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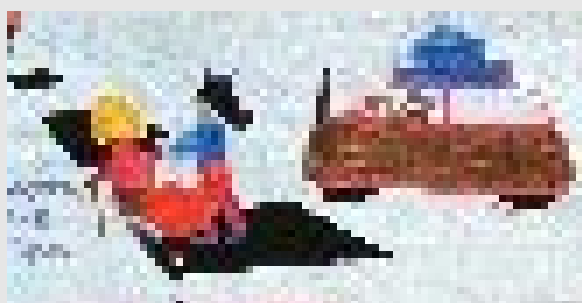
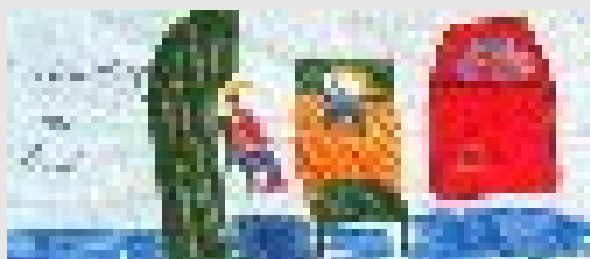
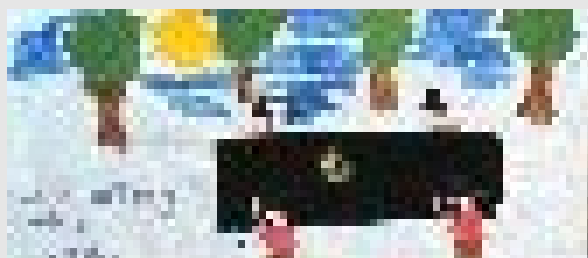


A publication of the CMC-Churches' Action for Health, World Council of Churches

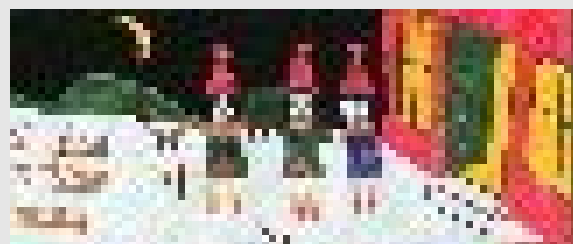
DOUBLE ISSUE

No 161/162

June-July and
August-September 1998



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In this double issue of *Contact*, we are delighted to share with readers "The CMC Story". It analyses the work of the Christian Medical Commission in a way which reminds us of what has been achieved and helps us to rethink where Christian health and healing should be heading in the future.

Over the past 30 years, the CMC has changed thinking on health both within the churches and in the international arena. In the early days, it stimulated the World Health Organization (WHO) into early discussions about primary health care. Then, by becoming the first major non-governmental organization (NGO) with an official relationship with WHO, it strengthened the foundations for a more public and community oriented approach to international health policy. Its campaigns—to promote breastfeeding and to limit "donations" of expired, useless and even dangerous medicines – have produced changes in thinking and policy both at WHO and within governments and transnational corporations.

Most recently, the renamed CMC - Churches' Action for Health has changed attitudes within the churches towards those infected with HIV or

suffering from AIDS. For several years after the epidemic began, there was considerable prejudice, ignorance and often moral condemnation in communities and churches. Since then, many churches have become role models of safe and welcoming centres for those living with AIDS.

Throughout the years, CMC has helped shape concepts of "health". Many of the NGOs and networks which have evolved more recently have adopted the "wholistic", or whole person, approach in which peace of mind, relationships with others, and a person's social, economic and cultural situation are

seen as crucial to an understanding of the root causes of ill-health. From its establishment in 1968, CMC has promoted a "bottom up" (or people- and community-determined) rather than a "top down" (government service- or health professional-determined) model. Today, nearly all justice-minded development groups have embraced CMC's fundamental principle of peoples' participation in decision making on issues affecting their own health and development. The practical benefits of CMC's approach and emphasis have been repeatedly documented in *Contact*.

CMC's ideals and achievements are highlighted throughout "The CMC Story". The final chapter "At the crossroads" poses questions for the future. Do let us know which ones you feel are the most important. We would like you to send your comments on the sheet found on page 53.

The "CMC Story" was written by Gillian Paterson, author of "Whose Ministry?" and "Love in a Time of AIDS", both WCC publications. Gillian made her writing a highly participatory process, and I would like to take this opportunity to thank Gillian and others involved in developing this issue.

Future of *Contact*

Thanks to the tremendous support of readers, and particularly to participants at a WCC meeting in March, *Contact* will continue publication. Appearing quarterly (rather than every two months), it will become the responsibility of a partnership of CMAI – the Christian Medical Association of India; WCC; DIFÄM, the German Institute for Medical Mission in Tübingen; and MCS, the Medical Coordination Secretariat of the Netherlands. From January 1998, Darlena David, who works at CMAI, will take over as editor, producing her first issue from the WCC Eighth Assembly in Harare, Zimbabwe.

Like myself, I am sure all *Contact* readers will want to congratulate Darlena on her new position, and to wish her all the very best for a very bright future.

Diana Smith
Editor

Cover

A child's drawing from WCC's Justice, Peace and the Integrity of Creation (JPIC) Children's Art Contest.

Below

Church community action at the Ephesus Church, Katutura, Namibia



Peter Williams/WCC

THE CMC STORY

1968 - 1998

by Gillian Paterson

Happy Birthday!

Imagine that it is June 1968. The world is changing. In Latin America, there is a strong liberationist force struggling to transform authoritarian and unjust structures. In Asia and Africa, colonialism is in retreat. In its wake, it leaves poverty, uncertainty, and in some places civil war. It leaves governmental, military and civil institutions modelled on those of the colonialist powers, with western values and expatriate staff. But for all that, there is optimism. A new and more democratic world order is possible. There is the conviction that the dispossessed will at last come into their own. There is the joy of liberation in the air. There is hope.

In the industrialised countries of the West, it is the booming sixties. It would be a happy time, but for the underlying anxiety about the future. The tides of Empire on the ebb, what will now be the relationship between South and North?

How does one protect oneself from the ideological and military threat from the eastern side of the iron curtain? And how to ensure that newly independent countries in the South do not fall under communist influence? The world is full of hidden dangers. By the end of 1968, Soviet tanks have rolled into Czechoslovakia and US forces are "defending democracy" in Vietnam.

