HEALTH DEVELOPMENT AMONG THE NOMADIC PEOPLES OF EAST AFRICA
INTRODUCTION

In this final decade of the Health for All by the Year 2000 initiative, much is being done to assess the progress made towards the goal set at Alma-Ata over ten years ago. The results of these assessments have been generally encouraging, suggesting either that the assessment tools used so far have been inappropriate to measure the actual progress or that the goal and strategies designed to reach it have been unrealistic.

Whatever the reason, it is clear that the quest for health for all is far from completed. We of the Christian Medical Commission believe that the goal cannot be achieved until:

• health is genuinely understood to be more than merely the absence of disease or infirmity and

• maintaining or restoring health is seen as the responsibility of each individual and his or her community, and not something left to medical personnel alone.

This issue of Contact focuses on health development among nomadic peoples of East Africa, particularly the Maasai.

Traditionally, the Maasai view health as a state of harmony in one’s relationships, and not simply the absence of illness. Health is a kind of dynamic wholeness within each person and between each person and the community—individual yet interdependent. In this context, each individual is primarily responsible for maintaining his or her harmony, or health.

Maasai tradition also enables the individual to assume this responsibility. The Maasai indigenous healer diagnoses an illness by identifying the broken relationship responsible for the “dis-ease” and then recommends specific steps to help the patient restore the harmony that has been lost.

With increasing access to Western medicine and a wider world, however, the Maasai today face new options in healing, as well as new problems that impact their health, for example AIDS and the loss of their grazing lands. Their resources for health now include more than the traditional healer, herbal medicine, and traditional healing rituals.

In this rapidly evolving context, the work of enabling individuals to take responsibility for their health becomes more complex. Health development now includes ensuring access to and the coordination of multiple resources for health—both traditional and Western, both within and without the community.

The programmes described in these pages carry on their health development work among the Maasai and other nomadic groups in this changing and complex context. They illustrate cases of peaceful coexistence between traditional and Western approaches.

The article of the ELCT-DAR, in particular, discusses health development in relation to the ancient way of life of the Maasai people—a way of life in which health has all along been far more than just the absence of illness and healing more than just the responsibility of a doctor. Health for All in its final decade would stand to benefit from an equally wholistic approach.
EXPERIENCES IN WHOLISTIC HEALTH DEVELOPMENT AMONG THE MAASAI OF THE ARUSHA REGION, TANZANIA

By Rev. Gabriel Kimirei, Dr Eliluruma M. Nangawe, Dr Mark L. Jacobson, and Ms Angelika Wohlenberg of the Maasai Health Services Project, Arusha, Tanzania

INTRODUCTION

The Evangelical Lutheran Church of Tanzania-Dioce in Arusha Region (ELCT-DAR) serves the people of the North Central Region of Tanzania, an area inhabited mainly by the Maasai people, the speakers of the Maa language.

Since its organization as an independent diocese in 1975, ELCT-DAR has been concerned with the health needs of the Maasai. Over the years, the Diocesan Health Department has accumulated considerable experience in implementing a wholistic approach to health, specifically among this semi-nomadic people. The work is multifaceted, including health development, community leadership development, women’s development, education, income generation for the poor, and programmes to provide “spiritual nourishment.” This article explains how these are integrated into a wholistic response to the needs of the Maasai.

BACKGROUND

The Maasai populate the Great Rift Valley, which extends through northern Tanzania and southern Kenya. They are more numerous in Tanzania, where the largest of the 12 main sections of the tribe, the Ilkisongo, are located. The Ilkisongo are semi-nomadic pastoralists, their economy revolving around their herds of cattle, goats, and sheep. Some Ilkisongo have adopted a more settled and agricultural lifestyle, but the majority continue in the tradition of pastoralism. Migration patterns vary with the seasons and the availability of water. The regular migrations are composed mainly of young men and warriors moving livestock from area to area in search of grass and water. Women, children, and the elderly tend to remain in one locality for longer periods of time, and some have taken up permanent residence in areas with sufficient water.

The Maasai occupy a semi-arid environment that can support only a limited population of livestock and people. The seasons alternate between rainy and dry periods of several months duration. Grazing areas are traditionally designated according to season and availability of fodder. Although the overall population density is less than five people per square kilometre, the concentration of people and livestock in water-endowed areas over the last three decades has had a serious negative impact on the ecosystem. The result has been an increase in erosion, aridity, and drought, with a concomitant scarcity of food during the long, dry season from May through September.
Religious beliefs

The Maasai are traditionally monotheists who believe in a creator God. God created the world and its people. God has many facets, each referred to by colour and indicating a different aspect of the deity character, for example loving, just, angry, or distant.

Traditional Maasai belief teaches that, at the time of creation, God was very near to the Maasai people. God was so near as to be able to lower cattle. His greatest gift to humankind, from heaven to earth on the umbilical cord that linked Him to his creation. At some point in the distant past, that umbilical cord was severed, and God distanced himself from his creation.

The myths vary as to whether humans or animals caused the offending infraction, but, ever since, God has been distant from his creation. The Maasai view human life in terms of three primary relationships: that of people with God, that of people with people or their departed spirits, and that of people with their environment. In accord with this view, the Maasai focus much of their time and energy on maintaining healthy relationships and healing broken ones. Reconciliation thus figures heavily in the Maasai understanding of health and healing.

Health systems

For the Maasai, health is a state of being in harmony in all one's relationships. For a person to be healthy, each of that person's three primary relationships must be whole. Illness occurs when one or more of these relationships has been broken or damaged. Broken relationships produce curses or the wrath of God, which then result in ill health. The first question asked of the sick person by the oloiboni, or healer and spiritual leader, will be, With whom have you quarrelled?

Diseases that result from a calamity or a misfortune and affect all people indiscriminately are considered to be sent by God, to which the traditionally correct response is to go the holy place to pray and make sacrifices. Such diseases include leprosy, cholera, or rinderpest in cattle, or they are common diseases that affect all people at some time. Death is also considered to be an act of God.

Diseases that strike the individual such as malaria, pneumonia, and miscarriages, however, are considered to be the act of another person or a spirit, or of God. These diseases reflect a broken relationship. The traditional healer diagnoses these diseases by fortune-telling and then treats the person with herbal medicines and through the restoration of the relationship involved.
Physical causation of illness is not ignored. The Maasai know that a well-nourished body is less likely to be attacked by disease and better able to withstand its effects. The young men who are expected to protect the nation must be strong and healthy. These young men are given extended periods of exercise to strengthen their bodies. Special foods, including large quantities of meat, and herbs are provided to them during this time.

Even while acknowledging physical causation, the Maasai concept of health and illness nonetheless concentrates on answering the question why a particular disease, rather than how. It is common, for example, for a Maasai with malaria to go to a practitioner of western medicine for treatment. The Maasai may fully understand how he was infected by a parasite that, in turn, resulted in his symptoms. Yet even as the medicine is working, he is being treated by the traditional healer to answer the more important question, Why did I get sick at this particular time?

Maasai tribal concepts of health and disease are reflected in community behaviour. For example, they are obviously embodied in the philosophy behind the common greetings takwenia and supai. Takwenia is a greeting used mainly among women, and supai among men. Takwenia literally means laugh or smile, and conveys a wish for a happy and healthy life. Supai or ira supai translates literally as the question, Are you well? The greeting is relevant only when the one to whom it is addressed responds. The response is always in the positive. The greeting is then followed by a dialogue covering the concerns of the greeters. When departing, each bids the other peace with the words sere naa or eserian i naa, derivatives of the word eseriani, meaning peace. Thus peace in one’s life and relationships is directly linked to health.

