SUSTAINABILITY

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ISSUES IN CHURCH-RELATED
HEALTH CARE

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2 Editorial

3 Introduction
The call for sustainability:
Does it empower or constrain churches’ action for health?

WCC study
What makes a church hospital sustainable?

0 Community-based
Deacons as health facilitators in Ethiopia

Mission
Discovering a healthy, meaningful life

5 Resources

3 Bible study

7 Update

9 Networking

Issues in
church-related
health care
Involvement in a mission hospital, a church-related community health programme or a non-governmental organization (NGO) in health always means being under pressure (a) to find funds and balance the books, and (b) to serve the poor who are in greatest need. These seemingly conflicting objectives are faced by churches and their health services throughout the world, especially in countries of the South where health work is the legacy of mission movements from the North.

Sadly, the survival of mission health care institutions is sometimes the central issue in the Christian involvement in health. The situation is aggravated by an environment in which funds from donors and overseas church partners are falling, government support is disappearing and there is growing competition from other providers of health care.

This issue of Contact takes the theme, "Sustainability: Issues in church-related health care." It is about making possible the fullness of life for all people especially those who have been marginalized, made poor or have little access to existing health services. Its concern is with the widening gap in health status between sections of society and with helping to build healthy, just and sustainable communities.

In her introductory article, Dr Sigrun Mogedal reminds us that originally the concept of sustainable development captured the complex relationships between human beings and the environment. Unfortunately, donors and their recipients came to see a "sustainable project" as a "time-limited effort that could become financially self-sufficient after the initial investment of foreign funds". The emphasis, even for church leaders who were trustees of the healing ministry, was on self-reliance, financial sustainability and not becoming a burden for the church or the donors. Yet Dr Mogedal claims that sustainability is about making choices for health that are both spiritual and moral.

In the second article, Dr Kofi Asante shares with us some preliminary findings from a WCC study on sustainability of church health care. He reports that community involvement, improvements in the health status of communities, good governance, a Christian atmosphere and commitment, well-trained and stable staff contributed significantly to the viability and long-term sustainability of church hospitals and health programmes.

Dr Pat Nickson describes a church programme in Ethiopia where congregational members are trained as volunteer deacons in spiritual and physical health care. Today, these church communities have trained more than 300 deacons and the impact of the programme has been considerable.

In her article from El Salvador, Rev Marta Benavides shares her personal experience of a process of sustainability and transformation for a durable peace. She says that every day each person can practise a commitment to life. The issue also contains some useful information on resources related to sustainability, and a bible study focusing on a sustainable ministry.

Our hope is that readers will look at this question of sustainability of church-related health care from a wider perspective than the survival of health institutions and financial resources. Dr Mogedal concludes that "churches should see sustainability as an option for empowerment". This empowerment is both for the communities in which we work and for the healing ministry of the church itself. It means building local capacity to continue, to take responsibility and to avoid dependence. This calls for painful choices and a willingness to give up some activities or close down some institutions. Who benefits from our present efforts to sustain church-related institutions? If it is not the poor, the weak, the vulnerable or the marginalized then we need to ask ourselves - sustainability for whom?

Daleep Mukarji
Executive Secretary
Health, Community and Justice
THE CALL FOR SUSTAINABILITY: DOES IT EMPower OR CONSTRAIN CHURCHES’ ACTION FOR HEALTH?

Faced with a crisis in financing, church-related health services are forced to consider whether they are sustainable. In this article, WCC commissioner Dr Sigrun Møgedal analyses the concept of sustainability and suggests that churches might be inspired and strengthened by doing the same.

Buzzwords come and go. When they are around, they seem almost to take on a life of their own. The word “sustainability” evolved from the concept of sustainable development which first appeared in the 1987 report of the United Nations Brundtland Commission entitled “Our Common Future”. The Commission pointed out the need to find roads to development that could meet the needs of the present without compromising the ability of future generations to meet their own needs.

Sustainable development captured the complex relationship between man and environment in a unique way. It demonstrated that what may appear attractive in the short term may have serious consequences when seen in a longer term perspective. Sustainability became a powerful concept because it underlined the need to deal with conflicting interests and to make technical, economic and moral choices for the survival of man and nature.

However, the call for sustainability was quickly adapted and simplified by the “me too” syndrome of international development assistance. A sustainable project came to be seen as a time-limited effort that would become financially self-sufficient after an initial investment of foreign funds. The preoccupation of donors with what their money could do for development diverted attention from the more complex questions of the values and interests guiding development.

Health – like the environment – is a basic resource which needs to be sustained. Health is a basic social good which needs to be protected and upheld. Health care, and the health benefits it produces, cannot easily be established and then withdrawn. Continuous, long-term attention and adaptation is required. This needs to be kept in mind when new services are established and when roles and responsibilities for providing health care are shifted around—from government to the private sector, for example.

Making health care sustainable has much to do with deciding what services can and should be sustained in a given local situation. It also has to do with...
who should benefit from the services. The challenge is to match the desired service profile with the required resources and capacity to maintain services in the long term. These questions present difficult value judgments and competing interests. That is why the call for sustainability in health care becomes very complex.

Health care is sustainable when, in a given context, there is a long-term ability to mobilize and allocate sufficient resources (manpower, technology, information and finance) for producing a desired set of services, and these services are demanded and used.

Churches engaged in health and healing have particular values and a motivation for service. Ideally, these qualities guide the churches' involvement in health, and represent a powerful resource for sustainability. With the call for sustainability, it may be useful to re-examine whether this resource is utilised to its full potential.

