HEALTH IN THE NORTH

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This issue of Contact is unusual because it concentrates on health in the wealthier countries of the so-called “North”. For over 25 years, CMC - Churches’ Action for Health, the former Christian Medical Commission, has concentrated on health issues in the “South” – the lesser developed countries.

Our focus on the South is partly historical and partly it relates to the fact that the community development approach grew out of critiques of aid programmes in Africa, Asia and Latin America. In health, the approach represents a response to some of the failures of top-down, non-participatory and non-wholistic programmes. Our approach represents a recognition that technological solutions are not necessarily the best solutions, that there is a need to both understand and act at the community level, and that a person’s health depends on social and spiritual factors as well as physical ones.

This issue of Contact is about health in the North because many of you, our readers, feel the need to give more attention to community-based, wholistic health care worldwide, and especially in inner city areas of Europe and the US. The intention of the issue is not only to show that there is a need for community-based health care in the North but also to provide examples of how the North is learning from successful experiences in the South.

Our introductory article is by Dr Christoph Benn who raised the issue of giving more attention to industrialized countries in Contact at a recent meeting. In his article, he describes how hospital staff in Tübingen, Germany, have brought back experiences from working abroad which have subsequently contributed to a “multi-dimensional” and patient-centred approach to health and healing. Like the other articles in the issue, it highlights some of the health problems in the North that are not catered to because of the approach adopted by western health services.

The second article is an interview with Daisy Morris, a health worker in charge of a successful community-based health care programme in an inner city area of the US. It highlights how her visit to Kenya, where she saw how the community-based approach is practised in the South, provided her with new inspiration. Daisy Morris now believes that pride in community and self-esteem are crucial resources for community-based health care.

From France, we include an article about a village mayor who is introducing social structures which imitate those which existed in Togo, his country of origin. For example, African Kofi Yamgnane has set up a conseil de sages (council of elders) in an attempt to restore the contribution of older people to finding solutions to community problems. When he arrived in France, Kofi Yamgnane found the exclusion of the old people to be one of the most shocking aspects of life in the West. Once elected mayor, he was determined to do something about it.

Finally, David Cowling, the coordinator of a small UK non-governmental organization called Grassroots, has contributed an article which begins by highlighting the need for a new approach to health in Great Britain. His organization creates opportunities for people in the South to work on mission and health issues in the North.

Into our “Update” section, we have added some “News briefs”. This is in response to requests from participants in the Contact evaluation who wanted more information on recent medical and health developments. In addition, and also in response to evaluation findings, the “Letters” section has been increased to provide more feedback from readers. Please keep the letters coming, and do write to us if you would like to write for a forthcoming issue of Contact. Information about the themes which will be covered in Contact are included on the back page. Do write to us with your ideas and comments! The more you write, the more we can provide you with readers’ feedback!

Diana Smith
Editor Contact
A HOSPITAL WITH A MISSION: GERMANY LEARNS FROM THE SOUTH

Many of those who work at the hospital linked to the German Institute for Medical Mission (DIFaM) in Tübingen, Germany, have worked in less affluent countries. Here Dr Christoph Benn*, working as a physician at the Tropenklinik Paul-Lechner-Krankenhaus, highlights the understanding of health and healing brought to the hospital from abroad and describes the approach that these concepts have stimulated.

There are not only well-known global challenges in health but also problems and questions related to particular situations. While some regions are suffering from a lack of resources and basic services, others are facing the question of how to maintain their extremely expensive health care systems and how to respond to changing demographic, social and cultural conditions. Christian health care institutions in industrialized countries are increasingly searching for their specific identity and for their role in a sophisticated health care system. In this process they can learn a lot from concepts and experiences which have been successfully implemented in less affluent countries.

The hospital and DIFaM

For about 90 years the DIFaM institute has been in close contact with church-related health care institutions worldwide, serving as health care consultants for German churches and mission boards and learning from the experience of its ecumenical partners. In 1916 the hospital was founded as part of the institute. Initially, its responsibility was to treat returning missionaries. In later decades the hospital developed into a specialized institution caring for all people travelling to or working in warm-climate countries. When scientific advances in tropical medicine made diagnosis and treatment of many common infectious diseases possible within a few days, the hospital began to admit more patients from the Tübingen region. Many of these patients present geriatric problems or have chronic diseases requiring terminal care.

* Dr Christoph Benn is also working with the Institute for Holistic Counselling (see Useful Contacts on page 15).
An example of a hospital which is learning from the experiences of the South is the Paul-Lechler-Krankenhaus in Tübingen. Its work is influenced by the worldwide ecumenical connections of the institute, and by the fact that many nurses, lab technicians and doctors have worked in different health care systems in less affluent countries for varying periods of time. Many of them have come into contact with the concept of primary health care and with a different understanding of health and healing. How does their experience influence the daily practice in the hospital? In this article, three specific aspects of this influence are highlighted, namely:

- the multi-dimensional approach to care in which the patient is seen as a whole person,
- the provision of care according to the patient’s own perception of his or her needs, and
- the development of home-based care for the terminally ill as the preferred option of those seeking to die with dignity and the care of family and community.

A hospital using a multi-dimensional approach

The concept of health and healing depends very much on the anthropology, or particular perspective of the human person, that is applied. As Christians, our task is that of helping a person to overcome the distortions of life in all its dimensions. While there is no universally agreed anthropology in theology or medicine, a concept which seems very useful for Christian health services describes the human person as being a multi-dimensional unity.

This concept owes much to the German-American theologian Paul Tillich. According to this approach, each human being has many dimensions. For example each has a biological, physical, emotional, social and spiritual dimension. All these dimensions can be differentiated but each one is potentially represented in the other. Distortions can affect any of these dimensions resulting in disease. Therefore the healing process has to be multi-dimensional as well. The therapeutic method applied has to correspond to the dimension which is most responsible for causing the disease. Otherwise all efforts will be ineffective and also inefficient. If the disease is caused by a distortion of the physical dimension then the therapeutic intervention should be directed at this dimension. But if it is caused by a distortion in the emotional or spiritual dimension, therapeutic interventions taking into consideration these specific aspects will be more appropriate and effective.

