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HEALTH IN A SEARCH FOR WHOLENESS:



The Journey of the Medical Mission Sisters

INTRODUCTION

Originally presented to a meeting of international missionary congregations (Roman Catholic religious orders) on health care and the poor, the paper featured here describes the evolution of the Medical Mission Sisters' approach to health care since their beginning nearly 65 years ago.

We think it describes the journey of many of us and helps us to reflect on where we have been, where we are, and, most importantly, where we are going in our quest for health for all.

COVER

Photo: Medical Mission Sisters

Sister Anne Marie Ooschot (The Netherlands) and her Peruvian neighbours monitor the communal water supply.

HEALTH IN A SEARCH FOR WHOLENESS: THE JOURNEY OF THE MEDICAL MISSION SISTERS

by Sarah Summers, MMS and Mary Pawath, MMS

The Gospel accounts show Jesus' active engagement in the healing ministry to be an integral dimension of the proclamation of the Good News. The stories point out that, in Jesus' endeavours to bring wholeness through healing, various approaches and understandings came into play.

"When he returned to that place some time later, word went round that he was back; and so many people gathered that there was no room left...some people came bringing him a paralytic carried by four men, but as the crowd made it impossible to get the paralytic to him, they stripped the roof over the place and when they had made an opening they lowered the stretcher on which the paralytic lay. Seeing their faith and ingenuity, Jesus said to the paralytic, 'Your sins are forgiven' (Mark 2: 1-5).

The Medical Mission Sisters have engaged in this same healing ministry of the Church for almost 65 years. We also have many stories to tell which relate to evolving understandings and approaches. We would hope that, in daring to tell stories from our corporate journey, all of us might be encouraged and helped to reflect on our experience and insights. In this sharing and searching based on our experience, we hope to broaden and deepen our appreciation of the Church's mission of health and healing, as we proclaim the wholeness that we seek in the Reign of God.

APPROACHES TO HEALTH MINISTRY THE FIRST GENERATION (1925-1960s)

If we trace our journey as women of health and healing, we can identify various phases in which questions, emphases, and strategies have varied and evolved from one another. We are helped to systematize our reflection, which is based on our experience, by borrowing the concept and terminology of Neil Brenden and David Korten who speak of "generations" of medical mission strategies (1).

The first generation approach was for immediate curative medicine, primarily hospital-based, oriented to the individual as a patient. This also included the establishment of training schools for nurses and midwives. The usual pattern was to bring to the "foreign missions" the medical solutions and institutional models that we had known and in which we were trained abroad. Local healing practices and systems of natural medicine were given little consideration or were explicitly negated. We made efforts to convince bishops, priests, and the local people of the professional efficacy of our approach.

These medical services were almost always linked with the building up of the visible presence of the Church and seen in the context of mission as a contribution to *pre-evangelization* (a term used at that time to mean the preparation of people for evangelization and christianization). Our hospitals were sanctuaries of professional cure; our patients the objects of our care. Many professionals and para-professionals were trained. A tremendous amount of curing with caring was accomplished, and the health of many people improved.

While there was much uniformity in the approaches used all over the world, there were also significant variations. The institutions in Africa, for example, were simple "bush" hospitals, while in Latin America and some parts of Asia they tended to be large urban centres that evolved into speciality and relatively sophisticated services. This generation, with its singleness of focus, lasted from 1925 until the 1960s.

Challenging questions

Certain questions then began to emerge. We were stimulated in our analysis by the Church, other groups, and professional studies. We asked ourselves

- Why is it that our patients make repeated visits for the same diseases?
- Are these communicable and preventable diseases?
- What is the basis of these diseases? Could it be poverty and lack of knowledge?
- Are we really caring for the poor, or are we caring for those who feel they can approach us and are able to pay for services?
- Are we, in some areas, duplicating government services? Do our services and presence impede the initiative which local governments should be taking?
- What about the local church's commitment to the hospitals and the quality staff we have trained through the years? Have we prepared them to carry on without us?
- What should be our next step?

"May we continue to exercise a prophetic role by pointing to new areas of concern and new responsibilities as they evolve with the times. As it says in our Constitution: 'May we be women of prayer—contemplatives in action.'"

Sister Lily Chunkapura

(speaking on the role of the Medical Mission Sisters, in *Intercontinent* (No. 190), a publication of the Society of Catholic Medical Missionaries)

THE SECOND GENERATION

The Late 1960s

This brings us to the story of the second generation, a generation born out of crisis and renewal:

It was born of crisis in the sense that some countries in which we were present had broken bonds with former colonial powers and were feeling their nationalistic identity and strength. Some were planning for or talking about the nationalization of private services.

It was born of renewal in that we realized that our corporate approach called for change and that it was possible to rechannel our personal energies and creativity. A process in the total Medical Mission Sisters Congregation was designed and implemented to facilitate dealing with the dimensions of crisis and renewal.

Many of our members realized that they need to "re-skill" themselves in order to pioneer this second-generation approach. A conversion process, together with further education, was giving birth to this approach, which focused on two levels:

1. preventive care and health education in villages and urban slums;
2. localization of hospitals.

1. Preventive care and village education

Preventive work was orientated towards an intermediate rather than an immediate response. It was community-oriented endeavour in which the local people were approached in their own environment. As some of our members came closer to the people, they were strengthened in the conviction that nutrition and environment had greater significance for health improvement than medical intervention (prevention and cure). Poverty and the social dimension of health had to be dealt with.

