HEALTH FOR ONE MILLION

Just Another Slogan?
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EDITORIAL NOTE

Actions speak louder than words. In India, millions of people need basic health care. And in India, a bold health care programme is currently reaching and actively involving 1 million people.

In 1973, the national convention of the Catholic Hospitals Association chose the theme Health for the Millions for its annual conference. But, as so many eye-catching titles become filed away when the meetings are over, would this enormous goal, too, turn into a dusty slogan?

Inspired by Mr. James McGilvray, the founding Director of the CMC, Bishop Lawrence Mar Ephraem decided to turn the slogan into action. He became the moving spirit behind a multi-layered cooperative of 1000 volunteers. And with the dedicated and able assistance of Sister Eymard, principal coordinator of the programme, the volunteers have been mobilized to a remarkable degree. It is a huge undertaking, but has been made simple. The workers are mostly women, community-selected, well-organized, and they form the heart of an ingenious, logically structured programme in the south of India.

Health for One Million is the programme’s name (HOM) now in operation for 12 years under the guidance of the Jana Kshema Sangam (which translates as “Association for People’s Well-Being”). Bishop Ephraem, its president, began with many questions: How do we set about the task? How far can the infrastructure provided by the church help in community health? But the biggest challenge of all was,

Can we, the followers of Christ the Healer, afford NOT to go out into the field in search of those at risk? Can we afford to wait for the sick to turn up at a hospital or dispensary?

Answers to these last 2 questions were immediately clear, and the qualities necessary for a positive decision to be made in 1975 were:

the WILLINGNESS TO LEARN and
the WILL to succeed.

The Health for One Million Programme is an outstanding example of how a church can use local resources, utilizing community organization and development principles, drawing upon the resources of the Government, the church, and all financial institutions within reach to empower the people themselves. Dr. Eric Ram, Director of the CMC, visited the programme in February 1987 and was very encouraged to see “ordinary people” taking the matter of health into their own hands. HOM provides a structured and viable method to meet the health needs of every person in a given population.

HOM Photo
This mother, the children’s first educator, is taking the matter of health into her own hands.
INTRODUCTION

Health, within the HOM Programme, is understood in holistic terms. Emphasis is more on prevention of illness. A sick person must overcome disease and move towards strengthening all the elements of total health. The health of the family and of the community are integral to one's own health as well as the basis for socio-economic development.

The state of Kerala has social indicators like literacy and infant mortality at levels that are impressive in relation to the rest of India. Yet economic opportunity, employment and productivity remain depressed, and the status of adult health and nutrition is lower than in most parts of the country. Could the literacy, particularly of rural women, be used in an organized way towards better health and improved living conditions?

If results could be demonstrated in 1 experiment, there would be no lack of motivation or personnel to multiply it into a movement in the state and across India. Some 12,000 priests and 60,000 nuns are in position — even in remote areas — under the umbrella of the Roman Catholic Church alone. The only investment needed is a policy decision!

Releasing the initiatives of the “ordinary people” (as well as the priests) and liberating their potential is the essence of the strategy adopted by the Sangam. Self-reliance, as defined by the Sangam, is central to its strategy.

The community itself raises the resources, including income for its own development. Its main strength is its knowledge and organization for putting the resources to optimal use. External aid, large or small, is used for specific projects, but not for the main programme. Activities are designed in such a way as not to be entirely dependent on money, so they need not come to a halt when its flow thins down.

Fortunately, HOM has proved its effectiveness and is partially subsidized by Government health services. They have access to already established Government facilities, and an active referral service is in operation.

Area of operation of ‘HOM’
(Kerala & Tamil Nadu)

What is Holism in Health?

‘Holism’ implies, by its spelling, that the whole is holy… Therefore look again at our Earth in its beauty and conceive that it is truly a living creature, a being, an organism with its own breathing, bloodstream, glands, sensitivity and intelligence. Furthermore, we must see that humanity is itself an organism, integrally part of the whole of nature… Teilhard de Chardin’s noosphere is a living body over the face of the Earth and we are each cells in the one great body. When cells in our physical bodies choose to ignore the programming of the whole and go off on their own, we call it cancer. Similarly, when human cells in the body of Earth act out of egoism, greed and violence, and go off on their own reckless way, the Earth itself becomes cancer-ridden. The disease is far advanced, though not necessarily terminal.

from SUMMONS TO A HIGH CRUSADE
by Sir George Trevelyan
The Guiding Principles of Health for One Million (HOM)