Language and usage both reflect the importance of relationships. Those who exchange greetings must be on good terms with one another. Their relationship must be healthy in order for them to eat, work, or even speak together. Individuals not on good terms literally do not greet one another. Thus enemies, witches, and wrongdoers neither receive nor extend greetings, since the community does not wish to know how they are. Healthy relationships are necessary in order to even begin to interact within the Maasai community.

Broken relationships arise from various sources. Constant quarrelling, hate, cruelty, and bearing grudges among community members are one source. Broken relationships between people and their environment—as seen in the misuse of trees, in the burning of grass before the rainy season, the desecration of holy places, and wanton cruelty to animals, for example—are another. Such acts are termed ngok and are evils that the creator God condemns. Ngok is also the breaking of taboos. Sleeping with a menstruating woman or defecating under a holy grove of trees are abhorrent sins that call for ritual purification. According to the Maasai, such attitudes and behaviour produce most of the suffering and bad health found in the world.

The first question asked of a sick person by the medicine man — With whom have you quarrelled? — is thus to discover whether the person has knowingly or unknowingly committed ngok. If the answer is yes, then ritual purification is needed to restore health to the wrongdoer. Physical ills may also be treated at the hospital, but sufferings arising from guilt and sin must be forgiven and ritually cleansed, and this is the work of a traditional practitioner, not a scientifically trained medical professional.
Traditional healing

Healing practices among the Maasai work to restore health to the sick person in two ways. The first is physical, through improved nutrition. If ill health persists, despite the use of highly nutritious foods, then herbs or medicines might be added. If there is no improvement, then the unhealthy person is believed to have committed some sin towards God, another person, an ancestral spirit, or creation. The curse must be lifted in order for the person to become healthy. Suffering caused by guilt hurts most, and if guilt came through offending someone or something, then reconciliation is required.

Approaches to reconciliation as part of the healing process are numerous and varied. In situations involving a quarrel, those who have quarreled must make amends. Reconciliation is usually affirmed by a ritual fellowship meal, or emururo, when the parties share the hind leg of a goat or sheep. After the meal, an elder pronounces a blessing upon the reconciled parties, and health is said to have been restored.

In cases when the ill health persists, fortune-telling through the casting of stones is used to determine whether the illness is the result of some offense against the ancestors. In the event that it is, reconciliation must then take a different form. The person who is suffering is brought to a holy grave site where a black sheep is sacrificed to the dead. Before killing the sheep, the face of the sick person is rubbed four times against the head of the sheep. Simultaneously, the leader of the reconciliation service commands the sickness or guilt to inhabit the sacrificial sheep. The sheep is then slaughtered and the blood sprinkled on the grave stones. Pieces of roasted meat are also strewn around the grave. The healer or priest recites a liturgy, saying, "Receive our sacrifice and be satisfied. Let our children and the sick live in peace. Take this sacrifice and share it." The community is both the mediator and the witness to this reconciliation.

TOWARDS COMMUNITY-BASED HEALTH CARE AMONG THE MAASAI

The ELCT-DAR Programme

The Maasai Health Services Project (MHSP) — now serving 30 villages in 14 sites — was conceived and initiated in 1981 by the ELCT-DAR. The overarching vision of the project is the realization of wholistic health for all and by all. The project specifically aims to enable people to liberate themselves from the constraints that prevent them from enjoying good health, so that they might enter into a state of complete well-being — in body, mind, and spirit.

The MHSP is founded on the belief that for individuals and communities to be whole and well, they must assume control of their own health and development. The MHSP promotes this kind of social transformation through a strategy of community involvement. The community first identifies the root causes of existing problems and then seeks solutions to these problems that are appropriate and feasible within the community. The project basically works at training communities to transform themselves. Its main effort is to awaken the community to an awareness of its particular situation and to the realization that they have within themselves the skills and capacity to solve their problems and improve their lives.

This approach utilizes health learning techniques that enable and motivate people to move toward healthier lives. By definition, the approach is multisectoral. Specific activities include

1) leadership training focusing on problem identification and problem solving,

2) transfer of skills to village-level volunteers such as traditional birth attendants and community health workers, and

3) community development projects aimed at self-help and of direct benefit to high-risk groups within the community.

In the early years of the MHSP, community involvement was understood to mean providing information and sensitizing the community about the need for health activities already planned by the MHSP team. MHSP efforts focused mainly on the training of community health workers to provide information and first aid and to promote health activities at the community level.

Gradually, however, the MHSP team realized that CHWs trained in this way were functioning as an extension of the medical services and that they were meeting the needs of the community as determined by the MHSP, rather than by the community itself.
As a result of this realization, the MHSP began shifting its efforts towards more genuine community involvement, specifically through the raising of critical awareness within the community of community problems and their causes and then seeking solutions to these from within the community. Dialogue between the MHSP team and the community and the freedom of the community to determine its own priorities were crucial to this process. The MHSP feels that this approach has resulted in a high level of community involvement and a high degree of volunteer continuation. MHSP staff training in participatory development and health education has also influenced these results.

The Evangelical Lutheran Church of Tanzania—Diocese in Arusha Region — a history of caring

The Lutheran Church in Tanzania was founded on the calling to preach the gospel, together with acts of loving service. Preaching, teaching, and healing have gone together since the church began its work in Tanzania. While the Diocese has come to emphasize the role of preventive services in health development, it continues to follow this original calling to provide competent and caring curative services.

The Diocesan Health Department has one small hospital and eight dispensaries serving an area of 150,000 square kilometres, peopled largely by the Maasai subethnic group, the Waarusha. Most of the area's inhabitants are either subsistence farmers with small land holdings or semi-nomadic herders of cattle or goats. Foodstuffs and coffee are the major crops cultivated.

In seeking to provide competent, loving care through its dispensaries, the Diocesan Health Department is confronted with tension between the demand for curative services and that for preventive services. The Health Department has found that communities have been conditioned to think of modern health care primarily in terms of curative facilities.

This «curative conditioning» encountered by the Diocesan health team is illustrated in the story of the injectable antibiotic. With its success among the Maasai, the injectable antibiotic has become such a powerful symbol of cure that all other methods of treatment are now considered inferior. Patients demanding medicine for their illnesses, regardless of whether such medicine is medically indicated, is a worldwide phenomenon. But it is a particularly troubling tendency among the Maasai, where the cost of injections is high and when, without proper sterilization procedures, injections carry the risk of AIDS transmission.

A major role of the dispensary work of the Diocese is countering such curative conditioning with a new vision of health. The curative dispensaries have thus been made into foci for community health outreach, as well as for conventional curative services.
CASE STUDIES

Perhaps more important than the number of volunteers trained and remaining active are the signs of change taking place within the communities.

In Orkesumet village, for example, the MHSP has trained a group of 41 CHWs. As part of their training, these women identified and analyzed the causes of some of their problems, such as lack of water, lack of affordable maize flour, and poor nutrition. The CHWs have specifically taken these up in a search for solutions from within the community. Water development is under discussion with the appropriate government team. The women have organized themselves and, with assistance from Oxfam, purchased a maize grinder for the village. They manage this mill as an income-generating activity. These efforts, combined with preventive services provided by the MHSP, are aimed at effecting improvements in the health and nutritional status of the village children—a priority decided upon by the CHWs themselves as part of a participatory evaluation.