The churches are changing, too. The Western missionary church, so closely tied in with the colonialist agenda, is

gradually handing over to national churches who are asking to run their own affairs. In the Roman Catholic church, preparing for the Second Vatican Council, the idea of Christianity as a force for change has taken root. At Medellin, in Colombia, the Bishops' Conference of Latin America sets out the basis for a renewed theology which looks to the oppressed to set the agenda for the people of God. At the WCC Assembly in Uppsala, the Council's member churches promise to take a lead in development and aid, and to give priority to justice and the voice of the poor.



Small beginnings

In Geneva, a little group of people gathers, called together by the World Council of Churches. The Christian Medical Commission, under its first director James McGilvray, has been charged with the responsibility to promote the coordination of national church-related medical programmes, and to engage in study and research into the most appropriate ways in which the churches might express their concern for total health care.

But that was then. Thirty years on, it is now 1998. A new millennium is just over the horizon. This year, CMC celebrates its thirtieth anniversary. We wish the CMC-Churches' Action for Health, and all the thousands of people who have been involved in its work, a "Happy Birthday".

WCC member churches promise to take a lead in development and aid.

TOWARDS HARARE

As the millennium approaches, what might the role of a global Christian health network be?

Street children at WCC's Conference on World Mission and Evangelism, Bahia, Brazil, November 1996.



Today, CMC-Churches' Action for Health is at a crossroads. It is part of the World Council of Churches (WCC), a fellowship of churches from around the world which is currently taking a radical look at the way it should be structuring its mission. This involves rethinking the way in which its different priorities relate to each other. Health is structured at present within the unit that deals with evangelism, education and mission. But there are important connections between the health agenda and that of the units focusing on faith and order, justice and peace, and service and sharing. The new relationships within WCC should make it possible for its member bodies to think about health and healing from a much broader base.

Thirty years ago, there seemed nothing strange in big, centralised, Europe-based organizations like WCC setting out to speak for everyone. But the world has moved on since those early days. Things that worked well in the late 1960s may no longer be appropriate in the late 1990s. From now on, the WCC in Geneva will be structured as a coordinating secretariat with a minimum staff, in recognition of the fact that the real action – and therefore the most pressing need for resources – is at the regional, national and grassroots level. The Eighth Assembly of the WCC, which will take place in Harare, Zimbabwe, in December 1998, will be the place

where other important changes in self-understanding and internal organization of the WCC take place.

As part of the restructuring, this double issue will be the final edition of *Contact* to come exclusively from the WCC. From now on, a partnership of the WCC and three Christian health agencies will produce *Contact* (see Editorial). So this is an excellent moment for looking back, not just on past glories, but on past realities, and on what, over the years, has made the Christian Medical Commission such an exciting family of which to be a part.

A future role

But times of change are also moments for looking forward, for dreaming dreams and seeing visions. As the millennium approaches, what might the role of a global Christian health network be? The promotion of the philosophy of primary health care (PHC), which was part of what made the CMC experience such a compelling one in the early days, has led to disappointments. Its promotion has not brought about the structural changes needed to alleviate the poverty that causes much of the world's ill-health. Today, the effect of market forces' economics in a globalizing world is increasing the gap between rich and poor, and the emphasis in PHC is on sustainability and long-term maintenance, and on the experience of digging in for a long struggle.

All the PHC issues remain important. Gender issues and the position of women, disability, rational use of drugs, inequitable use of resources, scarcity of funding: these will continue to be important challenges for any organization concerned with community-based

health care among poor people. They are the challenges which *Contact* readers face every day. They are vitally important, and they will always be with us.

But the early excitement of CMC stemmed from the fact that it was a think-tank for ideas. It attracted some extraordinary people, from all over the world. Some had come from a background in medical mission, seen the limitations of the mission hospital, and found themselves swept up in the movement to make primary health care happen. Others were theologians, church people, politicians and academics. Today, in most countries, PHC is widely discussed and accepted but its understanding is far from the visionary dream which fired so many with energy and enthusiasm in the early days. The disappointments came because many of the basic principles of PHC (see page 13) were not taken to heart, often resisted by key elements in governments and medical establishments. Most crucially, PHC came to be understood as a fragmented series of services – immunization and family planning for example – instead of a comprehensive and participatory initiative leading to a major reallocation of resources.

Which way now?

The true prophet always operates from *outside* the system. What are the prophets saying today? Here, on the cusp of change, the time has come to listen very carefully for the still small voices which may just be articulating the major themes of the future. *Contact* readers will be among those voices. Where will they come from? In recent years, CMC has taken the lead in WCC's work on AIDS. Maybe there are voices coming from the experience of living or working with HIV which might help set the agenda for the future. Or how about the Health, Healing and Wholeness study of the 1980s? What, in our violent, battered, confused world, do we *mean* today, when we talk about the healing ministry? Has the moment come, perhaps, to reclaim that ministry for and with the churches?

After each section of this issue, there are some suggestions designed to help you relate the-story-so-far to your own situation, and also some suggestions for biblical work which might light up your thinking. At the end, we have set out the themes and concerns that have been identified as concentration points for the CMC family, with the support and special guidance of the WCC. These have come up at recent international meetings. We hope you will read them carefully and we encourage you to write your comments on them, or offer other suggestions. To do this, we have included a response sheet that we invite you to send to our Geneva address. Readers' responses will be used by staff in discussions with the CMC family for the fine-tuning of their own work and for ideas for themes in *Contact* or other educational resources.

At the WCC Assembly in Harare, in December, there will be hearings and "*padares*" or workshops, where the delegates will report and discuss many of the key issues affecting the life and witness of the churches today. Among them, of course, are issues of health and healing. All these discussions will have a bearing on the shape of the future work of the WCC.

As the WCC restructures, the continuation of the link with you, your communities and the people with whom you work, through *Contact*, will be essential to our common involvement in health and healing.

But the early excitement of CMC stemmed from the fact that it was a think-tank for ideas.