A community approach was recognized as essential. Ornstein and Sobel refer to a related insight when they state: "The evidence that the way we interact with others, the way we see ourselves as *a part of* or *apart from* other people and society, also appears to influence general resistance to disease" (2).

Community development schemes were integrated in order to alleviate poverty and to

increase knowledge about health. It was basically a developmental model in which the medical model was informed by the sociological model.

We, too, had our own struggles. We realized that "prevention" is a peculiar phenomenon for the professional medical person. We were now asked to gain satisfaction more from what doesn't happen than from what does. Prevention was a much more difficult process to perceive and quantify!

The principles of **participatory management** were adopted by our Congregation to replace a hierarchical model of government. Our hospitals began to implement participatory management as an affirmation of the skills, caring, and culture of the local people. A lot of human development took place when we joined with co-workers to pioneer new modes of functioning together. Pastoral care was integrated into services. Helping persons to discover and affirm themselves, and their faith, was seen as a vital part in the healing process.

2. Localization of hospitals

Some of our hospitals were turned over to the local church or to other local organizations. The criteria for "turn-over" were varied. In some cases, the reorientation was meant to release Sisters to participate more in community health care; in other cases, it was a response to local situations in which expatriates were no longer wanted or needed in hospitals; in other instances, it was to address the problem of duplication of facilities; sometimes it was a response to the stance taken by the local church regarding the healing ministry.

Some hospitals remained in our hands, however, serving as a base for outreach programmes and as referral centres for persons needing hospital follow-up. In some instances, there was a programmed effort in these hospitals to



Photo: Medical Mission Sisters

In the late 1960s, the Medical Mission Sisters pioneered what was then a new and revolutionary approach: *community-oriented health care*. Here Sister Minka Skrlj (Yugoslavia) explores a topic with a group of Ugandan community health workers.

simplify care while retaining its quality (regarding equipment, medications, organizational schemes, etc.) and to include a policy of accompanying family members in in-patient care.

In other cases, hospital services were strengthened in collaboration with government to serve as district hospitals. These efforts aimed to orient the hospital to the community and encourage still fuller localization.

Local communities responsible

Our initial vision behind the localization of all our clinics, hospitals, and other work was to help local communities to take responsibility for the ownership and management of their own institution. We have had varying degrees of success in this. Our initial vision has been tempered by reality.

An assessment: collaboration with others

This "second generation" found us working much more in collaboration with government health schemes, other churches, and communities rather than exclusively attempting to "mind our own shop." Both giving and receiving were cultivated as attitudes.

Some who had experienced our first generation presence and now knew us in our second generation were in admiration of us; others were disappointed and misunderstood us.

Questions and comments about community health followed:

- Was this second-rate medicine?
- Were these attempts at low-cost programmes actually an insult to the poor?
- Are hospitals not the most productive and visible presence of the Church?

Further critique

These comments and questions were at times hurtful. They also challenged us to continue our search and provoked us to further critique and self-examination. We asked ourselves:

- Are we now being challenged to look at health care within the broader context of healing?
- Are there not ethical issues involved when we examine who gets sick and who stays healthy?
- What really is disease? Should we not put still more emphasis on health instead of sickness?

Some of our Sisters spoke out of their experience of people's daily grinding poverty and asked further:

- How does the environment influence people's ability to search for wholeness?
- Does our approach really help people to take responsibility for their own health, or do we continue to create dependence on "those who know" and "those who have access to foreign resources"?

Basic to this approach and moving us into the third generation were certain assumptions:

- Health in its true sense is an integration of the different aspects of the self (body, mind, and spirit); the self and others; the self and God.
- Health promotion involves clarifying and modifying self-responsibility for one's own health behaviour.
- Healing and health promotion for the whole person involves both preventive and curative medicine; mental and spiritual counselling.

- Wholeness of the person is best achieved by full participation in the community, be it church or local geographic groups.

THE THIRD GENERATION

The third generation was already evolving. The first generation fits into a time-frame, but we have found that the subsequent generations flow and build upon one another and mutually live together. At this point we could sense that our questions were leading us into uncharted territory. We began to recognize that we could no longer focus totally on persons or groups as the object of our care, but that we needed to help create caring communities in which people became the subjects of their own future.

Empowering people

Efforts were made to empower people, to bring them to awareness of their basic right to life and health. Programmes and projects became more community-based, and it was the people themselves who began to identify needs and make decisions about responses.

Justice in and for health was seen as vital to health and healing. We knew that we could no longer remain silent in the face of unjust local, national, and international systems and policies that affected life and health.

An example from a Medical Mission Sister hospital in the Philippines illustrates this. A government hospital had been located in front of our hospital for many years. It was operational but non-functional. Supported by the people, we began to curb our own services in order to bring pressure on the government hospital to put itself to use. The measure worked. The people now use the former waiting area of the hospital for a herbal garden to prepare local and natural remedies. The operating theatre has been turned into a production centre for soap, which when used helps to prevent mosquito bites and thus decrease the incidence of malaria.

Another example was in South India, where the Sisters accompanied the people in their efforts to exert pressure. They insisted that a government hospital, which was practically non-functional and without medicines, be made to function effectively. As a result of their working and organizing together, the people recognized that health is a basic human right and not something to be begged for. Their demand was granted.

In this approach, it would seem that efforts to implement primary health care and train community health workers have been more successful in Africa. In some parts of Asia and Latin America, the entire health care system, including our own approaches, create expectations of care at such a sophisticated level that it is sometimes difficult for people to accept that our priority is providing care at a more basic level. On the other hand, there are places in Asia and Latin America where it has been easier to gain the full participation of peoples in decision-making and to accompany them in their struggle to achieve health as a right.



