contact 43

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The Planning Dialogue in the Community

by Mary Johnston

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INTRODUCTION

Much has been written over the past few years about the necessary components of Primary Health Care, or Community Health Care. Among these, the participation of people in the planning process, in identifying needs, setting priorities and carrying out the programme has long been recognized by health planners and development planners to be perhaps the most essential.

In CONTACT 40, we presented one practical approach to making the community diagnosis. Such diagnosis is an essential process in determining which health problems require the major attention of a health programme and which population groups are most at risk. But many questions continue to be asked about how to secure the expression of the entire community of its needs and the priorities to be set within those needs. What steps are necessary in order to mobilize the community for its maximum involvement in all stages of the programme?

In this issue, we are pleased to present a very practical outline of the steps necessary to develop a community health programme. This formulation, by Ms Mary Johnston, is based on more than ten years' experience in the "Dana Sehat" programme in Central Java, Indonesia. This considerable experience is apparent in the careful working out of the approach she has presented. The Dana Sehat programme is based on the concept of a community development programme, built upon a health insurance scheme. "Dana Sehat", literally translated, means health funds. Beginning around the city of Solo, the programme has been expanded to include many communities and small hamlets in Indonesia, and incorporates a wide variety of development activities including cooperatives, credit unions and sanitary measures. Further details on the Dana Sehat programme can be found in CONTACT 31 "Community Health Care in Rural Java" and in the article by Dr Gunawan Nugroho in the WHO book, "Health by the People", 1975.

One lesson emerging from this experience was presented in a recently published report on the programme and was summarized as follows: "Success depended on such factors as correct timing in the presentation of ideas and adequate social preparation. Social preparation (involves) not only the dissemination of information and explanations about the purpose and aims of the scheme but, of even greater importance, the encouragement of the people themselves to actively participate and assume responsibility for the scheme."

A second lesson is emphasized in a letter received recently from Ms Johnston in which she says: "... cooperation with government services is essential for healthy growth of a community programme. This cooperation is with village leaders and with appropriate government services at the district level ... or possibly even higher."

We believe that this article constitutes one of the clearest presentations of the steps which may be followed in the development of community health care in many different regions around the world.

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DEVELOPMENT OF A COMMUNITY HEALTH PROGRAMME

MAJOR STEPS

A. PROMOTION WITH THE GOVERNMENT

B. CONSOLIDATION OF THE HEALTH STAFF

C. APPROACH TO THE COMMUNITY

D. SOCIAL PREPARATION OF THE COMMUNITY

E. FIELD PREPARATION

I. Selection of Initial Project Area
II. Collection of Data about the Community
III. Determination of Problems to be Tackled and Setting Priorities
IV. Planning Programme Implementation

F. IMPLEMENTATION OF THE PROGRAMME

G. MONITORING

H. ASSESSMENT

I. REVISION

J. EXPANSION OF ESTABLISHED PROGRAMME

K. EXTENSION OF PROGRAMME TO OTHER COMMUNITIES

L. PROMOTION AND TRAINING IN NEW AREA AND repeat of whole process in new community.

A. PROMOTION WITH THE GOVERNMENT

- How can a doctor gain acceptance from peers and supervisors for ideas of experimentation with a community-oriented health programme?
- How can such a programme be integrated into the overall government programme?
- How can the doctor avoid friction with senior officials if the programme is eventually more successful than their programme?

→ GOVERNMENT SUPPORT MUST BE GAINED IN THE INITIAL STAGES OF A PROGRAMME.

Purpose

1. To gain official support for the proposed programme.
2. To recruit government resources, including technical advice, facilities and funds.
3. To gain support from other disciplines at the same, or higher, levels in order to develop a comprehensive programme.
4. To integrate the programme into the government programme and prevent overlapping and competition.

Action

Discussion with senior government officials until some concensus is reached on concept of community health, and the idea to set up a community health programme in a specific locality is approved.

Information needed for successful action

1. Current government health policy, including opinions and statements from senior officials and international sources, on community health.
2. Overall plan of implementation should include ideas on:
   - organization/framework within which programme will be developed,
   - financial aspects,
   - advantages over current system, eg. wider coverage, more economical use of staff, cheaper. (In discussing advantages, factors of special interest and importance to the government officials should be emphasized.)
3. Criteria for the selection of locality for trial should include the following:
   - the community to be served should be manageable, viable and, preferably, an established administrative unit such as a village or kampong;
   - the unit should have economic potential;
   - it should have strong, active, honest leadership;
   - it should be strategically placed to enable expansion to other areas.

B. CONSOLIDATION OF HEALTH STAFF

- How will staff who have worked for years in a curative service accept a programme with a new orientation?
- How can a doctor secure the support of the rest of the health team for a new programme? No doctor can implement a community health programme alone.

→ IT IS IMPORTANT TO CONSOLIDATE THE STAFF OF THE HEALTH SERVICE.

Purpose

1. To prepare the health staff for a programme oriented to the community.
2. To provide the staff with skills required for community work.
3. To form a cohesive team.

