INTRODUCTION

My decision to undertake a Churchill Fellowship was made after I had been working with the Aboriginal children and their mothers of Warburton, for about 18 months. I realised that without further, specialised training and education in the areas of Primary Health Care and child nutrition I would make little progress or change either in Warburton or anywhere else in Western Australia that I might decide to work.

My fellowship was made possible by the support of W.A. child and family services and I would like to thank them for giving me the opportunity to study and work with people who are world leaders in these fields.

My fellowship consisted of 2 parts.

Between January and April 1998 I spent 13 weeks at Liverpool School of Tropical Medicine in England studying Community Medicine and Health.

Following this intensive course I spent 10 days in Capetown, South Africa, working with the nutrition staff of the Department of Health. I attended meetings and seminars as well as visiting community health centres and nutrition programmes in the townships surrounding the city.

I then spent 5 days in Nairobi, Kenya, at Gertrude's Garden Children's Hospital and Kenyatta National Hospital. I also had the opportunity to visit the headquarters of African Medical Research Foundation and The Flying Doctor Society of Africa, both of which are closely involved with community health programmes throughout East Africa.

LIVERPOOL SCHOOL OF TROPICAL MEDICINE

CERTIFICATE IN TROPICAL COMMUNITY MEDICINE AND HEALTH

"Why go to Liverpool in the middle of winter to study anything, let alone tropical medicine?"
A question I was asked so many times I stopped counting. Well, for those who didn't know, as far as 3rd world health and the education of those involved with tropical medicine are concerned Liverpool is the centre of the world and has been for the last 100 years.

With the employment of the world's first Medical Officer for Health in the mid 1800's, Liverpool was probably the first place in the world to develop a primary health care system.
The school was established in April 1898 when it was realised that there was a need for more appropriate training for doctors embarking on careers in tropical regions of The British Empire. The idea found support among the shipping industry based in Liverpool. The ship owners had obviously seen the effects of the tropics on their crews and passengers returning from these areas. Sir Alfred Lewis Jones provided the first funds and chaired the committee which established the school.

The school has since been involved in the education of medical and nursing staff, and the treatment of patients returning from the tropics. They are closely involved with international organisations working in 3rd world areas, and the development of health care systems, in partnership with new independent national governments of these areas.

The Department of Tropical Paediatrics and Child Health was established in 1969. The Certificate in Tropical Community Medicine and Health has been taught since 1973.

COURSE OUTLINE

The lecture component of the course was made up of 9 broad headings. These where Child Health, Clinical Medicine, Community Health, Emergencies, Environmental Health, Information Skills, Nutrition, Parasite and Vector Biology, and Women's Health. We also spent a substantial amount of time in the laboratories mastering diagnostic techniques and learning to identify different insects and organisms.

Most of the visiting lecturers had gained their experience and continued to practice in African countries. At first this was of concern to those of us interested in Australia, Asia and the Pacific region but we soon realised that the theories and concepts involved in community medicine can be applied to all regions eventhough the diseases may differ

slightly. Many of the lecturers had spent brief periods in Australia, Papua New Guinea, and South East Asia and where happy to discuss these areas in detail when requested.

Some areas of the course where obviously of more interest to me than others, my main interest being child and antenatal health and nutrition. I will discuss these subjects and their relevance to Aboriginal health in greater detail.

CHILD HEALTH

The child health component of the course covered common childhood illnesses found in developing countries, education techniques, and preventative medicine.

Most of the illnesses covered in the course are problems faced by nurses working in Aboriginal communities. It was interesting (and reassuring) to hear the lecturers describe these as not just 'tropical diseases' but diseases of poverty. They are not always the result of geographical location and weather conditions but of low income or unemployment and poor standard of living which result. These include low education levels, poor housing and sanitation, poor nutrition and in many cases geographical and cultural isolation from necessary health care facilities.

Some of the diseases discussed were low birth weight infants, childhood anaemia, diarrhoea, intestinal parasites, and respiratory tract infections. All of these can be related back to the above factors.

'Child-to-Child'
This approach to health education is a method which was developed in U.K. and is now used in over 60 countries. It educates and motivates children, through helping to care for their younger siblings and working with their parents, to improve the health of the whole family. They also work together to spread health ideas and improve health practices in school, home and the community.