Photo: Medical Mission Sisters

"We realized that as women of the Church we have a powerful role in overcoming obstacles to justice concerning health." Here Sister Joan Pritchard (Brazil) converses with community leaders in Northeast Brazil about land rights and reform.

Public life

In the third generation, we have moved into public life. We have realized that as women of the Church we have a powerful role in overcoming obstacles to justice concerning health. Where corruption, incompetence, classism, and racism impede people from their right to health, we can, together with them, use our institutional muscle to exert pressure.

These efforts have taken place not only at local and national levels in so-called Third World countries. Our mission in the First World is also filled with examples of our members helping migrants, people of racial minorities, and poor people to create and gain access to health services. As they become aware of the many First World policies that condition life and

development in the Third World, our members in North America and Europe lobby parliaments on issues which have implications for health in the Third World.

Investment policies

A proportion of our Congregation's monetary investments in the First World has been consciously used to bring about justice in health. For example, we have purposely invested in some pharmaceutical companies in order to speak as shareholders about policies whereby the companies "dump" unsafe medicines on Third World countries. These measures require expertise and long-term commitment, but we have seen them to be effective.

The Central Assembly of our Congregation is now formulating a letter to the International Monetary Fund and World Bank pointing out the effect of debt repayment strategies on the health of the poor. We are requesting reconsideration of these schemes.

Alternative health care systems

The third generation, learning from the attempts of the second generation, has intensified expertise in helping people to revive alternative health care systems that were displaced with the advent of modern medicine. This movement is impressive and extends around the world. Hospitals have developed natural therapy departments; centres have been created for teaching and demonstrating alternative therapies to communities and professionals; non-hospital-based treatment centres are functioning.

The challenge remains for us to help people find and integrate the best aspects of natural, allopathic, and other systems, so that we do not make any method an absolute.

An Historical Note

Anna Dengel, founder of the Medical Missionary Sisters, was inspired by a Scots woman named Agnes McLaren. Agnes was a doctor and an active participant in the women's suffrage movement in the late 19th century. She practised medicine among the poor. She learned from Fr. Dominic Wagner, a Mill Hill Missionary who had been working in India, that the service of women doctors was indispensable for women in India. According to custom, Muslim women in India could not be attended by a male doctor. Following a trip to India where she saw the situation for herself, Dr McLaren devoted her life to making known this cause and to taking action about it. She felt that the best solution would be to train religious Sisters as doctors and midwives. Her initial and enthusiastic insight was dampened by the knowledge that the Church did not allow religious Sisters to be doctors or to give aid in childbirth. Agnes remained steadfast, however, and with the help of others concerned established a hospital for women in Rawalpindi, India.

Anna Dengel, a young lay woman from the Austrian Tyrol, was interested in caring for the sick as a missionary. She was encouraged through correspondence with Dr McLaren to study medicine and take charge of this hospital. Having completed her medical studies, Dr Dengel went to India as the doctor in Rawalpindi. It was there that she came in touch with the conviction that she was called to religious life and to help establish the Catholic Medical Mission movement. As she writes, she felt especially attracted to "doing something that only women could do for suffering women. This touched the feeling of womanly kinship within me and fired my youthful enthusiasm."



Photo: Medical Mission Sisters

"We are learning again and again that the process of healing is essentially one of building relationships and so building one world!" Pictured here are participants in a Women's Motivation Course, co-sponsored by Holy Family Hospital, Mander, India.

After much soul-searching, Anna decided to found a religious Congregation and for this she went to the USA, where in 1925 she founded the Medical Mission Sisters. The Congregation, however, could not be formally instituted as a religious congregation because of Church Law. Thus for 11 years, our religious family functioned as a pious society. In the meantime, many professionally trained Sisters went to India and Anna Dengel challenged Rome to change Church Law. In 1936, the Roman ban was lifted and we were fully recognized as religious women in the Church and allowed to practise medicine in its full scope.

Our beginnings speak of women energizing women, of health service as a medium for the emancipation of women. Anna Dengel took major steps which initiated change and made us responsive to change. She left us a vision:

"We must have our ideal in view, to become women of solid virtue who can be trusted, who are willing to work in a humble and hidden way, but also who are not afraid to face difficulties and responsibilities of a more public life....We must adapt ourselves to the needs, the needs will not adapt themselves to us. We must never be afraid to change if it is needed."

Social analysis and inculturation

In our efforts to help people devise health promotion schemes and to develop local resources, we have been called to practise inculturation and to analysis of social systems. (*Inculturation* is a process of presence and dialogue within a culture that leads to being changed and helping to promote change in order that all involved become more fully human.) The communities of our Sisters who have lived for a significant time in urban slums, inner cities, and rural villages reflect on, analyze, and speak from this lived reality. As we have moved into the public arena with a concern for justice in health, we have encountered threats, conflict, new challenges, and stress.

Change policies

In summary, we come to realize that, together with the direct provision of health services, we are more and more challenged to direct our energies to changing policies related to health and enhancing the capacities of local peoples to promote health. By choice we have moved from an almost exclusively operational into a catalytic role. And this implies basic changes not only in

skills but in the way we perceive ourselves personally and corporately.

Monetary resources and healing

In these first three generations, concerns have repeatedly arisen regarding stewardship of monetary resources as related to healing and the search for wholeness. Our idea is that all efforts at health and healing become self-reliant, even when oriented to the poor.

