ALCOHOLISM AND DRUG ADDICTION

What is the Christian response?

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ALCOHOLISM AND DRUG ADDICTION

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Addiction turns the individual’s world upside down. It replaces worship of the one God and our love of our neighbour with a new god - the addicting substance. Family, friends, church, job, community all become secondary to satisfying an unquenchable need. The individual loses love and control of self to the substance to which he or she is addicted.

It is estimated that 10-15% of the world’s population is addicted to drugs or alcohol. These people are leaders in our communities and sitting in our churches. They are people living in the houses on the hill, and in shacks at the edge of the villages and in the doorways of city streets. They are lonely and afraid, and they are often in poor health. They use an addicting substance as a substitute for healthy eating and healthy relationships. They may beg or steal or even kill to obtain money to purchase the substance of their addiction. Some beat their spouses, neglect their children and pull their families deeper and deeper into poverty. Others drive vehicles under the influence of their addiction and kill themselves and others on the road. They fill our prisons, spawn illicit trade and criminal activity ranging from common theft to multi-billion dollar international crime rings.

Feeding the addictions is big business, involving almost as much money as the arms race. Countries that produce legal products, such as alcohol, seek markets internationally to sell their products. In countries in which illegal products are grown, processed, transported and distributed, governments may look the other way because of the economic impact of stopping the trade. In some countries, governments may not have the power to control the industries involved.

Where do the churches stand in the face of this? Do they ignore the problem? Do they point fingers at sinners or do they try to minister to those in need? Should not the churches challenge some of the causes of the ever-increasing number of persons who are becoming addicted to drugs and alcohol?

The Central Committee of the World Council of Churches approved a paper in September 1995 which calls upon its members to become “a part of the solution”. The paper concluded that as followers of Christ we have no choice. Addicts are the people who are marginalized, who are broken and in need of healing. Just as God led the people of Israel out of slavery in Egypt, the Church today is challenged to lead these addicted people and their families out of the slavery which their addiction imposes upon them. The paper affirms that it is not a time to judge or place blame, but a time to reach out in love to serve as Christ served.

Models are numerous, demonstrating how churches can help prevent addiction through education and by providing welcoming communities. We can become directly involved in accompanying addicted persons and their families on their road to recovery. We can allow our facilities to be used by other community groups trained in rehabilitation.

We can also become prophetic, seeking justice by challenging those forces which allow the greed of some to enslave others. In such work, we can truly be the Church of justice and loving kindness and walking humbly with God and those of God’s children who desperately need us.

This editorial was written by Gwen Crawley, a member of Unit II Commission, World Council of Churches, and co-moderator of the Working Group of CMC-Churches’ Action for Health.
THE POLITICAL FACE OF ADDICTION

Government and church policies on substance abuse, including alcohol and tobacco, are riddled with inconsistencies. Often, our own attitudes towards the problem are similarly confused. Secretary of the International Christian Federation for the prevention of alcoholism and drug addiction, Jonathan Gnanadasan helps to give some direction.

The oldest known code of laws, that of Hammurabi of Babylonia (circa 1770 BC) regulated drinking houses. Throughout history, governments have found it necessary to regulate alcohol and drugs. They regulate from a genuinely welfare-oriented perspective as well as to ensure excise duties.

The early Church was not anti-alcohol. In fact, alcohol and drugs came from the temples to the streets. However, the Church has always discouraged drunkenness and by the eighteenth and nineteenth centuries, it had involved itself in the temperance movement. Temperance came to mean abstinence, and prohibition hit the poor hardest. As the movement became more political, the churches tried to distance themselves from some of its activities and overzealous dogmatism.

By the 1960s, the alcohol problem became an issue of Christian freedom and responsibility. Tolerance of moderation, or the “wet model”, became the popular norm and links developed between the work of the churches and the philosophy of Alcoholics Anonymous. At the same time, churches worked towards the “dry model” in terms of regulation, supporting control of the supply of alcohol through measures such as high prices.

War on drugs
During the 1980s, the USA declared a “war on drugs”. The problem with this approach is that it has failed to clearly define the enemy. Is the enemy the poor junky on the streets or the local dealer or the impoverished farmer who produces the drug as a cash crop because there is no attractive market for his banana or coffee? Trying to reduce supply without considering the poverty associated with the trade is short-sighted. The war on drugs has been further complicated by becoming linked to America’s foreign and defence policies, and corrupted by its links with business interests. While the drug lords are hunted down,
The current liberal paradigm of growth-oriented development has serious ethical and spiritual defects. With its emphasis on individualism and the erosion of the welfare system, it encourages a process of marginalization and disempowerment. It is the poor and the weak who suffer most. As one rural Zambian man wrote to the *Zambia Mail*: "We have no water, no light, no schools, no washing facilities but the municipality says that they will build a beer hall for us. If we drink beer, the municipality can earn money so that one day we will have a water pipe. How much beer do I have to drink before my children have water to drink?"