The programme instills the importance of health in all aspects of the children's lives such as general happiness and wellbeing, education and family life. The results of the programme give the children a sense of pride that they are useful members of the community.

The resource books showing how to implement and maintain the programme are cheap and copyright free making them easily available to those who need them. The programme aids in bringing together different groups in the community such as health staff and school teachers who may at times have trouble agreeing who should be teaching what.

COMMUNITY MEDICINE

Primary Health Care

It was this component of the course that helped me to realise what I had been doing for the past 2 years in Warburton. At first the concepts and strategies discussed seemed confusing and unrelated to work in the field but as we started to look at practical situations I began to recognise methods I had been using in education and treatment programmes. It was interesting to learn the theory behind the practice.

Having access to this information as well as World Health Organisation (W.H.O.) and United Nations (U.N.) papers made me question how Primary Health Care was run within the health systems that I have been involved with. I had to keep asking myself "Why did we not have access to this information at work?", "Why were these principles not part of the work policy?".

Every community clinic within Aboriginal Australia is part of the Primary Health Care system and should be operated as such. The most important aspect of this process should be community involvement. As well as including Aboriginal people in staffing it should also include recognising the important contribution which the community as a whole can make to planning, implementation and evaluation of health programmes and understanding the responsibilities the health service and the community have to each other, remembering that this is a 2 way relationship.

Hopefully as I move around Western Australia over the next 12 months I will be able to experience these concepts in action as part of the community health aims and objectives instead of isolated but motivated individuals which unfortunately is all I have experienced so far.

Culture and Health

Understanding the important influence of indigenous culture upon health was also discussed. I think the importance of working around local beliefs and with traditional healers and midwives is well understood and practiced in Australia. If it wasn't the health system would quickly fall apart as it would not be accepted by the people.

Evaluation

Methods of evaluation are obviously of great importance when gauging the success of health programmes. Learning how to plan and carry out evaluations properly was of interest to someone like myself who had never been involved in the formal evaluation of any programmes I had organised. Learning to incorporate the evaluation into the original planning, when to carry it out and who to involve; this is information I will use many times in my future work. I was so taken by the subject that I managed to write a 2-page exam essay on it.

Training needs

Although I have been involved in education and training of both student nurses and health workers I have never had any formal education in this area. The course did not go into great detail but we did learn some basic guidelines for setting up and leading training sessions at a community level. Some areas covered were; obtaining community consent, sensitivity to cultural issues, finding funds, encouraging participation, organising the daily programme, buying and making health education materials. I found these guidelines very helpful as, although I usually get everything together in the end I am not very organised when doing so.

ENVIRONMENTAL HEALTH

Environmental health is a problem in many Aboriginal communities. Due to limited water supply and remote locations it is difficult to maintain satisfactory sanitation and human waste disposal systems as well as refuse collection and disposal.

Sanitation

During this component of the course we covered many sanitation and latrine systems which would be more appropriate in the Australian situation than those currently in use. The European style latrines and sewage system in use in most communities are prone to frequent breakages and leaks. As well as being expensive to install there is a significant delay in repairs while waiting for parts to be delivered. During this time there is the potential for rapid spread of gastro - intestinal diseases. Today there are some very sophisticated variations of the old- fashioned 'long drop' which are used with success in many parts of the world in similar situations to those which we experience in the outback. They take into account the need to control vectors such as flies and mosquitoes. They also remove the need for sewage plants which have always been a convenient place for mosquitoes to breed and also provide an attractive but unhealthy place for children to play.

Refuse Disposal

The problem of refuse disposal is not so easily solved. There are other factors involved such as encouraging people to actually use rubbish bins in their houses, taking their rubbish home with them when they have been travelling 'out bush' and also keeping the bins covered to stop the local dogs invading them and spreading rubbish. The main method of rubbish disposal in most areas of the world is bury and burn. This is really the only logical way of quickly disposing of large amounts of refuse. Recycling of materials is not feasible due to the isolation and lack of facilities. Efforts can be made however to cut down on the volume of rubbish generated from the community as a whole. In many areas this is being done by issuing reusable paper bags and boxes at the store instead of plastic.

The clinic is probably one of the main offenders in the community when it comes to generating large volumes of rubbish. We use many items of disposable equipment instead of taking the time to sterilise reusable items. It could be argued that this takes time and also that steam sterilising uses valuable water. There is also the problem of sharps disposal, which at present are transported out of the communities by either plane or road to the nearest hospital for safe disposal.