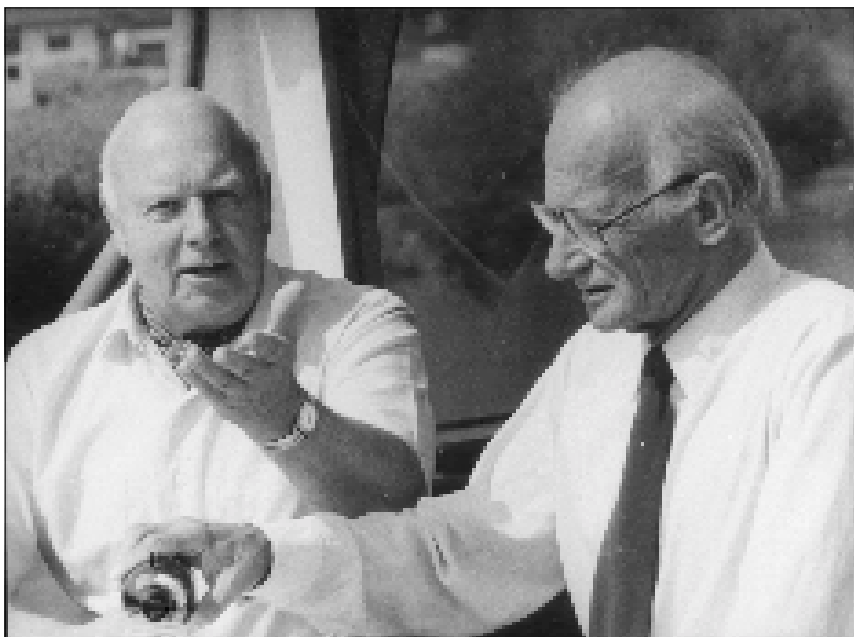
A beggar and her child in Berlin, Germany



Wolf Kuhnathorsky/WCC

CHAPTER ONE

THE QUEST FOR HEALTH



Mr James (Mac) McGilvray (left) with Dr Martin Scheel, Director of DIFÄM during Tübingen I and II.

The young CMC was born out of a long history of Christian involvement in health care.

Writing a history of the Christian Medical Commission is a confusing experience until you have grasped one very important fact: that certain key, agenda-setting things happened *before the Commission itself existed*.

The young CMC was born out of a long history of Christian involvement in health care. For over a hundred years, medical work had provided one of the main focuses for Christian missionary work, the others being education and church planting. As a result, there were more than 1,200 Christian hospitals in the world relating to member churches of WCC alone. What, if any, was the strategy behind their work? What was the healing ministry basically *for*? Was it a means of making converts? Were Christian health professionals just filling gaps in locations (for example by providing services in remote rural areas) and specialities (leprosy, for instance) which were unattractive to others?

There were many people working in Christian medical situations who believed that there was in fact a unique Christian understanding of health and healing, which should inform and colour the way the churches handled the current time of change. In 1964, WCC and the Lutheran World Federation (LWF) decided to sponsor a consultation on these issues. In parallel, they initiated a series of surveys which would do two things. First they would discover the relevance of Christian medical work to the existing needs of people in the developing world; and then they would look at the relevance of this work to the churches themselves at local and national level.

The first consultation – taking place in 1963 at DIFÄM (German Institute for Medical Mission) – came to be known as Tübingen I. Having reached the conclusion that health care was more than mission hospitals, it set in motion a process aimed at establishing what, in a post-colonialist world, the role of “medical mission” might be.

Tübingen I recognised that the Christian gospel was more concerned with the sick person than with the particular sickness and that the sick person was part of an environment and a community which also stood in need of healing.

James McGilvray, first Director of CMC

The report that emerged from this meeting was called *The Healing Church* (WCC 1965). From the regional consultations that followed the first Tübingen meeting, and from the surveys commissioned by WCC and LWF in 1963, came the evidence that set the agenda for the second Tübingen meeting in 1967, and ultimately for the Christian Medical Commission itself.

The first group of country-wide surveys, that led to CMC's formation, were requested by the Protestant churches of Kenya, Uganda and Nigeria. They were closely followed by Malawi, where by happy chance the Roman Catholic church was also involved. Then came Cameroon and Indonesia, and then India, and so on. *The Quest for Health and Wholeness*, James McGilvray's outstanding account of the 1960s and 1970s, contains a detailed report of the findings of these surveys. But in a nutshell, what they found was the following:

- The churches collectively were making a considerable contribution to the countries' medical facilities (for example 43% in Tanzania, 26% in Taiwan, 13% in Pakistan).
- Governments, in formulating development plans, tended to ignore the contribution of the churches, claiming that the lack of coordination between the churches made it impossible to work with them.
- Ninety-five per cent of the churches' medical activities were focused round curative services in hospitals and clinics, run mainly on Western models. Little was being done to promote health and prevent disease.
- The cost of operating these institutions was increasing annually by about four times the increase in per capita income. As a result, higher fees had to be charged, and the services became inaccessible to the poorest people.
- The location of the units tended to be determined not by health needs but by proximity to ecclesiastical (church) headquarters, leading to duplication.

In a word, there was an urgent need, in relation to medical provision, for collaboration and cooperation between the churches at national level so that scarce resources could be used more effectively, and negotiations with governments made possible. The current multiplicity of bi-lateral relationships between individual churches and "their" mission agencies, "their" hospitals was

exacerbating divisions at country level. Unless there was some kind of rationalisation of efforts, the bulk of their programmes would, before long, face closure.

The brief for the second Tübingen consultation, held in 1967, was to explore the relationship between healing and salvation. But the 1960s had seen an explosion of interest in medicine in the developing world; there was greater understanding of the significance for the health agenda of socio-economic factors; and participants had far more data – more, at any rate than those who took part in Tübingen I – to enable them to evaluate the actual role of the church in this field. The discussions that took place at Tübingen II, therefore, were much more concerned with finding a role for the church itself to play in an exciting and fast developing story. Bishop Ian Ramsey commented that they seemed to have invented an entirely new, liberated process for theological reflection, grappling with the problems and issues implicit in the context, allowing new insights to emerge, allowing these insights to throw light on the gospel, then bringing this illumination to bear on the particular problems before them.

The report, when it came, was entitled *Health - Theological and Medical Perspectives*. It consisted of just five papers, of which shortened versions are included in the back of James

There was greater understanding of the significance for the health agenda of socio-economic factors.

Girls and women in Central America demonstrate for health and work.