Global liberalisation, combined with the possibility of quick bulk transfer of goods, electronic money transfer and less restrictive border controls could have an important influence on drug use and drug markets in the next few years. It is possible that segments of the population, particularly youth, will become even more vulnerable.

Churches need to begin to listen sensitively and respond to the questions of alcoholics and drug addicts. Among the graffiti on the Berlin Wall was the painful question: "Is there a life before death?"

American commercial banks greatly profit by laundering their drug money.

In spite of the war on drugs, the supply and demand for drugs in America has grown. The US drug trade affects many countries throughout the world, and the spill over of drugs from the American market hits neighbouring small and underdeveloped countries. Addiction affects the quality of personal, family and community life, and causes crime and corruption. It adversely affects food production and agriculture as more farmers go for drug related cash crops. The problem generates "mal-development" of the region. Because the war on drugs is "top down" being imposed by government authorities, it fails to encourage local solutions at the community level. A better approach might be a "war on poverty" in which communities are involved in a process in which demand-reduction and supply-reduction go hand in hand.

In Western Europe, a looming problem is that of the overproduction of wine. While the European Union already spends more than half of its budget in subsidising and restructuring the agricultural sector, future production of wine is predicted to rise while demand falls. What will Europe do with the surplus? Will it be sold at very low prices in Third World countries or will it find its way into Eastern Europe?
Such questions need to be addressed by everyone, including those in the churches. Rather than being concerned only with life after death, the churches need to help reduce the life and pain around them. They need to search for what they can offer to someone who has nothing to lose. Concerted efforts also need to be made to understand alcohol and drug problems from a gender justice perspective. Women and children are primary victims in alcohol-aggravated, domestic violence.

Where do the churches stand?
On the whole, the churches have gone beyond the point of wondering whether drinking alcohol is a sin. On the other hand, they acknowledge a strong correlation between a drinking culture, the total consumption of alcohol, and the prevalence of alcohol-related harm. In practical terms, they aim to support an alcohol-free lifestyle and to work towards reducing the risks of resulting from the consumption of alcohol in the wider population.

With regard to drugs, the churches continue to have serious ethical problems. However, some churches in the US and UK have started discussions on the decriminalisation of soft drugs. This discussion is already taking place in some national parliaments, and churches need to be involved in the process if they are to be part of the outcome.

In terms of overall solutions, it appears that the failure of overzealous alcohol prohibition is being followed by the failure of the “war on drugs”. Many churches believe that the battle should be against poverty and that serious attempts to promote community involvement is needed in order to solve the problems.

In their advocacy work, churches need to take a political and a justice perspective. They need to speak out against alcohol and drug abuse collectively and in a well-formulated way. Overall, there is a need to link alcohol and drug abuse with poverty, while always encouraging approaches to reduce the harm associated with alcohol and drug use.

Draw your own conclusions

Excessive drinking is responsible for:

- 80% of deaths from fire
- 33% of child abuse cases
- 50% of all murders
- 33% of domestic accidents
- 30% of non-traffic accident deaths
- 66% of suicide attempts and deaths involve alcohol
- 40% of pedestrian traffic accidents
- 19% of drownings

An alcohol-free bar in North Wales, UK: a healthy life does not mean that you have to be miserable!

Churches aim to support an alcohol-free lifestyle

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IS “CONTROLLED PRESCRIBING” PART OF THE ANSWER?

In Western Europe, the current political assumption is that drug control has proved effective in the fight against drugs. “I can find little supporting evidence for this view,” says John Lowther, the Salvation Army’s representative on the International Christian Federation and a former UK National Health Service consultant-psychiatrist in South Wales.

Having attended UK and international conferences during the past year, he is perturbed by a number of facts. One is that an ever-increasing number of British young people are registered with the Home Office as drug addicts. Statistics also show a rise in illicit drug use. “This is hardly evidence that our present control is proving effective,” Dr Lowther says, “particularly when 60% of our national drug budget is spent on law enforcement measures and 40% on clinical services.”

Secondly, he is concerned about the paucity of facts, coupled with the extensive rhetoric from both extremes—those who want more controls and those who want legislation. “At last year’s Oakley Lecture at the Institute of Psychiatry in London, Professor Griffiths Edwards made a plea for more research. He told his audience: ‘Regrettably, that has been the professional advice to our government since about 1978 and we are little further advanced.’”