So, this area of the course did not solve all my problems but it did give me a lot of ideas to work on. The main challenge is to get the people in charge of these areas thinking about the changes which need to be made. The clinic staff are not often involved in the organisation of these fields but I think we have to be as the cleanliness of the community has a large impact on the health of the people.

INFORMATION SKILLS

In this module we covered many topics which will be useful in our community / primary health care careers

1.Understanding the importance of health information in primary health care.

2.Understanding the advantages and limitations of both qualitative and quantitative methods of data collection and their complementarity in PHC.

3. Understanding the common methods of data collection and their application to health needs assessment and health surveillance.

4. Accessing necessary information from available computer databases

NUTRITION

The main emphasis during this module of the course was on the relationship between nutrition/malnutrition and recurrent infection, and the effect of this combination on the immune system and general health of young children. We covered the two main classifications of malnutrition. The first of these, Marasmus refers to general wasting resulting from insufficient dietary intake. Kwashiorkor refers to the more complicated condition of Protein-Energy Malnutrition (PEM) which involves changes in the body due to metabolic imbalances.

Learning to recognise the more discrete signs of malnutrition and dietary deficiencies such as anaemia, changes in hair colour and texture, changes in skin pigmentation and texture, angular stomatitis, liver size, eye infections, irritability and apathy which could be attributed to the presenting problem or a more obvious condition. This is an important skill necessary to treat children that would otherwise escape treatment because they do not present with typical gross symptoms of wasted limbs and oedematous belly.

There are several schools of thought as to the main causes of malnutrition and whether it should be called PEM at all. There have been several studies and surveys carried out in different parts of the world to try and obtain a definite answer.

My main conclusion after covering all this material remains the same as when I first realised there was a problem with the children I was treating in Australia. Malnutrition is affecting the Aboriginal children of Australia. It may not be as obvious as the problems in Africa and other parts of Asia but it can be held responsible for many problems and illnesses which these children face later in life.

To further illustrate this point I have included as part of my report the essay which I wrote during the course. The subject was of our own choosing and contributed to our final assessment. My allocated tutor was Dr Brian Coulter, head of Tropical Child Health. He was very supportive during the time I was writing my essay and I think he learned just as much about the lifestyle and condition of Aboriginal children as I did about tropical child health in general.

Learning to recognise malnutrition and knowing how to treat it are probably the easier parts of the equation. Knowing how to prevent it and passing on this knowledge is more complicated especially when working with people from different cultures whose ideas and beliefs on health are very different to our own. My own ideas and opinion on health education where challenged and altered during the course. This was the result of hearing different opinions and learning new techniques. I will cover this in my final conclusions as it involves the course as a whole rather than individual modules.

WOMEN'S HEALTH

The main focus during this module was women's health during pregnancy. The effect of many diseases and conditions is exacerbated during pregnancy and obviously affect the child as well as the mother. Some of the main diseases covered, such as malaria are irrelevant to the Australian situation but there are others including STDs, Hepatitis, Diarrhoeal diseases, Diabetes, Anaemia and general poor health which prevent Aboriginal women from enjoying a trouble free pregnancy.

This area was of interest to me as it is so closely linked with the health of the children. Low birth weight babies can result from poor antenatal health and these children are put at a disadvantage from the day they are born if they don't receive optimum attention.

We also covered areas that might not be considered as health issues but certainly affect the lives of many women living in 3rd world situations and are prevalent in Aboriginal communities. The woman's position in society, and domestic violence are issues which

can be difficult to confront especially in a cross-cultural situation. As I have learned from experience it takes time and patience to get women to talk about their home lives and in some cases they never will. I have found that each case must be taken individually. Common guidelines can be used for dealing with them but they cannot be grouped together for treatment. Often there is little we can do but be available for guidance and support when it is requested.

I was able to share with the class my limited obstetric experience. I was the only person on the course who had been involved in deliveries in such isolated conditions. Other girls had worked as midwives in community clinics but had had the luxury of medical assistance and limited modern equipment.

Working with Traditional Birth Attendants (TBA) was also covered. They are seen as an essential part of the medical team as they are a link between the community and western medicine. There have been significant moves to improve techniques used by TBAs throughout Africa, which will safe guard the lives of mother and child without detracting from cultural traditions.