Sean Sprague/Panos photos

McGilvray's *The Quest for Health and Wholeness*. They were *On Death* by a physician and religious sister, Sister Mary Luke; *Health and the Congregation* by Dr R A Lambourne; *The Sacraments in the Church* by Dr David Jenkins, theologian; *Implications for Medicine* by Dr T F Davey, a physician; and *The Medicine of Poverty* by Dr Aart H von Soest, a physician. Between them, without providing real answers, these visionary papers set the agenda for the Christian Medical Commission, which started work, a year later in May 1968.

For discussion: Isaiah 61, 1-6. It gives people great confidence when they believe they are doing God's will, particularly if it is a group of people working together. How would you know if the spirit of the Lord was upon you? Does the passage give any clues? Have you ever felt like that?

Prophet and broker

CMC's importance was determined by the fact that it came around at the right time and it was possible to utilise the "kairos" of that time. New independent nations and churches in the former "mission lands" made it imperative to find new solutions for the healing mission of the churches and the CHURCH. Handling the medical mission heritage dominated during the first years.

Hakan Hellberg, 1998

CMC had first to identify and communicate the vision, and then to enable it to happen.

The first meeting of the Christian Medical Commission took place, in Geneva, in September 1968. CMC had an initial five year mandate. In effect, it was to be both prophet and broker. It had first to identify and communicate the vision, and then to enable it to happen. Its tasks were:

- a) to help the churches in their search for a Christian understanding of health and healing
- b) to promote innovative approaches to health care
- c) to encourage church-related health care programmes to collaborate with each other.

The statement that came out of that meeting was called *The Commission's Understanding of its Task*, and much of it is as relevant today as it was thirty years ago. Here is the first paragraph:

"While we are justifiably entitled to pride in reviewing the legacy of Christian medical work, we realise that some of the earlier initiatives are no longer open to us and that we must search for a new relevance today. Part of what was distinctive in Christian medical programmes was their pioneering nature – in offering medical care to those who otherwise would be destitute. However, today, governments and secular services are increasingly offering such services, and we must discover how our programmes can be coordinated with theirs. This is not to say that the pioneering aspect of our services is over. There are whole new dimensions of pioneering possibilities which are still open to us. Yet in the discovery of them we must always be aware that relevance is always relative. What is relevant today may be quite irrelevant in the days to come, and so we must always be open to renewal as we search for the appropriate ways in which the church can bring healing and wholeness to man."

Nine main priority areas were identified:

- Comprehensive health care
- Community organization
- Cooperation with governments and other agencies
- Inter-church coordination and cooperation
- Planning mechanisms appropriately structured in regional and local organizations
- Re-orientation of personnel
- Need for administrative reorganization
- Data systems
- Facing the problems of population dynamics.

And so the search for programmes began. CMC had a tiny staff and no funds to hand out. It was an enabling and supporting organization. When it identified an innovative programme, it would use the Commission's contacts to get funding for its work, and put its organizers in touch with people doing similar work elsewhere.

It difficult for us, today, to understand why the desirability of its objectives was not more obvious at the time. In many countries, in the 1950s, the principle of

"letting the people choose" was already accepted. In West Africa, India and elsewhere, there had been an emphasis on the establishment of basic health services in terms of village clinics, health centres and dispensaries. But in the 1960s and 1970s, the aid programmes of western governments were still geared to the creation of big hospitals and medical schools. Mulago (the hospital and medical college of Makerere University in Kampala, Uganda) was a gift from Britain; in Liberia, the John F Kennedy Memorial Hospital was given by the government of the USA. These hospitals absorbed a large part of the health budgets of both countries, preventing the development of more local health services that might have helped poor people; and then, because there was no effective filtering process, they became in effect the district hospitals for the capital cities, Kampala and Monrovia. All over the world, the "top-down" mind-set turned out to be hard to shift, primarily, one suspects, because it protected the professionals and because the people who made the decisions benefited from it.

Then in the early-1970s, news started to emerge from China of a revolutionary new medical system which started at the base, with health workers chosen by the community. It set out to ensure that medical care would be available to all. *Contact* devoted an entire issue to "China and the less developed nations" in December 1972. It concluded that "many third world nations have followed patterns of development which have better suited the demands of former colonial masters rather than their own present needs." The Chinese alternative, it suggested, stressed rural rather than urban health care, preventive rather than curative services, and the use of medical auxiliaries as a means of supporting highly trained doctors. But the new system was partly discounted in the West. How could a "barefoot doctor" with no medical education do a proper job? How could quality be maintained in this situation? Western governments came readily to the conclusion that such an approach



A barefoot doctor (left) serving the family of a rural herdsman.

could function only in a system very different from their own.

Those who were involved with CMC at the time describe vividly the tremendous excitement of those early days, the sense of adventure, of being at the forefront of a movement that seemed set to change the world. Its aim was the reorientation of Christian medical work towards health care that started with the community, and which focused on preventive activities as much as the treatment of disease. This would be done through the creation of structures and practices that would enable national and local churches to collaborate, both with one another and with governments. What did this look like in practice? The story of Jamkhed is an example (see box next page).

Today, this style of working is so familiar that it is hard for young professionals to imagine the newness and excitement of it all to those who were involved.

"I knew that health work was more than tablets and operations. But I felt isolated in that knowledge until one day, in the mail, I received the 1968 Tübingen report. It sought to bring back the spiritual role of healing, and it made connections between the mission of the church and what goes on in health care. It confirmed my belief that the roots of suffering are in the community. Those pioneering days were so exciting. We felt we were part of a world-wide movement that would

The Chinese alternative, it suggested, stressed rural rather than urban health care, preventive rather than curative services, and the use of medical auxiliaries as a means of supporting highly trained doctors.

Jamkhed, Maharashtra: a new experience in Christian medical work in India

Jamkhed is a small market town, the centre of a poor rural area in central India. Mabelle and Rajanikant Arole arrived there in 1969, having agreed with community leaders to explore the possibility of setting up a community-based health programme in the thirty villages in the surrounding area. Four years working in a rural hospital had convinced them that all they were doing was treating the individuals who came to the door, and doing nothing for the health of the surrounding community. Seventy per cent of the illnesses they treated were preventable, and large numbers of the patients "cured" were going home to the environment that caused the problem in the first place, and then returning to the hospital with the same illness. "This repetitive pattern of simple preventable illnesses," they said, "could not be changed by the hospital even though it was situated in the heart of the rural area."