Action

Retraining the staff of the health service, including, if necessary, its reorganization.

Information needed for successful action

1. On forming an effective team.

   A team which understands and accepts the new approach and feels confident in implementing it is needed. The team may consist of:
   - a doctor, or other team leader,
   - paramedics, and nursing staff,
   - social worker, and
   - agriculturalist (or other technical worker, depending on local community needs).

   If it is not possible to increase staff, current staff can perhaps be equipped with extra skills.

2. On training content and methods.

   i. Training should achieve changes in attitudes, through:
      - statements proving government interest in, and support of, new orientation;
      - proof of need for new orientation, eg. clinic statistics indicating limitations of existing service, reasons for non-attendance at health service, etc.;
      - contact with community health workers;
      - visits to successful community health programmes.

   ii. Training should provide skills in:
      - approaching the community,
      - communicating with the community,
      - working together with the community,
      - planning,
      - maintaining and developing a programme, and
      - simple administrative skills.

   iii. Training methods could include:
      - discussions,
      - exposure to situations followed by reflection on the situation,
      - problem solving, and
      - role playing, etc.

C. APPROACH TO COMMUNITY

- How can a health programme become a community-based programme?
- How can a doctor help the community to tackle its own health problems?

→ IT IS IMPORTANT THAT THE COMMUNITY BE APPROACHED IN THE VERY EARLY STAGES OF DEVELOPMENT OF THE PROGRAMME. CLOSE COOPERATION BETWEEN THE HEALTH SERVICE AND THE COMMUNITY IS ESSENTIAL.

Purpose

To gain the support and the direct, active participation of the community in developing the programme.

Action

Health worker approaches the community leader

or

Health worker is approached by the community leader. (This is only likely to happen in a community where a successful programme has already been established in the vicinity.)

Information needed for successful action

1. For the identification of a sympathetic community leader, criteria should include:
   - interest in health,
   - active interest in community welfare,
   - innovative ideas, and
   - influence in community.

2. Method of Approach.

   Discussions should focus on:
   - particular issues, events occurring in community (death, epidemic, special day);
   - statistics from local clinic (high disease incidence, disease patterns); and
   - examples of programmes in other areas.

Important factors

1. Official approval of local leader is prerequisite.
   If a direct approach to formal leaders is not possible, or unsuccessful, informal leaders, eg. teachers, religious leaders, may be approached. When they are convinced about the new ideas, they can be encouraged to influence the formal leadership.
   A government superior (eg. a district head) may be the needed contact person in other cases.

2. It is unusual for the initiative in setting up a health programme to be taken by the community. But where this occurs and the existing health workers are unresponsive to approaches from village leader, the help of a more senior official, eg. senior doctor, senior government official, could be requested to convince the health worker, through discussions and visits to successful programmes.

D. SOCIAL PREPARATION OF THE COMMUNITY

- How can the whole community (as opposed to leaders only) participate in programme development?
- How can a health worker make contact with members of the community? What channels can be used?
- How can the health worker avoid the danger of arousing a feeling within the community that their cooperation is desired merely to further the ambitions of the health worker?

→ SOCIAL PREPARATION OF THE COMMUNITY IS CRUCIAL TO THE SUCCESS OF A PROGRAMME.

Purpose

1. To develop community understanding of the basic aims of the programme.
2. To encourage the community to reach a decision to implement a programme based on its particular needs.
3. To mobilize local resources.

Action

1. Informal individual and group discussions about community problems and needs and the proposed community health programme, held between health worker and leaders in the community.
2. Community leaders, assisted by the health worker, then introduce the idea of the community health programme, informally and through community groups and meetings, to community members.
3. Discussions should be held until a decision is reached by community leaders and community members (if possible) to implement the community health programme.

Information needed for successful action

1. Influential community leaders include:
   - formal leaders, eg. government, traditional, religious; and
   - informal leaders, eg. religious, educated, wealthy, political.

   The support of both formal and informal leaders is important.

2. Existing 'effective' community organizations have:
   - ongoing activities,
   - membership representing the whole community,
   - sound leadership, and
   - a flexible programme.

   Approach should be made to such organizations as the community health programme could possibly be inserted as the programme of one of these organizations.

3. Research to identify community problems and needs may include investigations on:

   Health:
   - general observation, especially of deficiencies, including malnutrition, particularly in the under-fives' group;
   - noting major illnesses as recalled by members of the community (and indicative of the high incidence of certain diseases);
   - collecting data on number and causes of deaths and incidence of epidemics (or threat of);

   Education:
   - asking local teachers about their problems;
   - comparing number of school age children with number of school attenders;
   - checking drop-out figures and reasons;

   Transport/Communication:
   - checking distance from nearest market, school and other important facilities;
   - checking means of contact with, and transport to, secondary health care facilities;

   Agriculture:
   - comparing yields with expected average yields of area;
   - asking farmers for their opinions of problems and needs;
   - observing general conditions in the field.