The UK government stance is that illicit drugs will not be legalised. “I have no quarrel with that because we just do not know the long-term effects on the body of these drugs,” he told Contact. Dr Lowther says he has not even been able to find studies of the long-term effects of taking pharmaceutically pure heroin over long periods. However, he says a substantial percentage of addicts, whether they are addicted to work, food or tranquilizers such as benzodiazepines, are unwilling to give up their habit. “This virtually drives some heroin addicts into the street market for their supplies.”

Controlled prescribing
A few clinicians are prepared to consider prescribing pharmaceutical heroin for a minority of addicts for whom such well-controlled prescribing would be the lesser of two evils. The Dutch are now planning a research study to evaluate this approach. However, they are being severely criticised by some for doing so.

Dr Lowther’s contact with a small number of UK clinicians who have ventured down this path has impressed him. “Their approach is well-reasoned and they have documented their results and find that acquisitive crime rates have decreased,” he says. These doctors are “middle-ofthe-road” compared with the extremists who argue for all illicit drugs to be as freely available as alcohol, on the one hand, or who consider the harm minimizing approaches such as methadone maintenance and needle exchanges/programmes as a capitulation to the libertarians, on the other, he says.
A BLESSING FOR DRUG ADDICTS

A worrying increase in drug addiction followed the rapid liberalisation which took place in Egypt during the early 1980s. BLESS, the social programme of the Coptic Orthodox Church in Cairo, responded by creating “The Best Life Therapeutic Community Program”.

Anwar cares for drug addicts in the BLESS therapeutic community 110 kilometres outside Cairo. He used to be an addict himself. His mother had died when he was very young and he felt lost when his father remarried and brought a new family into the home. When he was 17 years old, he ran away to make a life for himself on his own.

Sadly, freedom did not bring Anwar the happiness he sought. He moved from city to city trying to find contentment. When a friend gave him some amphetamines to try, he quickly became addicted. One problem led to another and he eventually ended up in prison. When he managed to escape from there, he felt forced to return home. To his very good fortune, a family servant knew about the BLESS programme and took him to the out-patient clinic at St Mark Centre, Nasr City just outside Cairo.

The clinic is part of the Best Life Therapeutic Community Program which was started by Bishop Serapion five years ago. As head of the Bishopric of Public, Ecumenical and Social Services (BLESS), Bishop Serapion learnt about the sudden increase in students and educated people becoming drug addicts from priests in his church. “During the 1980s, Egyptian society was opening up – like it is in Eastern Europe today,” he told Contact. “One section of society was becoming very wealthy and drug addiction among the young people of these families was an unfortunate consequence.”

Since 1990, the programme has been providing prevention, treatment and therapy. Intensive training has been provided for 275 priests, church attendants and teachers, and awareness sessions have been organized in schools in both slum areas of Cairo and in wealthy areas. “Parents need to learn that there are risks involved in giving young people too much money,” Bishop Serapion says. “Some feel guilty about working abroad and send financial gifts to their children to compensate.”

Treatment and therapy

In terms of treatment, the programme offers the outpatients clinic which Anwar attended and referral services for detoxification. Therapy includes a telephone help-line, group therapy sessions, and the therapeutic community for treatment and rehabilitation of all types of substance abuse.
Although the concept of "a therapeutic community" may be new in terms of international public health, it is based on an approach adopted by the Pharaohs thousands of years ago. A therapeutic community is built on the healthy family model. The father is represented by the authority and the rules of the community, and the mother by the love and the care provided by its staff and members.

The rules of the community are very strict. From the start, the addict is involved in all the household activities and the daily schedule is defined and must be followed in the minutest detail. On the other hand, staff in the community provide a great deal of support and care. There is also psychotherapy, group therapy and spiritual therapy to help the individual find him or herself. If the addict survives the first stage, he or she achieves greater freedom and some responsibility in the second stage.

Happily, Anwar did survive the test. He found that he benefited from the strict regime. Once he was cured, he began to return to Cairo to spend time with his family. They have been attending weekly family group therapy sessions organized by BLESS in Cairo. He also attends celebrations held for friends who achieve a first birthday of freedom from addiction. Such parties give hope to those who are still addicted.

**Future plans**

Bishop Serapion would like to expand the programme. "There needs to be an entry programme to prepare addicts before they go into the community, and a re-entry programme to help them cope with life and find work afterwards." The community provides training in carpentry, agriculture, animal husbandry, health and fine arts but helping graduates to find jobs is proving more difficult to organize.

Nevertheless, the community has created new life and work for Anwar and three other ex-addicts. "We are always pleased when members finish the programme successfully," says Bishop Serapion. "We are also glad that some stay on to work with us. They are the best people to work with the newcomers."