In effect, the hospital appeared to be offering a solution to health problems, then failing to fulfil that promise, but in the process preventing the people from working out ways of improving their own health. In Jamkhed, agreement was reached with community leaders to spend six months "testing" the communities' willingness to solve its own problems.

Health – a low priority

The Aroles had been amazed to discover, in talking to local people, how low a priority health care was for them. Their greatest felt need was for food and water, schooling for children, and adequate roads for taking surplus produce to market. There was a drought at the time, so they raised money to finance the digging of deep tube-wells fitted with hand pumps, and villagers started poultry and dairy schemes. In the meantime they were recruiting and training local staff, and trying to identify and contact all indigenous practitioners and health workers in the area. They developed mobile health teams, consisting of a doctor, nurse supervisor, social worker, nurse midwife, driver, paramedical worker and village health worker.

These mobile teams proved to be hugely beneficial in terms of health promotion, health education, mother and child care, treatment of children with diarrhoea, immediate response to local emergencies and epidemics. They identified cases of tuberculosis and leprosy, which were treated alongside

other illnesses, thus reducing the stigma attached to the condition.

The logical next step was to have a village health worker in every community. But young auxiliary nurse midwives did not like going and living in the villages. Their level of achievement was therefore relatively low, although their pay was substantial. Furthermore, there was no real need for highly specialised people to do this work. The factors responsible for ill-health in rural areas are not technically complex. A high degree of trust in the health worker is far more important than literacy or a scientific education, either of which is likely to distance the health worker from the people. As one member of the team put it, "I can teach a chimpanzee how to give an injection, but I need human beings to go to the villages and change attitudes towards health." So the Aroles asked the village councils themselves to propose suitable middle-aged women, who would receive training in Jamkhed, work with families and children, and liaise with the health team on its regular visits.

There were no western-style health services in the area when the Aroles arrived, but there was an infrastructure of indigenous practitioners who would normally have been rebuffed by allopathic practitioners, whom they would see as a threat to their livelihood. The Aroles established a rapport with this network, treating them as colleagues and using them as consultants, so that eventually the indigenous practitioners became part of the health team.

Young, local women involved in community health work.



change everything. Being in contact with other people who thought the same thing made it possible to develop what was in effect a "hospital without walls".

Bert Supit, Director of the Church Hospital in the Christian Evangelical Church, Tomohon, Indonesia

For discussion: Romans 8, 31-end. St Paul makes it all sound easy. Think about times when things go wrong. How would you make sense of this passage?

Getting the act together

Dame Nita Barrow, subsequently Governor General of Barbados, describes a survey of the Christian health centres in Malawi. Dr Hastings Banda, the President, was trying to set up a national plan for hospitals and health centres. Church hospitals were not involved, in spite of the fact that they were among the best equipped in the country. Why was this, she asked Dr Banda. "How," he replied, "do you talk to twenty-nine people who do not even talk to each other over their own back fences?"

"What began as an exercise limited to the Protestant churches quickly became ecumenical when the surveyor was asked by a Catholic bishop if he would include their institutions in the study. With the approval of the National Council of Churches, he did so.

..... At the conclusion of the survey, those whose institutions had been examined were asked to assemble to hear the results of the study and its recommendations. The first of these was that they disregard the labels on their doors because labels never cured anyone but tended to inhibit dialogue. It was further recommended that they should form an association to co-ordinate their activities and engage in joint planning amongst themselves and, collectively, with government."

CMC report of the Third Conference for Coordinators of Church-related Health Work in Africa, Mombasa, Kenya, 1975

An important part of the challenge to CMC in the 1970s was to create more effective national structures for Christian medical work. Working in the Philippines in the 1950s, James McGilvray had experienced the benefits of cooperation between the programmes of different churches. In India, there had been a fellowship of doctors since 1905, but



A mother weighs her baby at Phebe hospital, Bong County, northern Liberia. The hospital is a long-standing member of the Christian Health Association of Liberia (CHAL).

Jonas Estromer/WCC

the Medical Association of India did not admit non-whites until 1950. Among church-related health professionals there was already considerable experience of productive collaboration.

As a result of the Malawian experience, a "coordinating agency for church-related health work" was established. With the encouragement of CMC, it was followed by similar groups: in 1967 the Church Hospital Association of Ghana (CHAG), in 1968 the Medical Association of Zambia, the Association of Rhodesian (now Zimbabwean) Church-related Hospitals (ZACH), the Association of Medical Missions in Botswana (AMMB), the Church Hospital Association of Nigeria (CHAN) and so on. In India, where the Christian Medical Association of India (CMAI) and the Catholic Health Association (CHA) already existed, the two bodies came together to form the Coordinating Agency for Health Planning.

Of course not all countries wanted to establish formal links of this kind. But the benefits, where it did happen, were enormous. They included the following:

- joining together to pressure governments to grant import duty exemptions to voluntary agencies
- cheaper pharmaceutical supplies through bulk buying
- provision of a platform for influencing governments and other NGOs, and lobbying governments on political issues

- avoidance of wasteful duplication and competition
- working together on training and other issues.

One great advantage of collaboration at this level was how often it brought Protestant and Roman Catholic agencies together: something which was proving less easy at the international level. There had been strong Catholic involvement in the early debates, and in particular at the second

Tübingen consultation in 1967. Today, sponsored by the Pontifical Council promoting Christian Unity, there is a Roman Catholic staff member in the mission team of the WCC secretariat in Geneva. At present this post is held by a Columban sister, Elizabeth Moran, with a mandate that is general enough to allow a very wide range of involvement and activity.

For discussion: Genesis 11,1-9. Not being able to talk together over the fence of the back yard was God's punishment to human beings for building the Tower of Babel. Are there organizations or people you do not communicate with? Can you work out why? Would Jesus approve or not?

Establishing Contact

Contact has always been a number one priority programme for CMC. It is impossible to over-emphasise the importance it has had in promoting primary health care and, in particular, encouraging communities to participate in building primary health care services. It has created links between people all over the world – Christian and non-Christian – who are involved in it.

My first knowledge of CMC was through the publication Contact. The issue on rural health quoting from a Chinese writer "Go to the people, learn from them" became an inspiration for me. It redirected my understanding of the practice of medicine since I took this as a "hermeneutic principle" in my

personal transformation.

Dr Erlinda Senturias

CMC's most valuable and influential work was through Contact. Everywhere I have gone to represent CMC I have heard testimony to the extraordinary value of the publication.