1. Health CARE is more important than disease CURE.
2. Health can be maintained only in the context of TOTAL HUMAN DEVELOPMENT.
3. Development means self-growth. Community development means community growth from within. SELF-HELP and SELF-SUSTAINED PROGRAMMES are the most effective.
4. Outside assistance is helpful to the extent that people are brought together. In this way, they may coordinate efforts and encourage local leadership. The role of the outside helpers should be to work WITH rather than FOR people.
5. Community DECISION is more meaningful than community PARTICIPATION alone.
6. LOCAL RESOURCES - personnel, financing, Government facilities, social structures - are used to the fullest, without regard to religious affiliation, caste distinction or political bias.
7. In the implementation of programmes, principles of APPROPRIATE TECHNOLOGY are followed to the greatest extent possible.
8. FORMAL as well as INFORMAL EDUCATIONAL METHODS are adopted to educate people on health and development.

The other 9 families (not nominated by the Sangam) on the strength of her organizational ability and leadership. In a unit of 200 families — approximately 1000 people — there are 20 such mother leaders. The 20 leaders meet every 2 weeks (for 2 hours) where they:

discuss health and development problems in their community, find solutions to these local problems AND the means to implement them.

The Sangam has a built-in system of monitoring. Each group of 10 volunteers has a promoter and every group of 10 promoters has an organizer. The programme has 10 organizers in all, brought together by a coordinator. Nearly all posts are held by village women from low-income backgrounds, except the coordinator. It is through their ranks that the mother leaders are first chosen, and next the volunteers, and next the promoters and last the organizers.

The aim of comprehensive, health-based, community development covering 1 million people, is pursued by 1000 village-level volunteers each involved in the WORK RELATING TO HER OWN VILLAGE COMMUNITY, referred to as a unit. Each volunteer so organizes her community that every small group of 10 families has 1 leader, usually a woman designated as mother leader, and chosen by

THE TREE OF HOM *

EXPERTS

COORDINATORS

teach

ORGANIZERS

teach

PROMOTERS

teach

VOLUNTEERS

teach

MOTHER LEADERS

teach

9 NEIGHBOURING FAMILIES **

* HOM's organizational structure as seen by S.J. Freeman based on their reports
** 10 including her own family

A formal classroom setting is not necessary for a mother leader to share what she knows!
Training

A great deal of emphasis is on the training — some of it formal, most of it informal. Village-level volunteers usually begin with training which lasts for 3 days. This is followed by a period of field work in their own village, lasting for about 1 month. They then attend a 1-week seminar where they refresh their skills and evaluate field performance. After this, they attend 1-day follow-up classes conducted by the promoter every month.

Promoters have 2 more weeks of training in addition to that of the village-level volunteers. They, too, attend monthly 1-day follow-up classes led by the organizer.

Organizers receive the same training as promoters, and commit themselves to 3 years' involvement in the programme. They attend 1-day follow-up classes conducted by the coordinator.

Responsibilities run parallel. On becoming a volunteer, a woman is also able to continue her duties as a mother leader. Functional hierarchy is thus not at the cost of fundamental equality, which is perhaps also an organizational imperative in a highly individualistic society like Kerala.

The volunteers is key to the programme. Any mother interested in the well-being of the community and able to communicate to others what she has learned can become a mother leader. She is compensated by the community according to the work demanded of her and the local paying capacity.

Where are the zones of activity located and how are they chosen?

The Sangam believes in working convenience. So each cluster of 200 families is generally located around a church. The whole effort is promoted and assisted, without interference in decision-making, by priests and nuns. Interestingly, the clergy are expected to promote community health and development as part of their normal work, without allocating separate time.

Even in the remote parts of Kerala, people of different faiths live in mixed groups. Thus a unit of 200 families is a micro sample of a multi-religious, economically struggling community.
Down to earth

The first phase 1975-80 was devoted to training 1000 voluntary workers and organizing them for health-related self-reliant action at the community level among the programme population of 1 million. This period also saw the establishment of communication and control systems and the promotion of primary health care through interaction of the entire team, from experts to mother leaders.*

In the 10 zones participating, the focus in the first phase was on education for health and development. The following topics were promoted through sessions meeting every 2 weeks:

- applied nutrition
- alternative medicine from local herbs
- safe drinking water and clean physical environment
- responsible parenthood through natural methods of family planning
- promotion of individual savings and their pooled use.

