

CHAPTER FOUR

BRAVE NEW WORLD?

Many countries in the South had huge debts.

CMC in the 1990s

Clockwise from top:
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**Looking forward, looking back**

On the political front, the 1990s opened in hope. A more just and peaceful world seemed a real possibility. In South Africa, there would soon be a black president; in the Middle East, a new commitment to peace. The Berlin wall had fallen, and the cold war, which had proved so damaging to the rest of the world, had finally ended.

For the world's poorest people, these shifts were largely irrelevant. The factors hampering the development of healthier communities were still in place. Many countries in the South had huge debts, and the conditions for rescheduling them included structural adjustment policies that entailed cuts in welfare spending and had disastrous effects on the health of families. Indebted to international

bodies like the World Bank, governments found their ability to act curtailed. The disintegration of the Soviet Union led to a loss of confidence in the socialist agenda, and also the loss of an ideological home for those who opposed capitalism. The growing power of transnational companies and international financial institutions was leading to a world without borders in which poor countries became poorer, and the marginalized had less hope that they would ever come in from the cold. In the

meantime, the gap between rich and poor, rich countries and poor countries, was widening rather than narrowing.

It had been a key principle for Christian Medical Commission that the road to better health lay in strengthening communities, and their members, to take responsibility for their own health and well-being. Globalization erodes that ability because those who are affected by the problems it creates are very far away from the centres of decision-making. National infrastructures are caught in the same trap as the poor communities themselves, being subject to global pressures over which they have little control.

Of the major pieces of work carried out by CMC in the eighties, two of them directly addressed these issues. The Pharmaceutical Programme established models for the procurement of appropriate and affordable drugs, as an alternative to the costly or unsuitable products marketed or dumped by many major drug companies in the developing world. The breastfeeding programme took a stand against the marketing practices of a multinational baby milk manufacturer. Both these programmes involved working with a range of other organizations, national and international, statutory and voluntary, Christian and non-Christian. Both targeted key points at which global economic power interfaces with the health of poor communities. There is much to be learnt from these initiatives, as examples of how action for community health can be effective in the context of globalization.

But the major legacy from the 1980s, as far as CMC was concerned, was the study process on Health, Healing and

Wholeness. The regional meetings had made a powerful impact. If the healing community was the church itself, what did that imply for Christian action and thinking, for church organization, for liturgy, for financing? The potential implications of this study, the mind-boggling possibilities it suggested, were almost too great – and ultimately too challenging – to contemplate.

For discussion: Romans 8, 31-39. What are the external threats to your own work, or your own organization? Which “principalities and powers” are you conscious of? How does this passage help?

CMC within WCC

When the World Council of Churches set up a Christian Medical Commission, back in 1968, the Commission formed part of the work of Mission and Evangelism. Following the Nairobi Assembly, in 1975, it became part of the Unit on Justice and Service. In 1992, there was a further re-organization and CMC moved back into what is now Unit II, Churches in Mission, Health, Education and Witness: a move which partially reflected the thrust of its work during the 1980s, since the Health, Healing and Wholeness study was so closely identified with the core-life of churches and congregations themselves.

Since the earliest days, there has been debate about how CMC relates to the traditional tasks of the churches. James McGilvray, in “The Quest for Health and Wholeness”, suggested that CMC’s *ministry* was its *service*, and that both were part of the whole *mission* of the church. These debates are not just semantics. If your work comes under the heading of “Justice”, or on the other hand of “Ministry”, it may well have implications for the style and language in which you talk about it; for the way you communicate it, and to whom; to the identity of the groups you relate to structurally, and to the theological tradition from which you draw your concepts.

CMC - Churches' Action for Health, today, falls within in the Council's work on *mission*. This means that the networks it relates to within the member churches are no longer the *justice* ones, but (in situations where these are struc-



Peter Williams/WCC

Dr Nelson Mandela, now President of South Africa, meets Dr Emilio Castro, General Secretary of WCC in Johannesburg, 1991.

turally separate) the *mission* ones. Fortunately, most churches are coming to realise that their concern for justice and for mission are so integrally connected that they cannot be separated without radically damaging the agenda of both. Nevertheless, the past has a powerful influence. With the best will in the world, the priorities of the justice and service networks may tend to be geared to activism, development, campaigning, social and political change, whereas the priorities of the mission networks may still, to a large extent, be geared to church growth and overseas service.

If CMC is going through an identity crisis, it has to face it during a period in which the WCC is faced with reinventing itself, and when the ecumenical movement itself is confronting challenges to its self-understanding. In many parts of the world, congregations in the mainstream churches are dwindling numerically, and in particular, are failing to attract a new generation of young people. Human and material resources which were once committed to ecumenical activity are now being diverted to building up denominational identity.

If the church itself is in such need of healing, what challenges does this represent to the future priorities of an ecumenical network committed to “action for health”?

For discussion: John 2, 18-22. The theme of destruction and renewal, death and resurrection occurs repeatedly in the New Testament. It can be applied to

Fortunately, most churches are coming to realise that their concern for justice and for mission are integrally connected.

institutions and organizations as well as individuals and their spiritual lives. Can you think of any examples in your own experience? Where can you identify the presence of God in these examples?

The challenge of HIV/AIDS

In the thirty years of CMC's life, no health issue has received so much public attention as the challenge of HIV/AIDS. For the churches, it is has involved soul-searching. Their pastoral calling to minister to the sick and marginalized has drawn many Christian institutions to care for people living with AIDS; but the connections between AIDS and sexuality, and AIDS and paternalistic structures have made it very difficult for churches to face up to the implications of HIV transmission not just for Christians but for the churches themselves. The challenge to the churches was to re-examine the conditions which promoted the pandemic, and to become more conscious of the human implications of broken relationships and unjust structures, and of their own complacency and complicity.

In 1994, the Central Committee of the World Council of Churches meeting in

Johannesburg, South Africa mandated the formation of a consultative group to conduct a study on HIV/AIDS. The aim would be to help the ecumenical movement to shape its response in four areas: theology; ethics; pastoral care and the church as a healing community; and, justice and human rights. The study should challenge the churches to be more honest,

more faithful and better informed, and also to become safe places for people living with HIV/AIDS. Dr Erlinda Senturias from the Philippines coordinated the process.

An international group was appointed: medical and non medical, clergy, religious and lay, all of them either living, or in some way working, with AIDS. The two-year process, chaired by Dr Christoph Benn, is described by those who took part as a journey, one on which the "travellers" – in spite of apparently irreconcilable differences of approach – found that they experienced a high degree of common vision. Members describe a sense of unity and inspiration in listening to each other, and in worshipping together, and in the various encounters with the reality of HIV/AIDS in different cultural contexts.

The report, when it was published, drew together the findings of the four working groups, (theology; ethics; justice and human rights; and pastoral care and the healing community), all of which addressed the real experience of people with AIDS in different parts of the world. It is impossible to do justice, in this brief section, to the insights or to the quality of dialogue contained in it. They are all presented in "Facing AIDS: The Challenge and the Churches' Response" published by WCC in 1997. I will, however, quote in full the recommendations that go into the final chapter (see box on page 36).

This consultative process was a major programme of WCC as a whole. While it was coordinated by CMC-Churches' Action for Health, the participants were drawn from different interest groups within the Council's life. In addition, CMC itself sponsored innovative pieces of work, and held regional meetings in Asia, Latin America, the USA, and Africa and Europe. It also supported the setting up of ICAN, the International Christian AIDS Network.

