DOCUMENTATION
SEDOS

2/1970 Rome, January 23rd, 1970.

To the Superiors General
To the Delegates for SEDOS
To the Members of the SEDOS groups

The meeting of the CATECHIST GROUP will be held at PROPAGANDA FIDE and NOT at the SEDOS Secretariat: Monday, 26-01-70, at 4.00 pm.

Enclosed please find all the documents connected with the last meeting of missionary sending institutes connected with health care.

This week's documents may not be of direct interest to the member Institutes which are not involved in medical work. But I thought it useful to keep all of them informed, through such an issue of the bulletin, of the thinking going on in the different ramifications of our common missionary endeavour.

I was struck, for example, by the convergence of the Medical Group with the conclusions of both the Education and the Catechist Groups: current work - whether medical, educational or catechetical - seeks to insert itself firmly in the context of the local communities.

Those directly interested in medical work will notice that the main document (transcribed from tape by the fmm-sisters) is given with the bulletin. Sr. Annemaria deVreede scmm-m has summarized it in two pages in order to help those who may not find time to read it through.

Please, note the following dates:
28-01-70, 4.00 pm, SEDOS Secretariat: MAINLAND CHINA
02-02-70, 4.00 pm, SEDOS Secretariat: EDUCATION IN THE MISSIONS

Sincerely yours,

Benjamin Tonna, Executive Secretary.

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SEDOS 70/35

REPORT OF THE PLENARY MEETING OF THE MEDICAL GROUP

On November 27, 1969, a plenary meeting of the Medical Group of Religious Institutes engaged in Health Care in developing countries, was held at the Generalate of the Ursuline Sisters, from 4 till 8 p.m.
43 sisters attended the meeting, representing 20 institutes.

Sr. Jane Gates SCMM-M chaired the meeting. After welcoming the participants, she introduced Dr. J.H. Hellberg as the guestspeaker. Dr. Hellberg from Finland, belongs to the Lutheran Church and is now Assistant Director of the Christian Medical Commission in Geneva. He worked for several years as a mission doctor in Africa and was engaged at the German Institute for Medical Mission Work in Tübingen, prior to his work in Geneva.

Dr. Hellberg gave a very thought-provoking talk on "Practical ways and means of moving our missionary efforts in the direction of community oriented health care".

Dr. Hellberg pointed out, that our hospital oriented medical care has been very one-sided: we gave very good care to very few people. Today we also want to look at the other side: how to improve the health of all people? This means asking ourselves: what can be done better and cheaper outside of the expensive hospital?
It is necessary, first of all, to look at the needs: why do people get ill? Or rather: what are the factors that keep people well? This is a concept of health, and not just a concept of curing disease.

When we have found the needs, we have to start with the deeds: what should we do about these needs? In order to do something, we will have to look at our use of staff and at the cost-factors. Very important is, to have the trained staff do the work that they are trained for to do: a doctor should not be doing what a nurse can do, a nurse should not be doing what a health visitor should do, etc.

Running expenses of hospitals increase by the day. Therefore, a patient should not be admitted when not really necessary. But if there is no place near his home to even get an injection, what to do? Does he really need an injection? Our whole concept of the need for admission might have to change. We should not take anything for granted without asking ourselves: do we really answer the patient's needs?

Dr. Hellberg had several practical suggestions in this regard, besides raising other questions, too.

He ended by saying: "Take people seriously where they are geographically and economically. Out-patient care is cheaper than in-patient care, prevention is cheaper than cure, small units are cheaper than big ones. Take people seriously where they are in their beliefs and traditions. Take them seriously where they are education-wise: promoting health and fullness of life is more worthwhile than just 'medical repair'. If someone thinks this is difficult, yes, but who said it was going to be easy 'to make all things new and to bring life and life abundantly'? The full text of Dr. Hellberg's talk is attached.

Animated discussions then followed in three English speaking and one French speaking group on the questions raised by Dr. Hellberg. A summary of the discussions is attached to this report.

Supper was had together, and after-wards the reports of the discussions were given to the entire group.

It was stressed that communication, information, and study of the subject is very important for the members of the Generalates, so that they are informed of existing trends, and that they can help and encourage the sisters in the field to implement them.

It was agreed by all those present that these meetings were very helpful, and that they should be continued. It was decided to have the next meeting, if possible, in March 1970. After this, the plenary meeting adjourned.

Sr. Annemaria de Vreede SCMM-M

SUMMARY OF THE REPORTS OF THE FOUR DISCUSSION GROUPS

1. What do your missionary Sisters know of the traditional ideas on health care of the people for whom they work? How does the answer to this question affect treatment and health education?

