Good practice for people working with children

CHILDREN AT RISK GUIDELINES

TEARFUND
CHRISTIAN ACTION WITH THE WORLD'S POOR

Community Child Health

CHILDREN AT RISK GUIDELINES: VOLUME 2

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Preface

What are the principles of good practice in the area of Child Development and how can we implement them? This series sets out the basic principles of Tearfund's Child Development Policy, and then seeks to apply them in different contexts. Here in Volume 2 we look at community child health. We recommend that you use this framework in conjunction with the *Tearfund Child Development Study Pack* (for details of how to order the study pack and other volumes see page 75). The study emerges from comprehensive field research and dialogue and has been reviewed by a variety of experts and practitioners. The authors hope and pray that you will find it useful and practical, and that for all who are working with children it will help you in changing children's lives for the better.

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NOTE The terms **First** and **Third Worlds**, **developed** and **developing countries** have been used interchangeably throughout the text as commonly accepted terminology for industrialised and developing countries.

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1 Introduction

WHAT IS COMMUNITY CHILD HEALTH?

A mother brings her child for immunisation and growth monitoring. The health worker knows the family and is involved in their progress. She discusses with the mother the concerns she has about her children's health. She is aware of the misconceptions the mother has about immunisations and tries to address them. She is also aware of the importance of immunising the majority of children in the community so that an outbreak of disease can be avoided. She therefore keeps accurate records and these are sent to the District Health Office to evaluate the immunisation rate for the district. The district health officer is then able to tell her the areas of the community where she needs to focus her attention. She encourages community leaders who then, in turn, encourage families to bring children to the clinic. This is a good example of child-centred community healthcare where the needs of the child and family are as important as the needs of the community. The danger is that too much emphasis on the community can detract from care of individual children and their families and vice versa. A balance is needed.

Primary Health Care and child development

In developing countries, child health in the community has generally been considered as part of 'Primary Health Care'. In 1978, health planners from 134 member states of the United Nations met at Alma Ata in the Soviet Union. Their purpose was to draw up a health charter, aiming to bring basic health services within the reach of every community and individual. It was here that the famous phrase 'Health for All by the Year 2000' was adopted.[1]

In the late 1970s the emphasis was therefore on community-based solutions for preventive health needs rather than institutional hospital based care. Primary Health Care centres were to be run by 'community health workers' who would provide mainly preventive healthcare by enlisting the help of community leaders.

This broad and optimistic approach was replaced in the 1980s with more focused interventions, targeted at those considered to be the most vulnerable. UNICEF focused on **GOBI**: **G**rowth monitoring for malnutrition, **O**ral Rehydration Solution (ORS) for Diarrhoea, **B**reast feeding promotion and **I**mmunisation which was considered to be 'low cost, high impact'. The other objectives were **FFF**: **F**emale literacy, **F**amily planning or child spacing and **F**ood security. UNICEF's prime concern was child survival, though this has subsequently changed.

1 WHO (1978).

To many Christian organisations, this strategy was seen as undermining a more holistic approach. The last ten years have seen the development of community-directed healthcare where health promotion, prevention and effective, simple, early treatment are combined. Much more attention is now paid to the underlying social reasons for poor health and nutrition.

FACTS FOR LIFE

Facts for Life was first published in 1989 by UNICEF, UNESCO and the World Health Organisation (WHO). It contains ten sections, each setting out essential survival and development messages. It was based on the belief that action must be preceded by essential facts. In 1993 *Facts for Life* was revised into 11 sections:

- Timing Births
- Safe Motherhood
- Breast-feeding
- Child Growth
- Immunisation
- Diarrhoea
- Coughs and Colds
- Hygiene
- Malaria
- AIDS
- Child Development

By mid 1993, eight million copies of *Facts for Life* had been sold in 178 languages.

The Child to Child Trust have used *Facts for Life* to develop methods by which children can participate in spreading the message in the book *Children for Health* (see page 67).

WHAT ABOUT CHILDREN'S RIGHTS AND PSYCHO-SOCIAL NEEDS?

The UN Convention on the Rights of the Child (1989) emphasises a 'rights' rather than 'needs' based approach to child health. Article 24 states that children and young people under 18 years old have the right to 'the enjoyment of the highest attainable standard of health' and that there is a duty to ensure this right to each and every child 'without discrimination of any kind' (Article 2.1). As of June 1996 the Convention has been ratified by 187 countries giving it almost total support.

UN agencies and child development

In the 1990s, UNICEF gave equal weight to **child development**, the psycho-social health of the child and to **child protection**. UNICEF estimates that 20% of the world's children live in 'especially difficult circumstances' (CEDC). This includes children caught up in armed conflict, refugees, and the more fluid category of 'street children'. The danger of focusing on the 'difficult circumstances' of these children is that the potential that children, families and communities have for progress may be forgotten even before intervention. That is why Tearfund's Child Development Policy emphasises children's resilience as well as their vulnerability, their ability as well as their inability or disability. They are valued as partners in achieving change.

UN Convention on the Rights of the Child emphasises a 'rights' based approach to child health.

Children's survival needs must clearly take priority immediately following, for example, a disaster, or in the initial setting up of a refugee camp. Yet often situations

Children have lots of good ideas and opinions and their involvement can make programmes more successful.

change rapidly and children can soon participate in decisions that affect them. There is a danger that managers of CEDC programmes may assume that children are incapable of participation because they are too vulnerable. But this is usually not true. Indeed, children have lots of good ideas and opinions and their involvement can make programmes more successful.

The World Food Summit, organised by the Food and Agricultural Organisation (FAO), of the UN in Rome in 1996 refocused international attention on food insecurity and malnutrition. The plan of action called for the promotion of a supportive social and economic environment to achieve food security. It drew attention to the special contribution women can make in ensuring family and child nutrition, to the importance of breast-feeding and to giving priority to children, especially girls.

Health services and child development

In practice, the way that child health and development programmes have been implemented varies from area to area, but there is always a tension between a 'top down' and a 'bottom up' approach. Some countries and infrastructures or systems have pressure from 'above' to ensure that the 'bottom' do the tasks. While this may create a clear framework for action, it can quickly become a non-participatory approach. Tasks are allocated and the community itself has little say in programme design and implementation. There is also the danger that if the pressure from above (in a dictatorial State, for example) disappears, as it has in many post-communist countries, the system falls apart.

District medical officers who are trained as doctors and who are responsible for primary health programmes, are often more used to a disease orientated, top down model of management. Initiative from the community is rarely encouraged, and more often ignored. In the end it is those who hold the purse strings, namely those at the top – including the donors – who have the most influence.

KEEPING THE BALANCE BETWEEN THE NEED FOR COMMUNITY DEVELOPMENT AND CONCERN FOR INDIVIDUAL CHILDREN..

Children and their mothers (not usually fathers) are seen as the 'target', rather than active participants whose voices have something of value to contribute to the debate. 'Community-based' can mean little more than 'mothers or immediate carers being taught', rather than genuine dialogue. 'Recipients' are not encouraged to ask questions.

HOW CAN A PROGRAMME BE COMMUNITY-BASED AND CHILD-FOCUSED?

Tearfund's Child Development Policy puts the needs of a child in the context of the whole family which is, in turn, part of the whole community.

Some programmes, and particularly church-related initiatives, have challenged the 'top down' approach. Instead the emphasis is on a shared responsibility of community and professionals for the well-being of individuals, families and communities. Tearfund's Child Development Policy puts the needs of a child in the context of the whole family which is, in turn, part of the whole community. Children are active participants in assessing need, evaluating progress and speaking for themselves and their peers. Moreover, the Policy seeks to maintain a balance between pursuing development, not only in the social and economic aspects of the community, but also in terms of the psychological, physical and cognitive development of the child.

Child to Child

The 'Child to Child' Trust has helped develop a number of ways in which children themselves can be involved and impacted by community child health. One important development has been the involving of schools. Active teaching methods mean that children are effectively involved in lifelong learning both for their own health and that of their families and friends. A number of activity sheets are available that have been adapted to different cultures and languages (see page 72).

WHAT ABOUT THE SPIRITUAL ASPECTS OF HEALTH?

As Christians we believe that wholeness cannot come about unless there is spiritual transformation of individuals (and of communities) through responding to the gospel

Westernised medicine has largely ignored non-Western spiritual world-views and traditional approaches to illness and healing. In many cases this has led to a lack of confidence in Westernised medicine because it fails to deal with the whole body.

Biblical wholeness is about health and harmony between body, mind and spirit, between the individual, the community and the environment. God's intention for creation is expressed in the word 'Shalom' which indicates wholeness, fulfilment, harmony and peace characterising the earth and all its inhabitants.

As Christians we believe that wholeness cannot come about unless there is spiritual transformation of individuals (and of communities) through responding to the gospel. Christ said he had come that we might have life more abundantly (John 10:10). In

2 See Roland, S in Ram, E (1995).

some Christian programmes, community health workers are taught to give equal priority both to evangelism and spiritual health and to preventive medicine and addressing people's physical needs.[2]

Furthermore, we believe in God's healing power.

UNDERSTANDING HEALING

To fully understand healing on an individual level we need to appreciate the following:

- Miraculous natural healing that occurs in our bodies every day. The use of medicine is often to assist the body's healing process.
- Modern scientifically-based medicine and healthcare is only one of a number of ways that God enables healing to take place.
- The power of prayer in healing – physical, emotional and spiritual healing are intertwined. Children can pray as effectively, and in some cases more effectively, than adults.
- Full healing and wholeness will not occur until we get to heaven where there will be no pain or crying. This does not mean that we do not work towards what can be changed or healed today.
- While supernatural healing may be an indication of faith, lack of healing need not be an indication of lack of faith.

The church has a holistic responsibility to children and their families which includes spiritual and physical healing of individuals and communities. Health programmes need to network with the church and understand their responsibilities to tackle the wider issues and root causes of poor individual and community health.

'Western influenced, one dimensional spirituality has failed to address justice issues in resource distribution, human rights, peace and community. This has contributed to social oppression, civil war, community violence, racism and inadequate land reform programmes.' Allen, EA in Ram, E (1995).

WHAT DOES SCRIPTURE SAY ABOUT THE PRINCIPLES OF COMMUNITY CHILD HEALTH?