Clearly, sustainability and health is not primarily about how to finance health care but rather a discussion of the choices that are made for achieving health, and the values that guide these choices.

Churches in a changing context
The policy context of health care has undergone rapid change during the last few decades. Health care is no longer seen as a public responsibility but rather considered a commodity in the market place. Centres of excellence offer care to any one who can pay the bill. Everywhere, people with the financial resources can choose the health care services that they find most attractive, inside or outside their country. At the same time, inequities in access to health care are growing rapidly in all countries, and a growing tendency to accept one health system for the rich and another for the poor is prevalent.

When churches started in Christian healing ministry, their facilities represented islands of hope and care largely for underserved populations. Their trademark was services of high quality, available for all, regardless of economic status. Later on, churches were at the forefront in challenging traditional, institution-based health care and developing models which reached out from the hospitals. This paved the way for engaging communities in how they could take the lead in improving their own health, and how churches could better facilitate and respond to such community initiatives.

Parallel to this development, health ministries were challenged to find their place within national health systems in which governments accepted the principal responsibility for health care delivery. Some church-related hospitals became nationalized, and others made contracts with governments which entitled them to government subsidies. Although in many cases the process was cumbersome and constraining, it was generally accepted as the way forward.

Governments are now seeing their resource base for health care provision dwindle. New health sector reforms aim to increase effectiveness, minimize costs, and reduce the public role as a service provider. In many countries, churches are seeing their health care efforts being shifted back to the private sphere. Donors encourage governments to downsize and ask private and voluntary organizations to pick up the responsibilities. Donations are often decreasing, including those from the international church-related agencies, and church-related institutions are forced to maximize their income from the private market.

Sustaining what?
Given this situation, a pressing challenge is for churches in the health and healing ministry to re-examine what services they should sustain and why. Many have heavy commitments in terms
of existing hospitals and primary care facilities. If such infrastructure is only being sustained for the sake of institutional interest, continuity and visible presence, it is likely to undermine both economy and energy in the long term.

In general, the response of the health planner in this situation is to re-orient care and specialize in services that people are willing to buy. Alternatively, they may identify services that the government is willing to subsidize on a contract basis. The trend is to consider that private providers, including voluntary organizations, should deal with non-essential or tertiary level care. However, such strategies are likely to exclude those groups which the churches believe they should be serving.

In the renewed attention given to the commitments for Health for All by the Year 2000, governments realize that there can be no path to sustainable health care without dealing with the stumbling block of equity. There is a growing acknowledgement that equity cannot be achieved if governments withdraw from health as a public responsibility. Sustainability and equity must go together. This requires new partnerships for health, locally and nationally, and calls on the churches to respond.

As long as there are large social and economic gaps in health status and access to care, churches must be a corrective force in their caring and healing ministry. They must associate themselves firmly with options for and by the poor. The call for sustainability and equity inspires choices and actions for health which are consistent with the unique resource base of the churches. This resource base is made up of the spiritual motivation and the commitment to equity, justice and caring which the churches share.

The answer to this call cannot be uniform. In each situation the churches must identify the cause which fits best with their basic spiritual and social values. Having defined their cause, they then be decisive in re-orienting their services and activities. Seen from this perspective, the call for sustainability is more empowering than constraining. The process requires a willingness to allow what exists to be torn apart so that new approaches can emerge. In any case, established health care institutions may not be the best way to serve the needs of the church for visibility and respect. Ties to external partners might have to go if these donors are not willing to join in the search for something more genuinely true to the identity and calling of the local church. However, making the changes necessitated by the call for sustainability will be worthwhile, even if, like in any other process of empowerment, it contains an element of vulnerability and pain.

Appraisal of sustainability
Given the multidimensional nature of sustainability, there is a need for approaches which help unmask its complexities. Basic values can serve as a useful starting point. Another approach might be an examination of existing services to determine which could best serve the people who may be denied access. Such a strategic assessment of what should be sustained needs to take into account important contextual factors. These might include the overall policy context (e.g. government regulations may have a strong bearing on what can be done); the involvement of various other care providers; potential

When churches started in Christian healing ministry, their facilities represented islands of hope and care largely for underserved populations.
conflicts of interest in the community, and so on.

Sustainability is at risk if there is a mismatch between the actual services and the desired services, or if the existing services do not reach the groups of people for whom they are intended. Here, demand and use of the services is a powerful indicator.

The capacity to produce services must obviously match the set of desired services that the health care provider intends to offer. One set of critical factors includes staff competence and motivation, and the extent of common purpose. Another set has to do with leadership, the organizational culture and the administrative systems required for efficient management. Systems which can contain costs and account for income and results are as crucial to sustainability as the level of and source of financing.

Programmes for institutional development can reduce organizational problems to a minimum, but they are often given inadequate attention by the churches and their partners. Where critical functions in the capacity to produce services are maintained through expatriate presence or control, the need to build capacity locally and hand over control stand out as the most crucial for achieving sustainability.

Obviously, income needs to cover costs. However, this does not mean that all the income needs to be generated through fees for services. What is vital is to achieve a revenue base which is dependable in the long term. The funds could be provided through subsidies from government or a long-term external partner, or through contracts with insurance companies, local governments or community groups. The higher the level of care, the less one can expect income from fees to cover the cost of care.

In the end, it may be necessary to trim down existing services or to transfer facilities to other parties (such as a private for profit) which can take different financial risks and cater for different types of need. In this way, the church would be released to get on with work closer to its own identity and values.

Conclusion
Churches should see sustainability as an option for empowerment rather than a constraint on their health and healing ministry. In this discussion, we have associated sustainability with equity, and with making choices for health consistent with spiritual and moral imperatives.