In Africa, encouraged by CMC, the Tanzanian, Ugandan and Zaïrian Protestant medical agencies set up an experimental Participatory Action Research (PAR) programme. This

The connections between AIDS and sexuality, and AIDS and paternalistic structures have made it very difficult for churches to face up to the implications of HIV transmission

WCC chapel prepared with the AIDS ribbon for the Central Committee meeting, September 1996.



Peter Williams/WCC

Theology from the standpoint of the body which suffers and dreams and delivers itself up to the Mystery.

It is hard not to speak in the first person singular. I do not think this implied reductionism or exaggerated individualism. Every time we pay attention to individual experience, we can identify elements which are more general, collective.

That is the case with the suffering body. When my infections became acute in recent years, the immediate sensation was the identification through my body with the bodies of so many other people, in anonymity and solidarity; with – somehow – the suffering and the limits to energy and the resistance to pain.

In a way, the suffering led me to realise the limits of my body. There was a kind of division between the pace of thought and awareness – a quicker one, more hopeful, trying to get around limits – and the lack of control over legs and feet, over the body in pain, over the unexpected sleepiness and intermittent diarrhoea.

As a normal response to the pain and despair of experiencing limits, a profound cry sometimes, in silence or in tears, a murmur that seems like Paul's image of all of creation groaning as if in the pangs of childbirth as it awaits its liberation from limits and vulnerability (Romans 8). A sensation of the collective unconscious: in one body, all bodies. The tired, suffering body of the world, the oppressed and down-trodden body of the poor, the repressed and violated body of so many women, the bodies, without energy and resistance of boys and girls...

It is impossible not to have the feeling, in spite of the particularity of my experience, of identifying with millions. Yes, we are millions who are *infected* and *affected*.

Ernesto Barros Cardoso, from his statement "The experience of faith in the face of suffering despair, the search for healing and salvation, the expectation of death, the hope of resurrection" to the HIV/AIDS study process.

turned out to be a crucial plank of the AIDS work they supported. The idea for PAR arose from the perception that communities so burdened with the problems produced by HIV are (a) in urgent need of building up their coping capacity and (b) strongly motivated towards a fundamental examination of cultural and other factors which reduce that capacity. PAR enabled communities to do their own research, to identify the issues that need to be addressed, and to develop strategies for dealing with those issues. This system is fully described in an excellent and clearly presented new handbook called "Confronting AIDS Together", written by Anne Skjelmerud and Christopher Tusubira, Director of the Kagoma project in Uganda (See *Contact* 160).

In the context of AIDS, the subordination of women has become an urgent threat to public health.

Jonathan Mann, former Director of WHO's Global AIDS Programme

The programme on women, health and the challenge of HIV was another major piece of work for CMC, drawing together programmes in Brazil, Argentina, Costa Rica, Chile, India, Thailand, Papua New Guinea, Uganda, Zaire, Tanzania and the USA. Attitudes to women, it found, are so ingrained in the cultures of communities that for most of the world's population it is almost impossible for the individual to change his or her behaviour except in the context of a general decision within the community

PAR enabled communities to do their own research, to identify the issues that need to be addressed, and to develop strategies for dealing with those issues.

A woman mourns her husband, her children mourn their father.



L Gubb/World Health Organization

WHAT THE CHURCHES CAN DO

A: The life of the churches: responses to HIV/AIDS

1. We ask the churches to provide a climate of love, acceptance and support for those who are vulnerable to, or affected by, HIV/AIDS. This could be expressed by providing space for these concerns to be raised within regular worship, by special worship events (for example, in observance of World AIDS Day on 1 December), through support groups and by visits to those affected by HIV/AIDS.
2. We ask the churches to reflect together on the theological basis for their response to the challenge posed by HIV/AIDS.
3. We ask the churches to reflect together on the ethical issues raised by HIV/AIDS, and to support their own members who, as health care professionals, face difficult ethical choices in the area of prevention and care.

B: The witness of the churches in relation to immediate effects and causes of HIV/AIDS

1. We ask the churches to work for better care for persons affected by HIV/AIDS.
2. We ask the churches to give particular attention to the conditions of infants and children affected by the HIV/AIDS pandemic and to seek ways to build a supportive environment.
3. We ask the churches to help safeguard the rights of persons affected by HIV/AIDS and to study, develop and promote the human rights of people living with HIV/AIDS through mechanisms at national and international levels.
4. We ask the churches to promote the sharing of accurate information

about HIV/AIDS, to promote a climate of open discussion and to work against the spread of misinformation and fear.

5. We ask the churches to advocate increased spending by governments and medical facilities to find solutions to the problems – both medical and social – raised by the pandemic.

C: The witness of the churches in relation to the long-term causes and factors encouraging the spread of HIV/AIDS

1. We ask the churches to recognise the linkage between AIDS and poverty, and to advocate measures to promote just and sustainable development.
2. We urge that special attention be focused on situations that increase vulnerability to AIDS such as migrant labour, mass refugee movements and commercial sex activity.
3. In particular, we ask the churches to work with women as they seek to attain the full measure of their dignity and express the full range of their gifts.
4. We ask the churches to educate and involve youth and men in order to prevent the spread of HIV/AIDS.
5. We ask the churches to seek to understand more fully the gift of human sexuality in the contexts of personal responsibility, relationships, family and Christian faith.
6. We ask the churches to address the pandemic of drug use and the role which this plays in the spread of HIV/AIDS and to develop locally relevant responses in terms of care, de-addiction, rehabilitation and prevention.

*We ask the churches
to provide a climate
of love, acceptance
and support*

that such change must occur. It was intended that the findings should be presented at the NGO forum of the UN Conference on Women in Beijing, though this was not in the end possible, and the group met, simultaneously with the Beijing conference, at Vellore in South India. The findings of this programme, plus the stories of many of the people who took part in it, appear in "Love in a Time of AIDS" by Gillian Paterson (WCC 1996, Orbis 1997).

There are many reasons why the HIV pandemic offered CMC a chance to make use of what it had learnt over the previous twenty years.

1. CMC networks have always recognised the association between ill health, poverty and marginalization, and tried to encourage change.
2. Sexual relations, and our gender-related behaviour generally, are part of our cultural heritage. They are therefore very difficult to change. CMC has always linked health with the need for development and community building.
3. For this infection, at this time, there is no cure. HIV/AIDS therefore challenges our view of what constitutes healing. Maybe. Healing after all involves living with confidence that you are loved and accepted, and dying with dignity, in a community which is at peace with itself. These are issues which CMC had been looking at in the Health, Healing and Wholeness programme.

Many churches have good records of setting up pastoral programmes for caring for people with AIDS and supporting their dependants. What is not so easily accepted is the extent to which the churches embody in their own being the complex of factors which leads to the spread of HIV. Churches tend to be hierarchical and patriarchal structures; they do not readily welcome people who are marginalized or stigmatized within society; they are bad at acknowledging sexuality; and for most of them, the healing role of the church is not a priority. The extraordinarily rich material



L Gubb/WHO

Women rejected because of AIDS find refuge at a special home run by the sisters of Mother Theresa's order.

that has emerged from WCC's HIV/AIDS programmes presents a huge challenge to the church, and to moral theologians. The immensity of this challenge has yet to be fully understood. There are lessons here, however, for the Christian understanding of health and healing, and the role of the churches in making it happen.

For discussion: John 11, 32-46. Ernesto Cardoso was a Brazilian lay theologian who died of AIDS in 1995. Ernesto's experience of living with AIDS made him identify strongly with Lazarus' experience of lying rotting in the tomb, and then being led out to new life by Jesus. Why might that be? How is "new life" possible, even for somebody who is dying?