As our African friends say, "We have tried!" Sometimes, we have succeeded, but in most cases we have not. Certainly our relationship with donor agencies has changed over the years. No longer are we willing to let the agencies set the agenda for people's healing based on the purpose of the agency and the availability of funds. We openly question the fact that most pharmaceutical companies continue to invest research monies into new treatments rather than into education and promotion of health.

We continue to struggle with what "option for the poor" means in the pursuit of health and healing. Many of us wonder about the policy of taking care of people who can pay for services in the hopes that their resources will trickle down to those who cannot pay.

Basic to all this discussion is a fundamental question that we feel is essential to a quest for wholeness: Can self-reliance ever be achieved unless justice is established?

"Wounded Healers" renewing themselves

We strongly believe in the value of our ongoing international renewal programmes. Each Sister is encouraged to participate in one of these every three to five years. Renewal programmes focus on attitudes related to health and healing, in ourselves and others. In this getting in touch with ourselves and others at a deeper level we build upon and integrate the mission experience of each generation. We can claim our identity as "wounded healers" in the sense that we are in mission, not only in working out of our strengths and know-how, but also in sharing our vulnerabilities. We have come to know that the way



Photo: Medical Mission Sisters

Sister Emily Kottaram (India) talks with a village group in Ghana that has undertaken leadership training.

in which we deal with our power and powerlessness is key to the healing mission. These processes, taken together and integrated, contribute to our individual and corporate search for wholeness.

THE FOURTH GENERATION

All this gives impetus to the fourth generation, in which the concepts of *health* and *healing* are being rethought. Healing is essentially a way of life in which all of us recognize that our humanness is being drawn by God into wholeness.

Wholeness

This implies recognizing and claiming all life experiences—sickness-health, pain-joy, justice-injustice—and working with the creative tensions in these experiences. It means learning to make life choices. We aim to acknowledge the woundedness of ourselves and our world so that the creation of healthy relationships can prevail. We yearn with others to integrate life rather than continue to deal with dualisms that have coloured our past approaches, such as body-soul, individual-community, male-female, medical-social, faith-action, pre-evangelization-reign of God.

Ecology

Through the members of our own Congregation and others we are being taught that ecology is about basic life-support systems and is integral to the healing process. So health implies integrating the movement of all creation, creating a web of life, perceiving and claiming connectedness and efforts to build one world. Interwoven in this search for wholeness through health are life attitudes which have become marked for us as we trace our corporate journey.

This quest to bring all of creation into its fullness flows from the graciousness of our God.

Our spirit includes a dialogue of life, a focus of energies, in which ongoing commitment to the well-being of oneself and others is, at once, an encounter with and a search for the sacred. It is an exploration of inner and outer space.

Passion and compassion

By passion we want to express that we are intensely moved by the sacredness of all life and are urged to action. This being urged to action can only be meaningful when we have discovered that compassion is a capacity to suffer with



Photo: Medical Mission Sisters
Sister Mary Em McGlone (USA) (right) at work in a Holistic Health Centre in the USA.

and to share solidarity with the other. It is a strength born of an awareness of shared weakness rather than a strength which depends on someone else's weakness.

As Thomas Merton stated so well shortly before his death, "The whole idea of compassion is based on a keen awareness of the interdependence of all living beings, which are all part of one another and all involved in one another." We have come to learn that a healing presence is most possible in the context of mutuality and interdependence.

Inculturation and solidarity

To suffer with, to be in solidarity with, implies that in fact we are really *with* people. Through the past years we have evolved a more experienced understanding of what inculturation involves. And we know that this challenge for inculturation is born out of the Gospel message. "He did not cling to his equality, but emptied himself..." (Philippians 2: 6-7). It asks a lot of us, and we are learning that, for each of us, it is basic to inculturation to have a positive claim on our personal identity and an appreciation of our cultural roots.

In some ways, the challenge of inculturation makes us slow and clumsy workers, at least initially. The religious and human heart always wants to take its time, to feel with, to wait, to listen deeply before jumping in with preconceived ideas and projects. Inculturation implies being able to touch those innate and God-given resources which people have within themselves, in their own setting, and which will release energies for healing and wholeness. More than involving ourselves from the outside in, we must involve ourselves from the inside out!

Internationality

One of the goals of inculturation is to overcome the attitude that a particular culture is the centre of the world or, worse still, to accept this blindly. Constantly we are challenged to help peoples connect and to be in solidarity with one another. In this respect, our internationality as a Congregation keeps before us the mandate of building one world and of searching for wholeness and healing as a caravan of God's people.

We recognize over and over again that our own efforts and struggles to live internationally reveal both the wounds and the connecting experiences of the world of which we are part.

"Now there was a woman who had suffered from a hemorrhage for 12 years; after long and painful treatment under various doctors, she had spent all she had without being any the better for it; in fact she was getting worse. She had heard about Jesus and she came up behind him through the crowd and touched his cloak....And the source of the bleeding dried up instantly and she felt in herself that she was cured. Jesus was immediately aware that power had gone out from him" (Mark 5:25-30).

Non-violence

The experiences of trying feebly but valiantly to be one with the poor and to be multi-racial as a group, recall to our minds and hearts, in the "dailyness" of life, that we have to deal with marginalization. We are only too aware of the violence that sometimes ensues when we realize how our own potential and that of other women has been subjugated. So, while acknowledging and working with the violence around us, we acknowledge the same violence in our own hearts. As we deal with this violence within us and around us, we feel invited by God, who suffers with us, to grow into a stance of non-violence.