There is a biblical mandate to heal (Matthew 10:8, Luke 9:2 and 10:9). Jesus mentioned healing as one of the signs that God was at work (Luke 7:22). Jesus said that we should love God with all our heart and secondly, love our neighbour. When he was asked, 'Who is our neighbour?' he gave the story of the Good Samaritan (Luke 10:25-37), who provided healthcare to a stranger out of compassion. Jesus was concerned and had compassion for people's physical needs. He healed the crowds and fed them after they had been following him all day and were hungry (Matthew 14:13-21).

God is also concerned for justice (Psalm 72:1-4, 11-14) and there is encouragement to share with the poor (Lev 19:9-11, 13-15) in the Old Testament. Jesus himself introduced his ministry at a synagogue in Galilee by reading from Isaiah 61: 'The Spirit of the Lord is on me because he has anointed me to preach good news to the poor. He has sent me to proclaim freedom for the captives, and recovery of sight for the blind, to release the oppressed, to proclaim the year of the Lord's favour' (Luke 4:18-19). The essence of community health is that it attempts to make healthcare accessible to all, including the poorest. Children are inevitably the most vulnerable, so access for them is paramount.

True development listens to and works in partnership with people including children.

As Christians, the issue of equal access is key, because we recognise that each and every person is made in the image of God (Gen 1:26-7) and as such has inherent worth. Access to healthcare not only improves or maintains people's health but also their resilience and therefore their ability to participate in family and community life. True development listens to and works in partnership with people including children. This expression of belief in each person's inherent worth in itself empowers people and develops self-esteem. The church then provides a model of interdependence (Acts 2:42-47, 4:32-35), where the weaker members of the body, who are seen to be indispensable, are helped by those who are stronger (1 Cor 12:22).[3]

As Thomas Merton said, '*The whole idea of compassion is based on a keen awareness of the interdependence of all living beings that are all part of one another and all involved in one another.*'

Tearfund Community Health Development Guidelines

In 1998, Tearfund conducted an extensive community health research programme (Chowdury, M, 1998) on key factors for effective sustainable community health development programmes. This was developed through consultation, using questionnaires to partners and community health consultants as well as field visits with partners in rural and urban situations. The results have been used to develop *Community Health Development: study pack for community development workers* (Jaeger, MC, 1999). This document is complementary to it. Both documents inevitably have a different emphasis but the intention is that they can be used together.

3 Further discussion of the biblical basis of children's ministry is looked at in the study pack, Section 3: Biblical basis of the child development study pack.

This particular guideline focuses on community child health and not hospital-based healthcare. There are other *Children at Risk Guidelines* (CARG) which may be helpful including:

- *Children and Family Breakdown* in CARG 1
- *Children and Disability* in CARG 3
- Psycho-social health of *Children and Sexual Abuse and Exploitation* in CARG 4
- Psycho-social health of *Children in Conflict and War* in CARG 6.

These, together with the *Community Health Development Study Pack*, can be requested from Tearfund. See page 75.

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Framework for Good Practice

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2 *Framework for Good Practice*

These guidelines are based on Tearfund's Child Development Policy found in the Child Development Study Pack. However they include more specific points that are relevant to projects working in community child health.

PRINCIPLE 1 BUILDING RELATIONSHIPS

1.1 Priority is given to building relationships – with the child, family, community, organisation or institution and between agencies.

PRINCIPLE 2 PARENTAL RESPONSIBILITIES

2.1 Parental responsibilities towards children are encouraged, as is the development of a caring, child-friendly community.

- Involving parents in the process of developing programmes will help affirm their responsibility and will ensure that the health professional and/or organisation/institution does not assume responsibility inappropriately.

PRINCIPLE 3 WORKING AT DIFFERENT LEVELS

3.1 There is an awareness of what level the programme is addressing, whilst consideration is also given to other levels.

- Individual
- Peer
- Family
- Organisational/Institutional
- Community
- National
- Policy/Political
- Spiritual

PRINCIPLE 4 IDENTIFYING NEEDS AND PRIORITIES

4.1 Children's (and parents') needs are identified. This includes listening to and involving children and parents.

- To assess the health status of children under five years, appropriate technology including weight scales and height charts will be used for measurements. 'Road to Health' cards help parents plot their children's nutritional status under the guidance of health workers. Parents can see for themselves whether the child is within normal levels ('on the road') or needing nutritional supplements. An evaluation of the overall nutritional status of all the children in the community may also need to consider root causes such as endemic illness or underlying poor social conditions.
- Questionnaire surveys can be conducted in schools and communities. If the school uptake is poor, or there is a high absentee rate, then it is obviously more difficult to get a representative sample. In such situations, more creative ways of listening to children in the community are required, including the use of peer group discussion. Drawings and drama are enjoyed by all children, literate or not, and can be another means of gathering information. The International Institute for Environment and Development (IIED) have material on the use of Participatory Rural Appraisal with children and using drawing, drama and other creative methods of listening.
- Children can also help to identify those who are excluded from healthcare, such as non-schoolgoers.
- Children themselves can be questioned regarding symptoms such as fevers, coughs, respiratory problems and skin infections. Nurses can perform simple clinical examinations for childhood infections and can arrange tests for parasitic infection of the blood, urine or intestine.
- The value of the local survey is that it allows a presentation of the facts about issues, rather than what might be dismissed as simply an outsider's view.

4.2 Staff are experienced and trained in communicating with children and their families and helping facilitate children's participation.

- Techniques for listening to and involving children.
- Community surveys: rapid appraisal technique, focus groups, semi-structured interviews for key people.
- Basic health screening techniques.

4.3 There is awareness of the spiritual, physical, mental, emotional and social (including educational and vocational) aspects of the child's development.

Examples

- **Spiritual** A child in a refugee camp who is bereaved has spiritual needs in helping him or her make sense of life after death. They need to understand that even in devastating situations they are loved and can receive strength from God. Children can lose the will to live, but prayer for healing can speed the healing process.
- **Physical** A displaced child's physical needs for food, shelter, and healthcare are as important as security and staying with their families. It is not enough to fill children's stomachs. Adequately nutritious foods and sometimes nutritional supplements are crucial for child development.
- **Mental and intellectual** Illness can affect a child's capacity to learn. Parasitic diseases such as malaria and intestinal helminths can undermine nutrition and impair school performance. A child who is considered to be 'slow' at school may be so not because of 'laziness' but because of partial deafness, visual handicap, anaemia, absence of breakfast, repeated abuse by a relative or the recent death of a close friend. These all emphasise how important it is that health and education sectors work closely together.
- **Emotional** A malnutrition programme will initially focus on the nutritional status of the child but will quickly need to consider other needs too. Children whose emotional needs are ignored or who are separated from their mothers may not survive, even where the diet is adequate.
- **Social** Children experiencing violence at home may not only have bruises but also act violently themselves, for example, in bullying. The Rutter Score is a means of measuring children's antisocial behaviour. It is relatively easy for teachers to use but may need to be adapted to ensure that it is culturally appropriate (see *Children at Risk Guidelines 6: Children in Conflict and War.*)

Integrated versus non-integrated programmes

- Programmes that focus on one problem in isolation (eg oral rehydration programmes for diarrhoea) may not tackle the underlying problems such as water supply, latrines and hand-washing behaviour. Even if they do, they may not address the root causes of poverty. Integrated programmes addressing multiple needs within the context of the community, seek to do just that, building on each other to tackle the root causes.

PRINCIPLE 5 CHILDREN'S PARTICIPATION

5.1 Children's abilities and needs are taken into consideration.

- In assessing children's needs and abilities, the emphasis should be on the positive rather than the negative. Thus we should look at their abilities rather than their disabilities, their resilience to change and trauma, rather than simply their vulnerability. There should be no prejudice based on gender, age, parentage, ethnicity, social class or caste, religious background or type of disability.
- Staff who assume that children (or their parents) are stupid or ignorant may treat them as such. These deep-seated prejudices are hard to overcome but they must not be ignored. They prevent the development of the confidence and self-esteem, and so inhibit people's potential to change themselves or their circumstances.
- Prejudice against children who are ill is made more acute in some cultures because of the belief that disease and other misfortune are deserved. Intolerance tends to be the response. Poor families are sometimes looked down on with contempt and those most in need of help are left to suffer and/or die. Other examples of prejudice include negative attitudes towards teenage soldiers who have lost limbs through landmines, and children with HIV/AIDS. The Christian ethic of caring challenges such attitudes, but entrenched beliefs may take time to overcome.
- Sometimes children have less access to services than adults. For example, street children are at high risk of getting HIV/AIDS, but do not have access to a Sexually Transmitted Disease (STD) clinic. Misunderstandings and prejudice often exacerbate such situations. The church may be reluctant to be involved, in case they are seen as 'promoting promiscuity'. Again, it is important that needs are identified by and for children.

5.2 Adults collaborate with children, according to their age and ability, individually and collectively in the programme, in things that affect them.

- There will be evidence of adults listening to and collaborating with children individually and collectively in the programme so that they are involved in things that affect them. How much this takes place obviously depends on the age and ability of the children. Where they are too young or otherwise unable to make decisions, then parents or other carers will be involved in making decisions in the child's best interest.

EXAMPLES OF CHILD PARTICIPATION

- Child to Child programmes have been used in over 70 countries, where children (often through schools) spread basic health messages to their peers and siblings. Some children as young as ten years old have been taught to be community health 'assistants', with a basic understanding of common diseases, prevention and treatment, and have proved to be conscientious, effective health agents, providing there is support from parents and community. More recently their impact on parents is also being reviewed.
- Peer education has been used extensively in drug and sex education programmes as an effective method of getting the message over where adults' opinions are less valued. Increasing self-esteem and self-confidence is vital if children are to be able to make decisions in their own best interests in spite of peer pressure[4].
- School-based feeding programmes have improved the nutritional and intellectual status of children. Those which involve children in learning about nutrition, hygiene and cooking in the class as well as preparing school meals are likely to have the greatest impact.[5]
- In one example of peer support, child soldiers who have lost limbs have involved older participants in the programme in helping the younger ones through the stages of grief. They have also helped one another in the practical making of artificial limbs and in other vocational training programmes.
- In another example of mutual support, young HIV positive women in Thailand who have been rejected from their community have become carers of HIV positive babies and children who have also been rejected.

PRINCIPLE 6 CHILDREN IN CONTEXT

6.1 Children are considered in the social, political and historical context of their community.

- It is important that even in specific programmes, such as an immunisation programme, the context of the community is taken into consideration, whether it is a slum community, a rural village, a conflict, war or disaster area. Each will have its own challenges.
- The degree to which national and community leaders are willing or able to back the programme (or not) will need to be considered.
- On a macro level the political and economic will of a government will affect how much is spent on health compared, for example, to the arms and military budget (see *Children at Risk Guidelines 6: Children in Conflict and War*).