Capacity building

I think the key is a process of situational analysis done by the community itself. By beginning to work on the health problems, the people begin to get a sense of their power to affect at least some aspects of their lives. In the process of situation analysis, determining the causes of poor health, people begin to move back from focusing on curative action to preventive action, and eventually they begin to take socio-political action.

Part of an interview with David Werner, author of "Where there is no Doctor". *Contact* 129, February 1993

The decade opened with a feeling that not enough headway had been made with the establishment of community-based health care, and a concern that problems of sustainability would further hamper its progress. The challenge that presented itself was to build up the coping capacity of communities, so that they were less dependent on help from outside. In 1987, in Zimbabwe, a set of

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Community training session in Latin America

"Training for Transformation" was designed to bring people together and equip them to tackle problems in their own environment in an effective way.

radically different course books for communities appeared. Developed by two Roman Catholic sisters, and based on Freirean methods used in Latin America, "Training for Transformation" was designed to bring people together and equip them to tackle problems in their own environment in an effective way.

Dan Kaseje, who was then Director, saw the importance of these methods for the CMC family. First, health professionals rarely have the training or experience for building up leadership patterns and coping capacity. This meant that there was a need for selection and training of community members as facilitators. Second, many church leaders did not understand the participatory approach, regarding it as a mystery or a threat rather than a valuable resource. And finally, with some exceptions, little progress had been made in changing priorities in the education of doctors, or introducing medical students (who tended to come from middle class families) to the realities of life in poor communities.

Think-tank meetings

In 1989, CMC sponsored an international think-tank on community-based health development, and in 1990, regional and sub-regional think-tanks were held in Benin, the Solomon Islands and Amsterdam. Participants in the think-tanks then organized a series of training workshops for facilitators,

notably in Benin, Sierra Leone, Zaire and Cameroon. In Sierra Leone and Liberia, workshops for church leaders were also held. The meetings were designed to give participants experience in using capacity-building methodologies, and help them develop workshops for their own localities.

Among the resources available, we would like to mention methodologies such as "educacion popular de salud" from Latin America, participatory health training methodologies from the Philippines, India and Japan, and community health methodologies coming from Africa (AMREF). The educational process is contextual and takes into account the cultural and social differences of each region. The value of the participatory approach is that it is a process, a movement which is alive and which is based on and nurtured by people's experiences and not imposed techniques.

Report on capacity building by
Margareta Sköld

I found (in being part of the CMC family) the possibility of opening spaces so that people, who were very isolated by reason of the national situation in Argentina, could share experiences. When I came in contact with people from Chile, Uruguay, Paraguay and Brazil, I learnt how important it is to know other experiences, to debate about the common problems and how to find mutual solidarity.

Mabel Filippini, Director of CEASOL
(Asociacion del centro ecumenico de accion solidaria), Buenos Aires, Argentina

The participants begin their learning experience in the workshop by sharing their own experiences in their respective communities and organizations. Facilitators and resource people help to manage the flow of communication among participants. The learning experience can only happen if the participants learn to share honestly among themselves, to listen to what others have to say and to express themselves freely.

We would like to believe that the training we offer at AHI (Asian Health Institute) is aimed not just at increasing knowledge but at providing a venue to share concrete experiences and insights; successes and failures and shortcomings; as well as dreams, visions, concrete alternatives and action plans to promote the transfor-

mation process, starting from oneself, in the struggle to improve the quality of life at the grassroots. The training process is aimed at initiating self-change, at renewing the conviction to be of greater service to people, through attitudinal change and the sharpening of critical faculties and understanding of social phenomena. There can be no social change without self-change within those who are catalysts of social change and also within the people who are the subjects of social change. We are speaking here of an education process for liberation, based on Paolo Freire's "Philosophy of Education".

Yoshi Ikezumi, Executive Secretary,
Asian Health Institute, Aichi, Japan
(published in *Contact* 129, February 1993)

These participants speak of the liberating effects of these regional meetings. Being part of a movement that was global, but also local, was an inspiring one. While the key to success was the ability to engage with a particular context, it became clear, too, that much was to be learnt from cross-cultural encounters. South-South consultancies and South-South dialogue at meetings were proving invaluable.

In the course of 1991, CMC employed a consultant, Dr Patricia Nickson, to promote and coordinate the programme among member churches and coordinating agencies in Africa, with a particular emphasis on Francophone countries. Her brief was to help local churches in organizing workshops and seminars, and to explore possible routes to curriculum development for community health courses. The only option for students was often to go for training in Europe: a costly exercise, and not always appropriate for people working at community level. In 1992, in Nyankunde in northern Zaire (now the Democratic Republic of Congo), the Institut Panafricain de Santé Communautaire (IPASC) was set up, with the collaboration of and support of the Liverpool School of Tropical Medicine in England. It runs three-month courses, and facilitates the organization of workshops and conferences in Francophone Africa.

In 1991, a regional conference was held in Quito, which led to the setting up of local networks in South America; between 1992 and 1994 workshops were held in Tahiti, Tonga and Kiribati, and the Cook Islands; leading to a range of local activities; and in 1993 CMC facilitated a training for transformation workshop with ecumenical church groups in Sweden.

For discussion: Ezekiel 37, 1-14. This powerful story is about God using Ezekiel to restore wholeness and life to a nation that was falling apart. It is a dream. But the flesh and the sinews are real, and God's plans for his people are, too. Can you think of any parallels in your own experience? They may be situations in which new life has happened, or situations in which it is desperately needed.

Crucial links and partners

Blessed are the flexible, for they shall not be bent out of shape.

Elizabeth Sele-Mulbah, former Executive Director of the Christian Health Association of Liberia

This section is an account of one of the think-tank meetings. It drew together people mainly from one continent. I am going to give it a section to itself because it led to a network in Africa which may provide food for thought among churches and health professionals in other regions.

In October 1995, CMC-Churches' Action for Health sponsored a consultation in Harare to which it invited representatives of the International Red Cross and Red Crescent Societies, and also Dr Hari John, a pioneer of the commu-

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Dan Kaseje, former Director of CMC



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nity-based health care movement in India. Organized by Dan Kaseje and Margareta Sköld, its aim was to set up networks and structures that would ensure the sustainability and effectiveness of community action for health in Africa into the 21st century. It was entitled, "The sustainability of community-based health care beyond the year 2000: The crucial links and partners."

The first impression that emerges from reports of this consultation is of a group of people who are all trying to find space for community-controlled health care within an overwhelmingly hostile environment. In their attempts to develop health and other programmes, participants had found their working



Rwandan refugees waiting to cross a bridge into Zaire.

agenda dictated by knee-jerk reactions to war, drought, AIDS, political instability, increasing poverty and chronic underdevelopment. In many of these situations, no immediate improvement seemed in sight. In a continent which seems to have been dogged, recently, by disasters of various kinds, how does one make a start, even, on the business of long-term capacity building? The most urgent needs, it seemed, were to be flexible, not to panic, to be prepared for the process of digging in for a long struggle, and to be willing to see health in its very broadest sense.

I will allow the participants in the Harare meeting to speak for themselves.

From the church compound, we witnessed the advance of what turned

out to be 1.5 million (Rwandan) refugees. In the initial panic, I failed to realise that I was not expected to cope with the influx of refugees. In retrospect, we have identified three priorities for the future. First, "preparedness arrangements" should be made. Second, requests for assistance should be sent out as quickly as possible. Third, provision for care for the carers was vital.

Patricia Nickson, Director of IPASC, Democratic Republic of Congo

When refugees were pouring over the border from Rwanda and Burundi into the western Tanzanian village of Ngara, the Tanzania Red Cross were the first agency on the spot to deal with the situation. Later, a German Red Cross team was sent, which took over all responsibilities and didn't even sit down to discuss the situation with the Tanzanians. Once the crisis was over, the German Red Cross team went home, leaving the Tanzania Red Cross to deal with all the problems associated with the intervention and to handle the repatriation, and also compensation to those living in the area.