4. Customary ways in which the community solves problems.

   When obtaining information about major needs and concerns, also ask about ways in which the community has tried to meet these needs. Possibly the customary ways of solving problems can be developed and incorprated into the new programme.
   Eg.: If a community collects funds to cover funeral expenses, this could be developed into a simple insurance scheme in which subscriptions are collected to provide health care for the living.

5. Methods by which the community reaches decisions.
   a. Determine which groups/group leaders are most influential in the community as they are the best channels through which to gain community support.
   b. Determine which is the officially recognized decision-making body/committee through which the final decision for acceptance of the programme should be made.
   c. Determine the type and frequency of group meetings. If the decision is reached in a formal meeting attended by a large proportion of leaders and community members, it will have stronger backing and support.
   d. Determine whether decision making is:
      - a decision by the recognized leader,
      - majority vote, or
      - discussion culminating in unanimous decision. Whichever decision-making method is used, it is important that as many community members and leaders as possible understand and agree with programme.

Important factors

1. The health worker must have an open, friendly attitude, indicating willingness to learn about the community from the people.
2. The introduction of the proposed programme should always be through discussions on major concerns of the community. Through discussions, assess what these are and start there.
   Eg. A volunter health promotor programme could be suggested as an answet to the problem of long distances from the health service.
3. In a community where health is not a major priority, eg. a poor, isolated community, implementation of a health programme may have to be postponed until other more pressing needs felt by the community are met.
   Egs. An agricultural programme which raises crop yields may provide the community with the economic means enabling them to use the proposed health service.
   Non-formal education may increase awareness and understanding of the advantages of healthier living.
4. NB: At this stage the community health programme is accepted in principle only. Details of the programme have not yet been worked out.

E. FIELD PREPARATION

→ JOINT PREPARATION OF THE FIELD, INCLUDING SELECTION OF A LIMITED AREA FOR TRIAL, COLLECTION OF DATA, DETERMINATION OF PRIORITIES, AND PLANNING IS IMPORTANT.

E. I. SELECTION OF INITIAL PROJECT AREA

- How can a community be convinced that a programme is feasible and of benefit to them?
- How can ideas be tried out without their failure jeopardizing the whole programme?
- How can programme implementors gain confidence from experience?

Purpose

To select a restricted area, with high probability of success, for trial.

Action

Community leaders and health worker reach a decision on locality for trial programme.

Information needed for successful action

1. Nature of appropriate locality.

   The site most conducive to successful implementation would be:
   - an existing community, preferably a small administrative unit, eg. subhamlet or village;
   - manageable in size;
   - an economically viable community; and
   - one with good leadership.

   (In subsequent development of the programme in other areas, weaknesses can be overcome by many means, eg. an economically weak unit could be combined with a vigorous and thriving village.)

2. Nature of local leadership.

   The leadership of the trial unit should be:
   - authoritative,
   - honest,
   - actively interested in the welfare of the community, and
   - supported by the community.

   (In subsequent development of the programme, weak leadership can be overcome by many means, eg. by working through strong informal leaders with formal leader as figurehead.)

E. II. COLLECTION OF DATA ABOUT THE COMMUNITY

- How can the community and health worker learn more about local conditions?
- How can a programme be based on real and felt needs of a community?

Purpose

1. To provide baseline data.
2. To enable local leaders to become more aware of conditions in their community.
3. To increase the awareness of the community of problems facing them.

Action

1. Prepare simple questionnaire suited to local needs and adapted to the skills of the interviewers.
2. Inform leaders of the purpose of the questionnaire and reason for collecting data.
3. Selection of interviewers, preferably from the community.
4. Training of interviewers.
5. Data collection.
6. Tabulation and analyses of data.

Information needed for successful action

1. Community to be covered.

   It is important to collect data from the whole community if conditions are favourable. However, if community to be covered is too large, sampling methods should be used. These methods can be studied in a handbook on surveys.

2. Content of survey.

   The data should cover both the community in general and individual families.
   On community, items such as number of families, average family size, public facilities and vital statistics, should be covered. On families, information on factors such as number in family, ages, education, occupations, income, health status, environment, mother and child care, agriculture and social customs should be included.

3. Method of composing questionnaire.

   - Questionnaire should be short and seek only information which can be used either directly for programme planning, or as an indicator of success for the monitoring of the programme.
   - Ensure that the questions have one meaning only and will bring the answers required.
   - Ensure that questions are not suggestive of a particular answer.
   - Ensure that answers are given in a way which is easily tabulated, eg. by using simple indicators, such as + = good; ± = fair; — = bad.

4. Selection of interviewers.

   If possible, community members should do the interviewing. Choose community members with:
   – ability to approach fellow community members,
   – ability to ask questions honestly and record answers accurately, and
   – interest in programme and time to spare.
   If volunteer health workers have been formed before collection of data, this task should be given to them to increase their awareness of community conditions, and to provide a basis for them to plan their programme.

5. Content and method of training interviewers.

   Training should include:
   – reasons for asking questions in questionnaire,
   – guidance on how to explain need for data collection to community members,
   – guidelines for interviewing techniques, including information on how to:
     - create an open, friendly atmosphere,
     - ask open and closed questions,
     - prevent bias in answers, and
     - cross-check answers, and
   – instruction on how to fill in questionnaire.