The significance of traditions during pregnancy and birth is often overlooked when dealing with Aboriginal women. Although on an individual basis many nurses are sympathetic to cultural differences and make allowances for these during antenatal care the final decisions are taken out of their hands. This is understandable when you consider the distances involved should an emergency occur and the fact that many nurses working in Aboriginal communities are not Certified Midwives. As full responsibility for health care has been taken on by government or other health department administrators they have to protect their staff from potentially dangerous situations but it does seem that more could be done to accommodate traditional practices and the women's wishes. After all, these women have been delivering healthy babies for thousands of years.

There were many more components of the course that I could write about but I think I have covered those most relevant to my work in Australia.

GROUP DYNAMICS

When I reflect on what I gained from the course the main thing, which stands out, is the relationship between our group. We were 22 nurses, from different parts of the world and varied professional backgrounds thrown together for 3 months. We all got along very well together and I know it was because we were there with common expectations and goals. There were about 6 other students, like myself, who had been working in the field for a number of years. I know we had all come straight from our work situations and were tired and a little run down. But it didn't take long for us to be revitalised by the passion and enthusiasm of those girls who are embarking on new careers in community health, and to realise that our own enthusiasm was not that far below the surface, even

though, it may have been buried under the stress of everyday work, government policies and the brick walls that are constantly thrown up when working in a cross-cultural situation.

I also know that by sharing our experiences of work with each other brought things back into a realistic perspective. We were taught by people who have many years experience in emergency and community health. The fact that they are still working in this field makes me think that they have come to realise that there are limitations on what one person can do, without loosing their original passion for their work.

The course has also made me realise that the priority of those working as health professionals in community situations should be health education and training. It is more beneficial to the community if we act as a guide rather than a controller. This is especially so in Aboriginal communities. The people have to realise that they are capable of gaining skills and knowledge to look after themselves and even, to eventually run their own clinics. This point was made even more obvious when I visited various projects in South Africa.

DEPARTMENT OF HEALTH AND NUTRITION

CAPETOWN, SOUTH AFRICA

My time in Capetown was spent with the dietitians from the Department of Health. The dietitians work in the community and are each responsible for their allocated area. A large part of each area is made up of the townships and squatter camps surrounding the city. They are used as a resource person by clinic staff, schoolteachers and project supervisors.

Not long before I left work in November1997 I received a letter from the Director of Nutrition in Pretoria saying that they would be pleased to organise for me to visit their community projects. The letter was dated 10 June 1997. As it had taken over 3 months to fly across the Indian Ocean I didn't hold much hope for a reply getting to Africa before I did but I sent one anyway.

I sent another note when I arrived in Liverpool in January with contact information and was pleasantly surprised to receive e-mail from the department with an itinerary attached. Unfortunately due to the vast number of sometimes incompatible inter-net servers I was unable to read it! We tried to rectify this problem with little success. So I went into a relaxed African 'everything will be alright when I get there' mode and enjoyed the rest of the course.

Arriving in Capetown was like heaven. After freezing in the north of England for nearly 5 months here I was back in summer even though we were in the southern hemisphere and it should have been well into the cooler weather. The sun was shining, the sky was blue and the ocean was sparkling and my mood lifted even though I had absolutely no idea what I would be doing for the next 10 days.

Following several telephone calls I finally found someone who knew about the itinerary. It seemed that somewhere along the communication lines over the last 12 months I had become 2 people; same name but one Australian, one English. An extremely competent Consultant Dietitian named Madaleen du Toit decided that I was one and the same, and I deposited myself in her capable hands.

My visit was arranged so that I would see examples of the different aspects of the departments' work.

The main areas involved were; **The Peninsula School Feeding Programme**

School gardens run as a commercial venture and providing employment for parents

Children's gardens

Feeding nurseries for infants run in conjunction with income initiative schemes for mothers

Community based income generation programmes

Government funded clinics in the townships

I attended several meetings with the department staff one of which was a planning meeting for the areas programmes.

I also visited private facilities which financially support the work of the nutrition staff in the nearby townships.

A nursing colleague arranged and conducted a visit to Red Cross Children's Hospital which is the only specialist children's facility in South Africa.