The CHWs of Naisinyai village, together with the MHSP team, first enabled the community to identify its most basic problem: tick-borne diseases in their cattle, resulting in the loss of livestock. The death of cattle in this Maasai community, as in others, triggers economic failure and widespread suffering. The first step in solving the problem in Naisinyai was the construction of a cattle dip. As part of their training, the CHWs had acquired sufficient knowledge of the problem and possible solutions so that they could serve as resource people and community mobilizers for the cattle dip project. The community contributed funds, labour, and supervision. With a modest grant from Oxfam for materials, they built the dip within a few months.

Once the problem of dying cattle had been addressed and the dip was in operation, the CHWs expanded their activities to cover the promotion of other, more conventional health interventions such as immunization, oral rehydration, and the provision of safe drinking water. As it turned out, when a cholera epidemic swept through the region, the people of Naisinyai, through the use of oral rehydration, were able to significantly reduce the number of deaths within their community in relation to other communities in the area.

The CHWs of the village of Kissongo have initiated a forestry project to provide firewood while simultaneously promoting reforestation.
Although farming is not a traditional Maasai activity, the CHWs in the village of Arash began cultivating maize in order to augment their otherwise meager diet. With the success of their efforts, their neighbours copied them and began cultivating, too.

Health and development activities promoted by the various CHWs and village health committees have taken many forms. Immunization coverage, to name a common reference point, has increased from 20-30% to 60-80% over the years.

The Maasai Health Services Project addresses the problem of AIDS

AIDS has become a major health threat to the Maasai. At present, the only means of dealing with the disease, within the Maasai community as elsewhere, is to prevent its spread.

ELCT-DAR approaches its AIDS prevention work in the spirit of the early Christian church, which from the time of Christ has viewed human beings as holistic creatures. The love of God is for the whole person — mind, body, and spirit.

AIDS embodies the opposite of wholeness. It destroys the body of the infected person, and frequently the spirit and mind as well. ELCT-DAR’s response to AIDS is based on the biblical passage “I have set before you life and death, blessing and cursing; therefore choose life, that you and your descendants may live” (Deuteronomy 30: 19). The church’s role in the battle with AIDS must be to put the behavioural choices before people so that they might choose life. The ELCT-DAR calls its strategy in this work of information sharing and education Chagua Uzima, which is Swahili for Choose Life.

Inasmuch as AIDS is primarily a social rather than a medical problem, it can be effectively challenged only by individuals and their communities. At the moment, in this terrible epidemic the medical professions are left standing on the sidelines as the real challenge takes place in the home, school, and village.

The Maasai Health Services Project (MHSP), which focuses on enabling communities to assume greater responsibility for their own health, was a natural choice as a structure to support AIDS control and prevention work in the ELCT-DAR area.

The result has been a programme with two primary components:

- **Awareness raising.** The MHSP team trains a wide range of resource persons within the community to help raise awareness and provide factual information about AIDS. The training curricula of CHWs and TBAs now incorporate AIDS control and prevention. CHWs and TBAs as AIDS resource persons can offer information and advice to their peers as trusted, known members of the community.

Weekly gatherings for Sunday worship at the village level provide a unique opportunity to share basic information on AIDS and to stimulate discussion on the subject. MHSP also trains village-level lay evangelists, responsible for religious education in primary and secondary schools, to inform their students about AIDS transmission, its consequences, and its prevention.

- **Counselling.** Local church congregations are well positioned to assume responsibility for AIDS counselling. Congregations have a potential counselling system in place in every village, through their pastors and evangelists. The AIDS training offered by the MHSP focuses on equipping these individuals to provide premarital counselling, counselling to HIV-infected persons, counselling to families of HIV-infected persons, and counselling to those actually sick or dying of the disease.
The South Maasai Mobile Unit

The South Maasai Mobile Unit (SMMU) began as a traditional mobile medical outreach team that made regular trips to villages to treat the sick. As a mobile unit, the SMMU team spent much time in the villages. Inevitably, during these visits they joined in discussions of the needs of the people. The programme grew from there.

Most recently, in response to the problem of blindness (95% of children under 10 surveyed showed evidence of trachoma), the SMMU has begun a mobile eye clinic and initiated, in remote sites, a programme of education and training in the treatment and prevention of eye diseases.

From the beginning, however, the communities were not satisfied with curative care alone. They also wanted preventive services, such as immunization and health education. The role of the SMMU has expanded in this direction.

The small women's meetings, instigated by the SMMU visits, have grown into established women's organizations whose goals are to improve the health of their people. These groups are the focal point for larger seminars held four times annually, when men are also included.

In the community of Orkesumet, where the SMMU team is based, the team joins in local Bible studies and development projects. Among Christian groups, the team links health and development to the Scriptures. The importance of hygiene, for example, is spoken of in the context of the biblical teaching of the body as a temple of the Holy Spirit.

Also in Orkesumet, the team helped create a children's play group, and it maintains an eye care programme. In the village of Loiborosoi, the team helped to establish seminars on spiritual concerns, in which both men and women participate.

Through the work of the SMMU, immunization coverage in remote areas has been increased. In sites inaccessible by road, local populations have helped to build airstrips for use by the SMMU team that provides first aid and primary eye care clinics.

In one community, a primary school has been constructed as a community initiative. Through awareness raising, the village of Malambo, which suffers a severe lack of water, has been earmarked for a water development project to counter the problems of trachoma and other diseases related to water shortage.

One of the most pressing problems of this semi-nomadic population is land speculation by outside investors. In one community, the SMMU has organized the people to safeguard their land rights through the creation of a non-governmental organization, Nyua’ e Moipo.

The broad and varied efforts of the SMMU are intimately linked to the team's sense of Christian witness and its commitment to community participation.

Photo: ELCT-DAR
A health worker receives training in drawing up a community profile.
MHSP EXPANDS

Historically, MHSP worked directly with villages or supported mobile dispensary workers who worked directly with villages. As the MHSP work expanded to new sites and as MHSP involvement with the community moved away from strictly curative services towards a more wholistic and community-based approach, the support structure for the work also evolved.

MHSP turned to the local churches as an existing infrastructure capable of supporting the expanding programme. Most of the villages involved have a congregation that belongs to a larger parish. MHSP is enabling each parish to create a health development team. Members of these "Wholeness Teams" are being trained as trainers, so that the awareness-raising process will eventually reach all the villages of the region.

THE MAASAI EXPERIENCE AND THE WORLD COMMUNITY

The Maasai's basic conservatism and resistance to change have allowed their world view to remain largely intact into the 20th century. Thus the opportunity still remains to learn from their concepts of relationships, wholeness, and community — which stand in contrast to those of a society in which relationships are increasingly superficial, creation is broken into ever smaller components, and traditional community is under attack.

In its health development work among the Maasai, the ELCT-DAR has come to recognize that the Maasai have developed their understanding of health and healing to the point that they provide the Church and other communities involved in health development a unique opportunity to expand their understanding of these
concepts, and not necessarily the other way around. Certain key aspects of the Maasai understanding call for further consideration.

The first is that of wholeness. According to the wholistic world view of the Maasai, the physical is not separate from the spiritual. Thus it is impossible to discuss health without discussing spiritual matters, and vice versa. It is only in considering them together that progress can be made in either. Among the Maasai, a community-based health care programme, or even a simple curative care programme, must include a "spiritual" component — through, for example, opportunities for prayer and for-giveness — if it is to have an impact.

The wholistic understanding of health of the Maasai provides a natural starting point for community health activities. It is a source of wisdom from which those outside the Maasai community may seek enlightenment. In the context of this understanding, health is not simply a medical issue, but rather a way of life.