This definition of healing correlates with the so-called “wholistic approach”. Wholistic health care, inspired very much by the experience of non-western cultures, has challenged the dualistic understanding of the human being which divides the person into body and mind. However we prefer the term “multi-dimensional approach” as it avoids the vagueness and ambiguity of the term “wholistic”, which is often misused to suggest any alternative to scientifically-based medicine.

Obviously concepts and theory are not easily translated into the daily work of a hospital. Nevertheless certain aspects of the work in Paul-Lechler-Krankenhaus might be considered to be inspired by this “multi-dimensional view” of the patient as a person. Specific examples of this emphasis are teamwork and the
involvement of many different professions, each with special skills in the treatment of particular dimensions of care. Although physicians with special skills in scientific medicine are a part of this team, they do not necessarily play the most important or dominant role.

A patient with a stroke admitted to the hospital might require intensive medical and physio-therapeutic care to address his/her biological and physical problem. The nurse and the social worker might establish a link with the patient’s family and community in order to help prepare him/her for reintegration after discharge from the hospital. The psychologist and the pastoral counsellor, who are both paid by the secular health insurance scheme, will help to overcome the emotional stress and the spiritual questions in a situation of losing self-control, of rethinking the important values in life and of confronting the patient with the possibility of having only a limited life span left.

Each specialty, with its own experience and skills, can only address certain aspects of the complex situation. Only by working together can they hope to address the various dimensions of their patients adequately. Therefore regular team meetings of nurses, physiotherapists, doctors, psychologists, social workers and speech therapists are part of the routine. Every patient on the wards, each with his/her specific needs and problems, is discussed and future treatment planned.

Care according to need

The second important aspect of our approach relates directly to the experience of staff and contacts working with health care programmes in other countries. In general, planning of health care initiatives has to start with two questions to a community. The first is, “What are your needs?” and the second, “How can you best develop your own skills to address your problem, and how might we collaborate to help you to achieve this goal?”

In a similar way, it should be part of the first interaction with a patient to ask the question: “What is your main worry or your particular need at this time?” and “How can you best utilize your own capabilities, and how can we contribute to achieving the state of health which you would like to reach?” It is not only the medical diagnosis as such that is important for the future course of treatment but the consequences for the patient with his/her particular needs, expectations and values.

This approach is contrary to a common approach, particularly in industrialized countries, which asks: “What is the latest technology which can be applied to our patients? Which kind of treatment is financially most lucrative for our institution? Or how can we compete best on the health care market?”

Admittedly, the principles we have described are ideals which cannot be fulfilled always and under all conditions. Sometimes a hectic clinic routine does not leave enough room for ambitious concepts and time-consuming interviews. But at least there should be room for developing ideals and readiness to try seriously ideas learned from sharing with partners who are committed to the same goal: to achieve the best possible state of health for our patients as defined by themselves and to care for the real needs of people.

Reaching out into the community

A third aspect of our work draws on our recognition of the strengths of community.
participation and home-based care which exists in many countries of the South.

Recently the German Institute for Medical Mission, together with the centre for tumour treatment of the University of Tübingen, started a project for the terminally ill in their own homes.

For some time the Paul-Lechler-Krankenhaus hospital had been caring, particularly for cancer patients, in the last phases of their life. The principles of the hospice movement are adopted with palliative (drugs to relieve symptoms) care, pain relief as well as emotional and spiritual support provided in the hospital. However, this did not provide an adequate response because many people prefer to die at home in the company of their families.

A needs assessment showed that there were no appropriate services available in Germany to provide home care for patients in the terminal phase of their life. Even the well-financed German health care system did not offer any support for this kind of service. Therefore a new project was developed enabling families to care for their terminally ill members at home. Professional nurses as well as volunteers were recruited and trained. Intensive nursing care in the home of the patient may include artificial feeding, intravenous (iv) infusions or subcutaneous continuous pain control provided 24 hours per day if necessary. The project administration is coordinating the services with hospitals, community nurses and family practitioners to ensure a continuum of care from the hospital to the community.

Developing our approach to health and healing?
The approach of the German Institute for Medical Mission (DIF AM) and the Paul-Lechler-Krankenhaus hospital can only be understood against the background of a particular understanding of the Christian meaning of health and healing and of the role of a Christian hospital in a secular, industrialized society in Germany.

The history of the institution as part of the missionary and ecumenical movement and the constant dialogue with people coming from other cultures and denominations provides the foundation for a continuing effort to relate theological reflections to practical questions in health and healing.

Healing means treating the person in all his or her dimensions and helping that person to become himself or herself even in illness and distress. It also means helping the person to accept and to live with his or her disabilities, to restore broken relationships with others and to be reconciled with God, our creator and redeemer. The aim of our institution is to work for an approach to healing which is multi-dimensional — treating the patient as a partner in the healing process, person-centred — providing care according to patient’s expressed needs, and community-oriented — recognizing the importance of family and community in care, particularly for the dying. We hope to achieve the approach in constant dialogue and exchange with our partners in the ecumenical movement worldwide.

The cost for this project is not fully covered by the health insurance system. However, as the project is answering a felt need of the community, it is widely accepted and receives financial support from many people in Tübingen region.

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US CITY LEARNS HEALTHY TIPS FROM KENYA

Daisy Morris, an Afro-American health worker in inner-city Baltimore, Maryland went to Kenya in 1994 and discovered that with fewer resources, Kenya had attained a better record on infant immunization and family programmes than her own community. She came back inspired by what she had seen and with a new vision of how she could contribute to better health in her neighbourhood. She spoke to Contact.