4 Miles (1999).

5 Tomkins (1998).

- International factors may also be involved. Structural adjustment programmes implemented in response to the debt crisis have led to less money being available for health programmes, and led to food crops being replaced by cash crops to help pay off national debt.[6]
- National and regional conflict may well affect the level of violence at community level, among families and in schools.
- There are increasing numbers of communities where the family has broken down because of promiscuity or because of the loss of men to war. Many women who are left to bring up children on their own will need to address the particular problems of single parenting. Children, too, may find themselves as heads of households with specific and urgent needs (see *Children at Risk Guidelines 1: Children and Family Breakdown*).

6.2 Parents, caregivers and families are involved and impacted.

- Parents are primarily responsible for the ongoing care of children so their participation is essential if changes in behaviour are to be sustainable.
- Ideally, the parents' and the children's community will be involved from the beginning, but where a programme is already in progress, efforts will be made to include them as soon as possible. This will ensure accountability, as well as making the most effective use of the people and material resources available in the child's best interest.

6.3 The child's community is involved and impacted.

- Westernised medicine has previously seen the 'patient' as separate from the community, but a community health approach involves the community.
- Even before a programme begins, a thorough survey of the community will be conducted, engaging with members of the community including District Health Officers, community leaders, other Non-Government Organisations (NGOs), parents and children themselves.
- If an NGO is entering a new area, the staff may like to begin with a rapid community appraisal. If they are already working in the area they may have existing contacts with key community members who can help them with conducting interview surveys, mapping and/or focus groups in the community. This will enable a good 'needs assessment' to be done.
- The collection of information will also take into account the resources available to deal with the results! It is important not to imply that something will happen or to create unrealistic expectations when the resources are not available.

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6 Westwood.

6.4 Links (networks) are developed with other local, national or international organisations, including those from other sectors.

- Networking and resource linking with others is an important way of making the most of resources and involving decision-makers co-operatively. Obvious groups to link with include the education sector, other NGOs and the state institutions responsible for health such as the Ministry of Health, or the Municipal/Provincial Department of Health.
- Networking with other churches working on child health issues may also be a supportive resource link.

EXAMPLES OF CULTURAL AND RELIGIOUS BELIEFS

- **Beliefs about children** Attitudes differ widely on the official and unofficial acceptability of abortion, contraception and infanticide, for example in many countries that are largely Catholic, contraception is frowned upon but still used by many women. In Moslem and Buddhist countries where the sanctity of life outlaws contraception, many women will turn to abortion even though it officially 'does not occur'.
- **Beliefs about breast-feeding** Views vary on when women should normally stop, whether water is interspersed with feeding, and which foods are considered to be acceptable or unacceptable for children. In south east Asia children are not given fish because it is thought that it may make them ill.
- **Positive and negative beliefs about child rearing and caring for children when ill** For example the practice of wrapping a child in blankets when he or she has a fever or withdrawing fluids in cases of diarrhoea may be dangerous.
- **Understanding the roles of parents and children** Mothers, for example, may have more influence on children than fathers.
- **Attitudes to physical (or sexual) violence towards the child** Views differ on what is an acceptable level of violence by adults, eg parents, neighbours and teachers or other children (bullying).
- **The traditional and modern initiation ceremonies for children** Practices such as early engagement or even marriage for girls in India, female genital mutilation in parts of Africa or a visit to a brothel for boys in Thailand need to be understood and addressed. Clearly they have implications for child health.
- **The specific local context also needs to be understood** Knowing the time and seasons when women (and children) work in the fields may help decide the time for a survey or clinic. Encouraging women to take the small babies to the fields and breast-feed them may prevent dehydration and dangerous bottle feeding.
- **Understanding of the economic value of children** The dowry system in Asia has an impact on the financial cost, and therefore 'value' of girls. Health programmes will need to facilitate discussion on family planning or child spacing to prevent girls being aborted or suffering infanticide. Also in many cultures children are valued for the money they bring to the family through work, though some forms of labour may be unsafe and/or cause ill health.

6.5 The cultural and religious context of the child, family and community is taken into consideration.

- It is essential to understand the underlying cultural beliefs about health and healing: for example, the Indian Ayuvedic medicine, traditional herbal medicines used in Africa or the Chinese 'ying- yang' concepts and medicines.[7]
- Some traditional healing techniques may be helpful or at least harmless, whilst others may be harmful. Careful discernment is needed to ensure that resources already available are not wasted.

PRINCIPLE 7 **ADVOCACY**

7.1 Lobbying and interceding with or on behalf of children and their families takes place at local, national or international levels.

- As healthcare provision is usually the responsibility of the State, the programme needs to interact with provincial or municipal and national health authorities, either working with them, or challenging them as necessary. Where the State does not have adequate resources, NGOs or the church may serve as a temporary stop gap, though not a permanent solution. They may also be involved in lobbying for change in government policy.
- Health programmes can sometimes be so focused that they become introspective. The most effective programmes are those that think in terms of preventive as well as curative care, that think inter-sectorally and that are concerned about the root causes of poverty and poor health.
- In a slum or rural community at risk of being bulldozed or under the control of an oppressive landlord, there might be involvement in land reform to address some of the root causes of poverty.

7.2 The programme staff are aware of the importance of the UN Convention on the Rights of the Child (UNRCRC) and other human rights issues and conventions.

- Health programmes are often not aware of the importance and use of the UN Convention on the Rights of the Child but it may be a helpful tool to use with governments who have signed it, when negotiating over the health budget.

7 These are simply described and discussed in Ram, E (1995).

UN CONVENTION ON THE RIGHTS OF THE CHILD

- Article 24 of the convention stresses the right of children to health services which prevent ill health and promote good health, and to facilities for the treatment of illness and rehabilitation. The aims are idealistic and the resources to meet them are slender.
- The UNCRC obliges health programmes to:
  - take steps to reduce infant mortality
  - provide healthcare for all children through Primary Health Care (PHC)
  - ensure that parents or carers have basic health promotion, information and appropriate support.
- Under the convention there is also a duty to develop appropriate facilities and services for protecting children and young people from illegal drug use (Article 33). There should also be resources for the support, care and rehabilitation of those who have suffered all forms of physical or mental violence (Articles 19 and 39).

Other associated rights include:

- Support for parents and carers of the child (Articles 5 and 18), contact between parents or carers and the child, and avoidance of separation of parents and child unless in the child's best interest (Article 9).
- Access to information: children have the right to information which takes account of their linguistic and communication needs (Article 17d).
- The right for children's views to be heard in accordance with their age and maturity (Article 12).
- The rights of disabled children: children with disabilities and learning difficulties have the right to services and facilities which help them to achieve the fullest possible social integration and individual development (Article 23).
- Education, play and leisure activities: children and young people including those in hospital or receiving long-term treatments have equal rights to education (Article 28 and 29) and play, recreational and cultural activities.

7.3 The barriers to advocacy are understood and addressed.

- One of the barriers to lobbying for community health rather than hospital-based care may be misunderstanding amongst health professionals and/or funders. There is a tendency to undervalue community health and its widely dispersed health centres available to the majority, in favour of what have been described as 'disease palaces', ie hospitals that are accessible only to a minority.
- Health professionals may prefer to work in more prestigious, better paid specialities and fear career stagnation. As a result, competent staff are sometimes hard to find.
- Doctors and pastors do not always acknowledge and respect one another's roles.

7.4 There is dialogue with parents and caregivers so that they can make informed decisions and represent their families.

- Where possible, parents (and other adults) will be involved in the planning and organisation of health programmes so that they are user-friendly. It may be appropriate in some circumstances for older siblings or grandparents to bring children to clinics so that parents can continue to work.

An example of advocacy at local level is the formation of a support group for families of children with a particular chronic illness or disability. Often families feel that it is only those who have a similar problem that really understand. They can provide mutual support, and promote advocacy around the issue. Groups of parents representing their children have managed to lobby for change in making information available to them so that they can make more informed decisions about healthcare, social services and education facilities.

7.5 There is dialogue with the children so that, depending on their age and ability, they can make informed decisions and represent themselves and their peers.

- Children can make decisions on issues that affect their lives: things that they feel strongly about and wish to advocate on.
- Children's participation in advocacy has sometimes been organised for them by adults but has not involved children themselves. Role plays and marches involving children will be much more authentic if instigated and run collaboratively with them. This is real participation instead of tokenism.

CHILDREN'S PARTICIPATION IN ADVOCACY

- Some groups of chronically sick children have, with the help of concerned adults, been involved in representing themselves and other children with similar problems.
- Children have had an impact on their parents' health by encouraging them to eat a better diet, to stop smoking and to be involved in sanitation programmes.
- On a broader level, children's concern for their environment has resulted in children's movements that have been important in pressurising government and communities to take issues such as pollution more seriously.
- The Child to Child programme has many examples of children speaking for their peers (see SECTION 5 for resource books and Child to Child contact details) such as ensuring that their younger peers or siblings are immunised.

7.6 There is awareness of the biblical basis of advocacy on behalf of children, and of the importance of prayer.

- The introduction gives some suggestions as to why healthcare is biblical, but further exploration of Scripture is needed to understand healing and wholeness. A more thorough look at the biblical basis of holistic healthcare is available in Eric Ram's *Transforming Health*. Transformation of society is as important as transformation of individuals. Kingdom lifestyles characterised by justice and equity are crucial for communities. Prayer is an important part of the Church's healing ministry for individuals and communities.

PRINCIPLE 8 CHILD-SENSITIVE INDICATORS

8.1 The impact of work on children and their families is measured both qualitatively and quantitatively.

- There should be a baseline community assessment before the project starts. Subsequent studies will be needed to make comparisons. It is important to be as objective as possible, recognising that those involved in the programme may be sensitive to potential criticism.
- Quantitative statistics, eg height and weight measurements, infant mortality, number of latrines built, provide a useful measure of outcomes and trends. These should be complemented by qualitative data that reveal changes in attitude, behaviour and quality of life.
- Where programmes are being monitored on an ongoing basis through accurate record keeping, the training of staff is essential to ensure that standards of accuracy are maintained.
- Health programmes are notorious for being institution-focused rather than client- or patient- focused. Annual reports and statistics compiled may reflect the amount of work done rather than the impact of that work on the community. For example, the percentage of children who completed courses of DPT immunisation during the year is much more useful than the total number of DPT immunisations given during the year. This becomes even more useful when it can be compared with the results of previous years. (Different tools for basic evaluation are listed on pages 243–244 of Lankester, 1992.)