Phase 2 began in 1981, and welcomed 1057 trained volunteers, all of them women. They were Christians (569), Hindus (419) and Muslims (69), with varied educational backgrounds, including 50 illiterate.

The 1000 volunteers are distributed over 10 zones in 4 districts (3 in Kerala and Kanyakumari in Tamil Nadu), with 100 of them in each zone guided by 10 promoters and 1 organizer. These workers and the 20,000 mothers they work with are trained to organize their own developmental activities.

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How close to fulfilling the projected goal has HOM come?

As of March 1985, all the 1000 volunteers were in position. Activities had started in some 644 units of which 393 were fully organized into units led by mother leaders. Of this number, 258 were making measurable progress in 1 or more established projects – as judged by their monthly reports.

Bishop Ephraem provided the CMC with a progress report just before Christmas, covering January through June 1987. Among other developments, he reported that 10 HOM workers were being taught English, to enable them to communicate about the programme in this language also. Two recent purchases have greatly facilitated office work – a new English keyboard typewriter and a filing shelf. And the data filing system is being computerized.

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A few principles that govern each unit's considerations:

1. All decisions are taken by the unit on its own. This responsibility is not shared with the Sangam in any sense.
2. There is no insistence by the Sangam on uniformity of content or approach to activities among units.

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* This name could, of course, be expanded to include father leaders, as appropriate, or even parent leaders.
3. A unit decides to implement only those projects for which the means are available or in sight.

**Two-Way Communication**

Communicating starts with and flows from the coordinators’ monthly meeting with the 10 organizers. The activities, based on reports from the mother leaders’ meetings with the units, are assessed. They next get filtered though the volunteers’ meetings at the centres and passed on to the promoters for further study at the zone level. Possibilities for future action are developed. A statistical update is prepared from the latest field data collected. Topics for discussion at the field level are suggested in light of recent promotional schemes of the Government, banks and other agencies. The result of this exercise is a monthly bulletin.

The field unit is free to respond to the above process in whatever way it likes and to provide an up-to-date report on performance and statistical data. Stacks of the bulletin travel through the organizational layers, breaking up into smaller stacks until single copies reach the mother leaders at the head of each unit. The leaders then share the content of the bulletin at their fortnightly meeting. Next, it is the responsibility of each of the 20 mother leaders to contact the 9 other mothers in her group in time for the next fortnightly meeting when decisions are taken reflecting the views of their 200 families.

At this next meeting, they complete the questions in the bulletin and start it on the return trip to the coordinator – gathering, as it travels, the comments, if any, of the concerned volunteer, promoter and organizer. The coordinator selects useful information and statistics, assesses the work, and sends the paper to the centre (usually located in a convent), where it is kept for a time as a reference. **It takes a little more than 2 months for a bulletin to complete its circular course.**

The monthly bulletin serves many purposes:

A. Education through correspondence related to one's own activity
B. Monitoring tool
C. Evaluative control mechanism
D. Channel for data collection
E. Help for advance programming
F. Medium for exchanging information and opinion (Monitoring and controlling their own collective activity is in itself a measure of the people’s development.)

The programme does not involve much monetary investment. And the only full-time workers are a couple of young assistants in the Sangam’s office at Trivandrum. Rather, it demands a whole-souled commitment from all concerned, from coordinator to mother leader, from bishop to nun. The involvement is not exactly part-time, but skillfully woven into their full-time pursuits.

**Room for Improvement**

As far as outside help is concerned, the spirit of self-reliance keeps it to a minimum. HOM does rely heavily on the existing channels of development assistance from Government schemes, financial institutions and several voluntary agencies. But progress of the programme beyond the reach of this assistance depends on external aid, which may not come when needed or in the right amounts.

This dilemma is common to many such programmes, and reflects a certain inability to summon the resources needed by the community from within its own geographic area.

Even in a densely populated state like Kerala, it cannot be said that the material, monetary and human resources are anywhere near exhaustion in the service of all the people. Instead, they are just not pooled and shared equitably. As long as the churches do not face this fact, their resource problems are likely to persist.

Talking to participants at a zonal meeting in Kottarakara, it was seen that the Sangam had limited working relations with other organiza-
tions in the same community. Women's groups, for example, (mahila samajams) are almost everywhere. But attempts at cooperation have not succeeded. The mahila samajams, usually supported by Government grants, and the Sangam units seem to keep a mutual distance.