In a context of health reform, rapid privatization and the public sector withdrawal from tertiary care, should established church hospitals provide private tertiary care in order to secure income and status for the church? From now on, it is unlikely that resources will be forthcoming to sustain the old institutions. Where there is an alternative to the church-related facilities, it may not even be appropriate for them to be sustained. Rather, the churches need to re-orient their services towards being a corrective element in health systems. They need to develop approaches that meet the challenge of equitable access to health care. After that, the next priority is to fill the gaps in basic, essential care for those who are still unserved, ensuring links with community initiatives and ownership.

This proposal is not a new insight. Rather it takes up the old imperative of the Christian Medical Commission (CMC) and simply applies it to a new context. Today, as we move toward the end of the century, we may be freer than ever before to follow this challenging path.
WHAT MAKES A CHURCH HOSPITAL SUSTAINABLE?

Dr Kofi Asante, executive secretary for health is completing the final stages of a World Council of Churches' study on the sustainability of church health care. In this article he explains why WCC undertook the study and highlights some key findings about church hospital services.

Churches run many small rural and urban hospitals, particularly in Africa. According to the International Hospital Federation, 34% of hospitals in Kenya are owned by the churches (19% of all available hospital beds) and 53% of hospitals in Zambia are church hospitals (7% of available beds). Church-related hospitals are often said to offer "better care" because of their humanitarian motives.

For several years after independence, non-aligned Third World countries could rely on grants, loans and investments from the industrialized countries. But in recent years, sources of funding have become much tighter for governments and churches alike. Official development assistance from OECD countries reached a peak in 1980, and since then, the trend has been downwards, especially following the collapse of the Soviet bloc. The reductions have affected health care particularly badly. Aid for health declined by 13% between 1983 and 1984, and it has fluctuated considerably since 1987. Declining external support, coupled with health reforms, have led churches involved in providing health services to reassess their mission.

To support the churches in this reflection, WCC has worked with 11 Christian health and medical associations on a study of the sustainability of church health care. The objective of the study was to identify which factors in existing structures and practices improve the viability and long-term sustainability of church hospitals and health programmes.

**Some key findings**

The study has provided important evidence that community involvement, one of WCC's guiding principles, is very important to sustainable church health services. For example, Hospital A, based in a hilly, rural area, is surrounded by a poor road network. Most patients arrive on foot or on an improvised, homemade stretcher known as a *nqozi*. Staff at the hospital recognized that the *nqozi* ambulance service was

Church-related hospitals are often said to offer "better care" because of their humanitarian motives.
an important community service. Each 20-30 households arrange among themselves how to ensure that all households can take advantage of the service should they need it. The ngozi groups also provide funeral services. Staff at Hospital A decided to organize a meeting with the representatives of the ngozi groups which led to the introduction of one of the first rural health insurance schemes in the country. Ngozi coordinators now collect a small but regular payment from each family which is paid to the hospital to cover the costs of necessary treatment.

**Self-reliance** was another important principle of this hospital, and of many other successful hospitals in the study. At Hospital A, the management had organized for water to be gravity piped, and the hospital’s electricity was provided from its own hydroelectric power plant. Both initiatives promoted a sense of self-reliance and kept costs down.

Church health services considered sustainable could show that they had contributed to **improvements in health**. For example, where local communities could see that an immunization programme had reduced the risk of measles, they were more likely to use the services and more willing to pay for them. Some of the sustainable hospitals benefited from the legacy of successful health education programmes, some of which have produced a generation of young mothers already convinced of the benefits of breastfeeding and oral rehydration therapy.

Management policies were also often different in the hospitals considered viable and sustainable. In particular, sustainable hospitals had a defined “vision” and “mission” which was known and respected by staff at all levels. An understanding of the mission or goal of the institution created a strong sense of ownership and commitment. For example, as a Christ-centred service, staff would be expected to “treat patients as they themselves would like to be treated”. The messages were often reinforced through practical Christian activities, including daily prayers, an effective chaplaincy, and organized support for the poor and marginalised.

**Good governance** was also important. The sustainable hospitals had a board of directors or managers who set the agenda and policy but understood their role to be different from that of the day-to-day management of the institution. Boards representing a wide range of different interest groups in society contributed particularly well when difficult policy issues arose. The range of skills and knowledge available on the board was another important factor. Where such bodies worked well, the management had autonomy and structures were less hierarchical. There was more likely to be information sharing on policy and finance, and candid discussions of pressures on hospital staff, such as the demands of the extended family, were encouraged and more likely to take place.

Institutions which had a long-standing reputation for high **quality care** were more sustainable. This reputation, often based on a specialty such as **eyes**, surgery or the treatment of leprosy, attracted patients from far and near. In order to maintain the high standing held by the community, **peer review** and other consultations between medical staff were also important. For example, in sustainable hospitals doctors regularly met to discuss seriously ill patients which led to improved clinical standards in diagnosis and treatment. The occasions also provided an important opportunity for discussion of ethical issues.

The study showed that the higher the ratio of trained staff the more likely the hospital was to be successful and sustainable. The training did not need to be formal. What was necessary was that supervisors shared skills with staff.
In particular, second-line leadership training was crucial.

Sustainability is threatened when expatriate doctors and nurses holding key positions leave without training anyone to take over from them. Departing expatriate staff need also to ensure good conditions for replacement local staff. Unlike senior staff recruited locally, expatriates have a “safety net” of direct connections with home providing pension rights, social security, and educational opportunities for their children. When the hospital tries to recruit and retain a replacement, compensation for the “safety net” needs to be made. Children’s education is often a particular concern. The fact that Hospital C in a WCC study was running a successful primary school was considered to contribute substantially to its staff stability and sustainability.