   Training methods could include: discussion, role play, trial run followed by discussion of problems.

6. Method of collecting data.

   a. Coverage: The capacity of one interviewer in a rural area where homes are widely separated is, at a rough estimate, 10 families a week;

   b. Timing: Home visits should be geared to times when community members are at home;

   c. Supervision: Supervision of interviewers is important to maintain their enthusiasm and increase validity of data. Such supervision should include spot checks of difficult questions, close recording of time taken in interview, number of interviews conducted, etc. Each interviewer should keep his/her own records. Daily discussion of results is helpful for increasing skills.

7. Method of tabulation.

   Tabulation can be done by community members with guidance from health workers.
   Response frequency for each question should be counted and tabulated.
   Respondents can be divided into groups based on employment, size of family, education of parents, or other relevant factors.

8. Method of analysis.

   Each item in the tabulation can be evaluated according to simple criteria, such as: good/bad, sufficient/insufficient, satisfactory/unsatisfactory. Those items assessed as bad, insufficient and unsatisfactory are raw material on which to base plans for programme.

Important factors

1. Data collection is important, but if problems arise (eg. suspicious community leader, suspicious community members, inappropriate timing), data can be collected in stages as the need arises for specific programmes (eg. under-fives' programme, environmental improvement programmes).

2. Data collection could also be postponed until volunteer health promotors have been formed.
   Advantages of using volunteer health promotors:
   - they are known by the community,
   - have an intimate knowledge of the community,
   - can gain increased awareness of problems, and
   - can obtain data for planning their programmes.

   NB: It is especially important to safeguard bias if health promotors or other local people are used.

E. III. DETERMINATION OF PROBLEMS TO BE TACKLED AND SETTING PRIORITIES

- How can a community set priorities in the face of a large number of problems?
- How does one select the 'right' initial activity?

Purpose

1. To initiate a dynamic programme.
2. To select a small-scale, low-cost activity which will produce quick results.
3. To provide stimulation for continuing development of the programme.

Action

1. Presentation of survey results to community leaders and community members (if possible).
2. Determination of priorities and of initial activity.

Information needed for successful action

1. Reporting survey results.

   Survey results should be reported back to the community in a form understandable to them. A descriptive, non-technical form highlighting problems and also potentials may be most effective. If possible the report should be made both orally and in writing. The oral presentation to community leaders, both formal and informal, provides a good opportunity for discussion of major community problems, both those in the report and those felt by the community.

2. Criteria for determining priorities to be considered.

   Four simple criteria can be considered:
   - What is the incidence of the problem in the community?
   - How serious is it as a health problem? (Opinion of health worker)
   - What importance does the community place on the problem?
   - How difficult is it to overcome? (Management considerations).

   The health worker together with the community can make a simple analysis of results by evaluating each problem according to the above criteria using a scale of 0-3. The scores are then multiplied to gain final score. Priorities are determined, the problem with the highest score gaining first priority.
   As far as possible, the key members of the community should be involved in determining priorities. Their involvement in all decision making will increase the validity of the decisions and increase their commitment to the programme. Both short- and long-term priorities should be determined to provide the vision of a continually developing, comprehensive programme.

3. Criteria for selecting initial activity:

   - low cost,
   - limited to small, feasible size,
   - ability to produce results within ± 6 months.

   Using these criteria, plans should be realistic and within the scope of the community. Hence success will be maximized, resulting in a relationship of trust and confidence between the community and the health worker.

   It is important also that the initial activity should stimulate further activities, leading to a more comprehensive programme, eg. that a nutrition programme might stimulate improvements in agricultural techniques, or a savings programme stimulate small productive activities.

E. IV. PLANNING PROGRAMME IMPLEMENTATION

- As experience is an invaluable teacher, how can members of the community acquire skills in planning and management through experience?

Purpose

1. To make plans acceptable to both the community and health service.
2. To involve all parties in planning and implementation.
3. To increase community skills.

Action

1. Meeting of community leaders, community members (if possible) and health worker to make plans for implementation, on invitation of community leaders.
2. Setting up committee and administration, including a division of responsibitilies.

Information needed for successful action

1. Existing organizations in the community.

   If possible, the programme should be set up through existing organizations.
   If necessary, these could be reactivated, given new functions, etc.
   Only when this proves impossible should a new organisation be created to carry out the programme.

2. Type of framework for programme.

   Examples of possible frameworks within which to set up a programme are as follows:

   a. A simple health insurance scheme can provide a framework for developing a comprehensive community health programme, eg. environmental improvements, credit union, volunteer health promotors, under-fives' weighing, etc. can all be built into the framework as community awareness increases and needs arise.

   b. A volunteer health promotors' programme could also provide the framework for similar activities, as well as improved use of home gardens, under-fives' nutrition programme, health posts, etc.