Contact: Has your work in an American inner city area benefited from your visits to hospitals and health centres in Kenya?

Daisy Morris: Yes! I discovered that our health programme based in a poor, rural neighbourhood faces many of the same challenges that exist in Kenya. My experience there turned out to be a real eye-opener for me. When the US Agency for International Development (USAID) came up with the idea of sharing our ideas with health workers in Kenya, I thought we had a pretty good programme. In many ways, our approach to community-based health care is similar to that in Kenya. In Baltimore, we recruit and train local people as community health workers. We have a 100 outreach workers – 80 of whom are community people and recipients of welfare. Each of them have received a two-week initial training and they come to a refresher training all day Wednesday each week. In return for their work, they receive a small stipend (payment). Our approach is a very unusual one around here, and we tend not to know what the rest of the world is doing. In Kenya, we discovered that they were doing similar things better – in terms of both immunization rates and family programmes – and despite more poverty and greater distances to cover.

Contact: Why do you think Kenyan maternal and child health services are more successful?

Daisy Morris: I think it has to do with the sense of community pride and the desire of the people to better their communities. In the US, we tend to work for a paycheque or a stipend. It is not enough to get a job done well. This means that we have a problem of motivation. In the programmes I visited in Kenya, people showed respect and listened to their health workers. Health workers had been chosen for the position because they are people with community pride, and people see them in that light. We need
our health workers

to take a more pride
and ownership in
our community.
The Kenyans are
proud of being Afri-
can. We can be
proud of our Afri-
can heritage. I saw
more pride in com-
community in Kenya. I
think it is partly this
pride that makes
their programmes
more effective than
ours.

Contact: But don’t
you have much
better facilities?

Daisy Morris: In
Kenya, there was
certainly a lot of
overcrowding. Some-
times, there

were two people in a bed. But in many
respects, there was a lot of richness
there and that came from the people
themselves. For example, in the wait-
ning room, people were sitting there quiet-
ly. They were patient because they know
they have to be. In the US, everything
has to be done yesterday. That in-
patience does not make the situation
better or worse, but it is stressful to the
patients themselves.

We also have a lot of technology that the
Kenyans clinics would not have – but
sometimes these facilities do not make
things easier or better. Take communi-
cation for example. We are always trying
to be more creative and more economi-
cal in communication. Getting 500 flyers
printed and distributed is expensive.
Meanwhile, we are forgetting that it is
much easier to get the clients involved
in the project and let them tell each other
about it. We don’t involve people as
much as we should. People in our com-

As a result of the
community health worker
programme, … there has
been a 50% reduction in
emergency room
admissions among
patients.

Community approach to diabetes

Poor patients suffering from diabetes
and high blood pressure are also
benefiting from the help of community
care workers in inner city areas of
Baltimore, USA.

For example Jeanetta Powell, a 42
year-old black mother of four, had a
hypertensive condition that had been
deteriorating for several years. In 1992,
she had 18 emergency room visits,
resulting in three hospitalizations. In
the worst phase, she was on twice-
weekly renal dialysis. She was almost
compulsive about keeping her appoint-
ment with her doctor, but did not follow
his instructions. She said she did not
understand the relationship of her loss
of function to her disease. Nor did she
accept that she had to take her
prescribed medicine – she said it made
her feel terrible. She was concerned
that if she did take her medicine, she
would not be able to look after her
husband and children.

Over a period of months her Com-

munity Health Worker (CHW) gained

her trust and was able, by sheer per-
sistence, to break through her resis-
tance to following the recommended
treatment. The CHW saw her about
100 times over, a period of six months
in order to achieve this relationship of
mutual confidence.

Today, Jeanetta is a CHW herself.
She works full-time with a caseload of
20 patients who she visits regularly.
She is no longer sick, although she
knows that she will always be hyper-
tensive. She takes only two prescrip-
tion drugs, and is delighted with her
achievement – especially given that at
one time she thought that she would
never work again.

As a result of the community health
worker programme, Michael Weinrich
of the University of Maryland says that
there has been a 50% reduction in
emergency room admissions among
patients. The savings total US$2,246
per patient per year.
Has the North gone wrong?

Although many reports in the USA and Europe over the years have indicated that more money should be spent on community health services and less on tertiary care, they are frequently ignored.

Most illnesses in the North are caused by what we do to ourselves, both individually and collectively. Health is not primarily medical, but rather an integral part of justice, peace, environment, and personal life-style. The highest cause of illness in the world is poverty. These problems are beyond the competence of medicine and are best dealt with by changing behaviours and socio-economic conditions.

Consider the following statements by David Hilton, former CMC staff member, in "The Lafiya Guide" (details of this publication on page 15):
- The Carter Center of Emory University has concluded after an extensive study that the leading causes of death in the US are tobacco, alcohol, and violence. For young people living in cities the most common cause of death is homicide.
- Sixteen of every thousand infants born in Jamaica in 1989 died, while in the District of Columbia (an area in the US with a high poverty rate) the figure was over 22 per thousand.
- More than 30 million Americans have no access to health care, and thousands lose their health insurance as they become unemployed or develop serious illness.

Sadly, David Hilton estimates that today more than 40 million US citizens are not covered by health insurance. He says that despite the fact that 14% of GNP is spent on health, huge sums are wasted on unnecessary tests and surgical procedures, including Caesarian deliveries.

Communities know each other. We should leave the technological ways behind and let people make a better job of spreading the word. If they are interested, they can tell each other about a talk on AIDS or some other special event being held.

Contact: Was there anything to learn from the approach to providing family planning services in Kenya?

Daisy Morris: Much more attention is given to the role of the father. Although our community contains mainly female-headed households, we have tried to involve men a bit, recognizing that they play a key part in family planning. However, I wasn't clear before exactly what we were doing with our men's programme. At a Kenyan family planning clinic, I met a man who had had vasectomy during his lunch break. Common sense should have told us that we should be providing such a service. Anyway, this young man talked openly to me about his mini-operation and about how he saw the spacing of children as just as much his responsibility as that of his significant other. I came back and immediately started working on improving our men's services programme. We now intend to bring together groups of young men to talk about their role in family planning.