The political and economic environment was another factor important to whether a hospital was considered sustainable. If the government appreciates what the church is doing in health, the Ministry of Health is likely to listen carefully to representations made by Christian medical or health associations. Church hospital staff may be given the same pension rights as government staff, as well as perhaps tax exemption on imported vehicles and equipment. Besides, seconded staff may be made available. In a hostile environment, a government may try to compete and therefore duplicate the efforts of the churches. The Ministry of health may require the church hospital to complete all the same papers as commercial companies, causing months of administrative delays and perhaps punitive charges on vital supplies. The attitude of the church is also important. Some raise funds to contribute to health services while others want hospitals to provide them with funds.

The ability of church health institutions to raise funds is another factor crucial to their success. Operating in a particularly poor area, or where there is competition from a neighbouring hospital, limits monies resulting from fees for service. Successful Hospital A, mentioned earlier, was involved in several money-generating activities. They included a grinding mill, tile sales, and cattle rearing. Other successful hospitals had bought property or land on which they earned rents. Some hospitals had schemes which allowed those with outstanding hospital bills to pay off their debts by contributing their own labour. Carefully-costed schemes had been created at some hospitals which allowed even unskilled ex-patients and community members to contribute to hospital maintenance.

Another useful scheme related to the demands of staff for free treatment. Hospital D had introduced a scheme in which the health costs of staff and their families would be covered but only up to a fixed limit. Each staff member had his or her own account which could be used up to a ceiling level, after which costs would be deducted from the staff member’s salary. This discouraged staff from seeking free treatment for anyone other than his or her immediate family.

The many important findings of this study present opportunities for solving problems in failing church health institutions. Models in community involvement, improving hospital governance, and fund-raising schemes, are just some of the practical ideas from which other hospitals may benefit. However, churches need to consider whether continuing institutional health care is always the best possible model of promoting health care. Is the hospital providing a needed social service or is there an inheritance from foreign missionaries? Reflecting on sustainability may produce a “moment of truth.”
DEACONS AS HEALTH FACILITATORS IN ETHIOPIA

The church, and the spiritual commitment of its congregation, can play a vital role in making community health care a reality. Dr Pat Nickson, Director of the Institut Panafriçain de Santé Communautaire (IPASC) describes a church programme in Ethiopia where congregational members are trained as volunteer deacons in spiritual and physical health care.

In 1992, the Health Coordination team of the Ethiopian Evangelical Church Mekane Yesus (EECMY) made an evaluation of the government’s community health programme. EECMY had previously supported this nationwide initiative. The results were disappointing. They found that many community health workers were discontented, and some were failing to undertake their duties. Others had left the programme to become private “injectors”. This was not a particularly surprising finding. As in many other parts of the world, the government scheme had started well but maintaining the momentum had proved difficult.

The evaluation had been undertaken in Boddj, western Ethiopia. While working there, the health team realized it would be possible to create an alternative community health initiative using the wide network of EECMY congregations. At a meeting with the church elders, a member of the health team invited a discussion about the priority needs of their community. Many problems were health-related, and the health team therefore proposed that they should train congregational members in information about health. They suggested that those whom they trained would work as unpaid deacons (assistants to church ministers). They would

Deacons would visit homes, sharing the gospel, praying, and talking about health problems with families.

Well done!
Dr Pat Nickson and the Contact team want to congratulate everyone involved in the EECMY’s health programme. Dr Nickson says that two features of this programme are especially important. First, the church, rather than the government, is responsible for the programme. This means that those coming forward for training were less likely to be motivated by money. Second, each health worker deals with only a very small community of people. Contacts can therefore be regular and personal.
visit homes in the locality sharing the gospel, praying, and talking about health problems with families. The elders greeted the idea positively and invited the health team to come and speak directly to the congregation. On this occasion, the health team described their proposal and asked for volunteers. Twenty-three members of the congregation came forward, but three later dropped out when they realized the work would be unpaid. This left 19 women and one man to take the 10-day training programme.

The volunteers decided which subjects should be covered and when the course should take place. Having completed the training, their church sent them out to visit homes in the Bodji area. They worked in pairs and were expected to visit 30-34 homes each month.

**Evaluation and follow-up**

A month after the programme began, the health coordination team brought the volunteer deacons together for follow-up. After prayers and a Bible study, a health team member asked the deacons to describe their experiences, and in particular to say how they had been received in the community. Most said that they had been welcomed and that the initiative was thoroughly appreciated. The deacons were then given an opportunity to share specific experiences and problems, and were asked which new health problem they would like to cover in a training session.

This meeting of feedback and refresher training became a monthly event. The deacons said that the new information gained during these meetings allowed them to answer more and more of the questions that were asked by the families. The event also gave the deacons an opportunity to discuss successes and difficulties. One of their concerns was that there were people who were too poor to visit the local clinic even when they needed urgent treatment.

The health team devised a system in which deacons could apply for free medical vouchers for the destitute.

The success of the initiative prompted other congregations in the area to organize a community health programme. Within a short period an additional 86 deacons had been trained to work in the Bodji area. Each of the four new groups followed the pattern of the monthly meetings. When necessary, the deacons organized additional sessions inviting particular members of the health team to provide answers on technical problems. For example, the deacons wanted information about immunization so that they could answer questions about the government vaccination programme. In some cases, questions about protecting wells and springs and mending pumps defeated the health team. They therefore asked experts in the church's development team to come and provide the answers.