PENINSULA SCHOOL FEEDING

This is an association which has been in operation for 40 years. They fund and oversee the feeding of school children throughout the Cape Province. Children at risk are identified by teaching staff and targeted. They are provided with breakfast as they arrive at school. Other foods are prepared at school and sold to the children very cheaply.

The Department of Health dietitian for the area monitors the nutritional value and costing of the foods. She works closely with the kitchen staff in each school.

The teaching staff is closely involved with the programme and in many cases has taken over the daily organisation of the scheme. The Association acts as overseer as they are still responsible for the majority of the funding.

Many of the schools also had small vegetable patches maintained by the children. The seeds are provided by the Association and an interested teacher usually initiates the project. The children proudly showed off their handiwork while I was there. Many of them had started their own gardens at home with seeds from the plants at school.

EASTVILLE PRIMARY SCHOOL COMMUNITY GARDEN

Eastville Primary School has given over a large area of their school grounds to the growing of vegetables and flowers on a commercial basis. The garden provides income

for the school but more importantly it is used as an 'income generation' project for the unemployed parents and other members of the community.

The Department of Nutrition oversees the operation of the garden. The foreman is in their employ but it could not operate without the parents coming everyday to carryout essential work. Each worker has to put in a certain number of hours per fortnight and at the end of the fortnight they are paid in vegetables. In this way it is providing the workers with employment and experience and also putting food on the table of those families who would otherwise be unable to afford it. The school benefits from the commercial sale of excess vegetables and cut flowers. The children obviously benefit from the nutritional value of fresh fruits and vegetables which improves their learning ability in school but they also benefit greatly at home due to their parents improved self esteem and pride in being able to provide for their families. There are plans to expand the project to cover unused areas of the school grounds.

NURSERIES AND CRECHES

Probably one of my most pleasant days was spent with the children and mothers at a community nursery for malnutritioned children. These are run by trained health workers and overseen by the dietitians. The mothers and children attend the nursery all day and the children are monitored and fed. When the children are well enough to be left for a short time the mothers attend income initiative training. The logic behind this idea is that you can't buy good food without money and you can't earn money unless you have the skills. Thus, the mothers are instructed in various crafts to enable them to earn money. These include carpet weaving, screen printing, and basket weaving. The community centres have shops on site but there is also a combined outlet in the large tourist shopping centre in the main city of Capetown. A percentage of each sale goes back to the centre to provide materials and the rest goes to the artist.

During the time they spend in the nurseries the mothers learn essential nutritional information which will benefit their families. The children have a lovely time playing, eating and sleeping. This improves their nutritional status, as well as their motor skills and social interaction.

International tourists visit the centres during their guided tours of the townships. They are encouraged to purchase the handicrafts as souvenirs of their visit.

COMMUNITY-BASED INCOME GENERATION

There are also many other income generation schemes based in either private homes or community centres. Because of the close link between the problems of poverty and malnutrition the Department of Nutrition maintains a close interest in these projects, offering both practical guidance and moral support.

The schemes range from small home based groups of seamstresses using two or three sewing machines in the garage, to large community centres producing on a commercial scale.

CLINICS AND HEALTH CENTRES.

Visiting the community health centres was a slightly disturbing experience. Eventhough I have worked in a very busy urban Emergency Department and organised my own community clinic nothing prepared me for the sheer number of people at the centres; crowds of crying babies, distraught parents and sick elderly, and inadequate numbers of overworked medical and nursing staff.

The centres are run as outpatient departments and refer patients on to district hospitals as necessary. Many of the children were presenting with common reoccurring problems such as chest infections and diarrhoeal diseases, which could be related back to their living conditions and poor nutritional status.

One section of the centres which impressed me was the maternity units. These local centres provided prenatal, delivery and postnatal care for the women. A three hour post delivery stay is all that is required to ensure that both mother and baby are well before they are discharged into the care of their families. The only aspect of care which I considered to be lacking was that the women did not receive any formal nutritional education during their pregnancies for either themselves or their babies. It is very difficult for one dietitian to be everywhere at once but in a society where the women are experiencing nutritional deficits before they fall pregnant, they do need guidance during this time when they should be at optimum health.