Cooperating in projects for and by the same community, sharing mutual facilities, should be possible. Even if it is difficult at the start, more direct communication would be worth the effort.

**Breaking New Ground Uncovers New Questions**

Resource constraints seriously affect the projects. But no one is as hard hit as the individuals themselves. **A story:**

One of 15 disabled children identified as needing help in a particular zone was taken to the medical college. There, expert advice and an estimate of the investment required for treatment and rehabilitation were provided. But there was not enough financial help to match the costs of therapy.

The parents owned a small plot of land. But they were driven to selling part of it to finance the treatment.

Question: Is a trade-off between health and development inevitable in cases like this?

WHERE ARE THE LINES TO BE DRAWN BETWEEN THE ESSENTIAL, THE OPTIONAL AND THE UNNECESSARY—IN THE CHOICE OF PROGRAMME GOALS?

More and more questions are surfacing as the Sangam, along with its HOM Programme, forge their way along the road to health.

Q: How can the capacity of the poor be improved to move farther ahead?

Q: Can this be done without persuading the non-poor in the same community to share their resources for the common good?

Q: Can the obvious relevance of the programme for the people be sustained, without new gains measurable in terms of indicators of health and development?

Q: How could the data being collected be put to more scientific and effective use than is possible now?

The Sangam is alive to these and allied issues and is drawing upon all possible sources of wisdom and examples of success, in the attempts to resolve them.

**ACTIVITIES**

Most health education activities use dance, drama and story-telling to enliven teaching methods.

**Health and Nutrition Education**

报告日期：1986年12月

**Goals:**

- To improve nutritional status of communities, particularly of most vulnerable group – children 0-5 years – and pregnant/lactating mothers.
- To improve general dietary practices among population.

**Objectives:**

- To increase body weight to normal level in children suffering from 1st, 2nd and 3rd degree malnutrition, by improving eating habits.
- To improve dietary practices through health education classes for mothers covering nutrition, health, hygiene, child care (better feeding
methods, etc.), and follow-up home visits conducted by volunteers through mother leaders.

Methods:
Active participation in the “Tree of HOM” structure (see page 2), with 2-way communication from experts to all levels of health workers, including the parents of each individual family, and back again. Tools include the monthly bulletin and simple, effective audio-visual aids such as flash cards and flannel boards.

- Classes for mothers every 2 weeks – listening to pertinent radio programmes and discussions

2. Rehabilitation of Children with Disabilities and Prevention of Disability

In 1981, the “Year of the Disabled”, HOM Volunteers conducted surveys to assess the extent of problems concerning persons with disabilities. This activity attracted the attention of UNICEF and it was with their encouragement and collaboration that the rehabilitation project unfolded.

Goals:
To strengthen the on-going activities of prevention of childhood disabilities.
To introduce early detection of disability signs in children.
To promote community-based rehabilitation of the disabled.

Objectives:
To create more community awareness of the realities and problems of people with disabilities, especially children.

To establish a community- and family-based rehabilitation programme for children with disabilities.

To promote the integration of children with disabilities in on-going community activities, such as schools, youth clubs, vocational training...

Methods:
Formulation of a Committee of Specialists to oversee and guide the project, from the Department of Physical Medicine and Rehabilitation, Government Medical College, Trivandrum/ the School for the Blind, Deaf and Dumb, Trivandrum/ the School for Mentally Retarded Children, Vattappara, Trivandrum/ and the Loyola College for Social Sciences, Trivandrum.

Use of Jana Kshema Sangam’s “Tree of HOM” as communication network to:
A. Promote awareness about community problems related to disabilities
B. Transfer technical skills from specialists through trainers, volunteers and mother leaders to members of the concerned families

The Committee of Specialists developed a 3-year plan of action, during which 423 children
under 15 years were identified as having disabilities:
161 children with severe disabilities
151 children with moderate disabilities
111 children with minimal disabilities.

Of these 423 children,
19 were admitted to special schools
219 were taught in normal schools with supplemental rehabilitation at home
185 were trained at home.

Steps taken to prevent illness and disabilities included:
- Maintaining growth charts
- Following ORT (oral Rehydration Therapy)
- Advocating breast-feeding
- Promoting Immunization
- Encouraging Natural Family Planning
- Providing Supplementary Food
- Promoting Education for Women.

4. Integrated Leprosy Control

Goal:
To effectively control the spread of leprosy and promote community health practices to prevent the disease.