Alice Mmari, head of community-based health programme, Tanzania Red Cross

People could have been encouraged to organise themselves from the start. We need to affirm that, whatever the situation, people must take care of themselves.

Elizabeth Sele-Mulbah, CHAL, Liberia

If the traditional health system provided by healers among the refugees (in Mozambique) had been allowed to develop, it might have produced a programme which made more sense to those involved, and would certainly have been more empowering.

Report of a participant, who had worked in Mozambique, to the Harare meeting

We learnt from the experience (of war in Liberia) that a healing and reconciliation process should be put into action as soon as possible. If not, false scars form which have to be opened up before healing can start. The focus of the programme should be justice and reconciliation, forgiveness, restoring dignity, and above all building hope and spiritual well-being. Peace education work with youth groups and community leaders must be a priority.

Quotation from report of Harare meeting

It will be a great day when our schools and hospitals have all the money they need and the military has to hold a jumble sale to buy a missile.

Busisiwe Mabatho Gcabashe, South African Development Education Programme

In the context of war and political turmoil, the factors that influence the sustainability of community-based health care are thrown into stark relief. Look at the quotations. Patricia Nickson describes feeling that you have to do everything when what you really need to do is to decide a strategy, ask for help, and support the people who are doing the work. Alice Mmari describes what happens when outside agencies ride roughshod over the local groups who will ultimately have to carry the can. Elizabeth Sele-Mulbah stresses the importance of making people feel, from the word go, that they must take care of themselves. For the participant who had worked with the refugees in Mozambique, life in the camp had demonstrated the limitations of western medicine. It also highlighted the crucial importance of recognising, encouraging and supporting indigenous healers, and the development of traditional health systems within the camps. From experience in Liberia, again, but also from Rwanda, Mozambique, Sudan and South Africa comes the suggestion that reconciliation is a key aspect of healing, and that peace education is an essential part of the training of health workers in areas where conflict is a possibility.

Finding health in disaster

It is difficult, in reading these testimonies, to discern much evidence of "the medical model". Throughout them, however, run the themes of reconciliation, of forgiveness, of human dignity, of hope and the healing of the human spirit as being cornerstones of health. Could it be that the agonies of the 1990s have insights and lessons for us, which will take us into the new millennium with a vision and a hope that could never have come out of a committee room, in Geneva or anywhere else?

The consultation drew up helpful guidelines for community health in times of



Diana Smith

Afri-CAN's Kambale Kavuo prepares for the next morning's training session.

war, and for community preparedness in times of disaster. It identified some of the lessons learnt from the experience of political change. It discussed the value of Participatory Action Research, and set out some principles for sustainability. And then it was ready to move on to consideration of the future.

What was needed was an Africa-wide community-based health care network. An overall goal would be to facilitate a healthy environment for community-based health care at local, national and continental levels, which would entail the mobilisation of human and material resources at every level. It would be supported by WCC, by CMC-Churches' Action for Health, and by the International Federation of Red Cross and Red Crescent Societies. Core groups would be Training, Advocacy, Resource Mobilisation and Evaluation. The new network was christened the Africa Community Action Network for Health (Afri-CAN for short).

Key to success would be the partnerships the network was able to build with potential allies. There were many other groups who had an interest in health. Sustainability would depend on having as broad a spectrum of partnerships as possible. Among them would be civic organizations, churches and other religious organizations, informal groups, external partners, government agencies and institutions. There was no question

What was needed was an Africa-wide community-based health care network.

of letting governments off the hook, though. The health of the people was ultimately their responsibility. A minimum level of state support and funding for community-based health care activities should be insisted on.

... But nothing lasting comes out of dependence on governments and outside donors.

Hari John, Asian Network for Innovative Training Trust

Afri-CAN commits itself to facilitate the liberation of people's potential, enabling them to transform situations which prevent the attainment of health in its fullness.

Mission statement of Afri-CAN network

The road will not be easy. Africa is many countries and cultures, and there is a chronic shortage of funds. Nevertheless, three years later the vision remains. The network is producing training materials, running courses and facilitating resourcing. It publishes a magazine called *Initiatives in Community Action for Health*, and provides training for local groups to be involved in the development of the publication. It coordinates a system of technical support for programmes and provides inspiration and solidarity. Afri-CAN is important for everyone, because it is a genuinely African network, born out of African situations and thinking, and managed in Africa, by Africans. The development of effective, regionally-based regional models is going to be crucial to the next chapter of the WCC's life: but it is difficult to see how these models can themselves be sustainable without substantial funding from the churches and other donors.

The first essential was a shared vision of what they were trying to achieve

Caring attitudes can be promoted and enhanced by the policies adopted by hospital management.



L. Gubb/WHO

For discussion: Mark 6, 31-44. The disciples ask Jesus to do something about the hungry people. Jesus tells them it is their job. But it seems impossible. The turning point in this story comes when Jesus gives thanks for what they do have. Can you see any parallels with the Afri-CAN story? How does this story help with problems in your own situation?

Building for the future

Why is it that one institution thrives, while another seems to be permanently tottering on the brink of crisis? Dr Kofi Asante, executive secretary for health at WCC, is currently winding up a study which seeks to answer this question in relation to church hospitals: a study which has major lessons for anyone engaged in church-related health care activities anywhere.

In 1994, CMC invited the national health coordinating bodies in 12 countries to participate in a study on the sustainability of health care institutions. Eleven agreed to do so, representing 43 church-owned or church-operated hospitals. The churches which ran the participating hospitals were Anglican, Roman Catholic, Reformed (mainly Presbyterian), Pentecostal or Evangelical, Lutheran, Baptist, Seventh Day Adventist and ecumenical. The study's aim was to identify which factors in existing structures and practices improve the viability and long-term sustainability of church hospitals and health programmes.

There were, as one would expect, many similarities among the hospitals in the study. Many of those which were tottering were seen to be doing good work in some areas. However, among those which had achieved a degree of sustainability, the following characteristics were noted.

The first essential was a *shared vision* of what they were trying to achieve, and a clearly articulated *mission statement*, creating between them a strong sense of shared ownership and commitment. These had been related to the daily work of the hospital and translated into *behaviour objectives*. They were revisited regularly in induction training sessions, retreats and other meetings.

Effective and dynamic *leadership* was another key factor in the way the

successful hospitals were run. This was backed by *boards of directors* or management committees representing a variety of interests, who set the agenda without trying to engage with the day-to-day management of the hospital. It was important for staff to feel that management and leadership were rooted in *Christian values*. It was also helpful if the hospital was managed in a way that was sensitive to the factors present in the community.

Hospital A, based in a hilly, rural area, is surrounded by a poor road network. Most patients arrive on foot or on an improvised home-made stretcher known as an ngozi. Staff at the hospital realised that the ngozi ambulance service was important to the community. Each 20-30 households arrange among themselves how to ensure that all households can take advantage of the service should they need it. The ngozi groups also provided funeral services. Hospital staff decided to organize a meeting with the representatives of the ngozi groups which led to the introduction of one of the first rural health insurance schemes in the country. Ngozi coordinators now collect a small but regular payment from each family which is paid to the hospital in order to cover the costs of necessary treatment.

Report of the study in *Contact* 158 on Sustainability.

A reputation for *quality of care* acts like a magnet in drawing patients to a hospital, as does a history of *excellence in a particular speciality* (for instance eyes or surgery), or a disease, such as leprosy. Sometimes this had been built up decades before by a missionary doctor and allied staff, and the tradition has been kept alive by their successors. Such a reputation boosts outpatient visits and increases bed occupancy, both criteria which increase sustainability.

