, Baasher and colleagues.

More information from: Oxford University Press, Walton St., Oxford OX2 6DP, UNITED KINGDOM.

The reports of the 1st 5 authors are listed below.

Social Psychiatry, "Development of an Alternative, Efficient, Low Cost Mental Health Delivery System in Cali, Colombia, Parts I and II, 1978, No. 13, pages 29-35 and 1983, No. 18, pages 95-102, by C.E. Climent, M.V. de Arango, R. Plutchik, and C.A. Leon (1978 only).

Available from: Springer Verlag, "Social Psychiatry" 175 5th Ave., NY, NY 10010, USA.

WHO Chronicle, 1980, No. 34, pages 231-236, "**Mental health in primary health care**", by C.E. Climent, B.S. M. Diop, T.W. Harding, H.H.A. Ibrahim, L. Ladrado-Ignacio and N.N. Wig. This article describes the interim results of the collaborative study undertaken in the 7 countries listed above, including investigation

of the extent of mental health problems and the communities' reactions to them.

Available from: World Health Organization, Distribution and Sales Service, 1211 Geneva 27, SWITZERLAND.

Indian Journal of Psychiatry, 1981, No. 23 (4) pages 275-290, "**A Model for Rural Psychiatric Services — Raipur Rani Experience**", by N.N. Wig, T.W. Harding, and R. Srinivasa Murthy, Assistant Professor, Dept. of Psychiatry, NIHMANS, Bangalore. As part of the same collaborative study, this working group included interviews of the health staff, screening of the clinic's population and interviews of community leaders.

More information from: the authors (in English and Hindi).

Psychopathologie Africaine, 1981, XVII, 1/2/3, pages 262-270, "**New Approaches to the Delivery of Mental Health Care in Developing Countries**" by A. Biegel, M.D. The author visited 4 of the 7 programme sites of the collaborative study: the Philippines, India, Egypt and Senegal. Having served on a Commission to advise the American President on the status of community mental health care in the United States, he was struck by the similarities in conceptual approaches and programmatic initiatives, despite cultural, social and economic differences among these countries. He also observed barriers common to developing countries in their extension of mental health care. The conclusion stresses the importance not only of the lessons being learned in developing countries, but also as they apply to more industrialized nations. Brief summaries included in French.

Available from: Allan Beigel, M.D., Professor of Psychiatry, University of Arizona, College of Medicine, Tucson, Arizona, 85724, USA.

CMC NOTES

THE HUNGER PROJECT announces "The Africa Prize for Leadership for the Sustainable End of Hunger". This award will be presented annually beginning in September 1987 to a distinguished African who, in the eyes of the jury, has exhibited exceptional leadership in bringing about the sustainable end of hunger at the national, regional or continent-wide level. The recipient will receive a cash prize of US\$ 100,000 in support of his or her continuing work on behalf of the people of Africa.

The prize particularly focuses on individuals working in public policy, science, agriculture, education and health whose leadership and policies reflect courage, initiative, creativity, boldness and, in some cases, personal sacrifice. The prize also seeks to increase awareness within the world community of the many African leaders who are making the difficult public policy decisions necessary to resolve the pressing agricultural, economic and social

issues facing the continent – including food, water, literacy and employment.

The Hunger Project is an international not-for-profit organization whose purpose is to create the end of hunger and starvation on our planet through worldwide programmes of education and communication.

An award ceremony will be held on 17 September 1987 in New York City, during the week of the opening of the United Nations General Assembly. **Nominations and accompanying materials must be received no later than 15 June 1987.**

For more information on the prize or The Hunger Project itself, contact:

Heather Schoen, Global Press Officer

The Hunger Project

1 Madison Avenue / New York, NY 10010
USA

1987 WHO AWARD FOR HEALTH EDUCATION IN PRIMARY HEALTH CARE

This annual award, in its 3rd year, has been made possible through the generosity of the L.I.S.Z. Foundation. Its purpose is to reward outstanding contributions made by any person(s), institution(s) or nongovernmental organization(s) towards strengthening health education in PHC. The award is a cash prize of US\$ 5000, to be used for continuing these health education activities, and a commemorative plaque.

Only health education activities still in progress will be considered for the award. They must be innovative in their planning and implementation, as well as in the evaluation of the activity's impact on the health of the people concerned.

Nominations must include the following information: (1) name and address of person(s) or institution(s) (2) brief summary of PHC project in which the health education activity is integrated, including project's objectives, geographical coverage, target groups, duration of

activities, personnel involved, and monitoring and evaluation of efforts planned/undertaken (3) description of health education activity being carried out as part of PHC project, which should emphasize planning, implementation and evaluation phases, highlighting innovative approaches being used and the impact of the education on people's behaviour.

Nominations must reach WHO before 31 August 1987 and be addressed to:

Health Education Service / Division of Public Information and Education for Health World Health Organization / 1211 Geneva 27 SWITZERLAND

(Note: The United Nations family of organizations and members of their staff are not eligible for nomination.)

A special note of thanks to Dr. John Orley, Senior Medical Officer, Division of Mental Health, WHO, Geneva, who provided valuable guidelines in the preparation of this issue of CONTACT.

CORRECTION:

CONTACT 95, pg. 3, Figure 2. Second column indicating dose of Chloroquine tablets should read "+" between 1st and 2nd dose for all ages.

CONTACT is the periodical bulletin of the Christian Medical Commission (CMC), a sub-unit of the World Council of Churches (WCC). It is published 6 times a year in 4 languages: English, French, Spanish and Portuguese. Present circulation is in excess of 26,000.

Papers presented in CONTACT deal with varied aspects of the Christian community's involvement in health and seek to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the 1st issue of each year in each language version. Articles may be freely reproduced, providing acknowledgement is made to: CONTACT, the bi-monthly bulletin of the Christian Medical Commission of the World Council of Churches.

Editor: Eric Ram (Director). Editorial Assistant: Sanda Freeman. Editorial Committee: Eric Ram, Reginald Amonoo-Lartson, David Hilton, Sanda Freeman, Jeanne Nemec, Birgitta Rubenson. The rest of the CMC staff also participate actively in choosing topics and the development of materials. Mailing List: Fernande Chandrasekharan. Printer: Imprimerie Arduino. Correspondence: CMC/WCC, PO Box 66, CH-1211 Geneva 20, Switzerland.

The average cost to produce and mail each copy of CONTACT is SF 2.50 (US\$ 1.25), which totals SF 15.– (US\$ 7.50) per year for 6 issues. Industrialized-country readers are strongly encouraged to subscribe to CONTACT to cover these costs. Please note that orders of back issues of CONTACT will be charged at the above rate.