The programme has continued to grow. Today, ECCMY has trained more than 300 deacons for this health information work. The impact of the programme has been considerable. More people know how to prevent common diseases, such as malaria, and to use simple remedies, such as oral rehydration therapy. Awareness of hygiene and sanitation has increased, and each month there is new evidence of steps being taken to make the community a cleaner place to be. The deacons play

*The deacons had been asked how wells and springs could be protected.*

*When wells and natural springs are protected, there is no risk that washing clothes nearby will contaminate the water supply.*
COMMUNITY-BASED

The sustainability of this programme depends on the resources of the Christian community of the church.

Setbacks
Inevitably, there have been setbacks. One difficulty has been that families belonging to religions other than Christianity sometimes refuse the deacons’ visits. Another disappointment has been that some deacons have dropped out. However, this has been mainly due to young women moving away for education or marriage. Few deacons have left to work in the private sector.

The sustainability of this programme depends on the resources of the Christian community of the church. At the formal level, EECMY’s health programme provides vital and continuous training and supervision. At an informal level, clergy and congregational members provide motivation for the deacons in their work. Perhaps even more important, the personal commitment of the deacons themselves contributes to the sustainability of the programme. The energy that their faith provides forms a vital component in the success and continuity of this valuable health initiative.

For more information, write to Mr Pat Nickson, Director, Institut Panarctique de Santé Communautaire (IPASC), c/o PO Box 21235, Nairobi, Kenya. IPASC is a training school for community-based health care in Goma, Zaire.

* “Injectors” charge for giving injections. Community health workers are often trained to give injections and are therefore in a particularly good position to offer this service privately. Injections are popular because they are perceived to have superior healing powers. In reality, injections are rarely effective in the treatment of common health problems. Worse, they are often unsafe, particularly in areas where they could be the source of hepatitis and HIV transmission.

Responding to a malaria epidemic
A malaria epidemic in Tchalia, western Ethiopia, was probably the result of two main factors. One was the building of a dam 10 kilometres outside the town which created a new breeding site for mosquitoes. The second was the opening of new private pharmacies selling incomplete courses of malaria treatment. The epidemic prompted several members of the Tchalia congregation to ask for training in the treatment of malaria. These “malaria health workers” then offered a daily treatment service. They had chloroquine, aspirin and primaquine (to reduce transmission) in accordance with government protocols. Patients who were not responding to treatment were promptly referred.

Within two years, the number of malaria cases had reduced drastically. There was also a decline in the number of drug-resistant and cerebral malaria cases treated in the clinic. The success was partly due to government efforts in providing mass treatment and insecticide spraying programmes. However, the fact that the church malaria workers could provide convenient, daily treatment (and thus prevent serious, drug-resistant cases developing) was also considered important. In addition, the church health workers had administered primaquine to patients which helped to reduce the spread of the disease.

Patients using the services of the church health workers paid for their treatment but the costs were low compared with what they would have paid at the local pharmacy. On the other hand, the charges more than covered the cost of replacing supplies. The small profit arising was therefore shared between the malaria workers and the congregation which had paid for the training course.
DISCOVERING A HEALTHY, MEANINGFUL LIFE

For Rev Marta Benavides, a Baptist Minister in Central America, believes that achieving better and sustainable health for her people means drawing on biblical messages and bringing attention to the root causes of much illness and physical suffering. Her programme is not financed by her church, which she considers to be an important factor for its sustainability.

When I was a teenager, I wanted to be a doctor. I was concerned about the great suffering of my sisters and brothers, the people of El Salvador. One of the major causes of this suffering was sickness, malnutrition and hunger. Discovered recently that El Salvador was considered to be part of what the United Nations refers to as the "Hunger Belt". I am angry that such a thing could be true today.

In the developed world there are communities, mostly of colour, where similar conditions exist, and where infant mortality continues to increase. Meanwhile, those who live better materially find themselves suffering stress, high blood pressure, alcoholism and workaholism. Such conditions are clearly related to industrialisation and the rapid pace of modern life. But people everywhere face stress.

Only a few weeks ago, I visited a peasant community who had been relocated by the government two years previously in the aftermath of the war in El Salvador. At a women's group meeting, I spoke to a grandmother who said she could no longer bear her back pain. She had been suffering for days. As we talked about it, we discovered that she was suffering from stress. Even in this remote community, too much work and worry, and too little rest and laughter, resulted in stress. She was worried because the government had announced recently that those working in the cooperatives created at the time of the 1992 peace agreements should pay back their loans within a year or face a 6% compound interest increase. Still trying to settle following their relocation, families were building homes and trying to survive. They were not in a position to repay their loans. We discussed the situation and began a group process to understand the socio-economic conditions that was causing the stress. We planned a programme of "detoxification" through massage, rest, walks, teas, music, aromas, and so on.
laughter, and cooperative work with family and community. The cooperative also set up a commission to take part in lobbying efforts and demonstrations against the policy. This was a process of “decolonization” for us, working to improve our mental and spiritual health.

A plan for action
Can we do anything to help ourselves and others to live a happy, healthy and meaningful life? Can we trust in Jesus’ declaration that He came that we might live and live in abundance (John 10:10)? I believe that this is one of the pillars of Jesus’ message because each of us can make intentional, mindful choices and thus collectively create the world in which we live. Even when the “reality” of the globalized market is destroying nature, exploiting people, and bringing suffering, sickness and death, we can act for transformation.