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Director of the centre, Dr Victor S Mikhael (seated centre), with some members and staff members
LEARNING TO COUNSEL IN A CHRISTIAN WAY

India's association of Christian hospitals and health programmes, the Christian Medical Association of India (CMAI), has been instrumental in the launch of a counselling training programme for those striving against alcoholism, drug addiction and substance abuse. Authors of this article, Prisquilas Peter and Darlena David Titus, both work at CMAI.

Alcohol and substance abuse affects all categories of people in India. No group of people is immune from alcohol-related problems. For example, according to various studies among students, 10-50% are dependent on alcohol. Added to this is an equal proportion of the general population, especially men, who are dependent on alcohol or other chemical substances.

India is currently very seriously affected by both substance abuse and HIV/AIDS. It is therefore imperative that churches in India realise their great responsibility to a collective struggle against substance abuse. The Christian Medical Association of India (CMAI), the official health agency of the National Council of Churches in India, started a programme to combat substance abuse in 1989 to facilitate healthier responses through education, awareness, training, assistance, advocacy, counselling and networking. Since then, working jointly with the Catholic Hospital Association of India (CHAI), CMAI has conducted several substance abuse prevention and management workshops for church leaders and others in an attempt to help combat substance abuse in different parts of the country.

CMAI has worked with member churches, de-addiction centres and hospitals and has initiated a network of Christian Agencies to Combat Substance Abuse (CACSAN). This network provides an opportunity for those involved in this work to encourage and support each other, and to plan future strategies. In addition, a few CACSAN chapters in different regions of India have started to share experiences and have fellowship. A major initiative coming out of CMAI's collaboration with various groups was the setting up of a one-year postgraduate training programme in de-addiction counselling in Kerala. It was the inspiration of Johny George, who was then working with CMAI, and now works at the new training centre.

Training in Kerala

The south-western Indian state of Kerala is often given as an example of a development miracle, boasting a 100% literacy rate. However, its alcohol addiction and

Between 10 and 50% of students are alcohol dependent

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suicide rates are unusually high. The inflow of money sent home by non-resident Malayalees has bred a generation that clamours for easy money. This easy money often finds its way into the local liquor shop. The associated social problems are serious. According to a report by a senior journalist with the Indian Express: "The worst hit are the women and children who find that their breadwinners squander a sizeable proportion of their income on liquor."

It was in this context that the CMAI and the Christian Temperance Movement in Kerala started a one-year de-addiction counselling course at TRADA, a church-related voluntary organization fighting against alcoholism and drug dependency based at Kottayam in central Kerala. TRADA is an acronym for Total Response to Alcohol and Drug Abuse. It is an offshoot of the Christian Temperance Movement, an ecumenical group that works closely with the Government's ministry of social welfare. It was formed in 1987 to control the production, distribution and use of alcohol and drugs.

CMAI recognises substance abuse as a disease with physical, mental, spiritual, social, ethical and moral dimensions. It also recognises that this disease prevents abusers from being totally healthy and whole. The training course therefore addresses ethical, moral and clinical issues with a focus on treating all aspects of the human personality. The care team comprises of medical doctors, psychiatrists, counsellors and spiritual therapists.

**Course content**
The course is based on the treatment developed in the first five steps of the Alcoholics Anonymous approach - but with a Christian interpretation. These five steps are:

1. Admitting that we are powerless over alcohol - that our lives have become unmanageable.
2. Coming to believe that a Power greater than ourselves can restore us to sanity.
3. Making a decision to turn our will and our lives over to the care of God as we understand Him.
4. Making a searching and fearless moral inventory of ourselves.
5. Admitting to God, to ourselves and to another human being the exact nature of our wrongdoings.

The perspective of the course is both theological and biblical. It aims to provide students with theological concepts and a responsible view of the problem of alcoholism and drug addiction. Discussion therefore often includes:

- theological and biblical understanding of the fullness of life in Christ (John 10.10) as freedom from the bondage of social and physical structures;
- the goal of Christian life as mature humanhood with special attention to a correct perspective on sin, guilt and forgiveness;
- the Church as a community which celebrates and concretises in its life and in its relation with others the freedom to love and to be loved;
- the misplaced emphasis on legalism and moralism in the Church; and freedom of responsible love as the basis of ethical reflection on the problem of alcoholism and drug addiction, and,
- how the student will bring about attitudinal changes in his or her congregation and help it become a therapeutic community.

As well as taking part in discussions, the student is exposed to the practical side
of caring for the addict and those affected by another’s addiction. This involves initiation in the clinical work, attending a range of Alcoholics Anonymous (AA) sessions.