8.2 Indicators show how the programme has an impact on the lives and environment of children (by age and gender) and their families.

- Due to lack of staff, child health programmes in developing countries often rely on the help of parents in the individual care of the child. However, parents have rarely been involved in evaluating their child's care with health staff either on an individual or organisational level.

- A key element in the evaluation of health services is reference to the 'quality' and 'user friendliness' of the service. It is important therefore to include the opinions of children themselves.
- The type of evaluation will depend on the size of the programme, the resources available and the reason for the evaluation. Information should only be obtained if it is going to be useful in changing the future of the programme and will ultimately benefit children.
- Surveys are often carried out after 3–5 years to evaluate the effectiveness of the programme. Targeted surveys will benefit the programme more than large reports full of interesting but useless information!
- Surveys may involve outside experts, but these experts will usually find it more difficult to understand the language, customs and the local situation. Evaluations are often better when conducted by local people because the culture is understood and so the right questions are asked. Overall it is better to agree at the beginning what indicators should be considered.

8.3 Parents, caregivers and children (according to age and ability) are involved in the evaluation of the child and the care given.

- Programmes must be child-sensitive, so that both parents and children have the opportunity to evaluate the care given.
- The relatively new practice of evaluation by the family could include interviews with those who have received care, and focus groups. Where possible, data will be broken down into age and gender of respondents, and interviews will be conducted in such a way that the respondent does not feel intimidated or feel that their future care might be jeopardised by their response.
- Research is needed on culturally sensitive ways of finding out users' views so that these can help improve services. Responsibility for poor services should not be placed solely on the health workers; management and health infrastructure may need to be improved.
- It is important to ensure that the poorest children in the community are benefitting from the programme.

8.4 The programme reflects on and uses the results of the impact assessments.

- Once results have been obtained they should be acted on and not filed! One way of acting on the results is to present them to key members of the community for discussion, with the purpose of drawing up points for action. Where possible children and their parents will also be partners in this process.

TEARFUND
CHRISTIAN ACTION WITH THE WORLD'S POOR

SECTION 3

Case Studies

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3 Case Studies

These case studies cover a wide range of types of programmes involved with children and sexual abuse and exploitation. Most of the studies were written by the programme staff and therefore come from a field perspective. This adds to the authenticity. While no single programme is likely to be 'ideal', each has examples of good practice from which we can learn. The 'questions to reflect' on at the end of each case study give an opportunity to think about your own programme in the light of what you have read.

Chetna Community Health and Development Programme: Malnutrition Programme, Duncan Hospital, Bihar, India (Emmanuel Hospital Association)
An example of working with children in a community-based rural health programme.

ASHA Toilet Block Programme in Ektar Vihar slum colony, Delhi, India
An example of an urban health programme that encourages youth participation.

Asociación San Lucas (St Luke's Association), Peru
A more traditional approach to using community health workers in rural areas.

Institut Panafrican de Santé Communautaire (IPASC), Democratic Republic of Congo
A comprehensive approach to participatory integrated community health in a poor and oppressed rural area.

Relief Programme, Tearfund Burundi, Disaster Response Team
A relief programme during a civil war, that seeks to change quickly from service delivery to participatory community-based work.

Eglise Trinité Internationale (Trinity International Church), Burundi
A strong urban church-based programme that reaches out to orphaned children and vulnerable families during a time of civil conflict.

BY DR MAWII MAWIZUALA, DIRECTOR, CHAMPAK AND CHETNA COMMUNITY HEALTH PROJECTS

Chetna Community Health and Development Programme

Malnutrition Programme, Duncan Hospital, Bihar, India (Emmanuel Hospital Association)

ORGANISATION

Emmanuel Hospital Association (EHA) is a major strategic co-ordinating agency in India, linking many hospitals, community health programmes and nurse training schools. Duncan Hospital's Chetna Community Health and Development Programme is a member of EHA. It was started in 1995, and aims to have a high degree of community participation in improving local healthcare.

CONTEXT

Sugali Block has been identified by Duncan Hospital as being one of the most backward areas of East Champaran District, in the economically poor State of Bihar. The population is mainly rural and the literacy rate is only 27%. The infant mortality rate is 110 in every 1000 babies (11%), with many infants dying from malnutrition and diarrhoea. Women's status is very low and infanticide is still practised due to the high cost of dowries. Government health services do not reach the poorest in the community.

DEMONSTRATING GOOD PRACTICE

The programme emphasises what the community already has in terms of food resources and how these can best be utilised.

The programme emphasises what the community already has in terms of food resources and how these can best be utilised. The nutrition programme ensures that the children, as well as the parents, like the food prepared for them. There is also dialogue with families on how they can cultivate their own kitchen garden. Participatory teaching methods are used for mothers in the home using locally available utensils and products to improve the nutritional status of the family including the child.

Horlicks is readily available but expensive. A cereal mix is therefore made by the programme that costs 2.5 rupees (about 5 US cents) to produce and is sold for 5 rupees (about 10 US cents) to mothers who are delighted with a product that is cheap, nutritious and tasty. This makes the programme financially sustainable. Furthermore, mothers learn to make up the cereal mix at home with visible results in

their malnourished children. A kitchen garden has also been grown at the back of the community health centre as a model and to raise some funds for the centre.

Necessary healthcare (such as de-worming, treating of Giardiasis, vitamin A and B complex supplementation and detection of other infections) is also given to all children.

A conscious effort has been necessary to ensure that girls as well as boys have access to the benefits of the nutrition programme.

In a situation such as India's, where girls can be selectively malnourished, the focus on the child is a particularly important aspect of the community approach. A conscious effort has been necessary to ensure that girls as well as boys have access to the benefits of the nutrition programme. There are also focused discussions amongst the women on family size, parenting and gender issues.

Nutrition cannot be taken in isolation. As children are more susceptible to malnutrition if they have measles or water-borne diseases, both an immunisation programme and provision of clean water are equally important.

The Chetna/Champak Community Health and Development Programmes have young people involved in the informal education literacy programmes and in a few apprenticeship schemes, for example in tailoring. This is a good example of a comprehensive approach to health and development: a health programme which meets the social, emotional and intellectual needs of young people as well as in the long run making them more employable, marriageable and educated so that they can support their own families and ensure the health of their future children.

The Chetna programme also has a non-formal education programme for children who for various reasons do not attend the local school. For example, the children put on an excellent play of the 'Good Samaritan' using local Indian dance, costumes and music. This is an illustration of including spiritual health in a community health programme – something which is often missing. Further participation might have occurred if the children were involved in actually writing and developing the play.

THE FUTURE

The programme will try to address some of the underlying causes of malnutrition.

The programme will try to address some of the underlying causes of malnutrition. This may include lobbying for land-rights against the landlords who force families to become land-less and/or make them work for an unreasonably small return. Chetna may be able to facilitate this, but it must be done carefully, with the decisions on how far and how quickly being taken by the community rather than the programme leaders, as this kind of confrontation frequently causes friction.

Questions to reflect on

- *How does Chetna consider the spiritual, physical, mental, emotional and social aspects of child development in their programme?* (PRINCIPLE 4.3)
- *Does your programme focus on one aspect of development and neglect others?*
- *How does Chetna ensure children's parents and families are involved and impacted?* (PRINCIPLE 6.2)
- *Does your programme seek to involve parents actively or is that seen as an optional extra?*
- *How does Chetna consider the cultural and religious context of the child, family and community?* (PRINCIPLE 6.5)
- *What are the cultural and religious beliefs regarding health in your area? How does this, and how should this, affect the way you work?*

BY DR KIRAN MARTIN, DIRECTOR OF ASHA

ASHA Toilet Block Programme

Ektar Vihar slum colony, Delhi, India

A description of the wider overall programme can be found in the Tearfund Case Study *Transforming the Slums by Relationships* by Simon Batchelor (1996) and in *Community Health Development: Study pack for community development workers* by Tine Jaeger, both available from Tearfund UK.

ORGANISATION

ASHA (Action for Securing Health for All) was started in 1988 by the Emmanuel Hospital Association. ASHA is a community outreach programme in the slums of Delhi. It started with one clinic in Sardar Patel slum colony (now called Ekta Vihar) of 4,000 people and rapidly grew to several services in a number of colonies. By 1991 it was covering a population of 150,000. It involves subsidised curative clinics with volunteer doctors and other health workers, including traditional birth attendants. It also involves mobilising the community through women's action groups.

CONTEXT

The slums in Ekta Vihar have been greatly improved by the community with ASHA's help. After much work ASHA was able to encourage the government to build well constructed houses. The deeds were given to the women to prevent men from selling the homes. Previously the houses were mud huts with makeshift roofs of plastic, straw or cardboard. There was inadequate clean water, few toilets, poor drainage and no refuse disposal. Most adults were unskilled labourers (80%) and literacy rates were low (men 25%, women 10%). Only one in five children went to school and many worked alongside their parents.

DEMONSTRATING GOOD PRACTICE

The youth of Ektar Vihar benefited as much as everyone else in the community from the integrated development project carried out by ASHA. A room was provided that became a youth centre for fun and games as well as a forum for debate and discussion about important issues.

The youth started an initiative that benefitted the health of the community, created employment and raised funds for their youth centre at the same time

The youth in Ektar Vihar started an initiative that benefitted the health of the community, created employment and raised funds for their youth centre at the same time. The youth leader approached ASHA with a proposal that ASHA renovate the toilet block which had fallen into disuse through poor maintenance. The youth group would provide the labour to keep it clean and collect the 50 paisa fee for each use. Part of the profit would go back to the community health centre and part would be used to pay for cleaning materials. The rest of the profits would be used to pay those collecting the money and to buy equipment for the youth group.

WE TRANSFORMED THIS INTO..... THIS

ASHA repaired part of the toilet block and had a six month trial period to see how the youth group would fare. At the end of the six months they were continuing to do a good job so ASHA repaired the whole block. Profit started to come in. In spite of several attempts by local businessmen to procure the toilet block, it is still in the hands of the youth group! This is an excellent example of participation with a reasonable financially sustainable solution.