There has been a dramatic fall in the number of women breastfeeding in South Africa. This has been attributed to the fact that, since the breakdown of the apartheid system many people have been moving from their traditional family groups to the city areas. This has caused them to abandon traditional ways. There has been a major campaign to encourage women to continue breast feeding. It is promoted as a cheap, clean and convenient and the most nutritionally beneficial way of feeding infants. Fortunately we do not have this problem in Australia, in fact it is often difficult to convince Aboriginal mothers that their children should be started on solid food.

OTHER VISITS

My visit to Red Cross Children's Hospital was organised and conducted by one of the nurse educators, Mrs. Penny Gill. This was not part of my planned itinerary but I was keen to see the other side of the health system. At present the Minister for Health is concentrating on channeling funds from the hospital system into Primary Health Care and

it was interesting to hear the opinions of people working in the area and to see how the reduction of funds is affecting the care of hospital patients.

I attended a planning meeting of all staff involved in nutrition work in the district. This included dietitians, clinic staff and the staff in charge of community projects. The other meeting of major interest, which I attended, was a gathering of all the dietitians working in Capetown, both hospital and community. These meetings are a regular occurrence with guest speakers. The meeting I attended concentrated on the dietary treatment of diabetes. This was of interest to me as diabetes is a major problem among Aboriginal people.

I also had the opportunity to visit the town of Stellenbosch. I was taken to a clinic where the nutrition education staff are funded by the profits from a private health farm. In fact all profits from the farm are channeled back into the community. It was good to see the poorer sector of the community benefiting from the indulgence and pleasure of the wealthier members. This was also an opportunity to see in action many of the programmes which we had learned about during the course in Liverpool, such as tuberculosis treatment, and the Extended Programme
of Immunisation

Overall I found my visit to Capetown extremely beneficial. It is inspiring to see people of all racial backgrounds working together to improve the health and nutritional status of their children. It is especially so when you consider the political history of the country and the enormous changes which have occurred over the past 4 years. Prior to the change of government, it would have been difficult to have different racial groups working together and the funding for such work would have been very limited.

GERTRUDE'S GARDEN CHILDREN'S HOSPITAL
NAIROBI, KENYA

I have been associated with Gertrude's for the past 5 years. In February 1994 I started corresponding with the then matron, Mrs. J. Sumner, in the hope of working at the hospital when I visited Africa in 1995-96. I did travel to Africa but the job did not eventuate, due to much bureaucratic red tape which delayed my nursing registration. I eventually returned to Australia and went to work in Warburton.

When it was suggested that I arrange some practical work as follow-up to my course as part of my Churchill Fellowship application, I saw this as an excellent opportunity to revisit people and a place I had grown very fond of. At the same time I would gain experience in the care of malnutrition and other conditions affecting children living in 3rd world conditions.

Gertrude's celebrated its 50th anniversary last year. It was founded in 1947 following the donation of land by Colonel Ewart Grogan. Although other hospitals have children's

wards Gertrude's is the only specialist children's facility in Central and East Africa. In fact it is one of only three children's hospitals in Africa, the others being in Cairo and of course Capetown. The hospital is independent of government support and relies on donations and paying patients to fund it's care of the community.

Mrs. Sumner retired at the end of 1997 but the new matron, Mrs. B. Hicks was equally enthusiastic about my visit. My week was organised by the nurse educator, Rose Ngumu.

Day 1 was spent in the kitchens observing and assisting with the preparation of meals and special diets. My initial tour of the kitchens included the various storerooms and details on how the food reaches the hospital from the markets. I accompanied the staff on their ward rounds to update the daily diet sheet and see new patients.

I then had 3 days working on the wards. Although I was not permitted to be responsible for the children's care (for legal reasons) I was able to feed babies, and spent time talking to both the staff and parents. There were a wide variety of conditions with special dietary requirements. Children recovering from burns and recent surgery, babies suffering from malnutrition and neglect, and premature babies.

My last day at Gertrude's was spent in the weekly immunisation clinic. This gave me the opportunity to talk to the mothers of well children. We discussed feeding traditions of babies in Kenya and the influence of western ideas on these traditions. Most of the women were breastfeeding and were surprised when I mentioned the decline of breastfeeding in South Africa. I was interested to hear about their weaning process, which still consists of traditional cereal products rather than introduced western foods.

KENYATTA NATIONAL HOSPITAL

Mrs. Hicks was very keen that I should visit the major government hospital in Nairobi, Kenyatta National Hospital. She arranged with the Matron of Kenyatta for me to spend a day at the hospital looking over the children's wards and clinics.