**Spiritual component**

The curriculum also includes psycho-pathology, counselling and psychotherapy with a spiritual approach. In addition, yoga, naturopathy (treatment using natural forces such as light, heat, massage, eating natural foods and herbal remedies), pranic healing (technique in which the prana or breath of life of the stronger and healthier person can bring healing to a weaker or sicker person), acupuncture (treatment originating in China, where needles are inserted through the skin into nerve centres to relieve pain) and relaxation therapy are taught. Following a three-month field placement at reputable de-addiction institutions such as the National Institute for Mental Health and Neuroscience in Bangalore, or the Pune Deaddiction Centre, the trainees submit their thesis.

The course is open to post-graduates with field experience, and should preferably be sponsored by a church or congregation. Graduates who have been dependent on alcohol or other chemical substances should have had two years of continuous sobriety (absence of drunkenness). The course aims to train counsellors in de-addiction who will be able to co-ordinate independent programmes. (Cost is US$800 (Rs.25,000) for one year.)

**Other CMAI activity**

In 1996, CMAI plans to start a similar training programme in Calcutta with emphasis on the situation in the north and north-eastern part of the country. In addition, a course in mental health and psychotherapy is planned.

CMAI's activities also include training in de-addiction counselling and programmes for seminary students. This course is a short term training in de-addiction for final year theological students. It explores the pastoral ministry as a ministry of healing, a ministry that includes caring for and helping alcohol-dependent persons towards recovery. Often, pastors are baffled and unable to relate to the problem of alcoholism when faced with it in their congregations.

A recent survey shows that very few of CMAI's 325 institutional members have specific treatment facilities to treat alcohol and substance abuse. In response, several staff from different centres have been identified for the one-year postgraduate training programme in de-addiction counselling. Later, they will start programmes for alcohol and substance abuse. Meanwhile, CMAI is preparing a treatment training model for de-addiction – a wholistic approach based on spiritual counselling.

Recovering addicts need the support of the community for keeping their sobriety. Long-term recovery of the addict depends on active support from the community, including church and Christian organizations. The spirit of acceptance and love which ultimately defeats the devastating power of shame and guilt, can restore the person who has been alcohol-dependent. Such a spirit can help a person back into his or her relationship with God, family members and self.

Father Prisquillas Peter works with the Programme to Combat Substance Abuse (PCSA), based in the community health department of CMAI, and Darlena David Titus is the executive editor of CMAI's official quarterly, the *Christian Medical Journal of India* (CMJ).
WHAT CAN THE COMMUNITY DO AGAINST ADDICTION?

Seek ways to control the use of all addictive substances within their settings.

Educate their members about the substance abuse cycle within the family and social systems.

Integrate local church programmes with other community education, prevention, treatment, rehabilitation and after care programmes.

Base all programmes, from education for prevention through to after-care, on a wholistic family and community involvement model, using parables and other participatory learning methods.

Develop “addiction awareness Sunday” services and special projects for youth and women’s groups by the local congregations as a means to begin implementation of a heightened local awareness about addiction.

Voice objections at local church level when films and commercials glamorise addictive substances, including alcohol and tobacco.

Finally, in the Spirit of Christ, accept the addict, whether recovered or not, as made in the image of God and show compassion.

.. AGAINST ALCOHOL ABUSE

Emphasise Christian values in personal and family relationships

Advocate alcohol – and drug-free congregations and communities

Promote healthy youth activities

Train both men’s and women’s groups in preventive and therapeutic measures

Train pastors, hospital staff, school teachers and members of congregations in programmes related to substance abuse

Listen to people recovering from substance abuse

Become therapeutic as well as healing communities
Advocate that the revenue received from selling alcohol and tobacco be used for health and public welfare
Raise awareness of the dangers of alcohol, drugs and tobacco abuse
Aim to reduce public consumption of alcohol, drugs and tobacco.

The Ninth World Conference on Tobacco and Health resolved that “Leaders of all religious communities be urged to adopt an official position and take action to protect humanity from the dangers to health from tobacco.”

Recommended strategies included intensive health education and information to young people and adults, “smokefree” public policies to protect the health and rights of people in all common environments, and effective national monitoring of the tobacco pandemic and the enforcement of these tobacco control measures.

Some churches have already taken up the challenge. For example, the Seventh-day Adventist Church has recently warned the general public about the addictive and health-destroying nature of tobacco and called for a uniform ban on tobacco advertising and stricter laws prohibiting smoking in non-residential places.