The implication from the Maasai experience is that health care and healing — within the Church and without — must be seen as spiritual as well as physical. This is an outlook that the Church is only beginning to explore.

Related to this is the second crucial factor, community, stemming from the Maasai view of life as a web of interconnecting relationships.

The Maasai experience challenges us to re-examine our understanding of community. For the Maasai, the individual is actually defined in terms of his relationship with his community, and the community thus has a significant part in this person's health and well-being. The challenge to the Church in this is for congregations to become healing communities where the congregation joins forces with God in the healing of relationships among persons and throughout creation.

The third factor is that of community participation. In the MHSP experience among the Maasai, as in health development programmes elsewhere, community participation is essential to development and improvement in health. Problem solving in this context is geared towards the community as a whole. The community is the main impetus for change, rather than the individual. Indeed, until the community opts for change there can be no meaningful change in the lives of individuals.

The final challenge embodied in the experience of wholistic health development among the Maasai is that of the universality of wholeness.

The Evangelical Lutheran Church of Tanzania-Diocese of Arusha bases its health development work among the Maasai on the biblical imperatives for health embodied in the words of Moses to "choose life" and of Jesus who "came to bring life, and life abundantly."

The imperative for health — to choose life and to seek a life — is open to translation into every language and culture. *
The Barabaig Woman

The Barabaig are a nomadic and pastoral people who live in Tanzania. They face many difficulties as more and more land becomes cultivated, and there is less and less pasture-land for their herds and flocks. Cows are an integral part of their life. The following portrait was written by Sr Margaret Garnett, a Medical Missionary of Mary, and appeared in the official organ of the Medical Missionaries of Mary (M.M.M.), Volume 51, No. 4, 1989. The Medical Missionaries of Mary, who run the Village Health Programme of Nangwa, Tanzania, serve the Barabaig women through the provision of maternity and child welfare clinics and home visiting.

When I think about the women of the Barabaig tribe, I am reminded of the Ideal Wife described in the Book of Proverbs; even though her environment and culture are very different from those of the women of Israel, yet the words of Proverbs can be applied to her. The Barabaig woman has neither wool nor flax, but she makes her clothes from the hides of goats and decorates them beautifully with beads, using her "skilful hands."

She "secures her provisions from afar." It may take her as much as an hour every morning and every evening to draw water for the needs of her household, and the whole day to gather enough firewood for the week's cooking. Her menfolk travel far with their donkeys to buy maize. "She is girt about with strength and sturdy are her arms" as she grinds the maize between two stones to prepare the family food. "She rises while it is still night" to milk the cows before her sons and daughters take them out to pasture. "She is clothed with strength and dignity and laughs at the days to come."

When expecting a baby, she attends the antenatal clinic at the first signs of pregnancy, for she understands how easy it is to lose a baby in the early months if she gets malaria or if she becomes anaemic. She then becomes a regular attender and, if she knows the Swahili language, she will interpret for her less knowledgeable friends. There are no secrets between the women. They discuss each other's problems and try to find solutions. "She opens her mouth in wisdom, and on her tongue is kindly counsel."

When the baby is born, custom dictates that she spend a month in the house without going out, but she will break with custom in order to bring her baby to the clinic as soon as possible to be vaccinated against tuberculosis.

The only time in her life that she may carry a stick is after delivery. If the baby is a boy, she may also carry an arrow.

She will bring her baby every month to the clinic for weighing and vaccination, and she will also bring her relatives and neighbours' children, if their own mother cannot come. Thus does she "extend her arms to the needy."

As in the world in general, so the Barabaig world is a man's world. But if the older women as a group officially make a decision, the men have to obey! To such women we can say, "Give her a reward of her labours and let her works praise her ...."
KIPSARAMAN INTEGRATED DEVELOPMENT PROGRAMME, KENYA

By Sister Fidelia Ogujawa, Medical Missionaries of May, Programme Coordinator, Kipsaraman Integrated Development Programme

BACKGROUND

Kipsaraman is in Baringo District, west Kenya, at the northern end of the Tugen hills. The operational area of the Kipsaraman Integrated Development Project covers most parts of Baringo north, about 1,692 square kilometres. The area is characterized by rugged hills, deep upland valleys and flat and rocky lowlands. The climate is variable, with the rains occurring between March and September.

The Baringo District is inhabited by the semi-nomadic Tugen people. With the introduction of land terracing, the Tugen in the highlands increasingly depend on agriculture. Coffee and cotton are the main cash crops in the area. In the lowlands, many families still tend livestock, with their wealth concentrated in large herds of cows. The area's population is estimated at 50,000. About three quarters of this population live in the lowlands where there is poor soil and very little rainfall. Access to these areas is severely restricted by bad roads. The people walk long distances when they need to travel to markets where they can buy maize, beans, and green vegetables. Most of the malnourished children treated at the Kipsaraman project dispensary and nutrition centre are from these areas.

THE PROGRAMME

The Kipsaraman Integrated Development Programme was begun in 1978 as a community-based health care project. A baseline survey of 15 villages surrounding Kipsaraman trading centre was first carried out to identify major health problems in the area. The survey showed the most significant medical problems to be tuberculosis, gastroenteritis, dysentry (both bacillary and amoebic), measles, whooping cough, pneumonia, chest infections, and malnutrition. In the community of Kituro, for example, 100% of children under five were not vaccinated and 61% of the children were malnourished. The infant mortality rate in Kituro over the five years prior to the survey was estimated at 42%.

In collaboration with local chiefs and community leaders, it was then decided that health education and preventive medicine should receive priority.

Programme goals

The main goal of the programme was, therefore, better health for the people, especially mothers and children. Since then, the programme has broadened to include a wide spectrum of activities aimed at improving the living standard of the people and promote self-reliance. For example, before a new mobile clinic is opened, the people must erect a small house where patients can be examined. They must provide a table, chair, and examination bed, all made from local materials. The programme activities also aim at raising the status of women, e.g. through forming committees for different activities. The women are always important members of these committees.

Key interventions

The key interventions of the programme have been

- introduction of mobile clinics and maintenance of a dispensary;
- training of community health helpers, traditional birth attendants, community leaders, and farmers, (including in adult literacy);
- developing links with women's groups;
- training of mothers and men in nutrition, hygiene, and sanitation practices, especially latrine construction;
- training in building of improved mud stoves, to prevent burns and save fuel;
- training in the protection of springs and wells and the construction of water tanks;
- introduction of agroforestry.

In each of the above activities, there has been a keen and enthusiastic response from the community.
Progress and achievement

From November 1985 to April 1986 a follow-up survey was carried out in seven communities to determine immunization coverage. The figures indicated a radically different situation than that at the beginning of the programme.

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<th>Community</th>
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<td>Kimugul</td>
<td>57%</td>
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<tr>
<td>Kabarasei</td>
<td>66%</td>
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<tr>
<td>Kitibe1</td>
<td>83.3%</td>
</tr>
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</table>

At present, the average coverage is 78%. Major diseases such as measles, whooping cough, polio, tetanus, and tuberculosis have virtually disappeared. There are still cases of underweight in about 30% of the children under five. Only very few, however, now suffer from kwashiorkor and marasmus, which were prevalent at the start of the project in 1978. The problem of underweight remains tied to a combination of local variables, for example lack of food during the months between March and August, poor farm management, and low income.