I was escorted for the day by the Deputy Matron, Mr. Paul Kimani. He first gave me an overview of the organisation of the hospital, staffing and size ("2000 patients, today"!). We first visited the children's emergency department, a small but very busy department. This really was the CTCM&H in action. There were children with every tropical disease and condition you could think of: Malaria, Trypanosomiasis, Gastroenteritis, Intestinal parasites, and Malnutrition. I was horrified to learn that 5 children had died in the department during the night simply because the doctor or nurse had not been able to see then in time due to the large number of patients. African people can be very patient and the mothers would not have thought of pushing to the front even though their children were obviously much sicker than those ahead of them.

We next visited the 3 children's wards in the hospital. There was the usual mix of medical and surgical patients. Once again it was the large number of children in the wards that

had an effect on me. Most hospitals around the world, especially those dealing with children, have a policy of never refusing a patient but when they are full, they're full and can redirect patients to other hospitals. Not so at Kenyatta. They keep on admitting because, apart from Gertrude's which is at least an hours drive across town, there is no where else for the children to go once they are at the hospital. The wards that would comfortably hold 25 beds have at least 40 patients. The isolation unit, an alcove in the main ward corridor, held a very ill child with measles, with other children constantly passing by. There were 3 nursing staff on duty for the ward. On the brighter side, each ward had its own dietitian. They are on the ward constantly monitoring the patients, updating care and educating and guiding parents.

As we were walking down a corridor I noticed a sign which said "Department of Nutrition, Education and Immunisation" and asked if I could visit this area. The department is an outpatient area that mothers and babies attend for immunisation and 0-5 developmental assessments. There are also weekly education sessions, covering baby care, weaning diets, and other aspects of child nutrition. I recognised many of the homemade education aids as being similar to those I had used myself. The hospital's chief dietitian, Ms. Penina Muli spends a lot of her time in this department and was very enthusiastic when telling me about her work. Unfortunately there was only 1 mother in the department at the time of my visit so I could not observe it in action.

AFRICAN MEDICAL RESEARCH FOUNDATION AND THE FLYING DOCTOR SERVICE OF EAST AFRICA

I am lucky enough to have family involved in tropical medicine resident in Nairobi. My cousin, Dr Philip Rees, held the position of Medical Director of AMREF for many years and it was through him that I was able to visit the organisations' base and meet the staff.

I was met by Dr Anne Spoering. Dr Spoering, having recently celebrated her 80th birthday and being semi-retired continues to play an active role in the work of the Foundation. She is a true 'flying doctor', piloting her own plane on her regular visits to rural clinics and emergency calls.

On the day that I visited, one of the community nurses, Ali, happened to be in Nairobi during his holidays and was at the base. We spent several hours discussing our jobs; the similarities and differences between them, working with and against traditional medicine, how distance from medical facilities prevents optimum care, the difficulties of working with nomadic people, and coping with racial differences. It may surprise people to learn that a native Kenyan nurse would have racial problems in his own country but Ali works outside his traditional tribal lands and faces similar problems working with other tribes as white nurses do working with the Aboriginal people in Australia. During the discussion Dr Spoering gave an example of the success of health education. After 10 years the Maasi women where happy to be responsible for their children's immunisation cards. Keeping them at home and knowing when the children were due for their next injection and turning up voluntarily. They have learned the vitally important part that

immunisation plays in the health of their children and an up-to-date card is seen as something to be proud of.

A tour of the FDSEA facilities completed my visit. I visited the radio room, pathology labs, and was able to talk to the flight nurses and other staff.

What have I learned from studies and visits during my fellowship and how am I going to use this knowledge?

The understanding of Primary Health Care, how was developed and how it should be operating is probably the most practical piece of knowledge that I gained during the CTCM&H course. I now have a point-by-point list of the objectives of PHC to use as a guideline for my work. It is very reassuring to have this material to present as solid evidence when or if my work methods are ever questioned. I would even go as far as having a copy of the objectives pasted on the wall of the clinic so there is no doubt where I am working from. Some people may think that because we live and work in a 1st world country we are beyond working under basic W.H.O. and U.N. guidelines. But they were developed to be used in community clinics in affluent urban areas as well as 3rd world countries. It has to be remembered that when working in an Aboriginal community health clinic the staff are involved in a 3rd world health situation. This situation has been labeled by the U.N. as 4th world; people living in 3rd world conditions within a 1st world country. This situation occurs in countries where the indigenous peoples are now the minority population namely Australia, United States, Canada and New Zealand. It is not a label to be proud of and should be something we are working towards abolishing.