First, we must affirm what we feel called to do through the lives we live and the choices we make. We need to find new ways to shape rather than change the world. This will provide a sense of wholeness and wellness. We must practice these understandings daily, personally and in community. The ideology of globalization is towards competition and individualism, consumption and achievement, and exploitation of people and resources. The process is pushed as far as possible taking just enough care enough not to create a crisis. Our response must be to live mindful lives, showing respect towards people and the planet and taking care of how and why and for what reason we live. We must decide to live simple lives, but this does not mean that we live simply. We need to share knowledge and resources with each other, create communal ways, and work together to solve conflicts. We must try to prevent problems rather than either cure or correct them. But when we make mistakes, we must quickly put them right rather than promote guilt and deception. We should cultivate our spirit to practise forgiveness, friendship and cooperation, and celebration of life. Then, we will understand what it means to live and walk in beauty by choosing it and doing it. We should honour everyone, and make sure that young and old are taken into account, giving babies and people who are ill special care. We should help to create community, and live shared lives, eating balanced and well-prepared meals. We should teach all these things to our children. This is the sustainability and transformation that must be our practice if we are to have the experience of life in abundance.

Tools for sustainability
How practically can we carry this out? In El Salvador, we are working on how to achieve sustainability after the experience of war. We are not defeated. We have turned to indigenous ways to heal ourselves and to heal nature. We are rediscovering and taking care of our medicinal plants and animals – learning how to prepare these medicines, and promoting the practice of prevention in everything we do. We are teaching how our food can be our medicine, and how our medicine can be our food. We learn about nutrition and that an important part of nutrition is adequate rest, including during the day. Our times of rest and recreation give us the opportunity to put our ideas into practice.

We are starting to use indigenous ways...
to restore the earth and conserve water. These methods were left behind during the "green revolution" of the 1960s. We plant trees and make natural fertilizers and pesticides. We are learning how to resolve our conflicts and difficult relationships with others at home, in the community and at work. We see the importance of practising governance and citizenship, so that we contribute to durable peace. We see all these as aspects of mental and spiritual health, and as expressions of love. We have programmes for children, youth-to-youth, women, as well as indigenous support groups. There are intentional inter-generational and intercultural exchanges. In this way we bring together rural and urban people, academics and various religious groups.

This is an ecumenical endeavour though it is not sustained by the church. For this reason, those of us who are involved in it call it a process of sustainability and transformation for a durable peace.

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RESOURCES

This list includes names and addresses of some useful publications about sustainability.

Ecumenical Church Loan Fund (ECLOF)
Based in World Council of Churches, ECLOF grants loans firstly to churches or to institutions that promote the life of the church in cases where other affordable credit sources are not available, and secondly to foster human development, socio-economic justice and self-reliance for alleviation of poverty. ECLOF has projects in 39 countries of Africa, Asia, Pacific, Europe, Caribbean, Latin America and Middle East. Loan category definitions include "social services" (church multi-purpose centres, homes for drug addicts, alcoholics, etc) and "development capital" (hospitals, clinics, dispensaries, drinking water wells, paramedical training and facilities, etc). For more information, write to ECLOF, Ecumenical Centre, PO Box 2100, 1211 Geneva 2, Switzerland. Tel: +41 22 791 6312. Fax: +41 22 791 0361. E-mail: ECLOF@info.wcc-coe.org

Sustainability and health sector development
Two working papers, *Health financing and sustainability* and *A review and analysis of five country case studies*, summarise the findings from the Save the Children's Fund three-year research programme on the sustainability of health sector development using data gathered in five countries (Uganda, Ghana, Pakistan, Nepal and Vietnam). Both papers are available at £1.95 each (plus 15% for postage and packing) from Publication Sales, Save the Children, 17 Grove Lane, London SE5 8RD, UK. Tel: +44 171 703 5400. Fax: +44 171 703 2278.

Beyond the Year 2000: Crucial links and partners
Report of a World Council of Churches/International Federation of Red Cross and Red Crescent Societies meeting in Harare in October 1995. Copies available from CMC - Churches' Action for Health, WCC, PO Box 2100, 1211 Geneva 2, Switzerland.

The new world of microenterprise finance
Citing cases in Asia, Africa and Latin America, this book provides information about recent innovations and is excellent reference for designing future programmes. It makes the case for creating sustainable and viable financial institutions which offer the poor greater access to financial services. Price £15.95. Orders to Intermediate Technology Publications Ltd, Unit 25, Longmead, Shaftesbury, Dorset SP7 8PL, UK. Fax: +44 171 436 2013. ISBN 1 85339 247 2.

Some back issues of *Contact* on related themes include *Contact 99* (October 1987) on *Financing primary health care programmes: Can they be self-sufficient?*. *Contact 141* (February-March 1995) *Financing health care: Strengthening partnerships to protect the poor*, and *Contact 146* (December 1995 - January 1996) *Health financing crisis: Can communities afford to pay?*
A SUSTAINABLE MINISTRY
MATTHEW 17.14-21 AND ACTS 14.21-23

The following reflection has been prepared by
Rev Simon Oxley,
WCC executive secretary for education.

We know that readers of Contact work in a wide variety of situations. Looking through the articles in this edition, which account of sustainability most closely reflects your own experience? What are the factors which make sustainability an important issue for you? What, in your situation, encourages you for the future of church-related health care? What threatens it?

The issue of sustainability is usually raised by the threatened or actual withdrawal of resources, especially human resources. Our Bible Study looks at two passages which relate to that kind of situation.

The twelve disciples witnessed Jesus’ ministry of healing and teaching first hand. They walked the roads in conversation with him. They watched and listened as Jesus encountered people. The stories about Jesus in the Gospels, which we can only read, were real experiences for them. However, sometimes it seemed that even though they had experienced much, they had learnt little.