It was acknowledged, in general, that the Sisters working as foreigners in a hospital situation, worked without sufficient knowledge of the people's traditional beliefs and ways of thinking. The local people have faith in their own healers. Therefore we should try to get to know their methods. But this demands a good knowledge of the language, work in the villages, employing local people: teachers, auxiliaries, our national sisters, social workers. One should try to enter into the attitudes of the people and respect them and develop the good that is there. We should go to the people, and not wait till they come to us.
Often the sisters wanted to get to know more about the people, but were overburdened with work in the hospital.
This all has often resulted in western-style treatment and very little people-oriented health education.

All groups said, that for any change to take place in the approach to health care, we must

- study the language, culture, beliefs of the people and try to understand the aspirations of the developing nations
- work in teams in the villages, using mobile clinics and methods relevant to the people to "sell" our product, using slides, pictures etc.
- have an active spirit of collaboration with the governments, continually evaluate our efforts, so that we are sure that there is no gap between what we think the people's needs are and what they actually are.
- be convinced that those on the spot are best able to judge and evaluate, and they should be encouraged to do so

One group stressed the need for an orientation period before the sisters begin their actual work, to provide proper understanding of the people and the culture, and of the aims to be achieved.

2. In "in-patient" situations, how can your Sisters act to mobilize both patient and his/her family for health education purposes?

All groups said, that the relatives are a "goldmine" in this respect. We should allow them to stay with the patients and they should be encouraged to learn about the care of the patients: proper preparation of food, personal hygiene, so that they may apply these technics at home. Other means mentioned were:

- it has to be recognized that preventive care is a progressive system: "each one teach one"
- in some countries health education is given to high school girls in a community oriented program, so that the girls can then teach the village people
- it is considered important that all missionaries are involved in this new type of health care: the nursing sisters should cooperate with those involved in education
- the nurses in hospitals are often overburdened, especially in the larger hospitals so that there is no time for health education
- may be a sister could be freed to contact the patients and their relatives, with the specific purpose of health education
- the missionaries should be the trainers of local teams who are to do the health education
- people are often afraid of hospitals, therefore it is very important that they are approached in the right way
- we must apply to principle of pertinency: if we are trying to get the concept of good nutrition across, we may have to start with information on how to plant good gardens.

For all this it is very important that our young sisters are trained from the very beginning in the awareness of the new approach to health care, and that they are given the opportunity to get prepared for this work and the encouragement to carry it out!

3. In "out-patient" situations, what
   a) structures and
   b) functions
   must be changed in order to launch a community oriented health program?

In general the remark was made, that it is very difficult to effect any change in existing situations, and sometimes only very trying circumstances (as the rebellion in the Congo) have forced us to accept the changes. When in Congo some sisters returned to their post after some time, they found that the Congolese had managed as well as they could, and that only a community centered program could serve the people in the remote areas.

Other answers to this question were:

- We have to recognize that there are three types of out-patient service, each having its own values: the out-patient department of a hospital, the out-patient station and the mobile clinic. They should complement and not duplicate each other. Where as the mobile clinic enables us to reach otherwise inaccessible places, the other two give that sense of permanency and stability tosocieties which may have a great need for this, so that the individual is assured of being respected in terms of an always available unit.
  In each situation we must be realistic and recognize that a mobile unit is not a hospital and use appropriate methods.
- Sometimes mobile clinics seem more feasible: it is then important to train the village women who can look after the sick between visits of the health team.
- We must aim to have social centres combined with the health centres, and cooperate with other movements for betterment of living conditions.
- We must stimulate those teachers, who put health education on their programs.
- We must use as much as we can local personnel, mass media, and to get to know as much as possible about the people.

4. How do your Sisters encourage the development of local, indigenous medical staff? How do you envisage the process of the indigenization of the staffs of your health institutions?

- by having training schools for nurses, midwives, auxiliaries, nurse-aids
- make sure of agreements with governments about the future of the school
- train counterparts in all areas, so that the work can continue when the day comes that the non-nationals would have to depart
- we must encourage local people to take responsibility, as we have been lacking in this respect
- begin with youth, training them in the hospital, giving them a minimum of theory and maximum of practical exercises

Two other remarks were made:

- when we train auxiliaries and nurse-aids, we have to be careful that we supervise them in an encouraging way, and that we do not give them too much responsibility
- when we train highly qualified personnel, we have to make sure that they can be employed in the country, and to make them aware of the needs of their country, encourage them to find for themselves a position that is of real service to their country

Only one group had time to answer questions 5 and 6 (partly). Here are the answers:

5. Where should the best people be deployed:
   a) in the hospitals, OR
   b) in the health centres (dispensaries)?
   How do your Sisters feel about this point?

- We can't give an absolute answer here, one has to see this in a concrete situation. But it is probably a mistake to deploy the more specialized sisters only in the hospitals. We must always consider whether the sister is willing to take the responsibility for the work.
- Often sisters prefer to work in health centres, as the possibility for health education is more real there.
- There is a need for planning, for the study of the needs of the country involved.