Objectives:
To identify, treat and rehabilitate leprosy patients.

To promote campaigns for early detection of the disease.

3. Natural Family Planning

Goal:
To assist couples of child-bearing age in their family planning.

Objective:
To educate couples about the non-chemical alternatives in birth control.

Methods:
NFP (Natural Family Planning) information classes:
A. Promotion of cervical mucus method, in which days of fertility are identified by self-observation of cervical mucus during a menstrual cycle. (Initially, the only method known besides the rhythm method.)
Methods:
Use of the Sangam's "Tree of HOM" as communication network to:
A. Identify leprosy patients
B. Bring patients for treatment
C. Follow-up patients to ensure continued and regular treatment
Use of all government and other readily available resources.

5. Treatment of Minor Ailments

Goal:
To provide medical care for fever, cough and cold, diarrhoea, eye infection and first aid for minor injuries.

Method:
Health workers are always equipped with drug kits during house visits, and ORT is easily taught "on the spot."

6. Use of Herbal Medicine

Goal:
To provide the safest, most practical and effective medicines to the population.

Objectives:
To assist in increasing public knowledge of
A. the identification of useful herbs and plants growing locally, and
B. their cultivation and preparation for home remedies.

Methods:
Distribution of printed information and instruction at the village level.

7. Immunization

The project avails itself of vaccine supplies and essential drugs provided by Government facilities. DPT, Polio and BCG immunization have successfully covered the target population.

8. Socio-economic development

Goal:
To generate income for development activities.

An Oral Rehydration Therapy (ORT) class.

This cow was purchased through a revolving fund.

This sewing machine was made possible with a bank loan.
Method:
In addition to taking out low-interest, long-term loans from local banks and other financial institutions, a **revolving fund** has been established. Registration fees and annual subscriptions to HOM are pooled and distributed back to the people as "seed money" to promote developmental work. This money is to be returned within 1 year with 6% interest. The interest is used to pay for clerical services.

9. Environmental Sanitation
Sound management has used local materials to improve living conditions: provision of safe water supply, better housing, hygienic disposal of human waste (latrines).

Kadakal-Chackamala is 1 of the 10 HOM zones of operation. It is located about 50 kms north of Trivandrum. The following statistics are taken from Sr. Eymard's letter received by the CMC in January, in which she outlined this zone's accomplishments – typical of HOM's overall achievements.

### Number of Families benefitting:
**4,400 (Population 22,000)**

<table>
<thead>
<tr>
<th>Nutritional Status in the year</th>
<th>1978</th>
<th>1985</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children in 3rd degree malnutrition</td>
<td>2.75%</td>
<td>0%</td>
</tr>
<tr>
<td>Children in 2nd degree malnutrition</td>
<td>22.25%</td>
<td>5%</td>
</tr>
<tr>
<td>Children in 1st degree malnutrition</td>
<td>42.42%</td>
<td>24%</td>
</tr>
<tr>
<td>Children in Normal degree malnutrition</td>
<td>32.58%</td>
<td>71%</td>
</tr>
</tbody>
</table>

100% 100%

Infant mortality rate 46.76/1000 22/1000

### Integrated Leprosy Care

<table>
<thead>
<tr>
<th>Number of HOM-units doing leprosy work</th>
<th>61</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population covered</td>
<td>110,241</td>
</tr>
<tr>
<td>Population examined</td>
<td>87,300</td>
</tr>
<tr>
<td>Leprosy Patients treated:</td>
<td></td>
</tr>
<tr>
<td>Leprumatus</td>
<td>83</td>
</tr>
<tr>
<td>Non Leprumatus</td>
<td>382</td>
</tr>
<tr>
<td>N ? L</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>488</td>
</tr>
</tbody>
</table>

Cured of leprosy (removed from treatment)
during the years 1982 - 86 = 36
during the year 1987 = 14

Total leprosy patients cured and released from treatment = 49

### Economic Development Activities

<table>
<thead>
<tr>
<th>Revolving Fund</th>
<th>Total amount utilised</th>
<th>Families benefitting</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1982-87</td>
<td>Rs 55,000/-</td>
<td>140</td>
<td>- Managing Rubber Nursery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Bee Keeping</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Garment making</td>
</tr>
<tr>
<td>Small Savings</td>
<td>Rs 80,000/-</td>
<td>1,200</td>
<td></td>
</tr>
<tr>
<td>1976-81</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank Loans</td>
<td>Rs 55,000/-</td>
<td>80</td>
<td></td>
</tr>
</tbody>
</table>
Latrines – numbering 13,220 – was impressive considering the near-total neglect of sanitation in much of rural India.