"Alternatives for Girls" is a programme for girls and women caught in homelessness, poverty or abuse. It is run by the US Presbyterian Church and was visited as part of the Ecumenical Decade "Churches in Solidarity with Women" of the World Council of Churches.

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Contact: Were the problems of drug addiction that you face in the US also a major health problem in Kenya?

Daisy Morris: There is certainly a problem of alcoholism. The women are making beer to sell to the men. The money they earn helps them; but at the same time, it makes the problems associated with alcohol worse. The church is trying to provide alternative skills for the women, such as making arts and crafts. However, some of the women who are brewing alcohol start drinking themselves. Now if a man gets drunk, he is soon forgiven. But if a woman gets drunk once, her reputation is shot. It is the same in the US, if you get drunk once you are a fallen woman. Wherever you are, the realities of the culture are the same towards women. I realize that it is a universal need to work on the value of women – even if we have to give it to ourselves. I came back to the US with a renewed spirit to do this.

I also came back from Kenya invigorated and feeling that we were closer together. People there said to me: “Don’t you have better things in the US?” Of course, it is true that US technology in terms of keeping babies alive is the cream of the crop, but despite the high-tech equipment, babies still die because of inadequate prenatal care, poor nutrition and drugs. In Kenya, I was reminded of the value of the people themselves, and the importance of the pride they had in their communities. It is their pride that creates commitment – and it was tenfold compared with ours. All of those we met had real pride in their communities. I feel convinced that poverty is about low self-esteem, and that the more we can involve people and build their self respect and their pride, the more successful we will be.

Daisy Morris is Project Director, Baltimore Healthy Start Project, Baltimore City Health Department, Baltimore, Maryland, USA. Tel: 1 410 728 75 39, Fax: 1 410 728 54 89. She visited non-governmental organizations, university hospitals as well as church hospitals, clinics and health centres in urban and rural areas of Kenya in 1994. She would like Kenyan health workers to be able to visit the US to complete the exchange of experiences.
A FRENCH VILLAGE TASTES
AFRICAN-STYLE COUNCIL OF ELDERS

When Kofi Yamgnane arrived in France from his home in West Africa he was horrified by the way older people were treated. When he later became mayor of the village of Saint-Coulitz in western France he introduced a Conseil des Sages or council of elders.

Kofi Yamgnane was educated at a missionary school in his home country of Togo, West Africa. A capable and clever pupil, he was sent to study engineering in Brest, western France where he later married and settled in his wife’s home area in Brittany.

Having become a French citizen, this African living in rural western France became known for his strong and outspoken views on the French way of life. “What is this civilization which excludes the immigrants, the unemployed, the old?... Here (in France), the only thing that counts is the economy, not human beings.” Kofi Yamgnane told Contact that he believes the abundance of information and intellectual knowledge in western culture has been allowed to overshadow the importance of wisdom. “What good is all the knowledge in the world if one is incapable of forming sensible judgements because they lack the maturity of experience?” he asked.

In March 1993, Kofi Yamgnane was made mayor of the small community of Saint-Coulitz. He was not only the first black mayor in the area but also the first socialist to be elected mayor in this traditionally right-wing region of France.

How did he achieve such a feat? By turning what could have been a disadvantage into a trump card. He was able to show the French people that they can learn from the richness of the traditional culture of Africa. As one fellow politician said of Kofi Yamgnane: “That which creates a handicap for many, constitutes an advantage for him.”

Wisdom of elders
Kofi Yamgnane is best known in France for creating a Conseil des Sages (council of elders). The idea comes from Africa where elders meet under a baobab tree to discuss the practical issues and moral questions to which the community needs to respond. In 1989 the 83 people of 60 years or more living in the Saint-Coulitz commune elected the council of nine retired people – five women and four men aged between 61 years and 82 years. These elders discuss the projects which are of particular concern to the elderly. Kofi Yamgnane sees this as a system of direct democracy and considers it to be one of his most important accomplishments. “In daily life, the old are the living memory of our village. We count on them to avoid repeating the mistakes already made by others, and for their experience, wisdom and advice.”

He says that the creation of the Conseil des Sages is both an expression of a desire to use the experience of older people... and at the same time to reinvent the opportunity for dialogue between the generations. “In this way, we rediscover the essence of the palabre (lengthy discussions), an African tradition and a fundamentally democratic debate. Instead of a minority who is wrong and frustrated, and a majority which is right and feels confidence of its dominance, there is a group at the heart of the village which creates consensus, and which unites and solidifies support for the action planned.”

For more information, write to: Monsieur Kofi Yamgnane, Fondation pour l'intégration républicaine, 62, boulevard Garibaldi, 75015 Paris, France. Tel: 33 1 43 06 91 03. Fax: 33 1 43 06 91 04.
GRASSROOTS OFFERS LESSONS FROM THE SOUTH

David Cowling, coordinator of Grassroots in the UK, believes that the western medical model must be challenged with the help of the other visions of health. Grassroots provides opportunities for people in the South to work and contribute to mission and development in the North.

The Western medical model is failing to deliver improved health. Consider the following few insights into the state of health in the UK today.

A little girl called Jamie generated huge publicity in Britain recently when her father challenged the decision of the local health authority to refuse further treatment of her leukaemia. It was argued that she had already undergone painful and stressful treatment, that had not been successful, and further treatment, which had only a small chance of success, could not be justified in the interests of the patient or in the interests of others requiring health care. The British public is suddenly recognizing the limits of health care. Choices now have to be made about which people should receive treatment because the present model of health care is unsustainable.