Sylvia Talbot, Moderator of CMC 1975-83

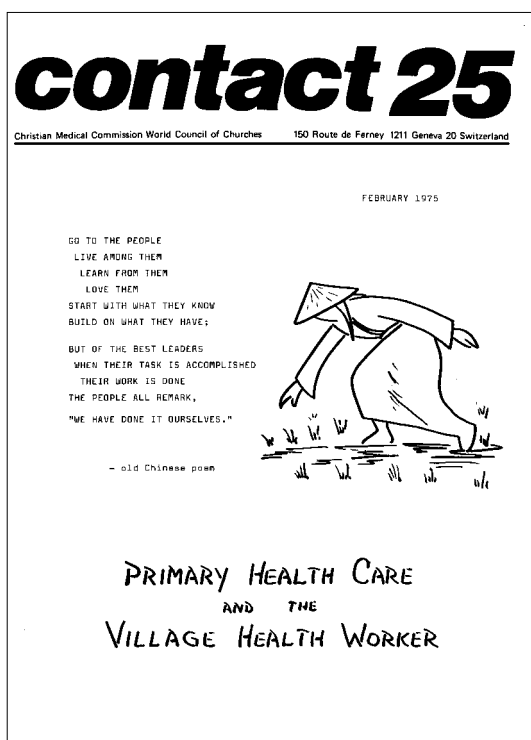
In the early days of CMC, primary health care was new and the small steps forward needed to be shared widely. Having identified key programmes, the challenge was how to make them internationally known. And so, in November 1970, *Contact* was born, initially as an occasional paper with a circulation of a few hundred copies. At first it was all hand-typed and printed from metal plates. By the mid-1970s, French and Spanish translations were being published, and circulation reached 10,000 by 1976. It has since developed into a popular bi-monthly magazine in four languages (English, French, Spanish and Portuguese), with a current circulation of about 15,000. Occasional issues were translated into Arabic and Kiswahili during the 1980s.

From the start, *Contact* has emphasised the varied aspects of the community's involvement in health. It was directed primarily at health workers, especially those working in church health programmes, government programmes, NGOs and community organizations. Today, it remains a unique international publication in that it combines ethical values with practical examples of community action to solve problems in health care. Each issue focuses on a particular theme (for instance, empowerment of women, financing health care, the rational use of drugs), with a main article supported by local experiences from different parts of the world. *Contact* also has a popular correspondence column, and a list of updated resources and addresses.

*Why are we not able to produce excellent things like this one done by that little outfit across the fields?**

Halfdan Mahler, Director General of World Health Organization, speaking to his staff

*WHO headquarters is situated very close by the WCC Ecumenical Centre.



Front cover of *Contact* 25, Primary Health Care and the Village Health Worker, February 1975

For discussion: Luke 28, 1-8. The two Marys brought good news to the disciples. At the end of the chapter, Jesus tells his followers to go out and teach all nations. What would be "good news" to you? Does it matter how or by whom it is communicated? Do you have good news to share with others? Why was *Contact* so successful?

The church mouse and the archbishop

On 22 March 1974, Dr Halfdan Mahler, Director-General of the World Health Organization (WHO), called together senior staff for a joint meeting with (all five!) senior staff of the Christian Medical Commission. As a result of this meeting, a joint committee was set up to explore the possibilities of collaboration and cooperation in "matters of mutual concern". Returning from this meeting, commenting on the bureaucratic atmosphere they had encountered at WHO, "Mac" McGilvray said to his colleagues, "I felt like a church mouse in front of an archbishop".

In spite of the disparity in size, the relationship between the two organizations turned out to be exceptionally fruitful. For a long time Mahler, McGilvray and Lesslie Newbigin (later Bishop of Madras) met for weekly lunch, to keep up to date with what was going on the other side of the field. The joint WHO/

UNICEF paper "Alternative approaches to meeting basic health needs of populations in developing countries" included some experimental work associated with CMC. In Ken Newell's *Health by the People*, a key book published by WHO in 1975, four out of the ten examples were CMC-affiliated programmes, ensuring that CMC's philosophy reached a much wider audience than the Commission's usual constituency. But the most significant result of the CMC/WHO relationship was the formulation by WHO, in 1975, of the principles of primary health care. This marked a radical shift in WHO priorities, with massive implications for health care systems everywhere.

At WHO's 1976 Assembly, Dr Mahler called for the use of primary health methodology to make health services available to all by the year 2000, and offered the facilities of WHO to analyze the problems of each country, so as to enable the development of health policies and targets which would help national governments to achieve this goal. This proposal was adopted, and became the subject of the International Conference on Primary Health Care



Dr Halfdan Mahler, Former
Director-General of the World
Health Organization

T Farkas/WCC

"I felt like a church mouse in front of an archbishop."

The Principles of Primary Health Care (WHO 1975)

- (i) Primary health care should be shaped around the life patterns of the population it should serve;
- (ii) A local population should be actively involved in the formulation of health care activities so that health care can be brought into line with local needs and priorities;
- (iii) Health care offered should place a maximum reliance on available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations that are often present;
- (iv) Primary health care should be an integrated approach of preventive, curative and promotive services for both the community and the individual;
- (v) All health interventions should be undertaken at the most peripheral practicable level of the health services by the worker most simply trained for this activity;
- (vi) Other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical, supply, supervisory and referral support;
- (vii) Primary health services should be fully integrated with the services of the other sectors involved in community development (agriculture, education, public works, housing and communication).

held in Alma Ata in the USSR in September 1978. CMC was closely involved in the planning, and many of the presentations came from members of the CMC family.

In this process, WHO was trying to develop a simple and easily understandable methodology, which could be replicated, and which carried a stamp of approval which might make it acceptable to governments. But making PHC universal through government programmes created its own problems. The original vision of PHC had been as a force for liberation and empowerment through the promotion of health care. Once it had been watered down to methodology acceptable to governments, it could no longer address key issues such as corruption and oppressive systems. Governments interpreted placing "maximum reliance on available community resources" as a means of saving costs. The controversy over whether PHC was an alternative to hospitals took the debate away from the more important issue of how "other echelons of services should be designed in support of the needs of the peripheral level".