The higher the *ratio of trained staff*, the more likely the hospital is to be sustainable. Second line training, with supervisors *sharing skills* with other staff, is important, particularly in the strongest specialities. But it is often difficult to keep good staff, particularly in remote areas. The *availability of good schooling* is often a key factor here.



Didier Bregnard/Unicef

The fact that Hospital C was running a successful primary school was considered to contribute substantially to its staff stability.

Report of the study in *Contact*.

While money is not everything, it goes without saying that *adequate financing* is a key factor in sustainability. It helps when a hospital is able to attract *local funds* as well as external donations. If the trust of donors is to be retained, it is essential that the *integrity* of the accounting procedures and the financial administration be widely known and accepted.

Other factors influencing sustainability were the *location of hospitals*. Those in urban areas, with a money earning clientele, did best; though some well populated rural areas were sufficiently prosperous to sustain hospitals. The *attitude of churches* also varied: where the church puts material support into the hospital rather than trying to take it out, it increases the likelihood of survival.

These findings may not appear to be particularly revolutionary. However, it must be said that not a single one of the hospitals surveyed complied with all the "critical determinants" set out above at the time when the study was carried out. Given the emphasis on market forces, and the current drought in external and local government funding, many of them may not survive unless they make remedial changes. This study provides a checklist for hospitals and

Primary school facilities make a difference: Guatemalan girls enjoy class.

The availability of good schooling is often a key factor here.



A WaakWHO

Global networking: Institute for Religious Studies (ISER) in Rio de Janeiro, Brazil, provides AIDS information materials as well as spiritual assistance for people with HIV and AIDS.

It gives readers a sense of not being on their own in their struggle for dignity in health care.

other health care organizations as they look into the future.

For discussion: Psalm 127, 1-2. The psalmist says people who build houses are wasting their time if the Lord is not the head builder. What would be the defining characteristics of an organization or community which God has built? What would not happen there? Relate this discussion to issues that have emerged in your own experience. I Corinthians 3-17 is also relevant here.

Maintaining Contact

If a global network is to function effectively, it must have a way of enabling its members to communicate with one another. Since 1970, *Contact* has been a major programme of the Christian Medical Commission, and subsequently of CMC-Churches Action for Health. It has continued to report on the issues, the thinking, the programmes, the debates, the priorities in health and healing worldwide.

In 1993, the decision was taken to commission a full evaluation of *Contact*. It was split into four parts: a readership survey of randomly selected readers, a bulk distribution questionnaire, an in-country mailing list review, and focus group discussions in nine countries. A total of 1,660 questionnaires were mailed to 30 countries, taking care to cover speakers of all the languages in which *Contact* is published (English, French, Spanish, Portuguese). The response rate for the questionnaires was high.

The study demonstrated that *Contact's* innovative approach to integrated health

care is much valued, both in urban and rural areas, for its wholistic view of health, and for the emphasis it gives to community health care. It gives readers a sense of not being on their own in their struggle for dignity in health care, and they identify with *Contact's* commitment to the poor. The questionnaire revealed that readers were well-educated. Eighty per cent of them had received at least 11 years of schooling, 75% were professionally involved in promoting community health, and 30% worked in church-based organizations.

Contact's Christian orientation is valued by readers, although it is also widely read by non-Christians, especially in Asia. In Latin America, where the Roman Catholic church heads up the majority of community health work, people expressed appreciation of the way *Contact* highlights issues of social justice and human rights. In Eastern Europe and Africa, the value of the Christian approach is underlined.

For a workshop on AIDS in Concepcion, Contact provided a theological background on AIDS which helped organizers understand what their standpoint should be the workshop was a great success.

Focus group discussion report, Chile

Asked to evaluate the usefulness of *Contact's* articles, there was an overwhelming consensus that it had benefited readers' work. It had been used to reinforce prevention in primary health care. In Asia, Africa and Latin America, articles have been used for working with groups.

The articles have helped in writing other health booklets such as "Practical Teaching in Health". Some themes were chosen and presented at referral centres for educating youth.

Focus group discussion report from Kenya

....its content alone validates it... Chile

The simple and informal language is easy to understand. Even a person educated up to school level (10 years of education) can understand it. Children can understand the language because of the very simple words used.

Focus group discussion report from India

Uses to which *Contact* is regularly put include reading and sharing, teaching, programme development, reading and keeping, lectures, sermons and storing for reference. Articles on population, breastfeeding, women's issues, agriculture and hygiene were mentioned as having been of particular interest.

Respondents and focus groups were asked to make suggestions about how *Contact* might be improved. Answers included the need for greater relevance to particular regions. Regional *Contact* networks and discussion groups, were suggested, plus giving better publicity and promotion, and improved methods of incorporating suggestions from the readership in the regions.

There has been much discussion, recently, about the future of *Contact*. There are other magazines, today, which fill similar functions. It is claimed in some quarters that the global newsletter is a clumsy channel of communication. It is expensive to produce, it costs money to mail. The newsletter of tomorrow, it is suggested, will be electronically transmitted, and accessed via the Internet. With your own Web site, why do you need a newsletter? Or so the story goes. In terms of the average *Contact* reader, this view is entirely

unrealistic. There is no likelihood, in the foreseeable future, of regular access to electronic communications among those to whom *Contact* is most valuable.

The evaluation, therefore, speaks of the value respondents placed on *Contact*. But it also speaks of a desire for change. If the magazine is to have a long-term future, it will need to give attention to how it combines the global perspective, on the one hand, with a more local and regional approach in the provision of news, thinking and examples. It will need to look more closely at what it means to be a specifically *Christian* newsletter.

For 28 years, *Contact* has provided a regular channel of communication within the CMC family, and it looks forward to continuing this tradition in a creative new way. After this double issue, *Contact* will be produced by the partnership described in the editorial.

The next chapter, entitled "At the crossroads", will speak of the turning point at which, not only *Contact*, but the CMC - Churches' Action for Health finds itself.

For discussion: Acts 2, 5-11. The disciples find themselves, miraculously, able to communicate good news to everyone. If you had to describe the newsletter that would help you most, what would it be like? How could it be achieved? For whom would it be good news?

It will need to look more closely at what it means to be a specifically Christian newsletter.



Diana Smith

Community health workers in London reading *Contact*.

CHAPTER FIVE

AT THE CROSSROADS



A Whaak/WHO

Love in a time of AIDS: the health clinic of Centro Velho, Santos, Brazil.

*But we should also
be willing to dream
dreams*

Realism and hope

In this edition of *Contact* we are inviting readers to start thinking about what comes next. What should be the priorities of a global Christian organization in the development of effective action for health? What, in the next decade, should set the agenda of CMC-Churches' Action for Health?

In his recently published book "To Be The Church", WCC's Secretary General Konrad Raiser argues that the future of the ecumenical movement should be rooted in the concept of what he calls "eschatological realism". On the one hand, we have the world we read about in the newspapers, or see in our own surroundings: a world that can seem full of fear and cynicism, poverty and pain. On the other hand, there is the expectation of that better world which Jesus called the kingdom of God: the hope for something beyond what we have now, of which we get occasional glimpses, and whose existence is the cornerstone of our faith. The Christian project is to live fully in the world as it is (from which all possible futures must be

born), but to do it in the light of that other, longed-for future, and in the anticipation that it can be achieved.