Jane experienced a traumatic divorce which led to serious depression. She was hospitalised and for six months her condition was managed by medication. There was no real improvement because the symptoms were being treated - not the underlying causes. Help from a member of her church to come to terms with her experience, rebuild her life and recover confidence in relationships has enabled Jane to leave hospital and resume a normal life. Health is not just a medical problem. Medical technology cannot by itself deliver improved health.

It is not only at the individual level that the limitations of the medical model are apparent. According to "The Nation's Health", a survey by Alwyn and Bobbie Jacobson:

- the expectation of life for a child with parents in social class V is about eight years shorter than for a child whose parents are in social class I
- 60-80% of the variation in death rates is related to socio-economic circumstances
- social class differences in death rates have widened almost continuously since 1951.

Medical technology cannot by itself deliver improved health.
Last year the number of teachers taking early retirement increased three fold in parts of Britain. In spite of improving economic indicators the "feel good" factor stubbornly refuses to return to the voters of Britain. Increased job insecurity, higher levels of stress, greater alienation are having an impact on health. There is new interest in alternative therapies. The emptiness and fear which is being generated by an individualistic society, whose values are shaped predominantly by the market, will not find well being and wholeness in pills and potions. Health involves relationships, affirmation, a sense of purpose and hope. The human spirit rebels against being reduced to a customer and consumer.

**Message from the South**
Contrast these reflections from the UK with that of Ignacio Ellacuria recorded by CAFOD, Britain's Catholic aid agency: "All this blood of martyrs shed in El Salvador and throughout Latin America - far from moving them into despondency and despair - infuses a new spirit of struggle and new hope in our people. In this way, even if we are not a "new world" or a "new continent", we are clearly and verifiably - and not necessarily by those from outside - a continent of hope. And this is something of utmost importance for future development in the face of other continents which have no hope and only fear."

**Complementary approaches**
If health is to be improved, an important approach to care in the South, namely community-based health care, has to be developed in the North. The western medical model needs to be complemented by community-based approaches to the provision of care. There are those in the North who recognise this and are working for change.

**Providing alternatives**
The Free Church in St Ives, Cambridgeshire, was built in 1862. With the rapid growth of St Ives in the 1970s, it became apparent that the church building, located centrally in the market place, had potential and mission for more than the two hours a week when it was in use.

After modifying the building, the Free Church Centre opened in 1981 and now provides a place for worship, as well as a growing range of health related services. Present activities include:
- a day centre for the elderly with facilities for bathing and chiropody;
- a counselling service and needle exchange for drug users;
- a counselling service for divorce and separation, and
- a coffee and non-alcoholic bar for teenagers.

St Ives provides the opportunity for health workers to volunteer to work together with the community in a relaxed and welcoming environment which is user centred (focused on the needs of those who use it) rather than funding centred (focused on those who are providing the financial input). It also provides an opportunity for church members to discover a new role in the community.

**Make connections**
In 1993, the Churches' Commission on Mission and the Evangelical Missionary Alliance organized a conference entitled "A Global Response to HIV/AIDS". This brought together those in Britain and countries of the South who are responding to the challenge of HIV/AIDS. The people who gathered for the conference were not only medical people but those drawn from many different fields.

There are those in the North who are working for change.

![Image of people enjoying a social event](image)

Alcohol can threaten health.
skills and backgrounds. Julian Filochowski, Director of CAFOD, reminded the conference that although AIDS raises enormous questions for medicine and science, it is also an economic issue, a social issue, a political issue, and a human rights issue. It raises spiritual, ecclesial and theological issues. The challenge is to make connections across disciplines, across cultural and geographical barriers, and between the different faith traditions. At Grassroots, we attempt to break barriers and build connections by ensuring that migrants and people from the South are included in our workshops. Health is bigger than one profession, culture or faith and demands the resources that all can contribute.

Build confidence
One of the most pernicious effects of the medical model is that it causes a loss of confidence. This means that people no longer believe they can help themselves or their community. They have been rendered powerless and impotent by a misplaced belief that "professionals" are the only ones able to help. Alan is a 19 year old student at Luton University who volunteered to befriend a person with learning disabilities. He attended a training programme run by the Luton Befrienders which enabled him to examine his own attitudes and feelings, and develop some of the skills necessary for befriending. He was then introduced to Trevor. They quickly developed a creative relationship that enabled Trevor to join in Alan's social life at the University. Trevor's speech has improved and he is much more relaxed in public places as he has felt himself to be valued by the volunteer. Alan has gained a deeper understanding of oppression and injustice in his own society which has meant a change in his career plans.

The year 2000 is only three years away. The vision of Alma Ata—Health for All by the Year 2000—has not been achieved in the countries of the North. The first of the 38 targets suggested for the WHO European Region in 1985 was: "By the year 2000 the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the levels of health of disadvantaged nations and groups."

In reality the differences have increased. The trend is clear. Fewer and fewer people will have access to ever more sophisticated and costly health care. This type of care may relieve suffering and prolong life but not necessarily create a sense of well being. More and more people will face increasing stress, a lower quality of life in terms of diet, leisure and housing. This, in turn, will generate more health problems, and a health care system that is driven by management and market criteria. There are those who recognise that the health of individuals cannot be separated from the health of a community, and that the health of a community is determined very largely by the provision for those who are most vulnerable and disadvantaged. Individuals and communities in the North are challenging the wisdom of the medical model and developing alternatives.

Address: Grassroots, Luton Industrial College, Chapel Street, Luton, Beds LU1 2SE, United Kingdom. Tel: 44 1582 416946. Fax: 44 1582 32032.