6. What more can be done in order to ensure closer cooperation with
   a) the local hierarchy?
   b) the missionary institutes for Men?
   c) other christian churches?
   d) Government?
   e) other institutions (including funding agencies)?

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a. Some sisters did not understand the question, as more often than not sisters are only responding to appeals of the hierarchy for medical service. It is the hierarchy who takes up the initiative and ensures official authorisation of the work.

SUMMARY OF DISCUSSION (answered by all groups)

What can be done about the conclusions of the discussion group:
a) at the Generalate level?
b) in the context of concerted action among the missionary sending Institutes?

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a. Regarding the Generalate level it was thought that:
- The reports of this meeting should be shared with all the sisters, and not just with those involved in medical work; all should be interested.

- From the top a great interest in the work of the sisters should be shown, and they should be encouraged to create new ideas and help the common effort.

- Sisters should be encouraged to work with secular staff, to hand over their work in some cases, in order to do pioneering work elsewhere.

- The deployments of and the future of our institutional commitments should be studied, with information from the countries concerned as a point of departure

- It must be recognized that the new concepts may demand a new mentality of sisters who have worked in the field for a long time, and some may not be able to change. The younger sisters have already been educated in this mentality and so they will find it easier.

- These concepts are very similar to the ones we are applying in our own religious renewal: respect for the individual, co-responsibility, subsidiarity. We have to encourage the sisters to use these concepts wherever they work.

- The Generalate level must see, that proper orientation be provided for the sisters for both, language and culture.

- Members of Generalates who go on visitation, should visit not only their own members, but also visit institutions of other religious, and of government, which may be working on the same problems we face.

- Generalates must realize that non-missionary bodies can contribute with their research in helping use to solve our problems which may be similar to theirs.

- Sedos meetings should be kept up, as they contribute most effectively to the changes in mentality, and in helping to find together the right approach in the discharge of our service in mission countries.

b. In the context of concerted action among the missionary sending institutes:

- It was suggested that more should be done for Joint Programs for the formation of missionaries.

- All religious must be made aware of the new approach in health care, and maybe combined sessions could be organized among the institutes working in the field. In this way we can work together, not only in jobs but also in sharing our varied talents for workshops, seminars etc.

- We should conceive of the work in an area as a unit, and understand that we are part of it, and that we can best handle the unit by working together.

- "Missionary sending groups" are all those who send people to help those in need. We should have a healthy respect for "secular ecumenism".

HOW TO ACTIVATE THE CONCEPT OF COMPREHENSIVE HEALTH CARE

Study Session, held on November 27th, 1969, 16.oo - 2o.3o h, at the Generalate of the Ursuline Sisters, Via Nomentana 236, oo162 Rome.

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SEDOS 70/45

PRACTICAL WAYS AND MEANS OF MOVING OUR MISSIONARY EFFORTS IN THE DIRECTION OF COMMUNITY ORIENTED HEALTH CARE

Talk given by Dr. J. H. Hellberg of the Christian Medical Commission, Geneva, to 43 members of 20 missionary sending institutes on occasion of a study session on "How to activate the concept of comprehensive health care" (Rome, November 27th, 1969)

Today, everywhere, we hear the word "change". It has definitely become part of our life and also part of the ecumenical language. I will not discuss the need for change very much here because you have been dealing with that at your previous meetings. Among the papers you received as you arrived there is one called, "Planning for Health Care" which is dealing with the problems of why there is need for change, as part of our involvement in Church medical work today.

I would just like, at the beginning, to take one example or, if you like, one parable and compare our medical work to that of growing vegetables for a whole population, you know: potatoes, carrots, cabbage and all that. You can do that in two ways, you can grow them in a greenhouse and you can get beautiful potatoes, carrots etc., but they will be so expensive that very few people will be able to afford them. Or you can grow them out in the fields in the ordinary way, and people can even grow them themselves.

I think our one-sided, hospital orientated medical care is sometimes like growing vegetables in a greenhouse under glass; and we also have been able to see that it is true that fewer and fewer people are able to afford our products. Looking therefore at our task to produce health for all the people, we must take a serious look at how we do this, because it is not enough to give only the fine greenhouse product for the few, it is neither enough for medical reasons, nor is it enough if we want to do this as part of the mission of the Church. And our task in this, as it will be here today, is to find out what we can do outside the greenhouse, outside the expensive hospital; what can we do better and cheaper outside it? And then, what are the problems for which you must have the greenhouse, the hospital? And then, I think, we will have to pray the Lord to help us keep these two apart, so that we don't mix them up, because part of our problem is that we do things in the hospital that should be done outside and perhaps sometimes the other way round.