**SHARING SUCCESSFUL DRUG PREVENTION PROGRAMMES**

WHO’s Mentor Foundation helps to identify and interconnect successful local drug prevention programmes worldwide. It creates a mechanism (the data network called MentorNet) for exchanging experiences and for studying, improving and replicating successful methodology. It provides programmes with the latest technical findings and fosters interchanges between programmes and technical centres of excellence. It establishes new programmes, based on proven or promising methodologies, and it helps to finance programmes and related research activities.


For further information, please contact the Mentor Foundation, c/o Programme on Substance Acuse, World Health Organization, 1211 Geneva 27, Switzerland. Fax: 41 22 791 4872.
This list includes some useful contacts and publications on the subject of alcoholism and drug addiction. Unless otherwise stated, these publications are available in English only. Addresses of distributors are provided in the Address box in the margin.

USEFUL CONTACTS

World Health Organization (WHO) headquarters in Geneva has a programme on substance abuse (Director Mr H Emblad), which deals with tobacco (Programme Manager Dr J R Menchaca) and alcohol. This programme also coordinates with International Labour Organization (Vocational Rehabilitation Branch) on a workplace prevention programme in which 250,000 workers in Egypt, Mexico, Namibia, Poland and Sri Lanka are involved in model initiatives.

International Christian Federation for the prevention of Alcoholism and drug addiction aims to keep alive the issues of alcoholism, drug addiction/substance abuse and AIDS within the agenda of the global church. In this work, the ICF motivates the churches to give priority to these interrelated areas of human suffering in their mission.

World Council of Churches held a recent consultation on substance abuse/drug addiction. The contact person is Erlinda Senturias, CMC - Churches' Action for Health. Papers on "Alcoholism and drug addiction: Challenges to the Church" (also in French, Spanish, German and Russian) and "Addiction: Churches' Responsibility. A statement by the consultation on addictions" (also in French, Spanish and German) are available.

USEFUL PUBLICATIONS

Address box
CMC - Churches' Action for Health, World Council of Churches
PO Box 2100
1211 Geneva 2
Switzerland
ICF
26A Ancienne route
1218 Grand Saconnex
Geneva, Switzerland
World Health Organization
1211 Geneva 27
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen 0
Denmark
Interdependences
c/o CIMADE
176 rue de Grenelle
75007 Paris, France
International Federation of the Blue Cross
POB 658
Ländestrasse 44
2501 Biel-Bienne
Switzerland

A theological response to the alcohol and drug trends is published by International Christian Federation for the prevention of alcoholism and drug addiction. This publication describes consumption, supply and policy trends and provides a theological response to those trends. It then highlights "good practices" and church strategies. It is edited by Jonathan N Gnanadason, the author of the introductory article in this issue of Contact. This small book is available free of charge in English and French from International Christian Federation for the prevention of Alcoholism and drug addiction (ICF).

Preventing and controlling drug abuse elaborates a number of concepts, models and approaches for understanding the complexities of drug abuse, establishing realistic goals for prevention and control, and adopting strategies having the greatest chance of success. It is available in English, French and Spanish from WHO, Geneva, at a price of CHF24.00 or CHF16.80 in developing countries. ISBN 92 4 156134 3. Order no 1150332.

World Health Organization Regional Office for Europe in Copenhagen has an European Alcohol Action Plan with an associated publication series which includes the following titles: Evaluation and monitoring of action on alcohol, The economics of alcohol policy, Alcohol and the media, Community and municipal action on alcohol, Alcohol and primary health care, Treatment approaches to alcohol problems, Young people and alcohol, drugs and tobacco, and Alcohol and the workplace. Each publication costs CHF20.00.

Interdependences is a bimonthly review providing an information link on all aspects of the drug chain. Some issues are available in English including "80,000 children endangered by drugs" and "Drugs and underdevelopment". It is available at a subscription of US$32 per year from CIMADE, the national council of churches in France.

Info is the twice-yearly newsletter of the International Federation of the Blue Cross, a Christian organization working on drug addiction. The newsletter is free of charge and available in various languages.
READING MEDICAL NEWS

Every day we read about new findings concerning health and medical matters. News about foods, habits, places and other things which could increase our risk of having heart attacks, cancers, mental diseases and a host of other diseases. Sometimes, the information we read is conflicting and contradictory. How do we gauge the reliability of studies and researches published in newspapers and magazines? How can we judge which report is sensationalist and which is significant to our lives?