Fewer and fewer people will have access to ever more sophisticated and costly health care.
CMC - Churches' Action for Health
World Council of Churches
For over 25 years, the former Christian Medical Commission, now CMC - Churches' Action for Health has raised issues of justice in health, encouraged innovative approaches to health care, fostered thinking and dialogue on health and wholeness, and promoted primary health care via community-based participation. Its main communication tool has been Contact. From a purely European perspective, "Who lives, who dies, who cares: Listening and caring", the report on a European consultation on the Christian Understanding of health, healing and community held in Hungary in 1986 is also available. Write to CMC - Churches' Action for Health at World Council of Churches, address is given below.
Institute for Wholistic Counselling
When healing is defined in terms of reconciliation with oneself, others and God (see article on page 3), it becomes crucial to integrate pastoral care even more strongly into the multi-dimensional therapeutic process. The Institute for Wholistic Counselling offers special courses for nurses and other professionals in counselling. The aim is to provide them with professional skills in counselling, integrating it into their daily interactions with patients. It also helps Christian health professionals and institutions to rediscover their distinctive identity within the healing ministry of the church. For more information, please write to Rev. Siegfried Metzger at the Institute.
Healthy Cities for Better Life
This was the theme of World Health Day in April 1996. World Health Organization chose it because of the dramatic growth of cities and associated health problems. Around the world, healthy city projects have shown that it is possible to improve life in cities, particularly among the poorest population groups. For further information, write to Healthy City Coordinator, WHO Geneva.

USEFUL CONTACTS

Address box
World Health Organization
1211 Geneva 27
Switzerland

Institute for Wholistic Counselling
(Institut für ganzheitliche Seelsorge)
Oberbehringerstr. 5
D-73312 Geislingen
Germany

USEFUL PUBLICATIONS

The face of pain and hope
How can the churches develop new forms of service which will both meet the needs of individuals, families and wider communities and promote social justice? The stories in this book describe creative efforts to work out just such a vision of Christian service in countries all around a changing Europe. The book is inspiringly written by Robin Gurney, a Methodist from the UK, who is secretary for information and communication with the Conference of European Churches, WCC. Available in English, French and German at a price of US$2.50 per copy, plus 20% for postage. Write to WCC Bookshop at World Council of Churches.

Case studies of community development in health
In Australia, 21 writing workshops were held at community health agencies to help authors get insights into their work and to provide others with a chance to learn from them. This book brings together 16 of the best, chosen to illustrate what the editors regard as good practice rather than good outcome and which include a cross-section of methods and topics. The book is edited by Paul Butler and Shirley Cass and published by Centre for Development and Innovation in Health, Blackburn, Victoria, Australia, March 1993, ISBN 0 646 13604 6.

The Lafiya Guide
The introduction to this beautifully-presented congregational handbook for whole-person ministry describes Lafiya as "a gift from Nigeria to the USA". It draws on the experiences of a committee of missionaries and Nigerians working in Lardin Gabas, a 10,000 square mile area in northeastern Nigeria, who decided to emphasize community involvement in preventative medicine. David Hilton, formerly with CMC and now a denominational and congregational health consultant, provided the introduction and the background materials. The guide aims to promote the Lafiya whole-person ministry by encouraging people and congregations to: become aware of healing and health needs and then to discover resources to meet those needs; make healthy, life-giving choices, and nurture people toward health, healing and wholeness in all areas of life - physically, spiritually, emotionally and in terms of their relationships with others. Copies cost US$10.95 (plus postage). Surface mail to Europe costs US$6.50. Write to Customer Service Department, Church of the Brethren, Association of Brethren Caregivers (ABC)

World Council of Churches
PO Box 2100
1211 Geneva 2
Switzerland

Centre for Development and Innovation in Health
Blackburn
Victoria
Australia

Association of Brethren Caregivers (ABC)
1451 Dundee Avenue
Elgin, IL 60120
USA
CHURCHES’ ACTION ON DRUG SUPPLY IN AFRICA

Pharmaceutical consultant at CMC - Churches’ Action for Health, Dr. Eva Ombaka, recently gave a talk to a working group of the German Christian Churches and Pharmaceutical industry on the drug supply situation in Africa. She described the problems of availability, accessibility, affordability, appropriateness and effectiveness, and what can be done to address these problems. She also described some of the work which the churches are doing through the pharmaceutical programme, which is reproduced here.

Donations
Probably as a result of having a large constituency that donate and receive donated drugs, and thus having experienced the problems in this area, the pharmaceutical programme developed the first-ever donations guidelines (known as the CMC drug donations guidelines). This document was prepared in consultation with a wide variety of donors and recipients. More recently, and as a mark of the importance given to this area, the WHO has produced, in collaboration with other international agencies, a “Guideline for Drug donations” document along the same lines as that of CMC. This document will be of immense value to donors and recipients. The churches continue to support this progress and call on all those for whom drug donations is truly a service activity, to support and use these guidelines.

Training
The training facilities available in Africa are not yet able to fulfil the need for trained pharmaceutical staff. Realizing this, the churches (North and South in partnership) are working together on a number of training activities including:

- Informal training in seminars and workshops on the essential drug concept and rational drug use.
- Formal training support. For example, a two-year basic pharmaceutical assistants course has been developed and is already about to start for students from the three East African countries. Similar courses are expected in the other sub-regions. There is also case-by-case assistance, especially with the help of South-South collaboration, for staff from Africa seeking particular degree and non-degree courses.

Procurement
The churches in some of the countries have joined together to form joint procurement units which:

- Serve as sources for good quality, affordable drugs and coordinators of training activities.
- Offer maintenance services, for example for equipment and the training of technicians.
- Serve as centres for production, or support their members in the productions of high bulk products, for example infusions. In addition, some units are planning to set up quality control facilities.

Dialogue
Discussions between consumers and suppliers create a process of learning and change. The programme offers opportunities for such dialogue. For
example in the pharmaceutical advisory group meetings, both suppliers and consumers are present.

There is also collaboration with governmental international agencies such as WHO, Unicef and other international organizations, and non-governmental health networks such as the Christian health agencies and associations, and consumer organizations such as Health Action International (HAI) and IBFAN. The collaborations and networking bring mutual understanding, support and benefit to all.