F. IMPLEMENTATION OF THE PROGRAMME

How can the community best be made aware of its own strengths and resources, and encouraged to use those resources?

Purpose

1. To carry out plans efficiently with active support and participation of the community.
2. To mobilize local potential and resources.
3. To develop management and other skills in the community.

Action

Community leaders, committee and health worker meet to discuss the implementation of plans, including steps, timetable, division of tasks, manpower use, etc.
(This may take several meetings.)

Information needed for successful action

1. Simple methods of planning and management.

2. Methods of conducting a meeting so that those present contribute and plans stem from joint discussion.

   Preferably these meetings should be called and led by the committee. If there is a division of responsibilities amongst the members, all will have a meaningful contribution to make to the meeting.

3. Resources available within the community and those from without the community (if required).

   These include: materials, equipment, funds, skills, technical knowledge and manpower.
   Data collected in initial stages should provide details on resources within the community.

Important factors

1. Plans should only be carried out **after** the community is prepared, ie. after social preparation and field preparation are completed.
2. The community leaders and members should be responsible for making the plans, not the health worker.
3. The role of the health worker is:
   - to assist the committee in considering problems which may arise during implementation,
   - to provide technical information, and
   - to 'prod' the committee (if needed), eg. if committee chairman 'forgets' to call a meeting.

G. MONITORING

- What should be done if action planned together is not implemented?
- How can the community closely follow the progress of a programme?

→ ONGOING MONITORING OF THE PROGRESS OF ACTIVITIES IS IMPORTANT.

Purpose

1. To follow the progress of implementation of plans.
2. To study the relationship between input, output and impact.
3. To stimulate the community through continual feedback.
4. To revise methods, if necessary.

Action

1. During implementation of the programme, progress is monitored by trained community members.
2. The community, community leaders and health worker meet periodically to discuss the results of the monitoring.

Information needed for successful action

1. Simple methods of monitoring.

   It is essential to work out a simple recording system which is meaningful to the community, and can be kept by community members. Community members should be trained in the use of the system.

2. Effective ways to provide feedback of information.

   The opportunity must be provided for the community to receive regular reports of progress, eg. at community meetings, at regular committee meetings, through poster displays.
   Informal contacts with community leaders should also be used for feedback of information about the programme. Both formal and informal contacts provide an opportunity for the community to give feedback to the committee on reasons for success or failure to progress.

H. ASSESSMENT

- What steps should be taken if a programme becomes static because the community loses interest and no new ideas arise?
- How can the community assess the results of its programme?

→ ASSESSMENT OF END RESULTS OF ACTIVITIES IS IMPORTANT FOR PROGRAMME DEVELOPMENT.

Purpose

1. To assess whether results of activities within the programme are satisfactory and meeting the aims of the programme.
2. To stimulate the development of other activities.

Action

1. Community leaders, committee and health workers meet for discussion of results of activity.
   (In a long-term programme, these meetings are held periodically.)
2. Community meetings are held by community leaders where results of assessment by committee are discussed, and ideas on expansion of the programme based on results of assessment are developed.

Information needed for successful action

1. Simple method of assessment.

   Criteria for measuring progress could include:
   - change of disease pattern,
   - infant mortality rate,
   - incidence of illness in community,
   - improvements in environment,
   - increased community participation in health programme,
   - community's use of service (accessibility and acceptability), and
   - effectiveness of service (cost and benefit).

   Data on results achieved through programme is compared with baseline data collected in initial stage of programme.

Important factors

The assessment must help the community to understand the results of their programme.

Therefore:

1. Community leaders (and if possible community members) should be involved in making the assessment. (Eg. the monitoring records could be used.)
2. The assessment must be prepared and presented in a form understood by the community.
3. The assessment must be reported back to the community members.

I. REVISION

NOTE: This step is only necessary if assessment reveals that an activity is not meeting programme objectives, or programme objectives are not meeting community needs.

→ IT IS IMPORTANT TO MAINTAIN A DYNAMIC PROGRAMME WHICH MEETS THE CHANGING NEEDS OF THE COMMUNITY.

Purpose

1. To increase the effectiveness and efficiency of the programme.
2. To reorganize the programme to meet the needs of the community more closely.

Action

In a meeting of the community leaders, committee and health worker, decisions are made on the need for revision and methods of revision.

Information needed for successful action

1. Aspects needing revision.

   These will be evident from the results of the monitoring and assessment.

2. Alternative activities which are more appropriate.

Important factors

A community is never static; community needs are continually changing. Therefore a flexible programme is required, and programme implementors must be openly willing to change and revise programme as needed. A programme should be dynamic, never static.

J. EXPANSION OF ESTABLISHED PROGRAMME

- How can the causes of problems be attacked? For example, the community not only collects blood samples to detect malaria infection, but also works towards the eradication of mosquitoes.
- How can the community reach the goal of healthier living?

Purpose

1. To improve the quality of the programme, through expanding the number and type of activities.
2. To meet health needs of the community more adequately through a comprehensive programme.

Action

In periodic meetings, possibly at the same time as assessment, community leaders, committee and health worker, propose, select and plan further activities.
(This meeting is preferably called by community leaders.)