A community health worker in Yamblo village, Sudan



Acceptance of PHC

WHO's approach was immediately adopted by the government of Sudan, then, with local modification, by Guinea-Bissau and Cape Verde. Many other countries followed, but few governments allocated the necessary funds and political will to create real change. In the Philippines, for example, the Department of Health organized a one-off, three-day programme for Barangay health workers who would be responsible for the health of the villages.

Meanwhile, CMC and other NGOs made every effort to promote the original concept emphasising the need for community involvement and the need to draw in other sections, such as agricultural and education. However, gradually PHC came to be a top-down government approach rather than bottom-up peoples' initiative.

Warning sounds about how PHC would work in practice were made early on. In 1975, the Christian Medical Commission invited Dr (now Professor) Charles Elliot, a priest and economist, to address its annual meeting. He entitled his talk 'Is Primary Health Care the New Priority? Yes, but.....' It is printed in full in *Contact* Issue 28.

Over twenty years on, Dr Elliott's concerns ring many bells. He had serious reservations about the ability of PHC to bring health care within reach of the millions who were currently denied it. He doubted whether equality of access to health care resources would ever be a realistic objective. He warned of the dangers of PHC methodologies predicting that they would become institutionalised in a way that prevented PHC from reaching the poorest; that health is not in fact stated as a high priority by most communities; that able people want to get on in life, and PHC made no provision for upward mobility among newly skilled health workers; and that without fundamental change in the budgetary allocations of governments, the structure of health services and the training of health professionals, it was unlikely that "other echelons of the service" would ever be designed "*in support of the needs of the base*". What was more likely was that the existing two-tier system would be strengthened, with the minority having access to high-cost technology while the poor majority got primary health care.

For discussion: Daniel 1, 3-20. Why is King Nebuchadnezzar favouring these young men in this way? He clearly believes that everything Babylonian is better than everything Israelite. Does this belief ring any bells in your own experience? How important is it, and for whom, to convince the king that their way is better?

CHAPTER TWO

A CHRISTIAN MEDICAL COMMISSION

Why Christian?

In the preface to the first Commission meeting in 1968, the then director, James McGilvray wrote: "The CMC came into being as a focus of two converging interests, one functional and one theological." The functional concern we have dealt with in the first chapter. The theological concern was that the Commission should seek new insights into the interconnections between healing, the Gospel and the mission of the churches. Eight years later, in reviewing the Commission's progress, members felt that they had done quite well with the functional without any comparable progress in clarifying what might be unique in Christian understandings of health and healing.

As a contribution to the Commission's study, a small group of participants had started to meet at DIFÄM in Tübingen. Their discussions focused on three issues. The first was the unease that was felt in promoting more egalitarian health policies for the developing world, when there was virtually no expectation that the industrialised nations would follow suit or set an example.

Second, the congregations of churches themselves were failing to engage with people in their present suffering. It was further felt that the actual systems and practices of parish life, worship and training did not often make such engagement easy. For the participants in the Tübingen group, this was a problem. They believed profoundly that the way to true health and wholeness lay in the salvation offered by Jesus Christ, but they saw the churches themselves failing to communicate this most important message.

The third issue was the extreme difficulty of changing people's attitudes to health without engaging with other political, sociological and cultural issues as well. People's feelings about their bodies are rooted in values, beliefs and spirituality that are part of our cultural identity. Change may meet resistance from – and also have implications for – the whole political and cultural context in which people live. As Christians, therefore, we should not be saying we want to reform our approach to health unless we are also willing to address the church's failure to engage with the struggle to reform society.

I think one trouble with us Christians is that we imagine that we are a healed community because Christ is whole. We also imagine that we can heal others although remaining sick ourselves, perhaps without noticing it while everyone else does notice.

Archbishop Anthony Bloom,
Metropolitan of Sourozhm

The group's first debate focused on possible starting points for discussion. Where should you begin? With the problems of the world, or with the Bible? "The Bible," said one participant, "does not portray the discovery of God's will and calling through being biblical. It displays such discoveries through facing



Woman in a Presbyterian chapel in Chimaltenango, Guatemala, carrying a bible on her head.

Change may meet resistance from – and also have implications for – the whole political and cultural context in which people live.



Seen near Juba, Sudan.

Peter Williams/WCC

The work of CMC and its friends had an importance which extended far beyond the provision of health services in the developing world.

up to problems in the contemporary history and experience of society, responded to in the light of insights derived from the tradition and life of the people of God.” It was agreed that the task of this study group would be to focus on the existing situation in medicine and health care and to scrutinise it in the light of a Christian understanding of human nature, and what the Bible has to say about health and healing. Their first position paper was called “The Mission and Service of the Church in Sickness and Health Care.”

It is difficult to overestimate the importance of this dialogue. Given the general feeling that CMC had concentrated too single-mindedly on the promotion of PHC, these discussions enabled the Commission to enter the 1980s with a much more deliberate focus on the exploration of the theological implications of health care. This exploration has been a major thrust for the Commission ever since.

That this new focus was so generally welcomed was due, in part, to the fact that WCC and its member churches had become convinced that the work of CMC and its friends had an importance which extended far beyond the provision of health services in the developing world. The ideas they were promoting rang bells in other quarters, too. They had implications for the identity of the

church itself and the history of the kingdom of God.

The last word in this section must come from Charles Elliott. “We have a lot in common with WHO,” he said, “but our ultimate aims are not the same. For a Christian organization to ignore the importance of the spiritual dimension of health is for it to ignore the really crucial input it has to make to the debate about the nature of healing. Health is more than medicine. It is to do with the way you live and the way you die, the quality of life and the quality of death. The ultimate answer to disease lies in a way of life – a life of surrender and obedience that leads to wholeness.”

The interesting thing is that WHO, today, is coming to agree.