Information sharing
Information is crucial to quality care. The programme therefore attempts to make available unbiased information on drugs to practitioners through providing relevant materials such as publications from WHO, HAI, journals and so on.

CHAL Update
The Christian Health Association of Liberia (CHAL) featured in Contact 148 on “Rebuilding Peace” has been ransacked and everything on the compound taken away. Conflict erupted in Monrovia, Liberia’s capital city, on 6 April 1996. Mrs Elizabeth Sele-Mulbah, CHAL’s executive director, fled to Accra, Ghana, with part of her family. Another member of CHAL staff, Sam G Doe of the Healing and Reconciliation Programme, had been scheduled to travel to the US to study with the support of the Mennonite Board of Missions. When the CHAL office was looted, his documents disappeared, though the Mennonite Board of Missions still hopes he will be able to start his study as scheduled. Many other CHAL staff are displaced and have lost their possessions. We have received this news through the CHAL Support Group c/o Jeannette Kpissay, 3838 Lyndale Ave N, Minneapolis, MN55412, USA.

"Cover-up" on baby milk
Scientists have discovered that leading brands of baby milk formula contain high levels of chemicals that could impair human fertility, according to UK newspaper reports. While manufacturers, UK Ministry of Agriculture and scientists attempted to reassure parents that the milk posed no threat, critics accused the ministry of a cover-up. It emerged that the ministry had urged manufacturers to find the source of the chemicals but had failed to warn the public of the test results. "Mothers will find this very frightening," said a spokesman at the British Medical Association. "They have a right to know the facts."

\[ IF\; BREASTFEEDING\; STRENGTHENS\; AND\; STRENGTHENS\; THE\; MOTHER'S\; BOND\; WITH\; HER\; CHILD\]

\[ BOTTLE\; FEEDING:\; STRENGTHENS\; THE\; MOTHER'S\; BOND\; WITH\; THE\; MULTINATIONALS\]

Editor's comment: Here at CMC - Churches' Action for Health we wholeheartedly support breastfeeding as the best option in infant feeding.
USEFUL CONTACTS

International campaign to ban landmines has "set up shop" in the Ecumenical Centre as a joint initiative of the Lutheran World Federation and the World Council of Churches. A booklet entitled "What is your church doing about landmines?" is available free of charge in English, French, German and Spanish. It calls for "A total ban on the production, use, trade and stockpiling of anti-personnel landmines." Worldwide, 800 persons die from mine explosions every month, especially women, children and agricultural workers. Write to: Joel McClellan, WCC, PO Box 2100, 1211 Geneva 2, Switzerland.

Involving the audience

Women's Health Journal 1/96 from Latin American and Caribbean Women's Health Network describes two important experiences in the health and communication process. One is from the US, where the California-based Women's Health Project is currently producing a collective work that draws on input from women around the world. The new book "Where women have no doctor: A health guide" should be available for distribution early in 1997. The other is from South Africa, where a Johannes-

burg-based Women's Health Project describes the pre-testing and modification process it used to "dry-run" workshop materials. There are three information packages on the female body, cervical cancer and AIDS. Both examples are rooted in the belief that, to be effective, health education materials must be developed in participatory fashion with the people to whom they will be addressed and by whom they will be used. Write to: Hesperian Foundation, 2796 Middlefield Road, Palo Alto CA 94306, USA, and Women's Health Project, PO Box 1038, Johannesburg 2000, South Africa.

Nairobi Peace Initiative

Dr Hizkia Assese, director of the Nairobi Peace Initiative and professor of conflict resolution at Pittsburgh University, USA, visited the World Council of Churches recently to describe the work of his African peacemaking organization. Discussions focused on recent reconciliation efforts in Ghana, but he also referred to reconciliation workshops and conflict resolution training seminars that he had conducted throughout the continent. For further information, write to: Nairobi Peace Initiative, PO Box 14894, Nairobi, Kenya.

USEFUL PUBLICATIONS

Love in a time of AIDS

Subtitled "Women, health and the challenge of HIV", this book was written by Gillian Paterson in conjunction with Dr Erlinda Senturias, who is responsible for the HIV/AIDS programme at the WCC and is part of the CMC - Churches' Action for Health team. The book brings attention to the recent research that shows that where the social, economic and cultural status of women is low, they are more likely to become infected with HIV. Recounting the stories of women from many countries and the work of churches and ecumenical organizations, the author argues that, in the face of the AIDS crisis, improving the status of women is not only a matter of ethics but of health and survival. This challenges the healing ministry of the churches, which have often justified and even colluded with forces that subordinate women. At present, the book is available in English only (ISBN 2 8254 1191 4). Price: CHF13.50, US$11.50, £7.25 plus 20% for postage and packing. Write to: Risk Series, WCC Publications, PO Box 2100, 1211 Geneva 2, Switzerland.

TALK catalogue

Teaching-aids At Low Cost (TALK) has produced its 1996 catalogue containing an extensive range of low priced books. These cover a variety of topics including Nutrition, Sanitation and Primary Health Care. If you would like a copy, please write to TALK, PO Box 49, St Albans, Herts AL1 5TX, United Kingdom.

World Health Report 1996

"Fighting disease - Fostering development" is the title of this year's WHO report. It explains that the struggle to control infectious diseases has reached a critical stage and explores the reasons why. It also explains what must be done. Over 50 old and new diseases from malaria, tuberculosis, and cholera to AIDS, plague and the mysterious Ebola haemorrhagic fever are profiled in terms of their incidence, causes, opportunities for control, and the impact on health and socio-economic development. Price to NGOs in developed countries is CHF9.00 and in developing countries, CHF 5.40 including surface mail. Write to: Distribution and Sales, WHO, 1211 Geneva 27, Switzerland.
We take this opportunity to introduce our established non-governmental organization (NGO) Gramin Seba Songstha (GSS). It was established in 1981 by a cross-section of dedicated youth in order to uplift the rural distressed, poor women and men, through functional education, human resource and skill development training, formation of groups, savings generation and providing credit for socio-economic development. The role of GSS is that of a catalyst in the empowerment of the poor, facilitating a “take-off” in which they themselves take charge of achieving their own personal goals.