Through the literacy, leadership, and other training, awareness on various aspects of life has been generated and issues of poverty, injustice, and oppression addressed. After the four phases of one of the training courses, one woman remarked that, as a result of the workshop, she and her husband dialogue and collaborate more at home. They joined hands to buy two cows, and they now work together to improve their farm. When an opportunity to attend an agricultural course was extended to the woman, she discussed it with her husband. They both decided that the husband should avail of the course, since he had had some training! Some of those who have attended the workshops talk of surmounting feelings of inferiority. They are able to open up and talk about the things that affect their lives.

Improvements in the provision of clean water as the result of training have reduced the incidence of diarrhoea and vomiting, dirty eyes, and scabies. With the increased availability of water, some communities in the lowlands have reduced their herds of local cows, replacing them with mixed breeds for better milk production. Women also walk shorter distances for water and thus have more time for training and other development activities.

The evolution of the programme and future concerns

The development of an integrated staff team has become necessary with the broadening of the programme, to ensure its smooth running, promote team spirit, and develop a unified approach. For this purpose, staff of all the programme areas, as well as the local government officials with whom they collaborate closely, attend an integrated staff meeting every month.

One of our major concerns at the moment is how to work towards sustainability. Oxfam has been the main donor supporting this programme since its beginning. We cannot expect Oxfam to fund us forever, thus the question of sustainability. Although we are working to address this burning issue (for example whenever we start any new project) the question still remains, Will the people be able to continue these projects when there is no longer help from the outside?

This is why we feel that the training programmes are so important, with their emphasis on the psychosocial and participatory methods that are designed to empower the people.

In the end, the Kipsaraman Integrated Development Programme has met many of the needs of the poor and done much to empower them to take responsibility for improving their own health and ultimately living a better life.
THE WORK OF THE AFRICAN MEDICAL RESEARCH FOUNDATION (AMREF) AMONG THE NOMADIC PEOPLES OF EAST AFRICA

The African Medical and Research Foundation (AMREF) was started in 1965, with one man and one plane providing curative services to isolated areas in East Africa. Over the years, AMREF has grown and evolved. While still providing curative services, it now includes a community-based health care component, to promote preventive health care through appropriate agriculture, nutrition, hygiene, sanitation, and behaviour.

AMREF’s Nomadic Health Unit provides curative services to nomadic populations such as the Maasai and Turkana. It also promotes community-based health development, essentially through its training programmes. Contact recently interviewed AMREF’s Dr Basil King on this work, and we provide excerpts from that interview below.

Contact: How did AMREF become involved with health promotion among nomadic peoples?

AMREF: This goes back to the early 1960s, when Dr Roy Shaffer started mobile clinics for the Maasai in Tanzania and Kenya. Basically, these were services provided intermittently, when a doctor would go out with a few assistants to examine and treat patients and to provide immunization. Then in 1966, more regular clinical services were started, under the supervision of two AMREF nurses. That programme was continued almost 20 years, until 1985.

The programme served a wide area in Maasailand in Kenya. A site would be visited by programme staff three times, at six-week intervals. The main focus was immunization. They also did some work on nutrition and treated sick patients. Later, a school health programme was introduced and a health educator added to the team. The clinical scope of the work was also extended with the establishment of a mobile laboratory. In 1984, a training programme was started for volunteer groups such as TBAs and CHWs.

Contact: So you see the current health promotion work as a continuation of these early programmes?

AMREF: Yes, we have continued to evolve, though the core of our activities remains similar to that of 25 years ago.

Contact: Are there some basic features in such a programme, which provides health services to nomadic peoples such as the Maasai? You have mentioned immunization. I gather there would be antenatal care, family planning, and other things. Over the years, have you developed an approach that enhances these activities?

AMREF: The reason we run mobile clinics, which is sometimes criticized because of their high cost, is because we are dealing with a very scattered people.

The people of Kenya living in isolated areas are served by AMREF’s Specialist Outreach programme, its Medicine by Air programme, and its Nomadic Health programme. The dots on this map indicate locations visited by the Specialist Outreach programme.
Population density in Kajiado District, for example, at least in the areas we serve, is not more than three or four persons per square kilometre. This kind of population density does not provide an economic base for many fixed centres. Mobile clinics are the only way in which many of these people can have access to services.

**Contact:** You have mentioned community health workers and TBAs. I imagine that your programme includes initial training of these groups, followed by ongoing training to update their skills and knowledge. Are there some unique aspects of the training programme?

**AMREF:** As regards our approach, I don't think there are any unique features. We use participatory learning techniques, such as role play and getting community members together to think about their problems and analyze possible solutions. The particular problem we face, however, is that among pastoralists there is a high level of illiteracy.

We work very closely with women's groups. Among pastoralists, the men are often actually quite difficult to find! The young men, for example, will take the animals off to remote grazing grounds. It is generally the women who are more available, and it is the women who are responsible in this society for handling domestic issues, which are closely related to health. We find that women are concerned with water supply, for example, and they are therefore very interested in suggestions for developing water sources. Women are responsible for the building of houses and are therefore the ones with whom to discuss possibilities for constructing a healthier or more comfortable house.

In many cases, we have stimulated the formation of women's groups. We have discovered that this is a welcome development among nomadic groups. It is easy to get a women's group to come together, and it is easy to get them to start particular community development projects.

**Contact:** And do you find that the women find it easy to make decisions with regard to health — health actions? Or are there some handicaps because of the non-involvement of the men?

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**Traditional birth attendants of Olosho Oibor, Masailand meet together for the first time during an AMREF training workshop**

The traditional birth attendants (TBAs) of Olosho Oibor came together for a training workshop as part of a Safe Motherhood Project initiated by AMREF in 1988 in the Kajiado District of Kenya.

Co-organizer Silole Mpeko explains that the project was started because «we were dissatisfied with the services provided to pregnant women by our mobile clinic.» The many pregnant women who came to the clinic came because they required treatment. Because the clinic was mobile, it was difficult or impossible to follow-up women with problems. It was also difficult to identify TBAs during clinic sessions, since they came for treatment as patients and did not identify themselves as TBAs.

With a safe motherhood project thus in mind, two AMREF staff and the government nurse in charge of the Olosho Oibor dispensary formed a team and began awareness raising within the community. In respect of the local leadership structures, they first visited community leaders such as the District Officer, through whom they met chiefs and other influential members of the community. They then introduced themselves to church leaders, women's groups, and youth leaders, and finally they visited bomas (compounds comprising several households), where they introduced themselves to the head of the family. If available, or to the eldest woman of the boma.

In speaking with each group, the team of organizers gave their names, their employer, and their profession. They explained that they were interested in working with the community in health education and that they were particularly interested in motherhood and young children.

The team was warmly welcomed by the heads of the bomas, who then introduced them to the women of child-bearing age in the boma. The team visited each woman in her house to explain why they were there. These visits were informal and carried out according
AMREF: The men take the financial responsibility, and it is difficult for a women's group to give a financial commitment to building a structure for a clinic, for example. In such cases, we really have to talk with the men. But we have discovered that women will offer the things that they have control over. They will offer to carry stones to make a road, for example, or to provide labour to accomplish other tasks.

Contact: And in this situation, do you think that women are overburdened by these activities, while the men take a peripheral position in the health and development processes? If that is the case, is there a way that men can be better involved?

AMREF: We would like to involve the men. Yet we recognize that there are cultural aspects in these societies that we can't readily change. Any outside observer is likely to comment that the Maasai women's life is harder than the men's and that they are overburdened. Yet it is not easy nor necessarily appropriate for outsiders to say that the burden could be shared more equally.