The Youth Centre contains weights for body-building and posters showing men with body-building physiques! Clearly, this meets their perceived needs to build better looking bodies with the added benefit of increasing self-esteem. The negative side of this approach is that a huge muscular physique may be unrealistic and creating a culture of unattainable beauty needs to be avoided.

Peer education is an effective method of disseminating health information.

The community youth group has also enabled peer education on issues important to youth such as sexual behaviour and illegal drug taking. Peer education is an effective method of disseminating health information.

It needs to be emphasised that this programme is only a very small part of an overall integrated approach.

Questions to reflect on

- *How do adults in ASHA listen to and collaborate with children so that they can make appropriate decisions about things that affect them?* (PRINCIPLE 5.2)
- *How can you ensure that the children you work with are heard?*
- *How does ASHA dialogue with children so that, depending on their age and ability, they can make informed decisions and speak for themselves?* (PRINCIPLE 7.5)
- *How can you give the children that you work with the opportunity to speak out?*
- *What styles of leadership are there in this programme, and what can your programme learn from this?*

BY MARIE-CHRISTINE LUX, FORMER OP WORKER

Asociación San Lucas (St Luke's Association)

Moyobamba, Peru

ORGANISATION

Asociación San Lucas (St Luke's Association) is an organisation founded by a North American physician who saw the need to reach the poorest in developing countries by enabling national Christians to fulfil their initiative and vision.

Training was provided in curative medicine, and women from 45 communities became part of a team of community health workers.

ASL started in the late 1980s in Moyobamba (the north eastern part of Peru), rapidly gaining momentum due to an outbreak of cholera in the country at that time. Health staff from various sectors were recruited to mobilise and teach well over 500 women to take the appropriate measures (hygiene including safe water, installation of latrines, rehydration, etc) and reduce the risks of contamination. From there, further training was provided in curative medicine, and women from 45 communities became part of a team of community health workers (CHWs). Every three months they brought together mothers and children for consultation with the visiting doctor.

CONTEXT

Since the same preventable health problems repeated themselves, ASL decided to change the focus of the work. In 1994, the number of villages was reduced to 24 (allowing for better follow-up and deeper impact). The number of CHWs dropped – mostly due to the women's workload in general, though also because there was less interest in preventive work than curative – and the approach became more community-based.

The work covered a total population of approximately 12,000 (or 2,200 families) of whom 2,000 were children under the age of five and almost 3,000 were women of reproductive age.

DEMONSTRATING GOOD PRACTICE

A survey of the 24 villages was carried out by the CHWs which revealed a 33% malnutrition rate in children under five, and high rates of mortality and morbidity due to diarrhoea and respiratory infections.

The results were presented to the village people and local authorities. Alternative plans of action were discussed. As a result CHWs were trained to monitor children

on a monthly basis (weight and charting) with mothers' participation, and to distribute vitamin A and de-worming medication. Using local materials, CHWs were shown how to teach mothers about simple methods of nutrition for their children, particularly for the sick or those recovering from an illness. They were also shown how to teach women to grow vegetables for the family, with demonstrations on how to use new or different vegetables. The aim was both to improve the family diet and possibly provide a small source of income from any surplus.

CHWs were encouraged to teach in schools where possible and to treat simple ailments. The health of women was also included in the programme because it was clear that it influenced the health of their children particularly regarding teenage pregnancy, sexually transmitted diseases and premature births. The programme has become part of a more integrated approach including pastoral care, agriculture and income generating programmes.

Strengths

- The CHWs were selected from and by their own community, with preference given to women because of their close involvement with children and other women.

Close co-ordination with the local government health sectors avoids duplication of tasks.

- There was close co-ordination with the local government health (and other) sectors to avoid duplication of tasks. The CHWs were trained in their community to detect any deviation from the norm and refer serious cases to local hospitals
- The CHWs had a limited workload (30 children maximum each) and were required to follow these children up. They did regular home visits and taught mothers on basic health (including nutrition and hygiene) and in particular prevention, on a one-to-one basis. They also taught groups during the children's clinics.
- The CHWs themselves were followed up at frequent intervals by the supervisory team and affirmed, helped or corrected where needed.

THE COMMUNITY HEALTH WORKERS HAD A MAXIMUM OF 30 CHILDREN TO OVERSEE.

Weaknesses and drawbacks

- The CHWs were volunteers, yet the communities were reluctant to help either in kind or service towards their support.
- The village authorities were changing constantly and often unwilling to be involved in the programme or ignorant of it.
- ASL personnel changed frequently, breaking the continuity of the work.

THE FUTURE

The people on the whole need time to evolve from passive recipients of curative care to active participants in their own health. Much has yet to be done, in particular in involving children and encouraging adults to take the initiative. More work is also needed in the setting up and strengthening of health committees. However, many communities have learned, and several have mobilised their own people for major activities such as the installation of safe water supplies and latrines. CHWs are keeping monthly records of the health situation in their villages and have already observed a marked drop in mortality and even morbidity due to diarrhoea and respiratory infections and noted a decrease in the incidence of malnutrition from 33% to 17%. ASL continues to strive for the improvement of the economic situation of the poorest families.

Questions to reflect on

- *How does St Luke's involve children and parents in identifying needs?* (PRINCIPLE 4.1)
- *How could your programme involve children more effectively in identifying needs?*
- *How does St Luke's measure the impact of their programme on children and families both qualitatively and quantitatively?* (PRINCIPLE 8.1)
- *How could your programme measure more effectively the impact of what you are doing both qualitatively and quantitatively?*
- *How valuable do you think the community found the work of the CHWs and how could their impact and acceptance be increased?*
- *What sort of inputs from the community would help and how could this be stimulated?*

BY DR PATRICIA J NICKSON, DIRECTOR, IPASC AND LECTURER, LIVERPOOL SCHOOL OF TROPICAL MEDICINE

Institut Panafrican de Santé Communautaire (IPASC)

Democratic Republic of Congo

ORGANISATION

The Institut Panafrican de Santé Communautaire (IPASC), situated in the north east of the Democratic Republic of the Congo (DRC), aims to improve the quality of healthcare provided by church-related programmes in French-speaking Africa. It favours a community-determined approach, whereby the community sets their priority needs, and decides strategies by which these can be met and how and when they will be evaluated. Health professionals are involved as facilitators. The Institute, which benefits from the academic support of the Liverpool School of Tropical Medicine, and is recognised by the Congolese government, is involved in training (a four year diploma course and a three year degree course) giving technical support to other programmes, research and consultancies.

CONTEXT

Communities have been severely disturbed by political instability during the past 18 years. Rapid inflation and currency devaluation have left many families destitute. The arrival of over a million Rwandan refugees in 1994 and the 1996 war brought new hardships and death to the vulnerable, while unpredictable and erratic climate changes robbed the land of several harvests. Communities rallied in anticipation of improvements with the new Kabila government in 1997, but only 15 months later they again lost hope as they watched almost a dozen African countries fighting against one another in their country, pushing them again from destitution into hopelessness.

Early childhood malnutrition means, at best, potential educational handicaps, and at worst, death.

What effects does this history have on children? Early childhood malnutrition means, at best, potential educational handicaps, and at worst, death. Government collapse has led to the unavailability of drugs and immunisations, while schools remain closed because teachers are not being paid. Civil disorder means that a peaceful, supportive, stimulating home environment has to be strived for and parents supported in their vision and provision for their children.

DEMONSTRATING GOOD PRACTICE

Marabo is a village of some 5,000 people situated three kilometres from the Christian Medical Centre of Nyankunde. Marabo has never had much contact with health activities, except for some primary healthcare and a small and inadequate health post. Often the people of Marabo were described as 'difficult'.

In July 1997, following the war and a long dry season, community members facilitated by IPASC did a health survey of their village. To their surprise they found that 53% of their children between one and five years old were malnourished and only 23% were fully immunised. IPASC staff and students visited the village several times a week, just to associate themselves with the community and listen to their problems. The community was puzzled by the attention they were receiving, since they had felt abandoned for many years.

Within ten days, they formed a committee so that they could organise themselves and consider their problems logically. The immediate need was that of the malnourished children. The committee asked for work so that the women could buy food and give a communal meal for weak children. A few weeks later, with the communal meal already having changed many of the pathetic children into cheerful toddlers, the community asked for spades for digging in return for work. The IPASC agriculturist went out with the students to give advice on what could be grown effectively and economically. Soon gardens started to sprout soya and other nutritious foods.

The next need the community expressed was that of a protected water source. A student spent several weeks with the community, working with them to clear trees and vegetation from a spring, and to put in a pipe and a cement apron to protect the spring. IPASC was able to purchase the cement, but the community provided all the work, and fed and lodged the student. Interestingly, Marabo's protected water source meant that it was one of the only villages in the area spared from a recent vicious cholera epidemic.

Despite the present insecurities, the community continues with its work – no longer despondent and with little mal-nutrition and few un-immunised children.

Only when malnutrition, agricultural and water problems had been solved, did the community turn its attention to the need for improved healthcare. The old hut which previously served as a health post, had almost fallen down. IPASC purchased a few essential drugs, and sent a fourth year student, named John, to work with the community. John's caring, listening attitude quickly won a warm response. The committee planned a new health centre. A community member immediately gave 8,000 bricks towards this, while others dug up large stones and rocks for the foundations. Despite the present insecurities, the community continues with its work – no longer despondent and with little malnutrition and few un-immunised children.

THE FUTURE

IPASC's approach of facilitating communities has won recognition from national and local government. The various training courses have full accreditation, and State diplomas and degrees are awarded. A new IPASC initiative will soon begin in Côte d'Ivoire in collaboration with the Medical Assistance Programme's West African Office. Most of IPASC's six year history has been lived through wars, refugee crises, massive epidemics, chronic instability and increasing poverty of communities. Yet we have learned how seemingly desperate situations, such as Marabo, can be improved by patient listening and facilitation in problem resolution.

Questions to reflect on

- *How does IPASC involve and impact the children's community?* (PRINCIPLE 6.3)
- *How could your organisation involve and impact the community more effectively?*
- *What networking is IPASC involved in with other local, national and international organisations, including those of other sectors?* (PRINCIPLE 6.4)
- *How could your organisation network more effectively and with whom?*
- *It was tempting for IPASC to offer to raise some funds for the child feeding programme. What are the advantages and disadvantages of IPASC taking a proactive role?*

BY CLAIRE BRITTON,
OP WORKER

Relief Programme, Tearfund Burundi

Disaster Response Team

ORGANISATION

Tearfund's Disaster Response Team (DRT), is involved in responding to emergencies or disasters in the world; providing assistance and reducing the incidence of death and suffering in the people affected. (For further details, see the DRT leaflet available from Tearfund UK.)