Some 33,600 households had water sources within 200 yards (reasonably safe for drinking).

**Positive Behavioural Changes**

- Improving the value of the common man’s staple of tapioca (cassava) by using its protein-rich leaf as well as the starchy tuber
- Preparation of indigenous substitutes for commercial tinned foods and tonics, using commonly available pulses and herbs
- Encouragement of kitchen gardens, consumption of green leafy vegetables
- Rearing of nutritious fruit trees like the papaya
- Use of sprouted cereals and pulses
- Hygienic disposal of wastes
- Motivation of couples to limit their family size by natural methods
- Building a revolving fund from annual subscriptions – used for short-term loans for development activities by individual families.

With only 2 exceptions*, **this encouraging situation has been brought about entirely by community education and effort.**

* Immunization from the public health system and supplementary food from Catholic Relief Services for 9500 pregnant mothers, and children under 3 years.

**A special thanks to the UNICEF Regional Office for South Central Asia for their article “Moving with a million on the road to health”, FUTURE Development Perspectives on Children 15-16, summer-autumn 1985, which was invaluable in the preparation of this issue. Their report was based on a visit to the Jana Kshema Sangam, Archbishop’s House, Trivandrum (Kerala, India), to some of the villages where volunteer meetings were being conducted and to individual households where health-related improvements have been demonstrated.**
WORTHY MENTIONS

The editors of CONTACT find the following efforts most heartening, as they are in keeping with the publication's goal of reporting on "topical, innovative and courageous approaches to the promotion of health and integrated development."

Sharing Life in a World Community

The World Consultation on Resource Sharing was held in El Escorial, Spain in October 1987. Two hundred fifty (250) persons from 80 countries gathered to discuss how to better share the world’s resources.

The participants met for bible studies, theme presentations, working groups, regional, women and youth groups to develop new models and guidelines for the sharing of resources among people. The daily morning worship was an important inspiration to all. Participants from churches in the developing countries stressed again and again that the changes necessary are not mainly in the mechanisms for transferring funds from the rich churches to the poorer ones, but more important in the causes of the rich being rich and the poor being poor. These issues challenge the churches to change. At the final worship-celebration all participants received a small stone, a part of a cross, to remind them of the consultation and the commitments we made in worship:
In all our sharing, we commit ourselves to

- Educating opinion in our countries regarding the structural causes of world economic disorder, particularly in our faculties of theology, with the assistance of witnesses from the countries of the South and of Eastern Europe.
- Developing in the short term exchange programmes for individuals and inter-church visits.
- Ensuring that our countries are centres of asylum for all under threat or having suffered persecutions on account of race, religion or politics.
- Asking that in North-South programmes, the partners should furnish all the financial documents of their own body, showing the allocation of the resources at their disposal.
- Challenging the Lutheran World Federation to participate in the ecumenical sharing of resources through the World Council of Churches and to adhere to the discipline emerging from the El Escorial consultation.

**European Consultation — Budapest — September 1986**

**Two follow-up reports from the European Consultation on the Christian Understanding of Health, Healing and Building Community held in Budapest, Hungary, September 1986, have been received.** At the Consultation, the aim of continued work in participants’ home countries was stated as developing and deepening the cooperation between church, medicine and social welfare. The letters are summarized here:

### Finland

The Health Care Ethics Commission of the Finnish Ecumenical Council is into its 2nd year and concentrating efforts on AIDS-related issues. In March 1987, the Commission organized a seminar on “AIDS and the Churches” for health authorities, decision makers, church workers... A 2nd seminar in October gathered 30 people under the theme “Facing the AIDS Phenomenon”. Its purpose was to assist hospital chaplains, health personnel and others, who in their daily work are faced with the multitude of situations revolving around the disease. Dr. Eric Ram, Director of the CMC, was a featured speaker.

Dr. Ram also spoke at 2 other ecumenical events — a seminar on “Ecumenical Encounter at School” arranged by the Education Commission, and a meeting of the International and Ecumenical Training Programme by the Youth Commission of the Finnish Ecumenical Council. In the words of Dr. Raimo J. Harjula, Chairman of the Health Care Ethics Commission, such visits provide them with “new insights on current issues (and) strengthen our ecumenical aspirations in many ways.”