I think it is necessary to state over and over again that we must start from the needs, from the factors that make people ill, or perhaps even rather from the factors that keep people well. You may have heard that in the old China, during some of the dynasties, the doctor was paid as long as his patients were well, when the patients fell ill they stopped paying the doctor, and they started paying him again on the day the patient was well. This is basically a different concept, it is a concept of health. We like to call us the health profession, but we really are, a "sickness profession" because we are geared to medical repair and we are very good at knowing the causes of illness but how much do we know of the causes of health? Today in the whole medical world from the World Health Organisation down to ministries of health and the single sisters or doctors, this new thinking is coming in many different ways: start with the needs and then come to the deeds, what you can do about these needs. And then, thirdly, look at what kind of people we have, what kind of hospitals and health programmes do we run? Our problem is that, because we have these two thousand or more Christian hospitals, we are so busy keeping them going that we do not get any further. If we start from what we have, it is not certain that we come down to the real needs, but we may nevertheless be kept extremely busy from morning to evening. When we then see these new words coming up: comprehensive health care, community health and so on, it is of course in one way easy to say things like: "the whole man is our concern", and "the community is the patient", and "this individual is the symptom" etc. We should go out and take all the needs of man seriously and help him where he is, not only with his parasites but with how he lives and how he eats and how he works or not works. But how do you do that? Most of us are stuck with hospitals, if we want it or not, and how can we go on from there?

Today I would like to spend most of my time, of our time, talking about this. When we have hospitals, as we do have them, and we think we ought to change the emphasis so as to bring more and more help to more people, how do we go about it?

We all suffer from lack of staff, we all have too little money and we are all busy. How do we then change? Firstly we should be aware of one thing: we are at the threshold of something we might call revolution, and this is a revolution with regard to change in health care systems, delivery of health care. It is just as revolutionary as the introduction of the antibiotics or, if we go further back in the history of medicine, it is just as revolutionary as when we found the bacterias and started, a

hundred years ago, a new era in medicine. But when you are in the beginning of something, it is confusing and not always convincing that you should start the new thing at all. It was easy with penicillin, you could soon see how it worked, it was fairly easy with the tuberculosis drugs, you could soon see the effect, but we all know that there were people who did not want to accept penicillin right away, who refused to accept the new T.B. drugs, and the problem is, how do we re-orientate ourselves to this new thinking about how to deliver health care?

1. Use of Staff

When you talk about these things it is true to say, as someone has said, "when all is said and done, more is said than done". And that is why I will try to take up small practical points where we should, where we could go forward, every one of us in our own situation. The first thing I want to suggest, in order to go forward towards a community orientated health programme, is to look at what we do in the hospital, and looking at the activities in the hospital we start with the people, because people are our most important asset, an asset that we also sometimes are abusing. How do we use staff? Do we have doctors doing things that the sisters would not only be able to do, but do better; or do nurses and sisters do today what other personnel, auxiliary personnel, less trained personnel, could do and could even perhaps do better? Not only administration and secretarial work and practical matters, but part of the health care, of taking care of patients. I think we must ask ourselves this question, how do we use staff? Do we use auxiliaries in a constructive way? You know that most of us doctors have thought we were using auxiliaries! When we gave orders to people we thought this was constructive use of personnel but nevertheless we still kept everything in our hands, but today we say that eighty per cent of the patients coming to a poly-clinic or an outpatients' department do not need to see the doctor. Eighty per cent of the patients, perhaps in some places ninety, do not need the doctor, so why should he see them? But who should take care of them? Do we have systems whereby people can be treated in for instance what they call in East Africa, filtre clinics. In Nairobi in the Kenyatta hospital, I saw this very word used and medical assistants saw eighty per cent of the patients with only twenty per cent coming in to the doctors and more sophisticated facilities. Routine procedures are easy to teach, even to less trained personnel, and the diagnosis and treatment of ordinary illnesses are routine procedures. Also more difficult illnesses, if they

are common in the area, can be treated by any school-teacher, and diagnosed and treated by a school-teacher or an auxiliary also in the hospital. This has also been shown in many places but do we really plan our work with things like this in our mind? Do we really act in such a way that this becomes true in our hospitals? It is also, generally speaking, easier to teach curative measures to assistants and auxiliaries than to teach them more complicated, preventative and health education measures.