We commit ourselves to nurturing the preciousness of all life, while trying courageously to resist all that is an obstacle to it. While struggling to empower others and ourselves we come to recognize that non-violence is precisely not about winning and losing. It is a struggle for truth and equality.

Reverence for all life

As we cultivate this attitude of non-violence, a reverence for all life permeates us. We sense that the gift of being a person is intimately related to the graciousness of God's whole creation. We realize that the energy of our universe is a shared energy. Our humanness is not one of self-sufficiency or domination, but of dependence on and interdependence with all manifestations of God's creation. Actually, peoples all over the world who live in communion with nature have been trying to teach us this for years. Maybe we have been slow learners!

WE LEARNED FROM OTHERS

The people

The people who have been part of our mission have helped to heal us. They have taught us that it is alright not to have all the answers or maybe even not to know the questions. We can search together. They have

patiently encouraged us to deeper inculturation. In their struggle with suffering and woundedness, they have inspired us to claim our own vulnerability and woundedness.

The Church

The Church has been a primary supporter of the health ministry through the years even though there was initial hesitation about religious practising the full scope of medicine. Although we experience support of the Church, we still have quite a journey to go in trying to fully understand the wholeness that is our mandate. We sense that the clergy, other religious, and some lay people do admire us for our expertise and experience. And we have often felt the support and participation of other religious congregations in our endeavours at healing! But sometimes we have also felt isolation and separation when a common search and teamwork were really necessary to bring about wholeness.

We are often perplexed when we hear comments that express the dualisms of soul/body, education/health, and human promotion/evangelization. Are we not all working toward an integral proclamation of the Good News? We realize that each group has a charism to which it is called within the Church; nevertheless, we can only approach truth when we work, think, and search together. As we have moved from generation to generation in our corporate journey, we have often felt we were alone in making decisions and that other church groups were trying to keep us in the mould of previous generations.

Ministries

As we have moved into efforts to localize the health ministry and incorporate lay people into key roles, we often feel disappointed that the local churches do not fully support lay people in assuming responsibility. And because we are intimately involved in curing and caring, it is painful for us that, when people ask explicitly for the sacraments of reconciliation and anointing of the sick, we as women

dedicated to healing have to stand back and hand over our engagement to a cleric. In some instances, where there is no cleric, it is painful that we have to stand by while people are deprived of these sacramental consolations and graces.

Other religions

Slowly we are discovering that other religious traditions have a spirituality of healing and wholeness. We feel that, in particular, the peoples of Africa and India among whom we work can and do teach us from the well-springs of their own traditions. We are only at the beginning of this discovery.

Traditional health systems

Many of the traditional systems of healing have always had an integral approach. In many ways the soul/body dualism we have struggled with has not existed for them. On the other hand, we have learned that some of their practices are based on fear, and in this way the liberational stance has a contribution to make. We learn from them and they learn from us. In Ghana, our Sisters have many years of experience working together with the traditional healers.

Many cultures have age-old approaches to diagnosis and cure that are both scientific and systematic. We have moved from ignoring and negating them to trying to learn from them and integrating them.



Photo: Medical Mission Sisters
Medical Mission Sisters in North India demonstrate the use of herbal gardens as a source of natural remedies.

Base ecclesiological communities and action groups

These groups are certainly involved in the betterment of health and see this as one of their primary agenda items. In Latin America, India, and the Philippines, they have literally initiated us in the justice and political dimensions of health. When those groups have an explicit religious perspective, their conception and practice of communal caring become striking.

World health organizations

Worldwide, there is a great concern for health. The number of caring and dedicated organizations, professionals, and community health workers is growing. Often all of us feel frustration at the way in which health is treated as a commodity to be bought and sold. But this frustration brings growing awareness that the escalation of health technology and costs is unjust and inappropriate; that the amount most governments spend on health is miniscule in comparison to spending on defense and national security. We know also that several developing countries have had to reduce their health budget to satisfy organizations like the International Monetary Fund and the World Bank. The negative repercussions of this fall on the poor.

On the other hand, several African governments are adjusting their priorities as they focus on primary health care. This movement is supported by expert bodies such as the World Health Organization (WHO). Dr Mahler, formerly director-general of WHO, states that the medical care system traditionally spends its energies repairing the consequences of diseases that could have been prevented. He insists that we should change our focus to health promotion. He gives content to this idea by saying that we should be involved in unlocking people's potential so that they can promote their own health through changes in attitude and lifestyle. Recognizing the broader implications of this, Dr Mahler goes on to challenge peoples to organize and create a common will for changing those social forces that threaten health.

Environmentalists

The environmentalists are addressing the issue of health as they help the world to analyze what is happening to the earth, water, air, plants, and animals—that web of life that sustains health.

Sometimes the question is asked: Why is the Third World so slow in taking up the issue of ecology? Certainly one of the main drawbacks is poverty. In the Third World, where public debt or private property is a driving force, natural resources that could be converted into cash or sustenance are being destroyed in the struggle for survival. Those who voice their disapproval from positions of relative affluence (and whose affluence is made possible by consumption of others' primary resources) will not be listened to in a kindly way. Global warming and ozone layer depletion look like academic concerns to people who are struggling for survival. The debt problem is a facet of the environmental problem. We have a long way to go before people at different stages of development can work together on ecology in a concerted way.