CONTEXT

Burundi has experienced ethnic conflict since 1993, resulting in periodic episodes of insecurity, population displacement, collapse and slow rehabilitation of infrastructure, and as a result of these, a change in the overall structure of communities. The most recent coup has resulted in an improvement in the social stability of the country.

DRT runs a post-emergency phase programme in Kayanza Province, where the continued episodes of insecurity result in temporary displacement of communities, destruction of housing, fields and schools, increased problems with food security, further disruption of education, looting of healthcare facilities, separation of families, and wounding or mortality of a small percentage of the population. Alongside these episodes is the continual movement of rebel forces across the province which results in looting from the local population and physical abuse of women.

PROGRAMME SUMMARY

There are three main parts to the first phase of the programme:

- **Construction** Rehabilitating primary schools in the province.
- **Water and sanitation** Providing latrines and some hand washing facilities at schools and other public places within the area, and repairing some of the community water supplies.
- **Public health education** (PHE) To meet the needs of the community and to ensure correct usage and maintenance of new facilities, and reduction in the incidence of communicable diseases.

Phase 2 hopes to include a food security programme, to help reduce the incidence of chronic malnutrition in the area.

Each site attempts to include children in the voluntary work, so that they have some 'ownership' of the programmes.

As the construction, water and sanitation programmes have direct benefits to children, each site attempts to include them in the voluntary work, so that the children have some 'ownership' of the programmes. This is seen as an important basis for the PHE programme, and any future child-to-child education which will occur.

The main consideration in any of the PHE work, is to leave in place a community which is empowered and able to continue rebuilding itself, independent of any organisation. To this end, the programme focuses mainly on:

- workshops with women community leaders
- child-to-child education in primary schools, creating hygiene committees and establishing peer 'buddy' schemes
- training of teachers in 'child-to-child' education
- training of trainers (agriculturists, water engineers, community workers, staff employed either by government or NGOs) specifically in the areas of hygiene, nutrition, and child-to-child education
- some education of non-school-attending children in the camps.

DEMONSTRATING GOOD PRACTICE

NGOs provide services in the areas of both health and nutrition, so expectations were not raised within the target groups.

Before any planning or formation of a programme for the PHE occurred, an initial assessment and then more detailed research was carried out in the province. This involved discussions with government employees, administration, healthcare workers, other NGOs and also accessing available reports and statistics. The detailed research involved a quantitative and qualitative questionnaire, which was answered in groups by 100 women and approximately 1,000 school children. This enabled the participants to be involved from the start, and to designate topics for further workshops. The research focused mainly on the areas of health and nutrition, and the understanding of both. Other NGOs provide services in the areas of both health and nutrition, so expectations were not raised within the target groups.

All staff involved in the programme have qualifications in primary school education and enjoy working closely with children. Training with staff takes place both informally and formally, in order to improve their understanding of the importance of child-to-child education.

By focusing on groups of women community leaders, PHE is able to encourage those who are in a position to help within the communities. It also tries to ensure community participation and involvement by disseminating information, and

through needs-based workshops. The women determine the theme of the workshops. Each session aims to look at how the theme relates to children – for example nutrition, and the preparation of weaning foods. It is hoped that by looking at these everyday issues and creating a 'safe' area, women will discuss the problems and trauma left by episodes of insecurity, and start to explore how they can adapt to their new communities.

Child-to-child education in the schools (and training other staff) aims to help children see that they are important and valued members of today's society. Children have positive reinforcement in the areas of hygiene, health and nutrition, and are encouraged to explore how they can make a difference in their communities. It is hoped that after the initial education is finished, there will be continuing links with the committees and groups. Towards the close of the programme or school year, it is hoped the above will participate in the collecting of new research, to evaluate the effectiveness of the programme. However, the real areas of stability, self-worth, and dealing with past trauma will be difficult to convey in statistics.

One of the PHE programmes is training animators in the therapeutic feeding centres. These sessions are usually held with groups of unaccompanied children. By listening to the children and helping them to explore their own ideas, PHE aims to show them how valuable they are. In one such session, exploring likes and dislikes of food, it was discovered the children really did not like the diet of the feeding centre. PHE approached the manager of the centre on their behalf and as a result there was a change to the menu.

Questions to reflect on

- *What are some of the ways the programme involved children and parents in identifying needs?* (PRINCIPLE 4.1)
- *How could these methods be useful in your own programme?*
- *How does understanding the social, political and historical context of their community affect the way that the programme developed?* (PRINCIPLE 6.1)
- *How does the social, political and historical context affect your programme and the way that you develop it?*
- *What are some of the key elements in helping a community to develop a vision and implement a corporate programme of activities during times of civil disorder?*

BY LEA PETERS,
CO-ORDINATOR

Eglise Trinité Internationale (Trinity International Church)

Burundi

ORGANISATION

Although it is a relatively young church, ETI's vision is to reach out to the city's community through cells.

ETI in Bujumbura, Burundi began in 1992. Although it is a relatively young church, ETI's vision is to reach out to the city's community through cells. A cell is made up of about 10–15 adults. At the end of 1998, ETI had 150 adult cells, located throughout the city, and had instituted children's cells, each children's cell having an adult cell to sponsor it. Evangelism, new convert follow-up, care of the displaced and feeding of hungry children all take place within the cell network.

ETI has reached out to the poor practically, since the onset of Burundi's crisis in October 1993. ETI, a young, small church, began to feed the children in the displaced camps located near to the church. At first this was done through church women volunteers. As the need increased, people gave to the programme from various churches. In a few years the programme mushroomed into a programme touching 1,200–1,500 children daily.

CONTEXT

Burundi has been in a state of civil war since October 1993. In spite of the long conflict, no solution seems to be within sight for Burundi. The differences that exist between the conflicting groups seem to run so deep that, at the time of writing, only a miracle can save Burundi from all-out war. War seems imminent. The regime that is now in power took over in a bloodless coup in July 1996. Since that time, an economic embargo has been in place over Burundi by the surrounding African countries. The UN has tried to encourage these nations to lift the embargo – with no success so far.

The embargo has made life unbearable for the poor (which is most of Burundi) while the rich become richer through exploitation of the black market. Food, medical care and schooling are practically non-existent for the poor. Childhood vaccinations, which are technically free, are in very short supply. Measles, diphtheria, whooping cough, tetanus, to give just a few examples, are rampant among the poor community (although all are preventable with proper vaccinations). Since the embargo was put into place, malnutrition has nearly doubled in Bujumbura alone. Amongst the poor, it is estimated that at least half the children are malnourished.

DEMONSTRATING GOOD PRACTICE

Cells are small groups of family units that gather together for a time of fellowship. Cells are most effective when they remain small. If a widowed mother, for example, is unable to cope with caring for many children in her home, the cell will help her by providing food. Mothers and other family members in the area benefitting from the outreach are then called on to help in the cooking effort, providing practical and emotional support. None of the cells are paid to feed. There are only five paid employees for the distribution part of the feeding programme.

Sometimes it is necessary to offer a written diet for parents of malnourished children to follow – many parents become so despondent that they seem to give up and watch their children die. In these cases we step in and oversee the parents as they feed the children through cell members' support, visiting them and checking on the situation.

Without the help of the cell members and families of the children, we cannot help them.

Often people who come for help are so touched by the love of God in the outreach that they give their lives to the Lord Jesus and the cells grow very rapidly as a result. If a child is hospitalised, the cell comes together to help the mother out with the rest of the children's care as she goes to the hospital to care for the sick child. Without the help of the cell members and families of the children, we cannot help them. They provide the labour required to feed and care for the kids and we do our best to supply, first of all, food and utensils needed for cooking; then other supplies (medical, clothes, schooling) as they are requested and as we have them available.

The young people and youth of our church have their own cells located throughout the city. Many of the youth have spearheaded outreaches to the poor and orphaned in their estates – they have the liberty to organise their outreaches. They are all very different and reflect the personality of the leaders of the cells. Some of the youth, for example, have organised football matches in the estates with the poorer youths and in this way build friendships and relationships among them and invite them to cell meetings. The youth work more on an individual basis and, with the counsel and help of their leaders, have been able to bring many youths to Christ and help the poor with clothing, food, and education, all in the name of Jesus.

Youth cells are similar in structure to the adult cells but work towards meeting the special needs that are present among the youth in Burundi. Some of their problems can be very complicated with the war having affected nearly every family in Burundi. When such problems arise, adults are there to discuss solutions with youth leaders.

The children's cells are still in the early stages of development, and work together in co-operation with the sponsoring adult cells. The children's cell is included in all adult activities (special gatherings, celebrations) and during these times will take an active part.

During feeding outreaches, the children in the cell, who are receiving food themselves, will notify the adults of other needy children and families in the area – children in Burundi form a society in their own right. They often provide some direction for the adults to follow in these situations.

THE FUTURE

Whatever the leadership has vision to accomplish can be accomplished through the cells.

To describe the future in just a few words would be very difficult. Briefly, the sky is the limit. Whatever the leadership has vision to accomplish can be accomplished through the cells. What is exciting about this means of working is that it releases the responsibility from the shoulders of just a few to the shoulders of the many. Just as the cells have taken on the feeding, they can take on any and all other outreach that they choose to initiate. How this all takes place will be exciting to see, but we know that it will come to pass. What we must do, no matter how big or successful the feeding outreach becomes, is to ensure that the physical needs of man never overshadow their spiritual needs. We can offer a plate of food to a starving person, but if it is not accompanied by the love of God and the Gospel, what are we really accomplishing except prolonging the inevitable?

Questions to reflect on

- *How does ETI involve and impact the children's community?* (PRINCIPLE 6.3)
- *How can your programme more effectively involve and make an impact on the children in your community ?*
- *Is there dialogue with children to help them make informed decisions and speak for themselves and their peers?* (PRINCIPLE 7.6)
- *Do children in your programme have an opportunity to make informed decisions and represent themselves and their peers? How could they do so?*
- *How can a climate of hope be established within a community which has been battered by civil disorder?*
- *How can you strike a balance between personal salvation and the transformation of society?*

SECTION 4

The Reflective Question Tool

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4 *The Reflective Question Tool*

This Reflective Question Tool can be used by any programme working with community child health programmes. The tool is designed to enable individuals and groups to evaluate their own programme by reflecting on how they might apply the principles of good practice.