Talking about how we use personnel, we must also ask ourselves the question, do we really use indigenous national staff and train national staff, or are we relying too much on foreigners? I have seen sisters in some places working themselves sick because they found it so difficult to see someone do a thing not quite as well as they were able to do it themselves. It is like a mother who cannot let the daughter wash up the dishes and clean the floor because she leaves spots on the glasses and she leaves a few specks of dirt on the floor, so the mother does everything herself and the daughter will never learn herself. I think we have made this mistake and are suffering from this also to some extent in our hospitals. And also regarding the problem of foreign and national staff, we have our difficulties with recruiting enough sisters. In some countries the Government says: "We don't allow more foreigners in." Then we have to employ nurses at the ordinary salary rates in the country, and this means trouble with the running costs of the hospital. But if we do not gradually start introducing national nurses at ordinary salary levels, there will, perhaps, come a day when suddenly we are faced with an impossible situation.

It is important to ask also, who spends most time with the patient? It has been found that it is usually the sweepers or those bringing the food, as they spend ten or fifteen times longer than the doctors and the nurses, but what training do we give these to help the patients, to talk about disease or health education? Are they just talking behind the back of the doctor or the nurses, or are we constructively using this situation?

2. Cost Factors

Apart from talking about our use of staff, look at the cost factors. In all this the goal is to cut expenses, but also to free man-power within the hospital so that we can look at what is outside the hospital, outside the greenhouse. Do we have such administrative procedures that we really know what the various parts of the hospitals cost? Do we know what the

different wards, the surgical or the medical or the pediatric, what they cost us? Where do we lose money and where do we earn money? In many Christian hospitals the doctor or sister has the bills in one box and the money in another and always, when there is enough money, pays off some of the bills on top of the pile.

Then we have the whole problem of drugs and equipment; one of the first things we do when we get together in ecumenical co-operation is to start buying things together, joint purchasing, which makes it cheaper.

Then, another factor, the length of stay in hospital. Have we really figured out if we keep patients in too long? If you keep, for instance, certain patients in for five days or for seven days. If you have ten beds and you keep patients in for seven days, you can treat about five hundred and twenty patients a year. If you have them in for five days only, you can treat over two hundred more patients, and so on.

There are a lot of things you ought to take a look at in the hospital and not just let things roll on as a routine. One thing is the whole problem if one should use tablets or injections? We now say we must give injections because people demand injections, but who taught them to begin with? Didn't we? There is a need to de-mythologize the syringe and the needle because if we start counting the money and the man-power that goes into buying ampules, giving injections and sterilizing the material or buying throw-away material, these make a lot of difference. I know that when we talk about cost, we doctors are often a big problem and many a sister has had difficulties with the doctors because we do not learn to think economically in medical schools, and those of us who think in economic terms have mostly learned this in mission work. Then there is one difficult thing with doctors, they do not like to be talked back to and in this respect they are like medical bishops, I am afraid. So this is something we also ought to take a look at, but I think you Roman Catholic sisters usually have more experience in these things and especially in your hospitals, because you run them and the doctor comes in as a technician. In the Protestant hospital it is a bit more difficult as the doctor is also the superintendent. But when you look at what is done in the hospital I would hope and pray that you would get the kind of doctor you can talk with and plan with and really get down to business to see what you are doing.

One question that one might add here, which cuts down cost and helps with

the use of manpower, is the problem of standardized treatment schemes. If a patient comes in as a malaria or a pneumonia: eight or ten tablets of cloroquin, or for a pneumonia one injection of penicillin and four days of sulphatablets. When you start using auxiliary personnel you must have this kind of standard treatments and print them in small manuals as this saves a lot of time and money.

3. What do we do?

When we then look at the use of personnel and look at the cost, we come to the third thing, the consequences of this. There may be certain things we must stop doing because it is too expensive, it is ruining us, and some things which we must develop further and put more effort and man-power into, because it brings out better results. It is of course easy to say that you should stop doing something which is very expensive, especially if in the first place you should not have started it at all. For instance, artificial kidneys in mission hospitals in one or two places have raise the cost to such levels that fewer people can come. With the artificial kidney, we can treat e.g. twenty-five people a year, but this brings up the cost so that five hundred people cannot come at all any more, so what do we choose? And there are this kind of situations though mostly not quite so dramatic, in our hospitals. Many people say we must recieve the patients, we cannot refuse to take the people. All right, but on what criteria? Does this screening not happen now, although our filtre systems are usually of an economic nature? Those that can afford it come, but how can we know that those are the most in need? How can we look at our work in such a way that we can develop filtre systems that are related to the needs and not only to the pocket-books?

One thing we have seen, when you get together ecumenically, is that one may decide that not all of us should try to do eye surgery, orthopaedic surgery, or urology, but let one hospital take care of a special service on behalf of all and not everybody try to do it badly.