Information needed for successful action

1. Methods of motivating community leaders and members to propose new activities may include:
   - visits to more advanced programmes;
   - development of a new activity in a limited locality, followed by encouragement of satisfied community members to stimulate other localities to follow their example; and
   - competitions.

2. Ways of encouraging community members to take more initiative should be based on increasing their awareness about their community and its problems.

   This can be achieved by:

   i. *Training selected community members as volunteer health promotors so that they will have a deeper and more critical understanding of the causes of health problems and ways to overcome them.*

   ii. Using important events to stimulate action, eg. Independence Day preparations could include work on environmental improvements.

   iii. Using dramatic events, eg. an outbreak of an epidemic or a death, to increase awareness and stimulate action to prevent a further occurrence of the same problem.

Important factors

Before implementing any new activity, it is essential to repeat the steps of social preparation and field preparation.

K. EXTENSION OF PROGRAMME TO OTHER COMMUNITIES

- How can other communities benefit from the experience gained earlier by an established community health programme?
- Who is responsible for the development of a community health programme in other communities?
- Who can find time to work with other communities, given the limited resources available?

Purpose

To motivate leaders in other communities to adopt a community health programme.

Action

Exposure of key people from other communities to the original programme.

Information needed for successful action

1. Media for promoting contact with other communities could include:

   i. Observation visits to original programme.
   ii. Contact between leaders of a community *which has not yet begun a programme with* experienced leaders of the community health programme.
   iii. Government channels, eg. introduction of programme at meeting of formal community.
   iv. Mass media.
   v. Audio-visual aids, eg. filmstrip describing community health programmes.
   vi. Public meetings, eg. seminars, workshops.
   vii. Printed brochures, manuals and other materials.

2. Early interest and motivation can be reinforced by the following:

   - government instruction which provides backing for the programme. To avoid negative effects of instruction from above, the community should be prepared to receive it;
   - provision of more detailed oral and written information, eg. full description of how to implement programme.

Important factors

1. This step may be carried out only when the initial programme is firmly established, i.e. when:

   - the community feels they are profiting from the programme,
   - community leaders and members are able to relate their experiences, and
   - intensive supervision is no longer required.

2. It is preferable that communities take the initiative in beginning the process of developing a programme in their area.

L. PROMOTION AND TRAINING IN NEW AREA, FOLLOWED BY REPEAT OF WHOLE PROCESS

- How can limited resources best be used to equip others to develop a satisfactory programme?
- How can the initiators of a new programme learn from the successes and failures?

→ A NEWLY DEVELOPING PROGRAMME CAN BENEFIT FROM THE EXPERIENCE GAINED THROUGH AN EXISTING PROGRAMME.

Purpose

1. To establish the programme in the new area on a firm foundation.
2. To provide a basic understanding of the philosophy and broad content of the programme.
3. To share information on setting up the programme in a new area.
4. To encourage the development of a flexible, dynamic programme related to local conditions and needs in the new area.

Action

1. Community leaders and/or health workers in new area commence promotion with the government and approaches to the community.
2. Training of key people from new area, *including community leaders and health* workers.

Information needed for successful action

1. On identity of key formal and informal leaders.
2. Appropriate training methods and content.

   Trainers should be people with experience in existing programme, including health workers, *community leaders, volunteer health promoters.* The curriculum and organisation of the training should be determined by trainers and trainees together, based on needs of trainees.
   Training material should include basic philosophy and broad outline of programme only, as it is important that the details of the programme should be determined by the local community, according to local conditions.

Important factors

1. It is important to be aware of the disadvantages which could arise from using a programme as a training field, and attempt to forestall them. Possible disadvantages could be: oversaturation of the field; jealousy from other areas which are not used for training; or development of excessive pride and self-satisfaction resulting in an inability to receive any new ideas from outside.
2. The training is followed by social preparation, field preparation and all the subsequent steps outlined above.
3. Continuous contact between those involved in the existing programme with those developing the new programme is valuable to both parties.

CMC News

NEWS ON STAFF CHANGES AT THE CMC

In August of 1977, **Ms Angela Horton,** for long our Editorial Assistant for Publications, left the CMC to take up another post within the World Council of Churches. We are grateful for her years of dedicated work with us, a feeling which we are sure many of our readers share because of her many contacts with them. We are delighted that she remains a colleague here and wish her well in her new post. We are fortunate in that we secured someone very soon to take up her responsibilities in Publications. **Ms Miriam Reidy** (of Australia) joined our staff in September and has quickly become a valuable and contributing member of our staff.

We have also accepted with regret the resignation of **Dr Ursula Liebrich** who left in December 1977 to take up a position as lecturer in Social Medicine at the University of Basel in Switzerland. We have valued her many contributions to our work and wish her much success in this fine position. Efforts are now beginning to seek her replacement.

A LETTER FROM ZAÏRE

The nursing school of the Evangelical Medical Centre at Nyankunde, Zaïre, sent in the following report by one of its students, Citizen Kyusa Kambale, which has been translated from the French.

