careful design makes it possible to detect problems related to the use of household technologies, to provide information on the way in which rural housewives' time and energy is employed, and to give an overall view of family activity patterns. It also provides the demographic and economic information needed and a scale to measure changes in the family unit.

The emphasis of Cebotarev's work is not to present a rigid conception of home economics or a static methodology, but rather to create an interest and awareness among home economics workers of the advantages of conceptual clarity and of the use of systematic procedures for guiding and strengthening their specific activities. Its main goal is to clarify particularly important aspects of this area of study and work, to propose an explicit conceptual framework, and to present a research methodology that can be used by field workers in planning and evaluating their work.

Its most important contribution is, no doubt, that it points out the importance of household technologies as an instrument to improve goods and services produced in the home, and also as a means of liberating women from such work. The relationship established between household technologies, time and energy savings, and women's traditional roles could turn home economics into a dynamic and positive development factor in Latin America.

However, the success of this strategy will depend, in the long run, on three factors: the rural family's recognition of the possibility of acting on and influencing the solution of problems; their motivation to act; and the adoption of improved processes or household technologies that make more time available for new activities.

Experience indicates that the emphasis on saving time and energy must also be accompanied by guidelines indicating the different ways in which this new free time and energy can be used. Without this guidance, without stimulation, and without an awareness of the new situation, few women show much desire to explore new opportunities. □

Stella de Feferbaum

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Health aides make themselves heard

Michelle Hibler

"I want big, fat, nice babies in my clinic", Mrs L. Levy warns a young mother who has come to the well-baby clinic at the Department of Social and Preventive Medicine, University of the West Indies (UWI), in Kingston, Jamaica. A community health aide, Mrs Levy has been at the clinic for over 10 years. The results of her work show: whereas gastroenteritis and malnutrition are the main health problems in the rest of the country, they are not in the low-income urban area served by the clinic. "They hear me", says Mrs Levy.

Mrs Levy was one of the first CHAs in Jamaica. Pioneered by the Department in 1967, a pilot program trained eight aides to work in the communities neighbouring the university, Hermitage and August Town. Today there are close to 1200 aides throughout the island and the government plans to double the figure in the coming years.

For many years in Jamaica the "practical nurse" served as an auxiliary nurse, but without legal status. When they were officially recognized in 1966, they became "enrolled assistant nurses", entitled, after training, to work in hospitals, doctors' offices and nursing homes. In community medicine, however, no auxiliary personnel existed.

The Department of Social and Preventive Medicine of the university had been working in Hermitage and August Town providing a health service while using the communities as "laboratories" for teaching community medicine. Some of the residents in the area worked as volunteers in the clinic. Impressed by their assistance, Dr Kenneth Standard, Head of the Department, wanted to give the volunteers some training that would help them to function more effectively and with greater confidence. Thus the CHA program was born.

Late in 1967, the Department explored the possibility of recruiting suitable persons from the community to become health aides — a public health equivalent to the hospital auxiliary worker. It was emphasized that the intention was not to train another category of nurse, but rather to prepare persons from within the community to involve others in accepting responsibility for improving standards of health, and at the same time, teach them to carry out basic home procedures. The aim was to give these persons basic training and motivate them to the extent that they would be willing to work with families and to identify problems that would then be brought to the attention of trained health personnel. They would serve as links between the community and the health services and perform basic tasks such as following up on broken appointments, assist in clinics as receptionists and by carrying out routine tests and treatments, advise on nutrition, and visit homes to help care for the sick, elderly and infirm, and young children.

Eleven persons were chosen in the Hermitage-August Town area for selection and orientation. Eight of these — including Mrs Levy — were then retained for a further three months of training, both theoretical and practical, in antenatal care, family planning, human relations, nutrition, human growth and development, basic anatomy and physiology,

first aid, sanitation and hygiene, as well as in the function and structure of government and social agencies.

In 1970 the program extended to the parish of St Elizabeth. Sponsored by UWI, the Ministry of Health and Environmental Control and the Cornell University Medical College, this second experimental program was to serve Elderslie, a remote rural community isolated from health facilities where infant malnutrition was severe. "The idea was growing", says Miss Olive Ennever, coordinator of the pilot program and research assistant at the university.

The program received a boost in 1972 when the government, based on the success of the experiments, adopted the CHA program. The expansion, initially into two parishes in the north of the island, was also designed to provide employment to otherwise unemployed — and unemployable — women, says Miss Ennever. The training course was reduced to eight weeks. Since then, expansion has continued and aides are at work in all parishes.

The aides, although literate, have not generally completed more than the 6th form. The main selection criteria are that the aide live and be active in the community and be interested in the health program. Age and sex are not determining factors, but most are women aged 25 to 45.

The Jamaican activities have had repercussions in another English-speaking island in the Caribbean, Antigua, where the Ministry of Health, with the assistance of UWI, recently trained its first group of 20 CHAs. In view of the continuing Jamaican expansion and the development of new programs in other islands, a critical evaluation of the CHA program was needed to improve, where possible, the aides' performance. Such an evaluation began in 1977 with IDRC support.

Conducted by the Department of Social and Preventive Medicine in collaboration with the Ministries of Health of Jamaica and Antigua, the study aimed to evaluate the training program, the performance of the aides and their supervision. In Jamaica, 200 aides were interviewed and observed at work. Their supervisors and other members of the health team were also interviewed, as was a random sample of residents in the communities where they work.

It was found that, except for a few tasks such as taking blood pressure, laying out service trays, and crowd control, the aides were satisfied with the training they had received. Almost all felt that the public enthusiastically welcomed their services, and job satisfaction was high. The performance of duties observed was satisfactory and corresponded well with their job descriptions.

Their supervisors, although they considered that the two-month training course was too short, felt they were able to function more effectively since the CHAs had joined the health team. The main problems encountered were the large number of aides they were called on to supervise, heavy work loads, and lack of regular contact. Dissatisfaction was also expressed about selection procedures of the aides, and most felt that the aides should have attained higher educational levels.

Similarly in Antigua where 19 aides were interviewed, most listed the distribution of food supplements, family planning, and taking blood pressure as the duties for which they were not adequately trained. Job satisfaction was high here as well. In both islands the public expressed confidence in the aides and felt they were doing useful work in the clinics and health centres, and during home visits.

The results of the evaluation will be used to make specific recommendations for improved training, performance and supervision. "You can say that in Jamaica and Antigua the programs are here to stay", says Mrs Patricia Desai, coordinator of the study, "but they have imperfections and the evaluation will suggest ways of improving these."

If Mrs Levy is typical of the aides at work, they are undoubtedly rendering useful services. A number have even expanded their activity into community action by organizing community group programs in handcrafts, health, and nutrition. This commitment to their community and their understanding of the people and their problems is probably their greatest asset.

"You can't find that in textbooks", says Mrs Levy. □

Photos: Jaime Rojas

In Jamaica, trained people from within the community act as health aides. Top: *Public confidence produces more demand for services.* Bottom: *Mrs Levy in the well-baby clinic, Kingston.*