Since we cannot all be experts on all fields of health and medicine, something we can do is use some expert advice on how to interpret the findings of medical researches. The Harvard Health Letter published a special supplement on the subject and offers a number of tips:

- It is important to remember that news, by its very definition, is something new and unusual. There have been hundreds of studies linking cholesterol with heart disease and editors are bored with them. When one study says otherwise, expect that it would be published and treated sensational. Do not change your lifestyle because of one news story. Look for supporting information.
- Try to see if a particular finding is the planned product of a study. If it is not, then the findings would just be casual observations and not very reliable. Even in the best of studies, reanalysing the data can yield false results.
- See if the article includes opinion by other scientists. One important safeguard against bad science is peer review, in which scientists scrutinise each other’s work. Any study that has not undergone peer review should be regarded with extreme scepticism. For example, one should be wary of findings announced at a press confer-

ence that do not accompany publication in a journal or a presentation at a scientific meeting.
- Look for the opinions of national or international agencies dealing with the subject. These institutions evaluate the studies themselves and their opinion can be very important.
- It is also important not to ask too much from a study, whether epidemiological or experimental.

In epidemiological studies, scientists observe a sample group of people in order to determine the frequency and distribution of disease. It is a good way to uncover risk factors but it can never actually prove cause and effect.

In experimental studies, scientists test a particular variable, whether a risk factor

.. news, by its very definition, is something new and unusual.
(Do not) pursue a healthy lifestyle in a way that it produces stress and anxiety

or a drug, under tightly controlled circumstances. It is important to know if animals were used as subjects because there are numerous factors which could make a treatment effective in animals but not in humans.

In clinical trials, where experiments are performed on people, it is helpful to know whether the treatment and control groups are adequately randomized. Randomization is one of the chief methods used by scientists to fight the distortion of findings by irrelevant factors. It should also be noted, however, that it is possible that two randomly-selected groups will differ in ways which skew the results of the study.

It is also good to know whether the tests were double-blinded. This means that the investigator and the participant do not know who, for example, received the active treatment and who received the placebo. The brain is a powerful organ and often we tend to see what we expect to find.

A test is also more credible if it was a multi-centre trial. If the test was done in only one hospital, it is always possible that its equipment, procedure and expertise of the staff is unique and cannot be duplicated somewhere else. A multi-centre study's conclusion can still be valid even if one centre supplied fraudulent data.

- Try to interpret statistics correctly. People do not usually know what "statistically significant" means. Scientists agreed that the results of a study are not considered statistically significant unless the probability that its results are due to chance alone is less than one in twenty. Because thousands of clinical trials are performed, some studies that yield statistically significant results eventually turn out to be wrong.

Even valid results may be less relevant to our own lives that we think at first. Most of us would be impressed if told that risk factor A increases our risk of disease X by 100%. And we would probably be less impressed if we were told that risk factor B increases our risk of disease Y by 25%.

But if the baseline risk for disease X is only 1 in 1,000, factor A would raise it to only 2 in 1,000. On the other hand, if the baseline risk for disease Y is 400 in 1,000, then factor B would increase our risk for disease Y by 100 cases, to 500 in 1,000.

- Always see the big picture. Keep the news in perspective. For example, because of the established links between oestrogen and breast cancer, women have refrained from using oestrogen to reduce the incidence of heart disease and osteoporosis. However, only 2.8% of Caucasian women between the ages of 50 and 94 die from breast cancer, compared to 31% who die from heart disease. Because perspective is so often missing from reports about risk factors, some people focus on the latest details at the expense of the big picture.

Finally, it is good to read about developments in health and medical research. However, if one tries to pursue a healthy lifestyle in a way that it produces stress and anxiety, then it might help to remember that in life, quality is every bit as important as quantity.

This article is reprinted from Health Alert, January 1-15 1994, the magazine of Health Action International Network (HAIN), Manila, Philippines. It originally appeared in Harvard Health Letter Special Supplement, October 1994.
WHO CALLS FOR "HEALTH CENTRE MOVEMENT"

Following Contact 143 on District Health Systems, Tanzanian doctor Mark Bura provides readers with a report of WHO Study Group on Improving the Performance of Health Centres in District Health Systems. He attended this meeting on behalf of CMC - Churches' Action for Health at WHO Headquarters, Geneva, 13-21 November 1995.

In her opening address, Dr A Koné-Diabi, WHO Assistant Director General of the WHO, stressed that: “Solutions to the problems of health development and health services provision lie in creating or strengthening local or district health systems based on primary health care principles.” She suggested the question before the participants to be: “How can health centres not only provide the best possible health services - curative, preventive, promotive - but also provide leadership, advocacy and action for populations within their catchment areas and as part of district and national health systems?” When health centres play this important developmental role, it is conceptualized by WHO as the “health centre movement”.

During the week-long meeting, the international study group presented and learned from experiences of running health centres within the public service and within the private sector. The new role of the health centre as a developmental agent was discussed in detail. For example, I described the ideas of the Evangelical Lutheran Church in Tanzania on the community role in health care management. Church hospitals have long been involved in raising funds, mainly through charging patients for curative services. We now recognise the inequities created by this approach. For a more just approach, we are embarked on the development of community, pre-payment systems.