We have found that women are often willing to make extra contributions. The men are more difficult to interest, and we think that a different approach may be needed. One such alternative can be seen in work done by the organization FARM (Food and Agricultural Research Management), where the thrust of the project is the improvement of livestock, in this instance the camels of the Turkana people. When one talks about livestock, camels in particular, men are very interested.

Health care, the care of children, domestic provision inside the home, and houses, for example, are traditionally the province of women. So far, it has been difficult to get men to take an interest in them.

to Maasai tradition. The guests start by saying who they are, where they come from, and what the news is from their area (this is the ainos lamon, or eating of the news). The guests then pause to indicate that they have finished. The host or hostess then gives the news of the boma.

It was during separate meetings with the three active women's groups in the area that the idea of training for TBAs arose. The women were interested in plans for the dispensary nurse and the TBAs to work together. The women said that even though some pregnant mothers wanted to go to the dispensary, it was too far away for them or for the newly delivered mother and her new-born. All of the women were in favour of providing training for TBAs.

A maternal and child health survey was then carried out by the team with the help of the community, and TBAs were identified. Ten TBAs responded to the invitation to join the workshop, including the oldest TBAs in the community.

The workshop was presented as an opportunity to share ideas and experiences. Every day of the workshop started and ended with a prayer.
Contact: So apart from the women, who seem to be the major resource for providing health care in these communities, have you identified other resource persons who have specific skills, specific experience that could be involved in health development for these people?

AMREF: We have a programme that is specifically concerned with identifying and training TBAs. Our nurse Silole Mpoke has formed an association of TBAs in the Olosko Oibor area of Maasailand [see box], and she has been engaging this group in discussions over several years now. The group has visited hospitals to see modern delivery techniques. They have met TBAs from another ethnic group, the Kamba, from the Kilwezi area. Through this work, we have discovered that these women, who we thought to be traditional in their outlook, hold some very modern ideas, for example on sex education and the importance of teenage education in sexual matters.

Contact: And this relates to AIDS education. Are there other programmes in Kenya dealing with health among nomadic peoples?

AMREF: There are quite a few, and I don’t know all of them. AMREF, to start with, has a programme of mobile clinics in northwest Turkana. There are several other NGOs that have done the same thing there for a long time: the Africa Inland Church, the Medical Missionaries of Mary, the Dutch Reformed Church, and several others. The organization FARM is running mobile medical clinics in an interesting combination with a livestock health development programme in the Samburu and Marsabit Districts. We have our Maasai programmes. There are many areas where similar projects are taking place.

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Participants sat on stools and benches, and there were spaces on the floor for those who wished to sit on the ground.

Introductions took nearly two days, and there was a lot of “buzzing” in small groups. Silole Mpoke reported a feeling of excitement. It was the first time that these professional women had had an opportunity to exchange their experiences. None of the participants had been to school.

Through group discussion, the TBAs expressed their expectations for the workshop. They thought it was God’s wish that the health team and the TBAs work together. Their expectations were:

- to share knowledge from each other and from the health team;
- to learn how to stop bleeding after delivery (e.g. through ergometrine injection); in the old days, they explained, the TBA either tied the toe or the thigh of the mother or gave cow’s blood to the woman to drink;
- to learn about nutritional practices during pregnancy;
- to stop starvation;
- to learn about new types of foods;
- to learn more about the perinatal period.

The group decided to work systematically through these topics. Over four days, they shared knowledge on the care of the pregnant woman, the newly delivered woman, and the newborn baby; on sexuality in adolescents; and on family planning methods.

They were concerned about the increase in school-girl pregnancies in their communities and decided to take action on this. They choose three women from among them who would approach three local-school committees to discuss the situation and suggest that boys and girls classes have sessions on personal hygiene, the anatomy and physiology of human reproduction, and the process of conception.

The Olosko Oibor TBAs workshop began as outlined above, with four consecutive days of training and action, as decided on by the group, on specific issues. The group decided that the workshop should continue thereafter as ongoing weekly meetings for sharing and learning.
NEWS AND VIEWS

The Christian Medical Commission, in its coordinating and advisory role, collaborates with a network of church-related agencies involved in health development around the world. While we have found such contacts indispensable in networking and knowing what is happening on the ground, we realize that many Contact readers are unaware of their existence or the scope of their work.

Considering the long history of church involvement in health care, ecumenical coordination in this field is relatively new. CMC recently received an account of the early steps towards ecumenical collaboration, written by former CMC director James C. McGilvary. Portions of his vigorous and personal narrative, which covers the period 1965 to 1975, are reproduced below.

We feel that Dr McGilvary’s record provides a fitting introduction to this new Contact column entitled News and Views, intended to promote sharing among ecumenical coordinating agencies and among all of those involved in health development, both inside and outside of the ecumenical movement.

Before my memory dims with age I believe that there should be a written account of how bridges were built, enduring friendships were made, and exciting evidences of ecumenical cooperation became possible, especially in the overseas medical missions of the churches. This account covers a period which was, for me, a most rewarding experience, and I shall always be grateful that I had the privilege of participating in it.

It began, providentially, at the Blantyre Airport, Malawi, Central Africa, in 1965. Responding to a request from the Malawi Council of Churches (Protestant), the World Council of Churches had agreed to organize a survey of the Protestant medical services in that country, many of which were facing problems following the transition from overseas mission support to ownership by national ecclesiastical bodies within Malawi. I was asked to lead the survey team.

Arriving at Blantyre Airport, I discovered that it was not immediately possible to reach the city because of a delay in the arrival of Haile Selassie, then Emperor of Ethiopia, who was coming on a state visit. The road into the city was lined with school children, waiting to wave their flags in greeting. Meanwhile, all traffic was halted.

During the delay, while we waited for Haile Selassie to arrive, I was introduced to Bishop Jobidain, a White Father, originally from Quebec, who had flown down from his diocese of Mzuzu to attend a meeting of the National Catholic Bishop’s Conference, of which he was chairman. During our conversation, he asked me the purpose of my visit to Malawi, and when I told him he immediately asked whether it would be possible to include the Catholic hospitals and clinics within the scope of the survey. When I agreed, he stated that he would request confirmation from the Bishops’ Conference meeting the following day, and this he did.

This was a period when colonialism as it had existed for centuries was rapidly crumbling. It was a time for euphoria of new nations, with many new flags flapping from UN flagpoles. It was a time when many western missions were transferring responsibility for the institutions they had developed in these countries to the newly formed national churches. However, denominational attachments were still in force, with many institutions more closely related to their founding congregations abroad than they were to each other locally.
Having read the Ten Year Health Plan of the Government of Malawi prior to my trip, I had been surprised to find no reference to the health facilities provided by the churches, which constituted approximately 40% of the total number of hospitals and clinics in the country. On my second day in the country, I had the good fortune to meet Dr Hastings Banda, the President, and remarked on this omission in the Health Plan. In return, he asked me whether I had ever engaged in joint planning with 28 different churches which had no facility for joint planning among themselves. I still remember his remark, "They are all playing in their own backyards and don't even look over the walls."

At the conclusion of the survey visit, I invited the superiors of each hospital visited to meet together to hear the survey recommendations for joint planning between the individual hospitals and clinics, and collectively for joint planning with the Ministry of Health. The survey team had observed so many possibilities for cooperation in joint training programmes, referral of discharged patients for follow-up, the use of certain hospitals for specialty care, and so on. It was clear that cooperation of this nature would benefit all, and especially the patients. This proposal was accepted and a constitution approved and signed by all present. Later, I had the opportunity of presenting this to Dr Banda. After expressing surprise, he offered office space within the Ministry of Health so as to facilitate joint planning with this new organization, now known as the Private Hospital Association of Malawi.