PRINCIPLE 1 BUILDING RELATIONSHIPS

- How is priority given to building relationships – with the child, family, community, organisation or institution and between organisations?

PRINCIPLE 2 PARENTAL RESPONSIBILITIES

- How does the programme encourage the development of parental responsibilities towards children and a caring, child-friendly community?
- Do the health professionals and/or organisation take appropriate responsibility or are they paternalistic in approach?

PRINCIPLE 3 WORKING AT DIFFERENT LEVELS

- At what level(s) does the programme work and how does it consider other levels?
  - Individual
  - Peer
  - Family
  - Organisational/Institutional
  - Community
  - National
  - Policy/Political
  - Spiritual

PRINCIPLE 4 IDENTIFYING NEEDS AND PRIORITIES

- How are children's (and parents') needs identified? How have children and parents been listened to and involved?
  - Has there been a thorough survey of the needs of the community, including District Health Officers, community leaders, other NGOs, parents and children themselves?
  - How is appropriate technology used in measurements? (For example, 'Road to Health' cards can help parents measure their children's nutritional status under the guidance of health workers.)
  - How are children themselves involved? (For example, identifying symptoms such as fevers, coughs, respiratory problems and skin infections.)
  - How could surveys and focus groups be used in schools as well as communities?
  - Does the survey take into consideration the resources available to deal with the results? Are questions avoided that could raise unrealistic expectations?
- What experience and training do staff have in communicating with children and their families and facilitating children's participation?
  - Does community health as well as institution-based health worker training include participation techniques? Are surveys an integral part of the training?
- How does the programme try to meet the spiritual, social (including educational and vocational), emotional, mental and physical aspects of the child's development?
  - Does the programme focus on one aspect in isolation? (For example, oral rehydration programmes for diarrhoea may omit to look at the underlying problems such as water supply, latrines and handwashing.)
  - Does the programme try to address the root causes of, for example, poverty? Does it consider multiple issues and integrate with non-health programmes, such as income generation projects?

PRINCIPLE 5 CHILDREN'S PARTICIPATION

- How does the programme take into account children's and parents' abilities? Is due regard given to their abilities, and not just to their inabilities or disabilities? Is their resilience considered, as well as their vulnerability to trauma and change?
  - Does the programme assume that children (or their parents) are stupid or ignorant? Are there any prejudices based on gender, parentage, age, ethnicity, caste, social class, religious background or disability? How are they being addressed?
  - In what ways is prejudice against children who are chronically ill or disabled exacerbated by cultural beliefs? Are poor families looked down on with contempt? Are those most in need of help left to suffer and/or die? How is the Christian ethic of caring being used to challenge this?
  - Do children have poor access to services compared to adults? Do misunderstandings or prejudice play a part in this?
  - Are the services provided 'child friendly' or 'adolescent friendly'?
- How do adults listen to and collaborate with children individually and collectively in the project? In what ways are they involved in decision-making regarding things that affect them?
  - Is the 'Child to Child' method of child participation used? Is peer education used as an effective method of getting the message over, where adults' opinions are less valued?
  - What evidence exists of adults listening to and collaborating with children?
  - In what ways are parents or other carers involved in making decisions where children are too young or otherwise unable to make their own decisions?
  - To what extent do parents and caregivers have a say in planning activities? Are clinics organised at times convenient to them, for example? Are children consulted?

PRINCIPLE 6 CHILDREN IN CONTEXT

- To what extent is the child considered in the social,political and historical context of their community?
  - How does being in a slum community, a rural village, a conflict, war or disaster situation affect the programme?
  - To what extent are the community and its leaders prepared to back the programme?

- How are the parents, caregivers and families of the children involved and impacted?
  - Have the parents' and the children's community been involved from the beginning?
  - Where a programme has already started, what efforts have been made to include children as soon as possible?
- How is the child's community involved and positively impacted?
  - Are the community mobilised? Do they 'own' the programme?
- In what ways are links developed (networking) with other local, national and international organisations, including organisations from other sectors?
  - Where health service provision is the responsibility of the State, does the programme interact with the provincial, municipal and national health authorities, either working with them, or challenging them, where necessary? Where the State has not got adequate resources, do the programme leaders see their role as a temporary stop gap or a permanent solution?
  - What kind of networking, resource linking and collaboration exists with other local sectors especially the education sector, other NGOs and State institutions responsible for health (such as the Ministry of Health, Municipal or Provincial Department of Health)?
- How is the cultural and religious context of the child, family and community taken into consideration?
  - What understanding is there of traditional healing methods? Are they considered helpful or harmful?

PRINCIPLE 7 **ADVOCACY**

- In what ways does the programme lobby with or on behalf of children and their families at local, national or international level?
  - What networks is the programme able to tap into and use?
- Are the programme staff aware of the importance of the UN Convention on the Rights of the Child and other human rights issues and conventions?

- What are the barriers to advocacy work? How can these be overcome?
  - Is there a professional 'blind-spot' to the need for policy and practical change at a local and national level? If so, how can this be addressed?
- Is there dialogue with parents and caregivers so that they can make informed decisions and represent their families?
  - To what extent are parents considered to be part of the health team?
- Is there dialogue with children so that, based on their age and ability, they can make informed decisions and represent themselves and their peers?
  - What opportunity is there for children to speak out, using their own initiative?
- Are the staff aware of the biblical basis of their ministry and the importance of prayer?
  - How is prayer, including healing prayer, an integral part of the programme?

PRINCIPLE 8 CHILD-SENSITIVE INDICATORS

- How does the programme measure the impact of its work on children and their families? Do the indicators measure both qualitative and quantitative impact?
  - Is there a baseline study and regular comparisons?
- Do indicators show how the programme has an impact on the lives and environment of children and their families? Is data broken down into age and gender groups?
- How are the parents, caregivers and children (according to age and ability) involved in the evaluation of the child and the care given?
  - Are the results of the indicators presented to the children, the parents and the community leaders? How might they participate in improving future results?
- How does the programme reflect on and use the results of evaluation?

SECTION 5

References and Resources

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5 References and Resources

WHAT TO READ

Key texts

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Bailey, D, Hawes, H and Bonati, G (1992) *Child to Child: a resource book*
Part 1: *Implementing the Child to Child Approach*
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The Child to Child Trust. ISBN 0 946 182 06X (available from TALC)

Jaeger, MC (1999) *Community Health Development: study pack for community development workers* (published and available from Programme Development Team, Tearfund, UK)

Lankester, T (1992) *Setting up Community Health Programmes,* Macmillan Press Ltd, London, in co-operation with Tearfund. ISBN 0 333 57423 0 (available from TALC)

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- Several leading healthcare professionals from around the world share their insights on the practices of health and healing today.

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Feuerstein, M-T (1986) *Partners in Evaluation: evaluating development and community programmes with participants*, Macmillan. ISBN 0 333 42261 9 (available from TALC)

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- '…the reality of human suffering is the thing to which biblical faith clings most insistently …as Christians are obligated to ask how, according to the gospel of Christ, human suffering is met, addressed, engaged, redeemed.' Written from a Christian theological position, the book is concerned with how God redeems suffering.

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- 'Why does a good and all powerful God allow us to experience pain and suffering? Drawing heavily on stories of ill and dying children to illustrate and clarify his discussion of theological issues, Hauerwas explores why we seek explanations for suffering and evil so desperately…' (book cover).

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- A collection of studies with the emphasis as much on social justice and community participation as on technical or medical intervention.

Hope, A and Timmel, S (1994) *Training for Transformation: a handbook for community workers,* I, II and III revised edition.
ISBN 0 86922 2562 (I) 2554 (II) 2619 (III) Mambo Press, PO Box 779, Gweru, Zimbabwe. Tel: +263 54 4016/7, Fax: +263 54 51991.

- Packed with illustrations for developing a community participatory approach.

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- Classic text on all aspects of nutrition and programmes.

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E-mail: zedbooks@zedbooks.demon.co.uk. (available from Zed Books, code 352 0)

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- Shows how to design, implement and evaluate the integration of public health into urban management.

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- Highly practical in community rural health, with many illustrations.

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- Describes training of village health workers.

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Useful newsletters/ journals

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Child Health Dialogue, a forum for exchange of information about prevention and treatment of key childhood diseases, as well as providing practical advice on related health education. *Child Health Dialogue* has replaced *ARI News* and *Dialogue on Diarrhoea*. English (international), English (India), English (Pakistan), Chinese, French, Gujarati, Hindi, Portuguese, Spanish, Tamil, and Urdu. ISSN 0950 0235 (available from Healthlink Worldwide)

Contact, CMC Churches Action for Health of the WCC (World Council of Churches). Published in English, French, Spanish, Portuguese. Selected issues in Kiswahili: c/o Mrs Darlena Davis, E-mail: ccd.cmai@gems.vsnl.net.in (for the attention of Darlena Davis)

Food and Nutrition Bulletin, International Nutrition Foundation Inc. Charles Street Station, PO Box 500, Boston, MA 0214-0500, USA. Tel: +1 617 227 8747, Fax: +1 617 227 9405, E-mail: unucpo@zork.tiac.net

Footsteps magazine, practical quarterly paper linking health and development workers worldwide. Produced and available from Tearfund, 100 Church Road, Teddington, Middlesex, TW11 8QE. Tel: +44 (0)208 977 9144, Fax: +44 (0)208 943 3594, E-mail: enquiry@tearfund.org, Website: www.tearfund.org

Health Action, a forum for exchange of experiences in implementing programmes in primary healthcare and related fields. English (Int'l) ISSN 0969 479X (available from Healthlink Worldwide)

Health Policy and Planning, London School of Tropical Medicine and Hygiene with Oxford University Press, Great Clarendon Street, Oxford, OX2 6DP, UK. Tel: +44 (0)1865 267907, Fax: +44 (0)1865 267485, E-mail: jnl.orders@oup.co.uk, Website: http://www.oup.co.uk/heapol

Health Promotion International, Oxford University Press, Great Clarendon Street, Oxford, OX2 6DP, UK. Tel: +44 (0)1865 267907 Fax: +44 (0)1865 267485, E-mail: jnl.orders@oup.co.uk, Website: http://www.oup.co.uk/heapro/?f8

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Journal of Tropical Paediatrics, Oxford University Press, Great Clarendon Press, Oxford, OX2 6DP, UK. Tel: +44 (0)1865 267907, Fax: +44 (0)1865 267485, E-mail: jnl.orders@oup.co.uk, Website: http://www.oup.co.uk/tropj

Reaching Children at Risk, for Christians in front line childcare. Produced and available from Viva Network

SCN Nutrition News (Subcommittee on Nutrition) (available four times per year from SCN at WHO Genève)

- Developments in nutrition with special focus on policy and planning.