Relationships

All of the people and groups we have met in our corporate journey have affected the way in which we look at health and how we perceive ourselves as instruments of God's healing power. Together we have become a community in mission, searching and daring to respond. Our Congregation's documents have encouraged and affirmed these relationships when they state:

"We live out our healing mission as we enter the lives of other people, open to be affected by them and simple enough to give of ourselves." And again, "As we have entered further into a relationship of being in community in mission, we have touched goodness and experienced God." We are learning again and again that the process of healing is essentially one of building relationships and so building one world!

Anna Dengel, our foundress, once reminded us: "When Christ went around healing...he had the power of performing miracles....Now the power of miracles we don't have, but we do have the power of growing all the time and of peering into the secrets of God." *

1) Brenden, Neil. "Challenges in World Health Faced by Churches," prepared for the Conference on Projected International Health Consultation, National Council of Churches, USA, 1987.

2) Ornstein, Robert and David Sobel. *The Healing Brain*. 1987.

Discussion questions

Do you share this *Contact* subscription with a friend or group? The following questions, based on a biblical text, may help you begin to explore the theme of alternative healing systems and taking, with the right encouragement, our health into our own hands.

Do you know any place where sick people are gathered together waiting to be healed? Are they all able to be healed, or even just properly cared for or treated?

How are people in your community dependent on the services of others?

Do sick people and people on the edges of society sometimes become so used to being that way that they cannot imagine being free to choose a different life?

"Now at the Sheep-Pool in Jerusalem there is a place with five colonnades....In these colonnades there lay a crowd of sick people, blind, lame, and paralysed. Among them was a man who had been crippled for thirty-eight years. When Jesus saw him lying there and was aware that he had been ill a long time, he asked him, '**Do you want to recover?**' 'Sir,' he replied, '**I have no one to put me in the pool** when the water is disturbed, but while I am moving, someone else is in the pool before me.' Jesus answered, '**Rise to your feet, take up your bed and walk.**' The man recovered instantly, took up his stretcher, and began to walk.

That day was a Sabbath. So the Jews said to the man who had been cured, 'It is the Sabbath. **You are not allowed to carry your bed on the Sabbath**'" (John 5: 2-11, New Revised Standard Version).

How could people use the potential to be healed that is already within them?

What if the system that offers the most justice in health does not please the authorities or people in power? What can you do about this as a person or in a group with other people seeking healing?

Healing Systems

In July 1990, the Christian Medical Commission convened a consultation on "Integrated Healing," held in Tuebingen, Germany. The resumé that follows, including suggested points for discussion, was intended to stimulate dialogue within the churches on this important topic.

The problem

From a global perspective the following problems had been identified as a basis for discussion:

1. Widespread confusion is evident among the churches in regard to both the need to and way of integrating traditional medicine with western/allopathic medicine, which leads to unwarranted rejection or neglect of one or both systems.
2. Inadequate access to western health care is common and can lead to the promotion of traditional medicine as a "cheap alternative," thus disregarding or degrading its intrinsic value.
3. The dominant (western) health care system is often inappropriate within a given cultural context.
4. There is inadequate understanding of the spiritual aspects of health.
5. There is a growing tendency to "overprofessionalize" health care and healing. Health care practices (including traditional healing methods) are becoming increasingly commercial.

The meeting

It was against this background that CMC realized the need to initiate a process of reflection on the complementarity of traditional and western/allopathic healing systems, particularly as affected by early evangelization. (It should be mentioned here that participants in the consultation found the term "integrated healing" difficult to define. Throughout the meeting, therefore, alternative terminology was used to refer to the healing process, including *western/allopathic, traditional/ indigenous, and alternative medicine.*)

Points for discussion

The world is broken and in need of healing so that it might conform to the original purpose for which it was created by God. There are factors that both contribute to and prevent this healing process.

The healing process includes the use of appropriate healing arts. Various healing systems can be complementary.

The continuing dominance of the allopathic/ western medical system, which is often imposed on people not in a position to analyse it critically, is a matter for great concern. This system is becoming increasingly commercialized, compartmentalized, and disease-centred, leading to professional overspecialization.

Allopathic/western medicine has much to contribute to the healing process. But its useful aspects must be made more accessible, affordable, and acceptable to those who would benefit from them.

At the same time, indigenous/traditional medicine and other alternative medicine currently in practice must be examined critically and harmful practices discouraged. While renewed respect for and recognition of these systems are needed, their commercialization is a negative development.

All healing comes from God, and it is God who provides the resources for the healing process. Critical analysis of values regarding health that were adopted or imposed in the past should be encouraged. Discussion within churches and communities on the people's understanding of health, including recognition of the various resources available for healing, should be stimulated. A prerequisite for this is the establishment of a framework for analysis.

The churches are in a position to initiate a critical assessment of the options which can contribute to the healing process, including the role of supernatural powers in health and disease and such practices as faith healing.

In this assessment, attention should be given to the needs of the neglected and deprived sectors of society in support of the struggle for justice in health. *

Health, Healing, and Wholeness

A Consultation of the Middle East Council of Churches (MECC)

First discussed in the Middle East region at a CMC meeting in Alexandria, Egypt in 1980, the subject of Health, Healing, and Wholeness returns ten years later to the same forum. Violence, poverty, and brokenness in the region meanwhile have made it increasingly urgent for the churches to reconsider their role in healing.

Thirty-five participants, including clergy and health professionals, attending from seven countries and representing most of the MECC member churches met in Limassol, Cyprus in November 1990 to explore the subject. Members of the Roman Catholic Church participated in the forum for the first time.