This Malawi experience set a precedent that all subsequent surveys tried to emulate, so that by 1968 there were similar coordinating agencies in 22 countries of Africa and Asia. The findings of these surveys, together with the recommendations of two consultations jointly sponsored by the WCC and the Lutheran World Federation in 1964 and 1967, led to the creation of the Christian Medical Commission in 1968.

The following pages provide a look at one ecumenical coordinating agency — the Christian Medical Association of India (CMAI) — recently visited by CMC on the occasion of Healing Ministry Sunday, a CMAI and CHAI (Catholic Hospital Association of India) joint initiative.

Although CMAI was in existence before the 1960s, when the coordinating agencies mentioned above by James McGilvray came into being, its coordinating role was stimulated by this development.

Profiles of the other coordinating agencies with which CMC collaborates will appear in future Contact issues, along with their news and selected agenda items.
THE CHRISTIAN MEDICAL ASSOCIATION OF INDIA

The Christian Medical Association of India (CMAI) is the official health agency of the Protestant and Orthodox Churches in India and is a registered non-profit voluntary organization committed to making health and wholeness a reality for the people of India. The work of CMAI is carried out irrespective of caste, creed, religion and economic status.

Born in 1905 as the Medical Missionary Association of India, the association was rechristened in 1926 and given its present name. CMAI today includes about 300 member institutions (hospitals, health centres, and community health programmes) and approximately 3000 individual members. It brings together Christian health professionals to work with and through churches in helping people to take responsibility for the promotion and maintenance of their own health. Its major activities include workshops, conferences, assistance and advisory services, production and distribution of educational material, and formal and non-formal training programmes. It is concerned with working with the government, other voluntary agencies, and the people to build healthy communities.

ORGANIZATION AND STRUCTURE

CMAI has five sections — Doctors, Nurses, Allied Health Professionals, Administrators, and Chaplains — to promote the professional and spiritual growth of its members.

Two area officers coordinate and support CMAI area and regional activities. In local activities they are assisted by honorary regional secretaries and their regional committees.

The Department of Community Health and Training helps members to understand the overall health situation in India and the need to reach weaker sections of society and rural communities through specially designed CMAI programmes for technical assistance and support.

The Policy of CMAI

We appreciate that for many in India health is not a reality. We are concerned with social justice in the provision and distribution of health services and believe that people have an important role to play in their own health. We want a better life for the poor and weaker sections of our country. To this end, we believe in educating, motivating, and sensitizing the Church and Christian health professionals to become involved in the practical issues of health and wholeness.

CMAI recognizes that it is mainly the government's duty to provide health care services, yet we believe that voluntary agencies have a crucial role to play in this process. CMAI emphasizes its commitment to community health — an approach that takes into consideration the needs and problems of the community and begins with a strong community-based primary health care system.

Community health starts with people — the community — and is based on the assumption that people have the right to health care. Community health is a process that empowers people to work together to promote their own health, including by demanding appropriate health care services. Appropriate health care services are those that are relevant, low-cost, effective, and acceptable to the community. They include a referral system. The hospital, too, has its rightful place in community health.
FUNCTIONS OF THE ASSOCIATION

Fellowship
- Promotes mutual support among institutional and individual members.
- Organizes conferences, seminars, workshops, retreats, etc.
- Motivates Christian health professionals to develop a vocation for service in the spirit of Christ.

Assistance
- Provides consultancy services to member institutions. Reviews, evaluates, and develops projects for members.
- Assists in the development of member institutions.
- Works with the government and supporting agencies on behalf of members.

Church liaison
- Studies the theological and operational aspects of the ministry of healing.
- Supports the churches in India in their health and medical work.
- Encourages congregations to take an active role in the ministry of healing.

Education
- Develops professional formal and non-formal training programmes for health workers.
- Facilitates in-service and continuing education activities.
- Educates churches and the public in matters of health.
- Publishes and distributes health educational material.

Membership
Institutional membership in CMAI is open to non-profit, voluntary and church-related hospitals, health centres, and health programmes. Individual membership is open to

- Doctors — men and women holding a qualification in medicine or dentistry recognized by the Indian Medical Council.
- Nurses — all registered nurses and auxiliary nurse midwives and multipurpose health workers whose training is recognized by CMAI.
- Allied Health Professionals — individuals in a wide variety of health-related disciplines, whose training is recognized by CMAI.
- Administrators — those in managerial or supervisory roles in health care services.
- Chaplains — people in the healing ministry with training in theology and pastoral counselling, including clergy with a special interest in this ministry.

Associate membership is available for those who do not qualify for full voting membership but have concern for the healing ministry, and student membership is open to students in various health profession courses.

THE CMAI PROGRAMME AT A GLANCE
CMAI cooperates with the Government of India on health and family welfare programmes. It cooperates on health concerns with other agencies such as the Voluntary Health Association of India (VHAI), the Catholic Hospital Association of India (CHAI), and others.
CMAI publishes and distributes health learning materials (see box).

CMAI runs CMAI laboratory training courses and other paramedical training programmes in hospitals throughout India. These are appreciated by the Government of India, and CMAI graduates find jobs easily. CMAI diplomas in nursing are recognized by the Indian Nursing Council and the Government of India. CMAI maintains a student nurture programme, enabling students to gain work exposure in mission hospitals and work camps and to share together during CMAI-organized retreats. It provides scholarships for medical, paramedical, and nursing students.

Together with CHAI, CMAI organizes Healing Ministry Sunday (see page 23), to enable churches to study, reflect on, and respond to challenges in health. The Week of Prayer and the CMAI Day of Prayer precede Healing Ministry Sunday.

Further information on CMAI and CMAI publications may be obtained by writing to

Christian Medical Association of India
Plot No. 2, A/3 Local Shopping Centre
Janakpuri
New Delhi-110 058, India.

CMAI publishes the Christian Medical Journal of India quarterly and the bi-monthly newsletter Life for All. It also publishes health education material such as Flora Plus and Drugs Today — A Biennial Update on Rational Drug Use.

Other CMAI publications (with their price indicated in rupees, exclusive of packing and postage) include

- Manual for Managers of PHC Projects (Rs 100)
- CHAI/CMAI Joint Hospital Formulary (Rs 45)
- Handbook on Hospital Pharmacy Administration (Rs 40)
- Growing Together in the Healing Ministry — New Strategies for Asian Christians 2000 A.D. (Rs 50)
- Woman, your faith has made you whole. (14 Bible Studies on Women and Health Issues) (Rs 25)

CMAI distributes within India the AHRTAG publication Dialogue on Diarrhoea, and both CMAI and VHAI (the Voluntary Health Association of India) distribute Contact within their networks. 

WCC Photo
Christian health institutions in India are renowned for their excellence. CMAI works to redefine medical models so that they might respond more fully to the need for healing within the Indian context.
Medical models and the healing ministry

There was a man who presented himself at the emergency ward of the hospital. His thumb had been cut off by a neighbour during an argument. The doctor examined him and explained that he could stitch it back on. As he worked, he asked the man what he would do once his thumb had healed. The man replied, «Go home and cut my neighbour’s throat.»

The doctor continued his work. And he talked to the man about the deeper meaning of healing. By the time he finished, the man had agreed to return home to try to make peace. Later he returned with the neighbour, who was now his friend.