The decisions we make and the plans we build for our institutions must be based on both the futures: the future which incorporates the raw material of the fragile and imperfect present, and the future which claims, as its own, the great prophetic visions of the Judaeo-Christian tradition. We must, of course, consider the signs of the times. We must be ruthlessly truthful with ourselves about the present. But we should also be willing to dream dreams, see visions, recognise the truth that is contained in our experiences of human love and friendship, of beauty and creativity, of reconciliation growing out of bitterness and war, of community, of courage and heroism, wisdom and endurance, of great parties and effective worship and inspiring liturgy. From the tension that exists between the reality and the dream, the right decisions will be born.

Looking back over the history of the Christian Medical Commission, it can be said that its fine record of achievements has resulted from the ability of its members to work for change in a way that combines both ways of looking at the future. The dual role of functionary and prophet can be confusing, but it has great strengths. CMC reflected on Jesus the healer; it dreamed of a model of health care that benefited the poorest; then it set out to be an advocate for that dream, and to show that it could really happen. It looked at New Testament models of community, and dreamed of what would happen if competing groups learnt to collaborate: and the coordinating agencies were born. Jesus perceived the fear and lack of confidence

which prevented people from picking up their beds and walking, and he freed them: CMC initiated a process of education for empowerment and capacity building that was based on honest assessment of realities combined with a vision of what could be.

To Jesus, people who were excluded from society were particularly dear; so when HIV made its appearance, CMC was at the forefront in promoting programmes, developing methodologies, which combined a grasp of realities with a vision of community made better and stronger by facing them. Jesus tried to make others face up to the exploitation of poor people by those who were part of "the system": CMC responded to the irresponsible marketing of pharmaceuticals to poor people not just by talking about it, but by showing that it was possible to challenge it responsibly and affordably, with the help of partnerships which are in themselves empowering.

But the CMC is not just about programmes: it is about movements. It is also about friendship: about friends falling out and coming together again, friends for whom the goal is always, ultimately, greater than the source of disagreement. It is the thirty-year story of a global network, rooted in human experience, dedicated to healing and to justice, inspired by the Spirit, returning always to the word of God for its primary inspiration and guidance.

Looking ahead

What, today, is the World Council of Churches' role in health? Twenty years ago there were few organizations operating on a global level. Then, many of the WCC's programmes were unique. Today, there is a huge list of international groups: environmental agencies, women's organizations, AIDS networks, human rights monitoring groups and so on. CMC was instrumental in setting some of them up: IBFAN, the International Breastfeeding Action Network; PAG, the Pharmaceutical Action Group; ICAN, the International Christian AIDS Network. Each has its own organizational base and its own natural constituency. These networks – many of them

struggling, constantly re-inventing themselves – are nevertheless the visible evidence of a commitment to health, in its very broadest sense, which is rooted in local situations, but keeps its eyes fixed on global realities.

CMC, like WHO, has made it a priority to resource the development of such initiatives. The fact that the international health networks have now taken up so many of the challenges is a tribute to the Commission's effectiveness. CMC has enabled communication and resource sharing between regions and organizations, set up educational activities, encouraged partnerships, found sources for funding, provided personnel, identified and promoted useful methodologies. As a result, many of the functions previously located in the coordinating office in Geneva can now be performed elsewhere. At regional level, Afri-CAN is now pioneering capacity-building in community-based health care; and from January 1999 the Christian Medical Association of India, with its long history of working with the churches on health care issues, will take responsibility for the publication of *Contact*.

What, then, are the new challenges confronting a global Christian health network?

Thirty years ago, it was out of a process of ethical reflection that the Christian Medical Commission was born. The

The fact that the international health networks have now taken up so many of the challenges is a tribute to the Commission's effectiveness.

Street demonstration in the Philippines.



Ideologies of continuous growth, the market, and liberal economics have become the dominating ideas of our time



Julio Etchart/Panos Pictures

Child beggar at the feet of wealthy citizens.

Tübingen meetings set the agenda which provided the ideas and the energy for WCC's early thinking about health care. The Jenkins/Bryant dialogues fired people with a sense that the crucial issues of justice and health care were, at long last, being addressed. These conversations acted like magnets, and people from all over the world found themselves drawn into them.

Today, talk to anybody involved in health care, and they will tell you that the challenges – while different – are as massive as they ever were. Everywhere in the world, people speak of a global environment which is itself hostile to the vision of wholeness which the ecumenical movement seeks to embody. Ideologies of continuous

growth, the market, and liberal economics have become the dominating ideas of our time – accepted as inevitable even among those they disempower. In the name of health care, huge resources are spent on

genetic engineering, and on therapies that will not touch the health needs of 90% of the world's population. In the meantime, there is a growing belief that scientifically based models of health care do not deliver the goods, combined with a lack of public information about the alternatives that are on offer.

Konrad Raiser speaks of the distinction between movement and institution: the importance of overcoming the institutional captivity of ecumenism, and of nurturing the sense of "ecumenical movement". These issues fall outside the agenda of most Christian churches and health care institutions. And yet they seem to be present in the very air we breathe. They are about how we

create non-exclusive institutions, how people can be helped to become self-sufficient, how wholeness can become a reality within communities. They are common to all cultures, north and south. They are issues for those who are inside and those who are outside major institutions. They are among the key ethical issues of our time.

In 1997, the World Health Organization renewed its commitment to "health for all" (see *WHO's Health for All in the 21st Century*). The development of an ethical dialogue about health is a key aspect of its new vision. The promotion of ethical dialogue is a key element, too, in the Christian project. It is an opportunity that must not be missed. In taking up the challenge, using the methodologies and networks developed over the years, the WCC family can once more become leaders in the field of international thinking about health care. It will expand the debate within the churches, promote it in secular academic and professional circles, and present in a form that ordinary people can understand.

Ethics or morality is not primarily a matter of formulating norms on which to base ethical judgements. Rather it is a process by which people learn in community the distinction between good and evil and how to walk the way towards a fully human life.

Konrad Raiser in "To Be The Church"

The next three sections suggest particular focuses within the three broad areas of concern set out above. Each focus is followed by a quotation and a description of the situation. A biblical reference is also suggested to read in relation to the issue described. We invite you to read and think about these focal areas and respond to us with any comments or suggestions you might have. Maybe you would like to describe how these issues affect you and your community. Maybe you could tell us about what is being done in your region to address one of these issues. Perhaps you want to voice a special challenge.

Please use the sheet found on page 53 to send your comments to us.

DISCUSSION THEMES

MORALITY AND THE MARKET

1. Privatized health care

Governments need to promote greater diversity and competition in the financing and delivery of health services. Government financing of public health and essential clinical services would leave the coverage of remaining clinical services to private finance, usually mediated through insurance, or to social insurance.

Investing in Health, The World Bank 1993

The ecumenical vision challenges all structures that produce exclusion.

Konrad Raiser, in "To Be The Church"

All over the world, government health services are under pressure. The rising costs of health care, the growth of technology, larger populations of old people, the catastrophic effect of HIV infection, reduced giving, the growth of middle classes with high expectations in terms of quality: in many countries, north and south, the statutory health care bodies are reeling under the combined weight of all these factors. In its 1993 World Development Report, the World Bank recommended a partial restoration of medical models of health care, which are much simpler to evaluate than the complex process that takes place in community-based health care. In tandem, it recommended (*see above*) that countries move towards privatized health services: suggestions that sent shivers down the spines of many people, who saw the gains of the past twenty years disappearing.

Is privatized health care an issue in your area? Is it, on the whole, a good or a bad thing? What can be done to monitor the effects of privatised health care? Suggested biblical passage to accompany this discussion: Luke 19, 11-27

Growing numbers of people will never benefit from the new, globalizing economic order.