An important element in Citizen Kyusa Kambale's training as a student nurse at the Evangelical Medical Centre was time spent within the MCH programme of the hospital. This part of his training took place mostly in rural health posts and the villages served by the programme.

I found it strange at first to visit villages simply in order to weigh children and keep the official health records but, as time went by, I was able to make a thorough study of the work and its aims. My thoughts and impressions are as follows :

Counting the amount of petrol used for travel to the villages, the cost of buying motor-scooters, vaccinations and medicine, of paying the nurses' salaries, it seems on the surface that what it all adds up to is a waste of money, time and material. However, the reverse is actually true. I would not hesitate to state that the MCH Service is the most important of all the Nyankunde Hospital's services. Prevention of illness saves suffering, poverty, destitution and even death. For a developing country like our own, there can be no more vital service. If preventive medicine is neglected, problems increase and multiply. To give an example : one morning, during the paediatric clinic, I saw two small children who were very anaemic, with less than 5 g of haemoglobin each in their blood. The doctor immediately ordered that they be given blood transfusions. Their blood groups had to be determined and donors found. Where ? Where to locate the necessary transfusion bottles ? Thanks to our well-equipped centre, all was found. Then came another problem : finding an accessible vein in a small anaemic child. Should one try the forearm, foot, head ? And all this suffering and laborious work was the result of a lack of preventive medicine !

My biggest lesson was the realization that I was responsible both for sick **and well** *persons. Having learned this, I joyously set to work, knowing that I was actually contributing to the health of the community. Weighing children each month and recording their weight curves, advising each mother on the health of her child, providing health education (with much persistence), medicines and vaccinations, may seem simple actions. And yet, they are extremely useful to those who benefit directly from them, to the entire community, the whole country and, ultimately, to the world.*

I am proud to have had the opportunity to exchange opinions on child health with the mothers from the area around Nyankunde. I talked to several mothers whose children were suffering from malnutrition. They did not know, or even suspect, that their children ran the risk of being the victims of kwashiorkor. Often, their ideas about this illness were erroneous. And, right near our famous medical centre, I discovered other children who were suffering from kwashiorkor. The family of one such child lives right near the Hayom Chapel, and another case was found in a village by the Songolo road. The latter child had never been brought to either the weighing clinic or the dispensary.

It is truly sad to see around us children suffering and even dying of kwashiorkor when mothers can be taught to avoid this. I am convinced that we are not able to carry out this exacting task unless we love our neighbour. We ought, above all else, to love our neighbour as ourselves, as Jesus told us to do (Mark 12:31).

MEETING OF THE EXECUTIVE COMMITTEE OF THE CHRISTIAN MEDICAL COMMISSION, GENEVA, 6, 7 FEBRUARY 1978

Just as this issue of CONTACT goes to the press, the CMC Executive Committee completed its first meeting of 1978. Under the Director, Ms Nita Barrow, and the Moderator of the Commission, Dr Sylvia Talbot, it undertook a review of the ten months of work since the meeting of the full Commission in Egham (see report of that meeting in CONTACT 39, June 1977). Of special interest was the summary prepared by our Secretary for Studies, Ms Jeanne Nemec, on the progress of the CMC study/enquiry into the activities of church and community groups in the areas of wholeness and healing, traditional medicine, and human values in bioethical issues. The response of individuals and groups around the world to our invitation to share in this study process has been extensive, and planning for the next steps was an important part of this meeting. An essential step in the process will be the encouragement of congregations to examine their own potential for healing and involvement. The progress of collaboration between churches, governments and international agencies in health promotion and primary health case was also discussed with an eye to plans for the coming year.

A detailed report on this meeting will appear in a subsequent issue of CONTACT.

CMC NOTES

New Film

The International Development Research Centre of Ottawa, Canada, has released a new film entitled **RURAL HEALTH WORKERS.** This 25-minute colour film (16 mm) examines six health programmes in different parts of the world where attempts are made to bridge the gap between sophisticated city hospitals and the small rural communities where health services are often non-existent. In examining these six examples, the film demonstrates that there is no one way to meet the health needs of rural peoples living in different situations. It further demonstrates the imagination and involvement of the rural people themselves in countries as diverse as Panama, Thailand, Canada, Bangladesh, Iran and Venezuela.

The film is available with English or French soundtrack.