In all of this we come back to one question, and that is the use of personnel, that we should not try, that I should not try to do the work of ten people, but try to find these ten people, train them, supervise them and keep them enthusiastic and stubborn to do this work. For the whole group of us, we have had, and we have still, something of the wrong kind of theology of sacrifice around among us. I hesitate to use the word

"selfish", but I don't think we can avoid it. But, you know, you can keep busy from 6 o'clock in the morning till 10 o'clock at night, doing or trying to do the work of ten people and you burn your candle at both ends. We think this is the narrow road of sacrifice, but it might, it just might be a wide road, where the narrow difficult road is finding these five or ten people and stubbornly going on training them, keeping them enthusiastic and knowledgeable and in this way do much more and longer. This is, I think, a greater service both to God and man.

4. Inpatient Services

Then let us look at what happens to our in-patients. You recognize that we are still within the hospital, but I claim that all these things are necessary if we want to re-orientate ourselves and look at the community because we will not have any hands free unless we look at the work within the hospital in a realistic way. In-patient medical care, this greenhouse work, is a very expensive type of work, so we should carefully look into how we are using this and if we are utilizing this one hundred per cent? For instance, do we give health education to the in-patients that are in our hospitals and to their relatives? Many of us are working in situations where we also have close contacts with relatives. Do we really give all the kinds of health education related also to their traditional beliefs and do we know what traditional beliefs are behind the behaviour of our patients?

We opened a new surgical ward in our hospital in South West Africa and did not allow "unwashed" relatives in there, nor did we allow all their stinking food. Then one of the heathen patients said, "Well, you know, these white people, they seem to know something after all. They know that when we lie here with our wounds not yet healed, our enemies can come in and put evil spirits into us through the wounds and make us ill." He had the same concept as I had, but I called it bacterious infection and he called it something else.

But do we really understand the beliefs of people and are we able to connect the traditional beliefs of the in-patient and his relatives to our aims to get health to him, not only during the week he is in hospital, but for the fifty-one weeks of the year when he is at home? When children are in hospital or when children come with their mothers into hospital, do we take care that they are immunized when they go away from there? Do we

introduce them into some well-baby clinics? Do we use relatives as assistants in hospitals in children's wards? I hope the Lord saves us from the disgrace of separating mothers and children in our hospitals. When we have children with malnutrition, do we realize that the real person needing treatment is the mother, or perhaps the grandmother, and the child is just a symptom of something that is wrong in the home, something that is wrong with the mother and the grandmother, and if we go on treating this child every time, we are giving symptomatic treatment and we are not getting down to the real problems?

Let us think of the problem of the time that lapses from the first symptoms to the moment when the patient comes into hospital. We all know that this is important, in things like tuberculosis and leprosy very important, but also in other illnesses and we also know that so many patients come in too late. One investigation in India showed that among those patients who came in fairly quickly for their symptoms, seventy-five per cent were sent in by a former patient of the hospital. This should deflate our ego a little bit, that the former patients are the best extension workers, but do we use this? Do we prepare the patients we have in the hospitals so that they work as our agents when they get back home? One doctor in Africa is now preparing to give his patients tickets when they go home, a kind of referal tickets of patients. This is in one possibility and in this case related to leprosy, with the advise that "when you recognize cases with leprosy patches, you know, you send them in here," and he gives them tickets. In this way, if you look at the in-patient and his relatives, we have a source of cheap and natural community health workers.

In this context, I would like to say a few words about the language problem, about the need to really know the right terminology. If you treat an unconscious patient, or operate on somebody under anaethesia, you do not have to know the language, but if you want to get deeper than that and if you want to influence the life situation of the patient while he is in hospital and afterwards, you must know the right language. One simple test I would suggest: you take a word in the area where you work, for instance the word for diarrhoea, tuberculosis, or for malnutrition or kwashiorkor and you ask the personnel in the hospital, "What do you understand by this word?" And then you ask the people in the village, the patients, what do they understand by this same word? In one hospital the nurses, eighty per cent of them, understood one word to mean tuberculosis but to the patients in the village it had to do with nutritional problems, it had to do with kwashiorkor, with malnutrition. If you then use this word in

one sense and the people who listen understand it in another sense, you won't get anywhere with health education. Knowing the right word and the right words in a situation like this is sometimes thousands of times more important in the long run than having the right kind of penicillin that is effective to the right kind of bacteria. A friend of mine found that a doctor in South Korea using a word that meant doctor in another part of the country, found out that in the new area it meant "dumb head", and this might cause some public relations problems. In South West Africa there was one word "mapunga" for lungs but I used the word "mapumba" for quite a while until I found out that it meant cow dung.

5. Out-patients

Then, let us look at out-patients. How does our out-patients work relate to problems in the community? We must first realise that sixty per cent or more of our out-patients are small children and their mothers. Here we must ask ourselves, whether our out-patients departments are structurally built and planned for the kind of patients we have there? Most out-patients are built for adult patients and not for children and not for mothers and children together. When you go from hospital to hospital you find out because you see mothers and children; they are very often not in these out-patients' places, they are out in the sun or in some different places of their own choosing. Also with regard to hospital and clinic buildings we too often rely on imported solutions, that have developed out of a different situation. There is a need again to start with the real situation, as it is and not as we would like it to be.