Having said all of this, it is no good having wonderful ideas and objectives if they are not going to be accepted by community leaders and the people. Having an administration team who understand the objectives of PHC is essential before you can even try to influence anyone else. One of the major problems faced when trying to introduce new ideas is that we are fighting against a history of abuse, mistrust and conflicting political views that many Aboriginal people have become apathetic and sceptical about accepting new ideas or trying new schemes.

I mentioned earlier that my ideas on education had been challenged during the course. In the past I have directed most nutrition education towards the mothers of young children, with some success but it was hard work both physically and mentally. These women developed already set ideas on how to bring up their children. They may also have suffered the consequences of gambling and petrol sniffing, 2 very difficult habits to break.

The Child-to-Child programme is a solid base for developing health education among the school children. My experience with school age children in the community is limited, as my main area has been the 0-5's. But I did organise several activity sessions with the children during school holidays. Admittedly the main objective was to keep them out of trouble around the community and to keep them out of my way in the clinic. There was always a health theme and they loved cutting, pasting and painting. Now, to have access to a programme which can be incorporated into clinic and school, makes learning about health fun and encourages the children to share their knowledge around the community, seems the best way to influence the whole community. The children absorb information much more readily than adults and have fewer established ideas. If the children absorb positive health information before they face the negative aspects they have a greater chance of growing up healthy and having healthy children themselves. Teaching the

school children about aspects of baby care and nutrition benefits themselves and also the babies in their families as they are keen to tell there parents what they have learned during the day. In this round about way the whole community benefits and hopefully as the children grow up old problems are eradicated.

There were several less practical results from both my time in Liverpool and my visit to Africa. I met people who have been involved in PHC for many years and despite many setbacks along with the successes, they are still there and still enthusiastic about their work. I have learned that one person can not change the world and that success comes in very small steps. A prime example of this being the immunisation cards in Kenya. Something, which in our society would be taken for granted, becomes a major achievement when working with different cultures.

There is a very fine line to be followed between professional and personal involvement with the community in which you are working. It is very difficult not to become 'too' involved when you are socialising with people as well as trying to have a professional influence on them. But if personal obligations are allowed to override professional judgement medical staff cannot fulfill their professional obligations to the community. It is only since I have been away and by talking to others involved in the same type of work that I have realised how influenced I was by living in such a close, isolated community. I took a long time to adjust being back in white society full-time. Eventhough it is important (and a great privilege) to be accepted by the community we mustn't forget that we are from very different cultures and it doesn't matter how long we are associated with an Aboriginal community we will always be European and to some extent outsiders.

All this may not seem to make me a better practical community nurse but it will give me direction in my future work. I can approach my work from a more objective angle and will be able to rectify situations before they affect my professional judgement.

I also now have a wide circle of professional colleagues working in the similar situations who I am able to call on for advice and support. They may be in different countries but I don't see this as an obstacle. We are all working towards the health of the children in our societies and if we are able to assist each other in doing so we should take advantage of each other's experience. Some of the people met during my Fellowship were surprised that someone from Australia should be looking for new ideas in Africa. I had to reassure them that in some areas they where far ahead of us.

I have been able to be of some practical help to the administration of Gertrude's. They are keen to send some of their staff for specialist training in the field of Neonatal Intensive Care as they hope to open a unit within the hospital. Apparently Australia is one of the few countries which offers this course. Since returning home I have spoken to the education staff at King Edward Memorial Hospital in Perth and put them in touch with the appropriate people in Nairobi. I will be very interested to see the results.

I was offered jobs at many of the places I visited and I was very tempted to say yes but resisted on the strength of my Fellowship commitment. There was one other factor that made coming home easier. The talk in Liverpool was always of the adventure of going off to work in wild, exotic places with people of different cultures. After a short burst of jealousy I realised that we have the privilege of living in what most Europeans consider a wild and exotic land. We can work with and have a positive influence upon the lives of our indigenous peoples and we don't have to leave home to do it.