At a meeting of the Health Care Ethics Commission last October, future plans were discussed and include the decision to promote a comprehensive understanding of health care ethics, including a relevant concept of man. A seminar on Drug Abuse is also being planned. And Dr. Harjula is preparing for a Budapest follow-up consultation next autumn with other Nordic representatives. A meeting in Sweden to finalize plans was set for January 1988.

### Sweden

One conference on “Wholeness and Health” was held in May 1987 and another in September on “Collaboration towards Health — Christian Ethics realized in Health Care”. About 110 representatives, including clergy, hospital staff, chaplains, health centre personnel and school employees attended the 2 conferences. Participants agreed that Christian “contact groups” should be established at hospitals and health centres throughout the country. Their purpose will be to integrate Christian ethics into the medical training and daily care. Study groups have already begun in several places to discuss ethical issues.

“Respect for Life” was the theme of a seminar held in Gothenburg last May and in Stockholm in December. The aim was A.) to discuss how
to reduce the high number of legal abortions in Sweden, presently in excess of 30,000 a year, and B.) how to assist pregnant women psychologically, socially and economically, in order to encourage seeing their pregnancy to term. Similar seminars are planned in various locations for 1988.

Hans E. and Märtta M. von Holst also look forward with their colleagues to the exchange of experiences which is scheduled to take place at the Nordic consultation later this year.

USEFUL PUBLICATIONS

New international quarterly newsletter on AIDS, by AHRTAG (Appropriate Health Resources and Technologies Action Group Ltd). Providing up-to-date information about the latest developments in research and measures which can be taken to combat the disease. Its goal is to be practical, and it is aimed at health planners, administrators and policymakers, health workers and trainers at all levels. Appearing initially in English, a French edition is scheduled soon.

Available from: AHRTAG / 85 Marylebone High Street / London W1M 3DE / U.K.

Price: Free to readers in developing countries. £5.00/$10.00 annual subscription to readers in Europe, North American and Australasia.

PROJECT FORMULATION & PROPOSAL WRITING by Dr. Katja Janovsky. World Health Organization, WHO/EDUC/87:187. Includes 1) the process – formulation, circulation and feedback, communication with donors, writing and submission and 2) the contents – 8 modules and project design frameworks. A well organized and concise guide for national project managers.