Read Matthew 17.14-21
Try to imagine that you are one of the disciples waiting for Jesus to return from the mountain with Peter, James and John. A father approaches you, concerned about his epileptic son. Normally you would take him over to Jesus but Jesus is not there. How would you feel?

Perhaps those disciples did not expect that they would have to do the work of Jesus without his physical presence with them. They expressed surprise that they were not able to do what Jesus did. Jesus’ answer encourages them to be ready to continue his ministry.

How important for sustainability is faith or commitment? Look again at the article by Rev Marta Benavides and think what you would want to say. From the accounts in Acts, we can trace St Paul’s missionary journeys as he moved from place to place spreading the gospel and strengthening the churches. Whether he spent days or weeks in a particular place, the effectiveness of his ministry needed to be seen in the continuing work of the Christian community and not just in the excitement generated by his visit at the time.

Read Acts 14.21-23
Paul not only encouraged individual Christians, he helped them develop structures or styles of leadership to take the ministry of each congregation forward. Even though the passage does not tell us, we could presume that Paul would have helped to equip or train these elders for their role.

The motivation of individuals may be important for sustainability but what is the role of decision making and leadership structures? How important is training and equipping the people involved? What does the article by Dr Kofi Asante on the study on sustainability of church health care and that by Dr Pat Nickson on the work of deacons in Ethiopia suggest?

People of different faiths and of no particular faith participate in discussions about sustainability. What does the Christian dimension of our work bring to our understanding of sustainability?
TUBERCULOSIS - A GLOBAL EMERGENCY

TB has become a crisis of alarming proportions. Despite effective treatment for non drug-resistant cases, the disease is spreading rapidly. Should Christian organizations like the World Council of Churches be doing more before drug-resistant tuberculosis makes the disease unconquerable?

Until recently, there was a commonly held view that tuberculosis, the Great White Plague of yesteryear, was virtually conquered. Sadly, the widespread loss of interest generated by this misperception led to such a resurgence of the disease that, in 1993, the World Health Organization (WHO) took the unprecedented step of declaring it a global emergency.

It may well be asked why tuberculosis should be singled out for special attention when the developing countries are faced with so many major health problems. One compelling reason is the sheer magnitude of the suffering caused by it. There are more cases of tuberculosis in the world today than at any time in the past. Between eight and 10 million people develop the disease each year and three million die. Tuberculosis is responsible for one in seven adult deaths and one in four preventable adult deaths. Among children, it is second only to acute respiratory and intestinal infections as a cause of death. Around 95% of all cases, and 98% of deaths, occur in the developing nations. The problem is currently fuelled by the HIV/AIDS pandemic, which renders those infected by the tuberculosis bacillus much more likely to develop active tuberculosis, and by the increasing incidence of drug-resistant forms of the disease.

**Effective treatment**

In the absence of drug resistance, tuberculosis is among the most effective, and cost effective, of all chronic infections to treat successfully. A course of drugs costs around US$15. Unfortunately, even this cost is far too high for a country such as Uganda which can only allocate US$2.50 per person to health care while faced with repayments on international loans of US$30 per person. Cancellation of the global debt to mark the Millennium, as advocated by Jubilee 2000 and other organizations, would be of enormous help, provided the money saved would then be directed to health care. It is here that religious leaders have a key role to play. WHO has stated that:
Religious leaders must use their stature to address inequities in health care for poor people. Since there is a cure for tuberculosis—a cure that is not being fully used—tuberculosis is no longer a medical epidemic, but an epidemic of injustice. Religious organizations may also be able to facilitate public health education and to shed light on the various local belief systems and stigmatising factors that often raise serious barriers to case finding and effective therapy.

Even where drugs are available, the failure rate of therapy is very high as few patients complete the course of treatment. The patient is usually blamed for such non-compliance but it is almost always the health services that are at fault by failing to provide caring supervision for those being treated. WHO has stressed that, for success, all medication should be given under supervision—the so-called Directly Observed Treatment, Short-course (DOTS) strategy. The efficacy of this strategy has recently been demonstrated in a study in Bangladesh, which also illustrated the key role of community health workers recruited from village organizations that are involved in other aspects of health care, education and improvement of socio-economic conditions. It also stressed the importance of a “therapeutic encounter” based on a partnership of equals rather than on the Western authoritarian approach. The implementation of the DOTS strategy therefore calls for a revolution of thinking in many aspects of health care provision, with the adoption of a much more holistic approach.

At present, however, only 10% of patients with tuberculosis receive DOTS. Surprisingly, several wealthy countries in the European Union have not yet adopted this strategy. Present WHO estimates suggest that the annual number of deaths from tuberculosis could rise to four million by the year 2004. However, with proper funding, amounting to no more than the cost of one less jet fighter aeroplane each year, this number could be cut to 1.6 million. Director of WHO’s Global TB Programme, Dr Arata Kochi says: “Tuberculosis is one of the world’s most neglected health crises. In spite of its alarming danger, surprisingly little action has been taken to address the epidemic ... Is it possible that no-one really cares whether 30 million people will die in the next decade from TB? How can TB be such a neglected priority when it is one of the most cost-effective adult diseases to treat? ... Can we comprehend the magnitude of this injustice?”

At the conference in London at which the WHO declared tuberculosis a global emergency, a list of “Ten Commitments” required for tuberculosis control was drawn up. Nine of these relate directly to control programmes but the tenth relates to the fight against poverty, demanding “... a much wider commitment internationally to reducing it, economic inequalities which allow tuberculosis to remain such a preventable scourge all over the world”. There is therefore a very great need for Christian organizations to address the growing problem of tuberculosis so that the human race may be freed from a great but unnecessary burden of suffering.