The WHO study group reached some recommendations. Firstly, it was recognised that if the health centre were to be able to play a medical and developmental role, a political and legal framework was needed to allow health centres to fundraise locally. Secondly, the group felt that health centres would play a stronger role in resource mobilization if the community empowerment and participation in the management of health centres were increased. Thirdly, it was agreed that vertical health programmes within the PHC umbrella needed to be replaced by multi-sectoral collaboration. In practical terms, this meant bringing school teachers, agricultural experts and others with managerial and developmental skills into the management committees.

The human resource factor received considerable attention. Health centre staff needed fair remuneration, better conditions of service and training in a range of skills, including leadership. Above all, those working in health centres needed entrepreneurial skills in order to effect the developmental role. Special initiatives to strengthen the health centre movement are being identified through research and development activities in public and private sectors.

Although I felt that more attention could have been given to standardization of district health centre equipment in order to help district health systems save costs, the report of the WHO study group will be an important strategic document for health centre reforms. Together, the many actors in the field have to meet the challenges of sustaining the health centres or the basic health units. They need to find new opportunities for involving the communities served, and for bringing more people into the management of their own health facilities. This participation is a step in community empowerment and development.

When health centres play this developmental role, it is conceptualized by WHO as the "health centre movement".

Dr Mark Bura is Health and Diakonia Director, Evangelical Lutheran Church in Tanzania, Arusha, Tanzania.
LETTERS

Women’s Health Book Project

I would like to take the opportunity to let you know about our current project. The Women’s Health Book Project is midway through development of a health care book for women and girls who have little or no access to medical care. Titled “Where women have no doctor”, the goal of the book is to provide women and girls with the tools necessary for informed self-care, in both prevention and treatment of common health problems. Like “Where there is no doctor”, the book for which we are best known, this new book is written in clear and simple English for low-literate readers, while also bearing in mind the social, political and economic issues that directly affect women’s lives.

Jane Maxwell, Project Coordinator
The Women’s Health Book Project, Hesperian Foundation
2796 Middlefield Road, Palo Alto, California 94306, USA

Contact readers are invited to write to the Hesperian Foundation if they would like to become involved in the project. The project is also looking for women artists. Jane Maxwell asks that you send two or three samples of your work - Editor.

Weighing infants

Congratulations on Contact 145 with the excellent article by Dr Kenneth Bailey on community-based nutrition programmes.

Could I comment, however, on your photograph on the front, which I am afraid demonstrates a common error in weighing. The Salter scale or any other scale used in weighing, should it at all possible be at eye level as otherwise there are likely to be parallax errors. Sometimes this will involve shortening the straps of the trousers in which the child is hung, so that the child’s feet cannot touch the floor. This I believe is a small but important point in weighing.

David Morley, Professor Emeritus
Institute of Child Health
London, UK

ANNOUNCEMENTS

AfriCAN network formed

CMC - Churches’ Action for Health has been instrumental in the formation of a network called AfriCAN for Health (African Community Action Network for Health). Participants at a meeting in Harare, Zimbabwe, 23-27 October 1995, decided that forming a network for those involved in health in Africa would be the best means to promoting community involvement in health in Africa. The meeting, which was opened by Timothy Stamps, Zimbabwe’s health minister, was joint sponsored by World Council of Churches (CMC - Churches’ Action for Health) and International Federation of Red Cross and Red Crescent Societies. More than 20 Africans involved in promoting community involvement in health care were brought together to share experiences, discuss problems and make plans for the future. WCC supports this initiative in networking as a move towards greater sustainability and self-reliance for community-based health care in Africa. The network will organize its own advocacy and training initiatives drawing on local resources. It is hoped that by the end of 1996 a coordinator will be appointed based in an NGO in Africa.

Health network’s statistical review

In the Philippines, Health Action Information Network (HAIN) has produced a statistical yearbook for 1995 which emphasizes how economic and social factors influence the health situation. Produced as Health Alert Special Issue 182, editor Michael Tan says: "The yearbook is not just a compilation of figures... they have been analyzed, reanalyzed and re-processed. When finally presented in this yearbook, the statistics are accompanied by commentaries, mainly to help people to be more critical about these figures." One important finding from the analysis is that violent deaths rank among the top 10 causes of death in the Philippines. In 1990, the Philippine National Police’s files show there were 18,248 murders and homicides. However, due to the way death certificates are drawn up in the country, 1990 Health Department reports show only 103 deaths from homicide.
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Happy New Year 1996

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