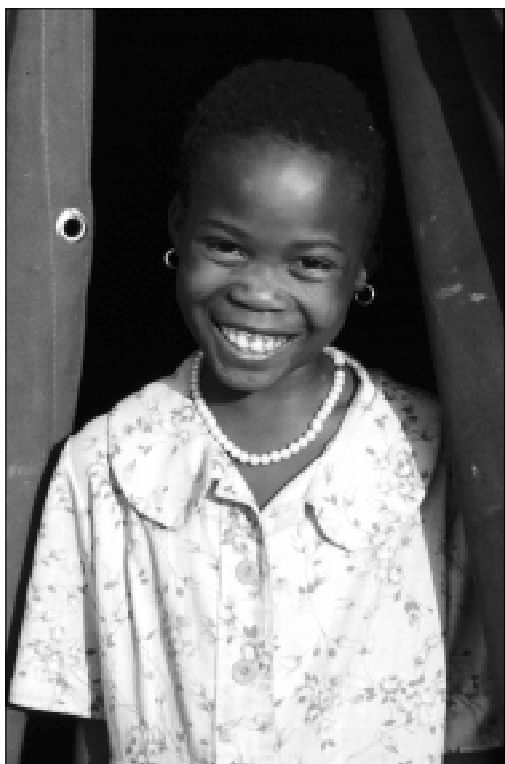
For discussion: Acts 5, 12-16. From the earliest times, belief in Christ has been associated with health and healing. What does this mean for you? Is it possible for the spiritual aspects of your work to become submerged by the urgency of getting the job done? Try relating the concerns set out in paragraphs 2 and 3 of this section to your own experience of the church.

The Jenkins/Bryant dialogues

There is a crisis in medicine, to the point at which some people are saying that healing lies outside the medical profession, and that doctors are the ones who oppose true health. There is a crisis for the church, with some saying that the real church lies outside the church. And there is a crisis in the consciousness of many Christian doctors, nurses, teachers and social workers who believe there is truth in Christ, in Bible and Christian religion, and yet find that what seems to enlighten them in their chosen work and in their personal lives is something else; hence they go through life divided.

R A Lambourne, 1969 (first printed in *Contact* Issue 1)

The Christian Medical Commission was born out of a belief that there is something peculiarly Christian about the business of health and healing. Jesus healed. The beneficiaries of his ministry were not primarily the rich or the strong, although these were by no means excluded: they were the poor, the sick, the stigmatised, the disabled. Since the Middle Ages (European history between 472 and 1453), then, the establishment



Peter Williams/WCC

development of a theology of healing: one that took seriously the relationship between the structures of health care and the kingdom of God.

Technology is to do with problem solving but theology is to do with living with problems.

David Jenkins, CMC annual meeting 1969

It had always been part of CMC's mandate that it should address these issues, which formed the subject matter of the second Tübingen consultation in 1967. In the early 1970s, the Commission's annual meetings opened with an on-going dialogue between Dr Jack Bryant, Moderator of CMC, and the British theologian Dr David Jenkins (later Bishop of Durham) who at that time was working for WCC. First Jack Bryant challenged Dr Jenkins to set out what the discipline of theology had to offer to physicians having to make life and death decisions about priorities in health work. Once, the hospital had provided a framework for these. What does it mean for a physician to be responsible for a rural area of – say – 100,000 people in 100 villages? Our care for individuals often results in the neglect of many times that number. Is there such a thing as "statistical compassion" and what is its theological equivalent? In trying to provide health care for large numbers of people on limited resources, what are the theological concepts that will give the decision makers a system of human

Spiritual dimension: the smile of a refugee girl in Namibia.

There was much work to be done on... the relationship between the structures of health care and the kingdom of God.

and maintenance of institutions to care for the sick had been a priority for the Western church. Medical work had been a major thrust of Christian mission in Africa, Asia and Latin America.

All over the world, though, it seemed the churches' health work had somehow become divorced from the life of the congregations of Christians who gathered in churches on Sundays. Christians saw it as their task to raise money to support it. They did not expect to get involved with it themselves. That was for the doctors, nurses and teachers whose job it was to do it. The church had in effect "contracted out" its caring role to professionals and told them to get on with it as best they could. As a result, the local church was in danger of becoming a ghetto, while the front-line of Christian encounter with the world was somewhere else. The consequence was an increasingly privatised religion that had nothing very much to do with what was happening in the world, while members of the so-called caring professions, many of whom came to the work with strongly Christian motivation, found it impossible to bring their professional concerns into the arena of the worshipping community. Further, there was much work to be done on the

Dr David Jenkins at a recent CMC meeting in London. With him are CMC/WCC Commissioners, Mrs Marion Morgan, Executive director of Christian Health Association of Sierra Leone (CHASL) and Ms Gwen Crawley.



Diana Smith

values to fit into the technological methodologies? Can the churches develop a social morality of health care that might be of use to governments and secular institutions?

The first dialogue, then, focused on making moral decisions, and the challenge of living with them. How do you make moral sense of a situation in which you are taking decisions which will benefit some while possibly bringing about the preventable death or disability of others? In asking this, we raise further questions. Of what value are those lives we are deciding about? What is human life for? How are human values to be brought into the framework of technology? What does it actually mean to be responsible for the health of 100,000 people in an area, and to have make choices between treatment and prevention? So the second dialogue, arising from the first, was about values.

In the third dialogue, the two of them addressed problems of health care and justice: issues which bring one face to face with politics, power and the injustices inherent in human systems. How far down that road is it appropriate to go? And what hope is there, if the dice are so loaded? Dr Jenkins finished with three memorable phrases. Christians do have resources to help them live with integrity while acknowledging the sin of the world. We need, he said, to

hang on to "the hopefulness of solidarity in sin"; "the non-utopian nature of impossible hopes"; and "the possibilities of the infinite in the finite".

The great problems of change seem to me to be institutional problems. But the institutional problems are those which trap human beings and to which human beings respond. And unless we can become ourselves persons who are free for re-identification and help others to become such, all this talk about re-identification and so on is quite hopeless.

David Jenkins, 1970

Commissioners who were present at these early meetings describe the Jenkins / Bryant debate as one of the highlights of their time with CMC. The Commission's work continually raised questions about morality, the role of the church, the relationship between health and salvation. The 1970s had seen the urgent need to implement the more functional aspects of the Commission's task. By the end of the decade, it was time to invite the CMC family and networks to start looking, in a more systematic way, at the theological and ecclesiological implications of what they had been doing.

For discussion: Luke 10, 38-42. This tends to be used as a story about the role of women. But it is not just women who find themselves too busy to talk theology. Why is it that we tend to leave it to the theologians? Do you think you make enough time to share with colleagues and friends about the connections between your work and your faith?

We need, said Dr Jenkins, to hang on to "the hopefulness of solidarity in sin"; "the non-utopian nature of impossible hopes"; and "the possibilities of the infinite in the finite".

Helper in a polio immunization programme in Morocco.

P. Abensur/WHO