Together they reviewed biblical sources and imperatives related to the theme of the meeting. Presentations covered the history of the health and healing ministry of the Church; issues and priorities in health and healing in the Middle East region; and the spiritual, ethical, social, and psychological aspects of health and healing.

Plenary discussions and work in small groups resulted in recommendations in the areas of primary health care, health rehabilitation, curative health care, and health in relation to social justice and human rights. Suggestions were made for increased cooperation between the MECC and the churches; within and between church groups; between countries in the region; and between church-related health projects, NGOs, and government health institutions.

In regard to human resource development in the health field, participants recommended continuing education, exchange visits between countries and projects, and the sharing of health personnel as needed.

Participants agreed that church-related health programmes and the community *together* should decide on their priorities, and follow-up and evaluation of health projects should be ongoing. *



Participants in the Middle East Council of Churches (MECC) consultation on Health, Healing, and Wholeness.

Health, Healing, and Community

by Father Francis Frost

Participants from 23 countries came together in May 1990 at the Ecumenical Institute, Bossey, Switzerland to discuss problems of sickness and suffering in relation to the community of faith and the ways in which unjust structures spawn disease and suffering.

Jointly sponsored by the Ecumenical Institute and CMC, the seminar made use of the participatory learning approach. In keeping with this methodology, each seminar participant was considered a resource person with his or her experience to share.

Participants from the developing world highlighted the massive scale of the suffering and sickness caused by poverty and misuse of wealth. For example, the poor in Ecuador are the most affected by natural disasters such as earthquakes, yet have the fewest resources to rebuild; only 11% of the population of Burma has access to safe water, and 76% of the country's rural population suffers from malaria; development aid intended for Nepal often ends up in the bank accounts of the rich; government misappropriation of wealth in Nigeria compromises a population of 90 million; overcrowding in Kenya's urban areas increases the risk of epidemics; and women in India and Sri Lanka are the greatest victims of social injustice.

Contributions from first-world participants centred around examples of the creation and strengthening of the healing community: the community that grows naturally and spontaneously in a home for the mentally handicapped; community-building around people who are dying; base communities; and the (formerly) East German model of the nuclear family. A presentation on changes in the immune system following stress conditions clearly illustrated the intimate connection of all levels of healing: spiritual, psychological, and physical.

Participants also recognized an interconnection between the apparently disparate perspectives

of the first and third worlds in that the development promoted by the first world leads to destruction in the third world of the very community values that the first world is desperately seeking.

Facilitating the seminar sharing process were staff members of CMC, the Ecumenical Institute, and the University of Hanover, Germany, who also shared recent thinking on the subject. Topics covered included the mental and spiritual crisis triggered by suffering; the stages in the process of coping with suffering; and ways in which the community of faith can effectively support the suffering individual.

Correspondence with participants before the seminar had evoked theological concerns centring around acceptance of death and the relation of the individual to the death and resurrection of Jesus. These were shared by a member of the facilitating team, together with insights into Jesus' words, "Your faith has made you whole." Being made whole meant being *saved*, being *healed*, and finally being made *well*.

Participants learned what lay behind the CMC report *Healing and Wholeness: The Churches' Role in Health* (see also page 16) and discussed its content. CMC also presented its experience of non-western forms of medical care and healing and invited discussion of the healing process and its relation to faith.

Sharing during the seminar was in the context of the participatory process. Communication and community-building proved sometimes painful and sometimes confused, yet in this sense the seminar exemplified the need to build healing community and, paradoxically, the pain that necessarily accompanies such an attempt. The daily morning worship and bible study were opportunities for participants to drink at the well-spring of healing and to reflect on the sharing process. *

Useful Publications

A Treatise on Healing Ministry

by Lee Myung-Soo

In this scholarly but easily readable book Dr Lee analyses, with depth and clarity, health and healing from the perspective of an integration of body, mind, and spirit. Drawing on his background as both a medical doctor and a professor of theology, he discusses the definition and cause of disease and the meaning of healing and health from the viewpoint of both contemporary medicine and the Bible, with particular reference to the healing ministry of Christ. This book, with its many diagrams and tables, would be very useful to anyone wishing to better understand an integrated, Christian approach to health and healing.

For more information, contact Dr Lee at:

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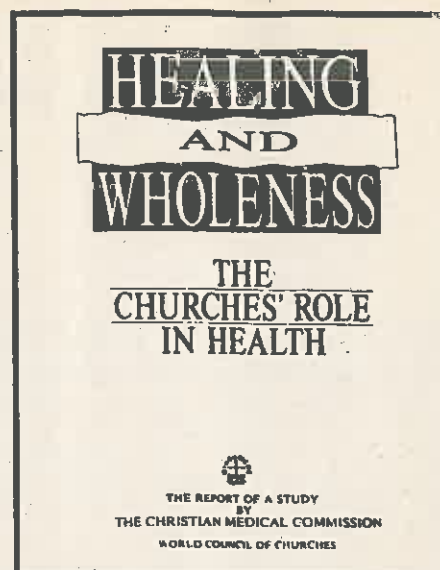
Towards theory and practice of pastoral counselling in Africa

by Abraham Berinyuu

This is a highly interesting and revealing look at African traditional healing by an author much at home in this subject, as well as in the Bible and psychology. Berinyuu draws numerous parallels between modern psychiatric theory and methods and what casual observers would call "witchcraft." Convinced that telling the true story of Africa is long overdue, he outlines an African Christian anthropology and redefines the goals of counselling in that environment. Although a knowledge of the vocabulary and theory of psychotherapy will make reading this book easier, it remains very useful to those interested in going to the heart of traditional healing.