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<table>
<thead>
<tr>
<th>No</th>
<th>Date of Issue</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>April 1978</td>
<td>Realization of an Integrated Health Services Programme in Rural India – Eric R. Ram</td>
</tr>
<tr>
<td>45</td>
<td>June 1978</td>
<td>Appropriate Technologies for Tackling Malnourishment – J. McDowell</td>
</tr>
<tr>
<td>46</td>
<td>August 1978</td>
<td>The Churches Take a New Look at the Contributions of the Handicapped – WCC</td>
</tr>
<tr>
<td>47</td>
<td>October 1978</td>
<td>Relationships – The Third Dimension of Medicine – P. Tournier</td>
</tr>
<tr>
<td>51</td>
<td>June 1979</td>
<td>In Search of Wholeness... Reaching Out to One Another in Caring and Healing – CMC</td>
</tr>
<tr>
<td>53</td>
<td>October 1979</td>
<td>Community Building Starts with People – a report of the work of an ecumenical health and development agency in Nicaragua – G. Parajón</td>
</tr>
<tr>
<td>57</td>
<td>August 1980</td>
<td>The Village Health Care Programme: Community-Supportive or Community-Oppressive? (An examination of rural health programmes in Latin America) – David Werner</td>
</tr>
<tr>
<td>59</td>
<td>December 1980</td>
<td>Nursing: The art, science and vocation in evolution – R. Nita Barrow</td>
</tr>
<tr>
<td>60</td>
<td>February 1981</td>
<td>International Year of Disabled Persons 1981 – Stuart Kingma/Norman Acton/John Steensma</td>
</tr>
<tr>
<td>67</td>
<td>April 1982</td>
<td>The Church and Injustices in the Health Sector – Julio Alberto Monsalvo</td>
</tr>
<tr>
<td>68</td>
<td>June 1982</td>
<td>Understanding the Causes of World Hunger – Frances Moore Lappé and Joseph Collins</td>
</tr>
<tr>
<td>71</td>
<td>December 1982</td>
<td>Healing and Sharing Life in Community – WCC/CMC, Stuart J. Kingma</td>
</tr>
<tr>
<td>73</td>
<td>June 1983</td>
<td>Strengthening &amp; Regulating the Supply, Distribution &amp; Production of Basic Pharmaceutical Products – CMC</td>
</tr>
<tr>
<td>74</td>
<td>August 1983</td>
<td>Malaria and Tetanus: Turning Back the Tide – CMC</td>
</tr>
<tr>
<td>77</td>
<td>February 1984</td>
<td>Rediscovering Traditional Community Health Resources: The Experience of Black Churches in the USA – Hatch, Robinson</td>
</tr>
<tr>
<td>78</td>
<td>April 1984</td>
<td>Training Health Workers – Voight</td>
</tr>
<tr>
<td>79</td>
<td>June 1984</td>
<td>The Ceará Experience: Traditional Birth Attendants and Spiritual Healers as Partners in Primary Health Care – Galba Araújo</td>
</tr>
<tr>
<td>80</td>
<td>August 1984</td>
<td>Women and Health; Women’s Health is More than a Medical Issue – Cathie Lyons</td>
</tr>
<tr>
<td>81</td>
<td>October 1984</td>
<td>The Church and Health; Reflections and Possibilities – J. McGilvray</td>
</tr>
<tr>
<td>82</td>
<td>December 1984</td>
<td>Evolution of a Community-Based Programme in Deenabandu – H. &amp; P. John</td>
</tr>
<tr>
<td>83</td>
<td>February 1985</td>
<td>Today’s Youth – What are Their Health Needs? – Bennett, Kodagoda, Denshire</td>
</tr>
<tr>
<td>84</td>
<td>April 1985</td>
<td>The Ghanaian Concept of Disease – Sarpong</td>
</tr>
<tr>
<td>85</td>
<td>June 1985</td>
<td>Setting our Priorities for Health – 1985 Meeting of CMC</td>
</tr>
<tr>
<td>86</td>
<td>August 1985</td>
<td>The Child’s Name is Today – D. Morley</td>
</tr>
<tr>
<td>87</td>
<td>October 1985</td>
<td>Nurses: A Resource to the Community – R. Harnar</td>
</tr>
<tr>
<td>88</td>
<td>December 1985</td>
<td>A Church Leads the Way in Health and Development – Okully/Iskandar</td>
</tr>
<tr>
<td>Date</td>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>February 1986</td>
<td>&quot;I've Made it — You can Make it, too&quot; + &quot;Adolescent Fertility: Looking for Solutions to a World-wide Problem&quot; — E. Coit</td>
<td></td>
</tr>
<tr>
<td>April 1986</td>
<td>From Indonesia — Practising Wholistic Healing — Dr Bert A. Supit</td>
<td></td>
</tr>
<tr>
<td>June 1986</td>
<td>Disabled Village Children — Part of Primary Health — David Werner and the Hesperian Foundation</td>
<td></td>
</tr>
<tr>
<td>October 1986</td>
<td>Infant Feeding Today — What's Best for the Babies? IBFAN and CMC</td>
<td></td>
</tr>
<tr>
<td>December 1986</td>
<td>Letting People Decide For Themselves — Eric Ram (CMC)</td>
<td></td>
</tr>
<tr>
<td>February 87</td>
<td>Updates on: Malaria, Aids, Guinea-Worm — David Hilton, CMC</td>
<td></td>
</tr>
<tr>
<td>April 1987</td>
<td>Enhancing Mental Health — Dr Akolawole Ayonrinde, David I. Ben-Tovim, George Nichols, David Hilton</td>
<td></td>
</tr>
<tr>
<td>June 1987</td>
<td>Listening and Caring, Towards Healing of Nations — Jeanne Nemec, CMC.</td>
<td></td>
</tr>
<tr>
<td>August 1987</td>
<td>National Black Women's Health Project, Empowerment through Wellness — Byllye Avery, Felicia Ward, WCC, CMC.</td>
<td></td>
</tr>
<tr>
<td>October 1987</td>
<td>Financing Primary Health Care Programmes, Can they be self-sufficient? — Victor H. Vaca, Sidney and Mildred S. Kreider</td>
<td></td>
</tr>
<tr>
<td>December 1987</td>
<td>Story-Telling for health teaching — David Hilton, CMC</td>
<td></td>
</tr>
</tbody>
</table>
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