Let us look at what happens when the child patient comes to an out-patient department:

The four most important questions are the following, and in this order:

a) the most important question, the education of mother and child;

b) weight control through weight control charts; (if you have seen the system of weight charts developed by Dr. Morley and used by Catholic Relief Service)

c) immunization, to find out about vaccinations and give necessary immunizations.

d) the symptoms for which they seek help; that comes only as number four and is of course important but we forget that this is a singular chance of influencing a family and a home for weeks and months and years, and not just treating this one diarrhoea or whatever the acute complaint may be.

Here one has to speak a lot about the principle of consultation. How do we help these nurses or these auxiliaries so that they can function and people have confidence in them and not always ask to be taken to the doctor? Some studies have shown that in places where the doctor insists on seeing every patient, he might have forty-five seconds or one minute per patient, but if he works through auxiliaries, these might have from five to ten minutes per patient. And if there is a right relationship of supervision and control, the result of this treatment, where the auxiliaries spend more time under the supervision of the doctor who does not insist on seeing every patient, the result is much better and the doctor will have time to spend on the community health programme, to visit the clinics and dispensaries and not just be in this vicious circle of routine work.

When you start looking, among the out-patients and the in-patients, at the deeper problems of the people and the context where they come from, you will become more interested and more knowledgeable about the whole situation of the people and this will mean that you learn to look at the hospital from outside and this is helpful for the planning of your work.

One feels that one could talk a great deal about the maternity cases because they are especially easy to involve in a community approach to disease, through the pre-natal care, through the post-natal care, and everything that has to do with deliveries because we know that in any culture, in any civilization, there are a lot of taboos, basic concept and traditional beliefs linked to the problem of pregnancy, delivery and rearing of small children. And if you establish contact at this level, the effect will be tremendous. With regard to the health of the community good work at this level will have the same effect as penicillin or antibiotics for a bad infection. One way to start a community oriented approach is through a follow-up of maternity cases. You have mothers coming in to deliver their babies and then you decide to do follow-up on five or fifteen or twenty of them, for two years, for instance. Some of the nurses or some of the sisters or some social workers, some teachers' wives or whoever it might be, visit these mothers in their homes. You give some health education while they are in hospital, then after a week, after two weeks you go home and check what has happened. I am sure you

know the good rule of how to teach things:
(i) tell them why,
(ii) show them how,
(iii) get them started,
(iv) see that they continue, and
(v) make them teach somebody else,
then they really, grasp the thing.

This can be done in relation to maternity cases by follow-up in the home. When I go to visit hospitals and I want to know how much the staff knows about what people think and believe about disease, I used to ask, for instance: "What do people do with the placenta in your area?" If you get a blank face, you know they have not got a clue, they have never asked themselves the question. But if they really have been concerned, they will give you some most interesting answers, you could write books about it because, when you deal with the mother and the child, you deal with the whole context, you deal with how they live, how they eat, how they grow etc. And we know this problem of protein, lack of protein and malnutrition for brain development. We know that lack of protein during the first two years of life causes brain damage which can never be repaired, and, not only that, but a generally malnourished child sits just passively, listlessly, and does not investigate surroundings, with fingers and mouth and does not develop.

We therefore deal here not only with disease but with the very quality of human life. We learn something about basic attitudes to health and disease, the need to think about the causes of health and the need to realize that routine medicine is always only a beginning, if you want to bring health to people. Curing a pneumonia, a diarrhoea, a malaria, whatever it is, is only just an "open sesame" to something, the first step to a contact with the larger life situation of that patient. But we put almost a hundred per cent of our resources in the beginning only and cannot do any follow-up of that situation. Especially since our hospitals started growing we have had this problem. In the early days when you had a small clinic, when the same person was doing the teaching, the healing and the preaching under the one tree, it was easier in many ways, apart from many obvious difficulties, but there was integration in the mission. Later on this became difficult, but I think we have to go back or rather bring in more comprehensive thinking about the total life situations, also into our institutions. One way to do this, and I want to take up this as the last thing here, is to look at the situation from the patient's point of view of those who seek health. What happens if somebody is ill

anywhere in the world, in any culture, in any civilization? You look if there is aspirin in the home, if there is any help at home or with the neighbours. That is where you start. And then, what kind of information is given in the home or from the neighbours? Is the aid positive or is it negative? How does it influence the whole course of the illness? The next step is the local practitioner. In some civilizations it is a nurse and possibly a doctor. But for the majority of the people, especially those that you and I have to do with, it is a diviner, a witch doctor of some kind, the herbalist, some traditional healer or some bazaar doctor, as you have them in parts of Asia. Investigations in India have shown that more than sixty per cent of the patient contacts are taken care of by these unqualified, untrained, more or less obscure people but they are the ones that see most of the patients, they are, in a way, a kind of medical assistant corps, if we want it or not.