2. Globalization

The emergence over the past decades of transnational and increasingly world-wide structures of communication, finance and economy has created a particular kind of global unity. It is evident that the cost of this has been growing fragmentation of societies and exclusion for more and more of the human family.

Towards a Common Understanding and Vision of the World Council of Churches.
(WCC 1997)

All relationships within civil society are based on a sense of moral obligation and basic trust in the reliability of the social order. Under the impact of aggressive globalization and the spread of materialistic values, this essential moral fabric is beginning to erode.

Konrad Raiser, in "To Be The Church"

Gradually, over the past ten years, the power of national governments has been eroded. In Chile, for instance, the government has been pressured into repaying its debts and into making people pay for health care and other services. As a result, many people do not seek help when they need it. Also, TV, fast travel and international communications networks give an illusion that we are one world, with shared values. In fact, growing numbers of people will never benefit from the new, globalizing economic order.

What evidence of globalization do you meet in your own life? Is it good, or harmful, or both? What can a Christian health network do to counteract the harmful effects of globalization? Suggested biblical passage to accompany this discussion: Psalm 19, 1-4

3. Hospital and community?

The criterion for re-assessing the institutional structures of ecumenical organizations must be this: are their activities and the way they function geared to building and nurturing the kind of relationships between the churches which enable the common life and witness of local Christian communities as communities of hope?

Konrad Raiser in "To Be The Church"

Much has been said about the relationship between hospital-controlled and community-controlled health services. This, in a sense, is where the Christian Medical Commission began, back in 1968. Today, immense progress has been made in the creation of viable community health services. And yet few people, today, question the crucial role played by the hospital in providing back-up for those services. The time has long passed when WHO, CMC and others could take the view that tertiary services must go. The research, referral, training and financial resources of the hospital are essential to the system as a whole. Furthermore, in many areas mission hospitals are making a comeback: reluctantly perhaps, and in response to desperate national situations, but part nevertheless of the ministry of the church world-wide. Contemporary thinking about civil society places great stress on the role these medium sized institutions play in strengthening the lives of communities and nations.

What is the relationship between hospital-controlled and community-controlled health services in your area? What would you ideally like this relationship to be? What could be done to help this happen? Suggested biblical passage: Matthew 22, 15-21

THE CHALLENGE OF BIO-ETHICS

1. Genetic engineering

The central dynamic of the ecumenical vision is the conviction that the possibilities of life are enhanced for all when they are shared.

Konrad Raiser in "To Be The Church"

*The technical feats
which seem capable
of producing
customised human
beings have to be
paid for with a huge
slice of the budget
available globally for
health*

Feelings tend to run high when there is talk of genetic engineering. The cloning of animals, for instance, is the first step to the cloning of people, and this can open the way to all kinds of political and social manipulation. In the imagination – and maybe in reality – it becomes an instrument for ensuring ethnic purity, or producing boy babies, workers, or an endless supply of replicas of this or that dictator. But there is no halting the advance of technology, nor would it be desirable. It was science, after all, which produced clean water technology, antiseptics and vaccination. Further, scientific advance has a momentum of its own. If scientific developments are found to be possible, they will happen provided somebody wants them enough and will pay for them.

The task of science is to dictate what *can* be done. Deciding what *should* be done is a matter for the ethicist, whose criteria will be to do with values, human dignity and quality of life. Much of what passes for scientific progress goes largely ignored by the majority of health professionals, because it seems not to interface with their world in any way. And yet it does. The technical feats which seem capable of producing customised human beings have to be paid for with a huge slice of the budget available globally for health: a budget which, in many parts of the world, is not currently providing enough to pay for basic community health services for the 1.1 billion people who currently live in acute poverty. And that really is a matter for ethical debate.

What would be your vision of a healed, integrated health service? What is the ethical issue for Christian health professionals when decisions have to be taken about money spent on scientific research? Suggested biblical passage to accompany this discussion: I Corinthians 12-31

2. Controlling population

The ecumenical vision seeks to strengthen processes which heal broken relationships and enhance the viability of human communities. It therefore challenges all notions of human rights and human freedom which disregard the common good and rights, dignity and freedom of others.

Konrad Raiser in "To Be The Church"

Population control is a deeply contentious issue, and a huge challenge to ecumenical collaboration. It was passionately debated at the UN International Conference on Population (Cairo 1994) and the UN Conference on Women (Beijing 1995). As a result, ecumenical groupings, terrified of rocking the boat, will often avoid any over-specific discussion on the subject. Nevertheless, contraception, abortion and euthanasia are key ethical issues for our time, both personally and in the development of healthy communities. Confrontation and the language of human rights are not always the most helpful way of dealing with them. But there are other possible ways forward. The experience of HIV/AIDS has led to mature reflection on the use of condoms. A statement from the US Catholic Bishops set out convincing arguments for the concept of a "consistent life ethic". In any serious debate about the ethics of health care, it is hard to see how these issues can be ignored.

These issues raise questions about the sanctity of life itself. What kind of society do we want to live in? Suggested biblical passage: Zechariah 8, 1-8

FAITH AND HEALING

1. Traditional medicine and indigenous peoples

To Maori, physical well-being is inseparable from that of our spiritual, cultural and environmental / economic well-being.

Tara Tautari, Aotearoa-New Zealand, *Contact* 154, 1997

Authentic African health programmes need to be built on local interpretation of traditional beliefs and practices relating to polygamy, disease, death and burial.

Kwame Bediako, Ghana, *Contact* 151, 1997

Health was defined as a dynamic process of striving both for harmony and for the source of life. It was also recognised that the process involved maintaining the link between nature and the community.

Delegate to a Guatemalan seminar on indigenous health

Imposing western medical principles on traditional communities is often counter-productive, particularly when this is combined with an aggressive campaign – as in Nestlé's babymilk marketing – to discredit the old ways. Because it destroys people's confidence in what they know and makes them opt for what they don't understand, it also makes it difficult for a community to work out its own survival strategies in times of crisis. And yet traditional communities frequently have very well developed spiritualities of health, and also a system of indigenous medicines that costs very little and has stood the test of time. So far there have been few objective trials of the efficacy of indigenous medicines, and as a result, people are denied the resources for making informed decisions about their own health care.

What contribution have indigenous communities to make to our understanding of healing and the healed community? What are the potential advantages of experimenting with traditional medicines? Is a balance desirable, and if so, how is it to be achieved? Suggested biblical passage to accompany this discussion: Mark 12, 28-34

Traditional communities frequently have... a system of indigenous medicines that costs very little and has stood the test of time.

2. The churches as healing communities

Within and outside the fellowship of the congregation are people longing for mutual caring and solidarity. They are the sick, lonely, handicapped, oppressed, marginalized, and those with social problems such as divorce, unemployment, unplanned pregnancy etc. In ministering to these people churches are involved in healing.

Health Healing and Wholeness: The churches' role in health WCC 1990

The Bethel Baptist Healing Ministry in Kingston, Jamaica, is a congregation-sponsored wholistic community-based service. It offers a setting where care is provided in the church by Christian medical personnel who work together with pastors and psychologists to provide prayer and spiritual counselling as well as medicines. The motto of Bethel's ministry is "Total healing to the whole person".

Caribbean consultation, Health Healing and Wholeness study

For the whole of CMC's thirty years, it has had two separate briefs. One is the functional one, focusing on structures of health care and so on. The other is the mandate to relate the healing ministry to local congregations, the churches themselves, and the lives of ordinary churchgoing Christians. The Commission has come back again and again to the challenge of developing characteristically Christian theologies of spirituality and of healing, but seems always to have drawn back and moved on to things which seemed, at the time, more urgent.