Address all inquiries to:

Audiovisual Unit
IDRC, Box 8500
Ottawa, Canada K1G 3H9

New Publications

A handy book has just been released in East Africa to provide health workers with guidance in the area of health education. It is designed specifically for the issues they face in maternal and child health work and is filled with good and practical hints. **HELPING THE RURAL AFRICAN MOTHER TO CARE FOR HER CHILD - A Handbook of Health Education for Health Workers,** by C. Desjardins, MD, and S. Desjardins, is based on the experience of the health team of the St Mary's Hospital, Gulu, Uganda. It covers the general topics of child care (including breast feeding) and specific suggestions on care of the sick child. This small book of 133 pages is priced at 10 shillings (approximately US $ 1.30) and can be obtained from:

St. Paul Book Centre
PO Box 4392
KAMPALA, Uganda

Catholic Bookshop
PO Box 30249
NAIROBI, Kenya

Cathedral Bookshop
PO Box 2381
DAR ES SALAAM, Tanzania

Among the concerns that are often voiced by those involved in health care planning is one which can be summed up in the phrase: "Let's make the most of the lessons we have already learned; the wheel may not yet be perfect, but it **has** been invented." Dr Rufino L. Macagba, Jr, of the Health Care Systems of World Vision International, believes that the last two decades have not only provided many rational guidelines which can now be applied to the health planning process, but also that there are time-proven principles of management that can be brought to bear on the administration of health programmes. His book **HEALTH CARE GUIDELINES *for* use in developing countries** seeks to present a simplified course in management for key people leading health projects or community health teams. It encompasses many of the same concerns as the article presented in this issue of CONTACT, with a good deal more stress on the organizational and management aspects, in the effort to promote wider application of care with existing resources.
This paperback book is 111 pages and is priced at US$ 4.00 plus postage and 10% handling charges.

HEALTH CARE GUIDELINES can be obtained from:

MARC
919 West Huntington Drive
Monrovia, California 91016
USA

Evangelical
Missionary Alliance
19 Draycott Place
London SW3 2SJ
England

The division of International Health Programs of the American Public Health Association, in co-sponsorship with the World Federation of Public Health Associations, is publishing **SALUBRITAS,** a quarterly newsletter on low-cost health delivery systems in developing countries. The publication is aimed at establishing a two-way communication flow among health workers having common problems and similar goals and is published in English, Spanish and French.

The target audience includes health-related workers at the grass roots level and the decision makers who are responsible for establishing policies and priorities within their countries' health systems. The newsletter is also distributed to government agencies, training institutions and bilateral and multilateral organizations.

It is hoped that this publication will provide a useful tool for exchanging ideas and strengthening communications between colleagues in different parts of the world.

For further information, write to:

Sylvia C. McCracken, Editor
International Health Programs
American Public Health Association
1015 Eighteenth Street, NW
Washington, DC 20036
USA

Mention that you « read it in CONTACT »!

INDEX OF PAST ISSUES AVAILABLE ON REQUEST

No.	Date of Issue	
2	March 1971	Community Medicine – Dr W. H. Foege
4	July 1971	Dialogue on Moral Issues and Health Care – Dr J. H. Bryant/Canon D. Jenkins
13	February 1973	Rural Health: Vanga Hospital, Republic of Zaïre – Dr D. Fountain
14	April 1973	Traditional Beliefs, Health and Christianity – Dr D. McGregor
17	October 1973	Evaluation of Medical Missions: A Pilot Project – Sr Dr Maureen O'Keeffe Lusaka, Zambia; How Much of a Hospital's Work Could be Done by Paramedical Workers? – Dr H. Gideon
19	February 1974	The Chimaltenango Development Project, Guatemala – Dr C. Behrhorst
20	April 1974	Some Steps Through Which Hospitals May Become More Deeply Involved in Community Health Care – edited by Dr D. Morley
21	June 1974	Africanization in Mission Hospitals – Dr J. W. Bodenstein; A "Missionary" Doctor's Disquiet in Papua New Guinea – Dr P. Strang
25	February 1975	Primary Health Care and the Village Health Worker – CMC
28	August 1975	Is Primary Health Care the New Priority? Yes, but ... – Rev. Dr C. Elliott
29	October 1975	Towards a Broader Understanding of Support and Healing: The Church's Healing Ministry in Africa – Rev. K. Appiah-Kubi; The Experience of Healing in the Church in Africa – Rev. H.-J. Becken
31	February 1976	Community Health Care in Rural Java – Dr L. Hendrata
32	April 1976	Self-Reliance and Nutrition – Prof. S. Parmar/Mr J. McDowell/CMC
33	June 1976	Medical Goals at Home and Away – Dr T. Heller
34	August 1976	Rural Health Care in Bangladesh – Dr C. McCord
35	October 1976	Breast Feeding-a Myth or a Must? – Dr M. Crawford/Ms B. Hall/CMC; plus a brief note on Family-Retained Health Records in Botswana
36	December 1976	Health and Development in Zaïre – Konde Pambu Yemba/Dr D. Fountain
37	February 1977	The Day the Afar Called-Beginning a Health Plan for Nomads – Dr P. Yoder
38	April 1977	Finding the Community in Our Crowded Cities – Drs E. H. Paterson and R.C.P. Tang/Ms D. Garrison/Mr M Borrelli
39	June 1977	The Annual Meeting of the Christian Medical Commission
40	August 1977	Making the Community Diagnosis – Dr H. Gideon
41	October 1977	Rural Basic Health Services: The Lardin Gabas Way – edited by Dr E. Ram, Ms J. Stromberg and Dr D. Hilton
42	December 1977	Five Challenges to the Churches in Health Work – Dr J. H. Bryant