The next step after the home and the neighbours and the local practitioner, is the dispensary or the clinic and only after that comes the hospital, and by that time most of the money is gone and most of the natural resistance to disease. At this stage you get these bad cases which we get into our hospitals when it is often too late to treat them and in any case very expensive to attempt a cure. The earlier in this development we can influence the patient, in the home-neighbour-practitioner-clinic-hospital chain of develoment, the better it is medically, the cheaper it is for the patient and for the institution and the more human, the more Christian, the more Christ-like it is, the earlier you are able to do something. That is why it is necessary for us to take people seriously where they are geographically through home visits and health centres close to their homes.

There is another paper among the ones that you have been given which is an extract from the book, "Medical Care in Developing Countries." There it says, among other things, that "medical care should be given through the cheapest, smallest unit, situated as near to the home of the patient as possible, that can give adequate care". This may be a box of three drugs, three mixtures, in the home of a teacher's wife, and this may be able to influence eighty per cent of these early cases of disease before any money is spent or spoilt, and before any damage is done to the people.

Take people seriously, geographically where they are. Take them seriously where they are in their beliefs and traditions. We should not blindly

come in with our organized, specialized, natural science-based narrow-minded medicine and think that this is the whole answer.

Take people seriously where they are economically. Out-patient care is cheaper than in-patient care, prevention is cheaper than cure, small units are cheaper than big ones.

Take people seriously where they are education-wise: promoting health and fulness of life is a more worthwhile thing than "medical repair". If someone thinks this is difficult, all right, yes, but who said it was going to be easy "to make all things new and to bring life and life abundantly?"

Further copies of this talk are available at the SEDOS Secretariat, Via dei Verbiti 1, 00154 Roma, in English and in French.

SEDOS Secretariat
January 1970

MEDICAL CONTACT GROUP

Report of the meeting, held on December 18th, 1969, from 4 - 6.30 p.m. at the Generalate of the Sisters of the Holy Family of Bordeaux. Present were:

Sr. Hélène de l'Annonciation fs, Sr. Marie Duarte fmm, Sr. Cécile Gonthier sfb, Sr. Michael Marie Keyes scmm-t, Sr. Bellarmine Romuáldez ssps; in the chair: Sr. Annemaria de Vreede scmm-m; from the Secretariat: Miss AM. Kohler.

Sr. Annemaria de Vreede welcomed the two new members and explained the reason for expanding the Medical Contact Group. With the original five-member group, the attendance at the meetings was often reduced to two or three, the other members being out of Rome. It is hoped that, with the increased membership which allows for unavoidable absence, there will be at least always four or five out of the seven members present for the meetings. It was not found helpful for absent members to be replaced by substitutes who are not aware of the work done previously by the Group. With the re-organisation of the Working Groups of Sedos in January, it will be seen if it is necessary to have any alterations made.

Pending the appointment of a Working Group Secretary for Sedos, one of the members of the Medical Contact Group will act as secretary.

1. The first point of the agenda: Review of the General Meeting of November 1969, was then taken up. Miss Kohler gave the information that the report of the meeting would be published in January as a separate bulletin. It was decided that it should consist of:
   - an account of the meeting
   - text of Dr. Hellberg's lecture, and a summary of the discussion groups' reports
   - list with addresses of the participating Generalates

2. As all had agreed that the general meetings were very helpful and informative regarding Medical Work in Developing Countries, it was then decided to organize another meeting in early March. Some suggestions were made regarding speaker and subject, and information will be sought before the next Contact Group meeting.

   The question of the financial contribution of the non-Sedos members participating in the Medical Group was discussed. It was re-called that last year an annual contribution was asked. The unanimous opinion was that a contribution is very welcome, but that also a registration fee for the General Meetings should be asked, which would cover all expenses involved.

3. Referring to the 3rd point of the agenda: suggestion of the ICCH (Intern. Cath. Confederation of Hospitals) to have a symposium on Medical Work in Developing Countries, jointly sponsored by Sedos and ICCH in Rome in November 1970, Sr. Annemaria gave a summary of the facts that lead to the request on the part of the ICCH.

   As from the side of the ICCH the goal of the meeting was not made clear, more information has to be had before any further commitment for involvement can be made. Due to postal strikes no answer was as yet received on a letter requesting more information.

Each of the members of the Contact Group received a copy of the terms of reference, drawn up in January 1969, which are to be studied at the next meeting, scheduled tentatively for January 29, at 3.30 p.m. at the Sedos Secretariat, later changed to January 22, 1970.