What makes this a timely challenge? Can most churches be described as "healing churches"? What would be the characteristics of "a healing church"? Suggested biblical passage: Ephesians 4, 1-16

3. Faith healing

Ten thousand people went to the stadium to the healer last night. He came from up-country in the north. If you give him money he will cure you from Slim (AIDS). Then next day you go for a blood test and you are cured.

Young man on bus in Kampala

One of the main reasons for church growth in the protestant churches in China is the practice of faith healing.

Chinese pastor

Faith healing is a major source of concern to some churches, and a source of new members for others.

Faith healing is a major source of concern to some churches, and a source of new members for others. It is particularly popular among pentecostal Christians. There seems no doubt that it sometimes works. Also, there is no doubt that people are sometimes exploited. Often claims are made for it that seriously undermine crucial health education messages: for example that you can be cured of AIDS, or that it can replace childhood immunization. But there is very little objective evidence, to help give people the confidence that they know when they are being exploited.

Have you or your family or friends ever experienced faith healing? How seriously do you think the church should take it? Suggested biblical passage to accompany this discussion: Luke 17, 11-19

The awareness of a common calling is the inner dynamic of the ecumenical movement. Thus no institutional reform will be successful unless it is accompanied and guided by the effort to clarify and re-affirm the ecumenical vision.

Konrad Raiser in "To Be The Church"

The leaves of the tree of life are for the healing of the nations.

Revelation 22,2



TELL US WHAT YOU THINK!

These two pages are for you to write what you feel about the recommendations put forward in the previous section.

Please send your ideas to: *Contact*,
World Council of Churches, PO Box
2100, 1211 Geneva 2, Switzerland.



USEFUL PUBLICATIONS

Dame Nita: Caribbean Woman, World Citizen

Blackman, a life-long family friend, wrote this book in 1995, the same year in which Dame Nita Barrow, former director of CMC, died. She had assumed the highest office in her native Barbados, that of governor general, in 1990. Prior to that Nita had been her country's representative to the United Nations. The role she played in both these positions was built on a life experience of choosing challenges and opportunities to learn and serve. Each prepared her for the next.

I met her at international nursing meetings and, as a nurse, I was always proud that her five-year training programme at Barbados General Hospital had led her to public health and into education of nurses in many English-speaking Caribbean countries.

Nita's efforts not only helped nurses but led to the improvement in positions for women worldwide. She became world president of the YWCA and then president of the International Council of Adult Education. Another important leadership role she played was as head of the NGO Forum

at the Third Assembly of Women in Nairobi, Kenya, in 1985. At the World Council of Churches, she received global acclaim for her work and competence as the director of CMC.

The worldwide respect shown to Nita is reflected in the many honorary degrees and awards made to her, but perhaps most important is to understand her desire for new challenges and to work in new ways. Her biographer gives examples of the spirit of diplomacy and competence she brought to the tasks she performed. He justly describes her as charming, inspiring, powerful and warmhearted. Nita was also fearless, fair and faithful to the Christian teachings of her upbringing. She was truly a good and faithful servant, who did well in all she did. She was also a Caribbean woman and a world citizen.

Dame Nita: Caribbean Woman, World Citizen is published in hardback and paperback by Francis Blackman, Ian Randle Publishers, 206 Old Hope Road, Kingston 6, Jamaica. ISBN 976 8100 74 5 (paperback).

Review by Marilyne Gustafson, University of Minnesota School of Nursing, USA.

LETTERS

I read with some concern your comments on the changes on the horizon and the future of Contact on the last page of the April-May edition. I sincerely hope that ways of continuing with this publication can be found. Although not doubting the need of the WCC to consider health and wholeness from the various listed perspectives, the strength of Contact is in its great practical relevance. I am sure that many people working under very difficult and demoralising conditions must have been greatly helped and encouraged by the articles. For those of us working in somewhat "ivory tower" environments, Contact exposes us to the realities of sickness and suffering and helps to make our work much more relevant. I have found Contact to be most enlightening and have cited several articles in my recent publications on the global emergency of tuberculosis. I hope that Contact will continue to exist and will go from strength to strength.

John M Grange
Imperial College School of Medicine
University College London, UK

Contact's future

Sales and distribution of "Where women have no doctor" (reviewed in Contact 160) are going very well, and it is currently being translated into Arabic, Spanish, Burmese, Vietnamese, Haitian Creole, Chinese, Tagalog, Hindi, Gujarati, Marathi (and there may be a few more that I've forgotten). As you can imagine, we're delighted!

Jane Maxwell
Women's Health Editor
Hesperian Foundation
Berkeley, California, USA

Translations for women

ANNOUNCEMENTS



Dr Gro Harlem Brundtland

Woman heads WHO

Dr Gro Harlem Brundtland, a leading environmentalist and former Norwegian prime minister, became WHO's new Director-General on 21 July 1998. In her acceptance speech, Dr Brundtland affirmed her conviction that societies can be changed and that poverty can be fought. One of her main targets is "to help countries build sustainable health systems that can help reach equity targets and render quality services to all". She believes that WHO should back two projects. One would "roll back malaria" and would be "spearheaded by Africa". The second would address a major cause of premature death – tobacco. She said: "I am a doctor. I believe in

science and evidence. Let me state here today. Tobacco is a killer".

Dr Brundtland, the first woman to become Director-General of WHO, clearly intends to give special attention to the health of the poor. She concluded her speech with these words: "I envisage a world where solidarity binds the fortunate with those less favoured. Where our collective efforts will help roll back *all* the diseases of the poor. Where our collective efforts assure universal access to compassionate and competent health care. Bringing the world one step closer to that goal is our call for action."

On her first day in office, Dr Brundtland implemented a new code of conduct for financial disclosure. From now on, all high-level officials – including the Director-General and her cabinet members – will have to reveal all their financial and other

interests in the private sector. On 24 July, the Rockefeller Foundation signed the papers for a US\$2.5 million Global Health Leadership Fund to support the reform process at WHO.

World Health Organization home page on the Internet is at <http://www.who.ch>

Launch of *Initiatives in community action for health*

Afri-CAN, the African Community Action Network for Health, founded at a meeting in Harare jointly organized by CMC-Churches' Action for Health and the International Federation of Red Cross and Red Crescent Societies, has launched its own magazine. *Initiatives* is published quarterly in English and French and aims to bring attention to individual and collective initiatives that will help to build a continental community health strategy. The first issue, which appeared in April 1998, posed the question "What about health for all?" and includes an interview with Dr Dan Kaseje, a former CMC director, on the need for charismatic and democratic leadership in community-based health care. If you would like to receive and copy of the magazine and become a member of Afri-CAN, write to: Dr Dan Kaseje, Afri-CAN General Secretary, Afri-CAN Secretariat, PO Box 73860, Nairobi, Kenya. Tel: 254 2 711416 or 729095. Fax: 254 2 711918.

WCC Assembly *Padares*

At the World Council of Churches' Eighth General Assembly in Harare, Zimbabwe, participants will run *padares* (which means "meeting place, especially to discuss community concerns" in the Shona language spoken in Zimbabwe) on the following health themes: the work of CMC, church health services, disability, women's health, alcoholism and drug abuse, and community participation and sustainability.

Contact is a periodical publication of "CMC-Churches' Action for Health" of Unit II, Churches in Mission: Health, Education, Witness, of the World Council of Churches (WCC). It is published six times a year in English, French, Spanish and Portuguese. Selected issues are also published in Kiswahili in Kenya. Following our recent mailing list review, present circulation is approximately 15,000.

Contact deals with varied aspects of the community's involvement in health and seeks to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to: *Contact*, the publication of CMC-Churches' Action for Health, WCC.

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