Tropical Medicine and International Health, London School of Hygiene and Tropical Medicine, Keppel Street, London, WC1E 7HT. Tel: +44 (0)207 927 2272, Fax: +44 (0)207 436 4230, E-mail: Ahall@lshtm.ac.uk, Website: http://www.blackwell-science.com/products/journals/tmih.htm

Wholeness (previously *Healing and Wholeness Magazine*), Broadway House, The Broadway, Crowborough, East Sussex, TN6 1HQ, UK. Tel: +44 (0)1892 652364

- Looks at Christian approach to healing.

World Health Forum, an international journal of health development, World Health Organisation. ISSN 0251 2432 (available from WHO)

WHO TO CONTACT

African Medical and Research Foundation (AMREF), Wilson Airport, PO Box 30125, Nairobi, Kenya. Tel: +254 2 501 301/2/3/ 609520, Fax: +254 2 506112/ 602531

- Undertakes health related materials production and distribution as well as training and research, mostly in East Africa.

Arab Resource Collective (ARC), PO Box 7380, Nicosia, Cyprus

- Produces, publishes and distributes Arabic language books and teaching aids for use in community health and development programmes in the Arab world. ARC resources are also available from distributors in Bahrain, Egypt, Jordan, Lebanon, Syria, West Bank and Yemen – details from ARC.

Afri-CAN, the African Community Action Network for Health

- *Initiatives*, quarterly in English (soon to be in French) aims to bring attention to individual and collective initiatives that will help to build a continental community health strategy. Dr Dan Kaseje, Afri-CAN, PO Box 73860, Nairobi, Kenya. Tel: 254 2 711416 or 729095, Fax: 254 2 711918

Burrswood Christian Centre for Healthcare and Ministry, Groombridge, Tunbridge Wells, Kent, TN3 9PY, UK. Tel: +44 (0)1892 863637, Fax: +44 (0)1892 862597, E-mail: admin@burrswood.org.uk, Website: www.burrswood.org.uk

- A Christian centre for medical and spiritual care. People find healing through medical expertise, counselling and prayer.

Centre for Health Education, Training and Nutrition Awareness (CHETNA), Lilavatiben Lalbhais Bungalow, Civil Camp Road, Shahibaug, Ahmedabad 380 004, Gujarat, India. Tel: +91 272 866513/866695, Fax: +91 272 420242

Centre for International Child Health, Institute of Child Health, University College London, 30 Guilford Street, London, WC1N 1EH, UK. Tel: +44 (0)171 242 9789, 24hr Answerphone: +44 (0)207 404 1096, Fax: +44 (0)207 474 2062, E-mail: cich@ich.ucl.ac.uk, Website: http://cich.ich.ucl.ac.uk

- Encourages and conducts research, runs courses and has a resource centre.

Child to Child Trust, Institute of Education, 20 Bedford Way, London, WC1N OAL, UK. Tel: +44 (0)20 7612 6650, Fax: +44 (0)20 7612 6645.

Also sister organisation in Paris, **L'Enfant pour Enfant, Institut Santé et Developpement**, and in other countries including:
Child to Child Project, c/o Community Based Nutrition Project, 9th Floor, Electricity House, Harambee Avenue, PO Box 30276, Nairobi, Kenya.
Tel/Fax: +253 2 248602, E-mail: child-to-child@africaonline.co.ke

- Exists to encourage and enable children and young people to play an active and responsible role in the health and development of themselves, other children and their families.

Christian Medical Association of India (CMAI), Plot No 2, A-3 Shopping Centre, Janakpuri, New Delhi, 110 058, India. Tel: +91 11 5552046/5599992, Fax: +91 11 5598150, E-mail: cmai@cmai.univ.ernet.in

- Official health agency of the Protestant church in India. Publishes *Child Health Dialogue* in English for India.

Harvard School of Public Health, 677 Huntingdon Avenue, SPH1 1210 Boston, MA 02115, USA. Tel: +1 617 432 4515, Fax: +1 617 432 1323, E-mail: nmajid@sph.hrvard.edu

Healthlink Worldwide (formerly AHRTAG), Farringdon Point, 29–35 Farringdon Road, London, EC1M 3JB, UK. Tel: +44 (0)171 242 0606, Fax: +44 (0)171 242 0041, E-mail: info@healthlink.org.uk, Website: http://www.healthlink.org.uk

- Information on extensive resources through the internet or by visiting centre. Also books, some of which are free to organisations in developing countries.

HealthWrights, 964 Hamilton Avenue, Palo Alto, CA 94301, USA. Tel: +1 650 327 9368, Website: http://www.healthwrights.org

Institute of Child Health, University of London (see Centre for International Child Health)

Institute of Education, University of London, 20 Bedford Way, London, W1H OAL, UK. Tel: +44 (0)207 612 6621, Fax: +44 (0)207 831 6902, E-mail: courses@ich.ucl.ac.uk

- Research and training in health promotion in developing countries.

International Institute for Environment and Development (IIED), 3 Endsleigh Street, London, WC1H ODD, UK. Tel: +44 (0)20 7388 2117, Fax: +44 (0)20 7388 2826, E-mail: iiedagri@gn.apc.org

International Society for the Prevention of Child Abuse and Neglect (ISPCAN), 200 North Michigan Ave, Suite 500, Chicago IL 60601, USA.
Tel: +1 312 578 1401, Fax: +1 312 578 1405, E-mail: ispcan@aol.com,
Website: http://ispcan.org

International Training in Health (INTRAH), University of North Carolina, 208 North Columbia Street, Chapel Hill, NC 27514, USA.

L'Enfant pour Enfant, Institut Santé et Développment, 15 Rue de l'Ecole de Médecine, 75270 Paris – Cedex 06, France

- Produces materials in French to promote the child to child approach, assists in French-speaking countries and acts as a resource centre.

Liverpool School of Tropical Medicine, International Health Division, Pembroke Place, L3 5QA, UK. Tel: +44 (0)151 708 9393, Fax: +44 (0)151 708 8733,
Website: http://www.liv.ac.uk/lstm/lstm/html

- Research and training in community health.

London School of Hygiene and Tropical Medicine, Keppel (Gower) Street, London, WC1 7HT, UK. Tel: +44 (0)207 299 4646, Fax: +44 (0)207 323 0638,
E-mail: library@lshtm.ac.uk, Website: http:/www.lshtm.ac.uk

MARC Publications, 800 West Chestnut Ave, Monrovia, CA 91016-3198, USA.
Fax: +1 626/301 7786, E-mail: MARCpubs@wvi.org
Website: www.marcpublications.com

Oxfam Publishing, 274 Banbury Road, Oxford, OX2 7DZ, UK.
Tel: +44 (0)1865 313922, Fax: +44 (0)1865 313925, E-mail: publish@oxfam.org.uk

Resource Centre for Primary Health Care (RECPHEC), PO Box 117, Bagbazar, Kathmandu, Nepal. Tel: +977 1 225675, Fax: +977 1 225675,
E-mail: recphec@npl.healthnet.org

Royal Society of Paediatrics and Child Health, 50 Hallam Street, London, W1N 6DE, Tel: +44 (0)207 307 5600, Fax: +44 (0)207 307 5601,
E-mail: enquiries@rcph.ac.uk, Website: www.repch.ac.uk

Royal Society of Tropical Medicine and International Health, Manson House, 26 Portland Place, London, W1N 4EY, UK. Tel: +44 (0)207 580 2127,
Fax: +44 (0)207 436 1389, E-mail: mail@rstmh.org, Website: http://www.rstmh.org

Swiss Tropical Institute (STI), Socinstrasse 57, 4002 Basel, Switzerland.
Tel: +41 61 2848111, Fax: +41 61 2717951, E-mail: adsti@atge.automail.com

Tearfund, 100 Church Road, Teddington, Middlesex, TW11 8QE, UK.
Tel: +44 (0)20 8977 9144, Fax: +44 (0)20 8943 3594,
E-mail: enquiry@tearfund.org, Website: www.tearfund.org

Teaching Aids at Low Cost (TALC), PO Box 49, St Albans, Herts, AL1 4AX, UK.
Tel: +44 (0)1727 853869, Fax: +44 (0)1727 846852, E-mail: talcuk@btinternet.com

- Distributes low cost books (see above), slides and other teaching aids and equipment all over the world by mail order. Most titles in English – some other languages also available.

UNHCR, C.P. 2500, 1211 Genève 2, Switzerland. Tel: +41 22 739 8111,
Website: http://www.unhcr.ch/

UNICEF, 3 United Nations Plaza, New York, NY 10017, USA.
Tel: +1 212 326 7333, Fax: +1 212 326 7294, Website: www.unicef.org/,
Convention on the Rights of the Child at www.unicef.org/crc/

Viva Network, PO Box 633, Oxford, OX2 OXZ, UK. Tel: +44 (0)1865 450800,
Fax: +44 (0)1865 203567, E-mail: info@viva.org, Website: www.viva.org

- Networking organisation for Christian organisations working with children at risk.

Voluntary Health Association of India (VHAI), Tong Swasthya Bavan, 40 Institutional Area, South of IIT, New Delhi 110 016, India

- Publishes and distributes books, slides and films in Hindi and English and provides training and information to grass roots organisations working in health and community development. State voluntary health associations publish and distribute materials in Indian regional languages; details from VHAI.

World Health Organisation, 20 Avenue Appia, Genève 27, CH 1211, Switzerland.
Tel: +41 22 791 21 11, Fax: +41 22 791 07 46, Publications Fax: +41 22 791 48 57,
E-mail: publications@who.ch, Website: http://www.who.ch

World Vision International, 121 East Huntington Drive, Monrovia, California 91016-34400, USA. Website: http://www.wvi.org

- World Vision's magazine *Together* is designed for development workers.

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The Children at Risk Team,
Tearfund, 100 Church Road, Teddington,
Middlesex, TW11 8QE, United Kingdom
Tel: +44 (0)20 8943 7757, Fax: +44 (0)20 8943 3594
E-mail: roots@tearfund.org

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If you have suggestions as to information that you feel should have been included/omitted and/or on how the pack could be improved, including regionally appropriate resources, please send these to the address given above.