At present, GSS has formed 43 both male and female groups in five Thana (sub-districts) under Manikgonj and Dhaka district. Activities have generated total savings of DBT 300,000 (US$7,250) and provided basic literacy to 2,050 organized group members. GSS has a strong savings-credit operating system with a loan recovery rate of 99%. Eleven volunteers, including one female director, performed the services.

Currently, GSS is operating six major activity areas: Awareness-based literacy for adults; primary health care and family welfare with both preventive and curative services; credit for small entrepreneurship development for the rural poor; AIDS awareness and prevention programme; mother and child programme, and family welfare programme.

Mahabuba Ferdusheyy, Director
Gramin Seba Songstha (GSS)
Manikgonj, Bangladesh

Information for the disabled

Our staff are trying to set up an information services for people who have recently become disabled, especially with spinal injuries. We have a workshop where we are producing wheelchairs for people who are paralysed. We need materials about all kinds of disability because there is a real need for this type of service in Albania. Social and medical information about the abilities of the disabled and their personal care is particularly welcome.

Gezim Hoxha, Disability Unit at Oxfam
Tirana, Albania

We referred Gezim to AHRTAG’s Disability Programme which promotes disabled people’s rights and community-based rehabilitation through an information service and print, braille and cassette editions of CBR News. Address: AHRTAG, Farringdon Point, 29-35 Farringdon Road, London EC1M 3JB, UK.

Thank you for sending Contact to FAMES. You may be interested to know that, free of charge, we are coordinating activities in information, education and communication (IEC), and different medico-social issues and on reproductive health on behalf of 110 medical centres in Bolivia. The people responsible for these health centres have links with La Secretaria Nacional de Salud del Ministerio de Desarrollo Humano (national health secretariat of the Ministry of Human Development), with health insurance companies, and with university professors. This is where the material you send is put to use.

Dr Ruth Maldonado Balon, Executive Director
Fundacion de Asistencia Medico-Social (FAMES)
La Paz, Bolivia

In REAP (Rural Extension for Africa’s Poor), we have developed a ministry of encouraging the churches in Eastern Africa to be involved in extension-type teaching through the churches. We emphasize agriculture, environment and health.

A major aspect of our health teaching in our work with the churches relates to our women’s programme. We feel strongly that this is beneficial since in most of the churches in Africa today the majority of the members are women and most of these in rural areas. The practical teaching in which REAP is involved, and that we feel is most relevant for the churches includes: timing births, breastfeeding, child growth, immunization, and safe motherhood.

Dr Roger W Sharland, REAP Director
Rural Extension for Africa’s Poor
PO Box 76584, Nairobi, Kenya
Thank you very much for copies of your Contact publication. They have been very helpful in my health programmes, in particular, the issue on “Rational use of drugs”, and articles on drug abuse and misuse, prevention and treatment of minor ailments, and nutrition programmes. I provide lectures to health professionals, women’s organizations, students and the public.

Mrs A E Abina, Deputy Director
Pharm Clinical Service, PO Box 59
Garki, Abuja, Nigeria

ANNOUNCEMENTS

Coming soon!
At our CMC - Churches’ Action for Health editorial meeting in May, we decided on six themes for Contact issues during 1997. They are: Ethics, Health of indigenous people, Health and spirituality, Environmental health, Networking, and Sustainability. Each one of the themes was recommended by participants in our recent Contact evaluation.

If you would like to contribute an article on one of these themes, we would be delighted to receive your proposals. To avoid disappointment, write to us first with a brief outline and we shall write back providing our editorial guidelines. We look forward to hearing from you, either with ideas for articles or with your reaction to this or previous issues. We welcome your letters.

Do you want to join?
Readers of Contact 148 already know of the existence of the newly-formed Afri-CAN (Africa Community Action Network for Health). It was formed at a meeting in Harare, Zimbabwe, in October 1995 entitled “Sustainability of Community-based health care beyond the year 2000: Crucial links and partners”, joint sponsored by CMC - Churches’ Action for Health and International Federation of Red Cross and Red Crescent Societies. The report of the meeting is now available. It describes recent local experiences in community-based initiatives in situations of conflict; in countries where new governments have usurped the original role of local NGOs; in care for the chronically sick, and in participatory action research. It also introduces Afri-CAN and reports on the network’s first board meeting. If you would like a copy of the report and information about joining the network, please write to: Ms Margareta Sköld, CMC - Churches’ Action for Health, WCC, PO Box 2100, 1211 Geneva 14, Switzerland.

International CBHC conference
A first announcement and call for papers has come from CISS International organizers of the “1st International Conference on Community Based Health Care”. The meeting will take place 16-20 March 1997 in Nairobi, Kenya. The theme is “Community Based Health Care beyond the year 2000”. For details, write to: CISS International, Ngon Road, Kindaruma Lane, Nicholson Drive, PO Box 73860, Nairobi, Kenya. Fax: 254 2 711918.

IPHC calls for papers
International People’s Health Council (IPHC) are calling for “Stories for Change: Primary health care that makes a difference”. They plan to invite these stories to be told at an international conference Primary Health Care to be held 5-7 February 1997 in Cape Town, South Africa. If you have a story to tell, write for details and guidelines to: Maria Hamlin Zuniga, Global Coordination, International People’s Health Council, Apartado No 3267, Managua, Nicaragua, Central America.

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

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

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The average cost of producing and mailing each copy of Contact is Swiss francs (CHF) 4 (US$3.50), which totals CHF 24 (US$21) per year for six issues. Readers who can afford it are strongly encouraged to subscribe to Contact to cover these costs. Please note that orders of back issues of Contact are also charged the above rate.