The above story of the man whose need for healing went far deeper than a flesh wound was told by CMAI chaplain Ninan Chacko as part of his message to the congregation of Free Church, New Delhi on the occasion of Healing Ministry Sunday, 9 February 1992.

Healing Ministry Sunday is a joint initiative of CMAI and CHAI (The Catholic Hospital Association of India). Healing Ministry Sunday and the preparatory week preceding it provide an opportunity for congregations to reflect on themes involving healing. The 1992 theme was Building Healthy Communities.

Both CMAI and CHAI provide broad outlines for the week of celebrations leading up to Healing Ministry Sunday, including Bible studies and a suggested order of service. This year CMAI supplied Healing Ministry Sunday materials to an average of 12,000 local churches, institutions, and individuals. Nine members of the CMAI staff preached in New Delhi churches on Healing Ministry Sunday itself.

Bible studies focused on defining a healthy community (Acts 3: 44-47), evolving as a community (Exodus 40: 34-38), making radical changes as a community (Leviticus 25: 8-17), and continuing to heal and share as a community even in the face of discouragement (Matthew 25: 31-46).

The key message of the preparatory material for the week, based on Romans 14: 1-10, spoke directly to Christian health professionals in India:

Why participate in the building of healthy communities in our country? Are we able to respond adequately to the challenges all around us? If not, what hinders our role as healers and reconcilers?

The bloodshed, the violence, and the inhuman killings in Assam, Kashmir, and Punjab again remind us that we should go beyond medical solutions in order to heal the brokenness and divisions in our country.

Prior to 1986, Healing Ministry Sunday was celebrated among Christian churches in India as Hospital Sunday. The change in name reflects an understanding of healing that has moved beyond the four walls of medical institutions and the narrow confines of physical healing alone.

The health care provided by Christian institutions in India enjoys a well-earned reputation for excellence. As both a professional and a Christian body, CMAI continues to examine medical models and to redefine health in the Indian context so as to promote true healing among neighbours and communities in this vast and diverse country.
USEFUL PUBLICATIONS


Medico International has revised and updated this highly useful booklet, which gives current prices for generic drugs on the international market. Medico International is a non-profit medical relief organization with over 20 years experience working with organizations in Africa, Asia, and Latin America in the field of primary health care. This booklet was developed as a contribution toward making essential drugs available to all people, but particularly those of the developing world.

The list of drugs is based on the most recent WHO Model List of Essential Drugs, with a few additional products that are in widespread use. Lists of drugs are in English only, but the booklet’s introductory and explanatory notes are in English, French, and Spanish.

Prices are given in US dollars, based on the most recent price information available from a selected group of eight suppliers of generic drugs. Additional information from the suppliers, such as terms of payment, minimum order, transport and packing costs in relation to price quoted, extra costs, and special product information, is also included.

Available at DM10 plus mailing costs (up to three copies free to non-profit organizations in developing countries) from

Medico International
Obermainanlage 7
D-6000 Frankfurt/M
Germany.

The Centre for World Development Education (CWDE) Worldaware Education Catalogue

This exciting collection of materials for development education has just been revised. The resources listed include teaching packs, books, leaflets, maps, posters, slides and filmstrips, videos, classroom games, and computer software. All are designed to enhance young people’s awareness and understanding of world development issues and of sustainable development. CWDE is an independent educational agency that promotes education about world development issues and the
interdependence of developed and developing countries. The orientation of some materials towards students in industrialized countries, particularly Britain where CWDE is based, does not undermine their relevance to learning situations in other parts of the world.

Further information on CWDE and copies of the Worldaware Education Catalogue may be obtained from

Centre for World Development
1 Catton Street
London WC1R 4AB
United Kingdom.

Maternal Mortality Ratios and Rates
(Third Edition)

For those involved in maternal health, the 1991 tabulation by the World Health Organization of available information on maternal mortality ratios and rates from around the world may be of use.

WHO names maternal mortality as among the leading causes, if not the leading cause, of death among women of reproductive age in most of the developing world. Recognizing that the difficulty of measuring maternal mortality has resulted in an underestimation of the problem among health planners, WHO has compiled this data from all relevant databases in an attempt to provide a more complete picture.

Copies of the tabulation (WHO doc. number WHO/MCH/MSM/91.6) may be obtained at the following address:

Maternal Health and Safe Motherhood Programme Division of Family Health World Health Organization
1211 Geneva 27
Switzerland.

People’s Health Network

The People’s Health Network is a group of organizations and individuals concerned with a holistic approach towards health problems in the Third World. Its secretariat is lodged in the Third World Network, at the Consumers’ Association of Penang, Penang, Malaysia.

The People’s Health Network aims to exchange information among health workers, to organize campaigns in favour of good health policies and practices, to encourage the establishment of health groups in the Third World, and to represent Third World peoples in international policies relating to health.

The Network is a recent initiative, intended to provide a forum and framework to highlight major health issues facing the Third World and to act collectively to counter the factors causing ill health. These factors are enumerated in the General Statement of the People’s Health Network.

The Network would like to receive the names and addresses of active health groups working at the grassroots for the purpose of exchange of information or publications.

Further information on the Network and Network materials, such as the General Statement and health “alerts” on specific subjects, are available from the coordinator at the following address:

S.M. Mohd Idris
Coordinator
People’s Health Network
Third World Network
87, Cantonment Road
10250 Penang
Malaysia.
CMC NEWS

It is with regret that we announce the departure of CMC pharmaceutical adviser Christel Albert, in February 1992. Christel joined CMC in 1987, intending to remain only a short while! Under Christel's guidance, the pharmaceutical programme has taken shape, strengthening its role in the promotion of the essential drugs concept among church-related programmes in the developing world. Christel will be returning to her home country, Germany. Although this departure has been foreseen for some time, we are sad to see Christel go and wish her well.

The one bright spot in Christel's leaving has been the arrival of Dr Eva Ombaka, who took up the post of pharmaceutical adviser in January of this year. Eva and her daughter, Rachel, come to Geneva from Moshi, Tanzania. Eva is a member of the Lutheran Church.

Eva received her primary and secondary education in Tanzania, before undertaking her PhD studies at Aston University, Birmingham, UK. Upon receipt of her PhD in Pharmacy in 1981, she spent two years as a registered pharmacist with the West Midlands Regional Health Authority, Birmingham.

From 1976 to 1980, Eva worked as a tutorial assistant at the Faculty of Medicine, University of Dar es Salaam (now incorporated into the Muhimbili Medical Centre) and in 1981 was appointed lecturer at the Muhimbili Medical Centre. In 1987 she was appointed senior lecturer, and from 1985 through 1988 was responsible for the administration of various departments of the medical centre.

To obtain further managerial experience, in 1988 Eva left the Muhimbili Medical Centre to assume the post of technical manager and acting general manager, Keko Pharmaceutical Industries Limited, a position in which she remained until coming to Geneva.

Eva has a special interest in microbiological and pharmaceutical research, in particular on the use of oral rehydration salts, and for work in this field she was awarded a Fulbright Grant to undertake seven months of research at the University of Illinois in Chicago, USA. Also concerned about the misuse of drugs in developing countries, Eva undertook a study on this subject in Tanzania. The study results were communicated to the government, the Pharmaceutical Society, and the Medical Association of Tanzania, in contribution to the formulation of a national drug policy.

We are pleased to welcome Eva to our team, both as a highly qualified professional and as a warm and personable colleague.

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