For more information, contact the publisher at the following address:

Verlag Peter Lang GmbH
Hinter den Ulmen 19
D-W 6000 Frankfurt 50
Germany



The Christian Medical Commission was engaged for twelve years in a study on health and healing from the Christian perspective. The study was carried out through ten meetings held in all regions of the world, which brought together pastors, theologians, and health professionals to discuss their understanding of health and the role of the churches in it. This report presents a synthesis of the theological reflections, stories, issues and challenges that emerged from the meetings.

One copy is free upon request to those in developing countries. Others and those requesting multiple copies are charged at US\$ 5.50 (SF7), including postage (by surface mail). Write to:

Christian Medical Commission
P.O. Box 2100
1211 Geneva 2
Switzerland

Alive and Kicking: Towards a Practical Theology of Illness and Healing

by Stephen Pattison

The stated aim of this book is to invite those concerned with the relationship between healing, illness, and Christianity to think more deeply and widely on this subject amidst the complexities and ambiguities of modern technological society.

Recognizing that the world has changed considerably, even just in the last two decades, the author outlines a basic reassessment of illness and healing, bringing into use such tools as anthropology, sociology, and psychology to evaluate the currently dominant "medical model," as well as sacramental and "faith" healing.

Noting that among those Christians involved in healing and illness on a practical level, the imperative has been to heal, not to understand illness and healing, the author poses questions dealing with the many different ways of looking at illness and appropriate Christian responses to these. His basic thesis—that Christians must go beyond the curing of illness to deal with root socio-political causes as well—is expanded in a chapter devoted to exploring the ways in which both illness and healing can be sources of power and conflict.

Two final chapters use mental illness and AIDS as models for putting into context the ideas and questions raised.

This book is recommended for both healers and theologians who would like to think more deeply about the role of the Christian in health.

Available for purchase from:

SCM Press, Ltd.,
26 Tottenham Road
London N1 4BZ
United Kingdom

In His Hands: Towards a Theology of Healing

by David Dale

This book looks at healing from still another perspective: that of a pastor with 40 years' experience in congregational healing activities.

His discussion includes a survey of the various understandings of health in both biblical times and now. It analyses worship, the sacraments, prayer, and miraculous healing, as well as accompanying the suffering, relief programmes, institutional care, and political involvement.

Understanding of the nature of God is seen as fundamental to our approach to the healing ministry of the Church. The importance of seeing healing as a community as well as individual experience is emphasized. One chapter deals with the reality and mystery of suffering and various responses to it.

This book is a superb blend of penetrating theoretical discussion with practical examples and stories. It is intended for ministers and lay persons who may have theological and other problems with the Church's healing ministry.

For more information contact the publisher at the following address:

Darton, Longman and Todd, Ltd.
89 Lillie Road
London SW6 1UD
United Kingdom

Peddling Placebos

This report, published by Health Action International (HAI), takes a close look at cough and cold remedies and questions the rationale behind them. Although such remedies are highly popular and heavily advertised, most of them are ineffective and use up money that could be better spent on essential drugs. The report includes a detailed list of preparations currently on the market in selected countries.

Information on how to obtain this report is available from HAI at the following address:

HAI Europe
J. van Lennepkade 334-T
1054 NJ Amsterdam
The Netherlands

The Program for International Training in Health (INTRAH) of the University of North Carolina at Chapel Hill, USA has compiled a **List of Free Materials In Family Planning and Maternal and Child Health, 1990**. Recognizing that health professionals require reference and training materials to do their jobs effectively and to keep up-to-date in their fields, INTRAH has devised this list (in English and French) of materials available free of charge from health agencies around the world.

Information about how to obtain the list is available from INTRAH at the following addresses:

Catherine Murphy, Training
Materials Officer
INTRAH
208 N. Columbia Street
Chapel Hill, NC 27514
USA

Pauline Muhuhu, Director
INTRAH/Angelphone
P.O. Box 55699
Nairobi
Kenya

Pape Gaye, Director
INTRAH/Francophone
B.P. 12357
Lomé
Togo

Request for healing

Oh God!

With your moccasins of dark cloud, come to us.

With your clothing of dark cloud, come to us.

With your mind enveloped in cloud, come to us.

With the dark thunder above you, come to us soaring.

With the earth at your feet, come to us soaring.

With the clouds on the ends of your wings, come to us soaring.

With the he-rain on the ends of your wings, come to us soaring.

With the dark mist on the ends of your wings, come to us soaring.

With the she-rain on the ends of your wings, come to us soaring.

With the zig-zag lightning over your head, come to us soaring.

With the rainbow over your head, come to us soaring.

Oh God, come to us.

adapted from Navajo Night Chant

Assurance of healing

In beauty may I dwell.

In beauty may I walk.

In beauty may my male kindred dwell.

In beauty may my female kindred dwell.

In beauty may it rain on my young men.

In beauty may it rain on my young women.

In beauty may it rain on the chiefs.

In beauty may it rain on us.

In beauty may our corn grow.

On the trail of pollen may it rain.

In beauty before us, may it rain.

In beauty behind us, may it rain.

In beauty above us, may it rain.

In beauty all around us, may it rain.

In beauty may I walk.

Navajo Night Chant

from Sandner, Donald, *Navajo Symbols of Healing*, New York: Harvest Books, 1979.

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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 bi-monthly bulletin of the Christian Medical Commission of the World Council of Churches.

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