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Further information on tuberculosis and its control can be obtained from Kraig Klaudt, Public Affairs and Advocacy Officer, Global Tuberculosis Programme, World Health Organization, CH-1211 Geneva 27, Switzerland and from the International Union Against Tuberculosis and Lung Disease, 68 Boulevard Saint Michel, 75006 Paris, France.
USEFUL PUBLICATIONS

Poverty and health: Reaping a richer harvest

Headlines in newspapers around the world are making references to the biggest threat to health today - poverty. World leaders, UN organizations and the World Bank are all saying that we must do something about it. Few, however, are actually giving us tools to take action. One exception is Marie-Thérèse Feuerstein who has worked for many years in the area of health and community development. In her book, she brings together both experiences from communities as well as several years of research in the area of poverty and the struggle against it. She is also author of Partners in Evaluation and Turning the Tide.

Her new book is unique in that it tackles many of the complex dimensions of poverty and its effects on health, and also offers readers many ideas and suggestions for addressing both root causes and the consequences of poverty. Although global issues affecting health are mentioned, the emphasis of the book is on activities which can be developed at local/district level together with communities. Many examples of innovative feasible community activities aimed at alleviating poverty are shared. Written in a way that will appeal to a broad audience, the book is a well-illustrated practical guide for those wishing to increase awareness and engage communities, policy makers and health professionals in the fight against poverty.

The book offers readers an in-depth analysis of the concept of poverty, which enables them to become familiar with terms, issues and definitions such as poverty analysis, feminization of poverty, poverty indices, and poverty lines. Practical advice on how to construct a poverty profile in a participatory way is described and suggestions are made on how to use the information gathered to draw the attention of professionals or policy makers.

In order to further understand and address the broader issues of poverty, the book analyses policies which may affect both the human life cycle in terms of health, as well as the policies regulating development. The link is made between needs assessment, policy development and planning, and practical suggestions are proposed to strengthen the collaboration between NGOs and government. Focus is also given to planning financial services and credit for the poor. Financing mechanisms of health services such as user fees and how they affect the poor are discussed and several alternative community financing schemes presented. Finally, the issues of designing, monitoring and evaluating health care are highlighted.

Reviewed by Margareta Sköld

The book is published by Macmillan Education Limited, and is also available from TALC, PO Box 49, St Albans, Herts, AL1 5TX, UK at a price: £6.90 per copy plus £3.75 airmail or £2.75 surface postage and packing.

LETTERS

A spirit for the street

The series of articles on Spirituality and health in Contact June-July 1997 strengthened our belief that the comprehensive requirements of patients/clients have to be taken care of while dealing with body-mind problems, and that no single or standard method is applicable for all.

Our views are largely acquired through experience over the past seven years in dealing with drug abusers and alcoholics from different walks of life, from the affluent to street boys. It prompted us to develop a treatment model which is acceptable, suitable and effective - result-wise as well as cost-wise. Our "Hill Top Camp" was designed with the help of street educators, counsellors, psychiatrists, educationalists, youth workers and so on. It enables street boys and working children to understand the hazards they face in life, and encourages them to adopt behaviour that does not harm their body and mind but rather helps them to achieve their goals. We plan to conduct Hill Top Camps at quarterly intervals for 15 boys at a time.

Jayakumar Daniel
Turning Point
Madras, India

Contact nº158 - December 1997 - January 1998
More on "Networking"
Dr Rajaratnam Abel, Head of RUHSA Department, Christian Medical College and Hospital, Tamil Nadu, India contributed a useful article to Contact on networking. Unfortunately, it arrived too late for publication in our issue. However, if readers would like to receive a copy, please write to Contact, World Council of Churches, PO Box 2100, 1211 Geneva 2, Switzerland.

HIV and the infant formula comeback?
In 1981, the WHO Code on Breast-milk Substitutes banned the donation of free supplies of infant formula. Since then, studies have shown that transmission of HIV infection from mother to child is usually higher in breastfed babies than in bottle-fed infants. According to the World Health Organization, approximately one in five babies born to HIV-positive mothers becomes infected around delivery and one in seven during the breastfeeding period. In response to this risk, the government in Thailand has decided to give HIV-positive mothers free infant formula and to encourage them not to breastfeed. International Baby Food Action Network (IBFAN) observers say that as a result of this decision (creating a new justification for the promotion of infant formula), the quantities of free supplies being made available in Thailand are expanding disproportionately. Although approximately 2% of mothers test HIV-positive in Thailand, enough free supplies are donated to some hospitals to feed 25% of births, according to reports from UNICEF Thailand. Will this practice of donations of free supplies beyond needs lead to the return of routine bottle feeding in hospitals?

Bossey programme 1998
A leaflet about the programme of the Graduate School of Ecumenical Study at the Ecumenical Institute, Bossey, Switzerland during 1998 is now available. For a copy, write to Ecumenical Institute, Château de Bossey (Vaud), CH-1298 Céligny, Switzerland. Tel: 41 22 960 93 33. Fax: 41 22 776 01 69. e-mail: sr@wcc-coe.org

"Peace I give you"
This Christmas greeting comes from all of us at CMC - Church's Action for Health.
The design is by the eldest daughter of Dr. Philip Ahazinge of the Christian Health Association of Ghana.
She was 10 years old when Dr. Ahazinge sent it to us last year.
We really appreciated it, and kept it to share with Contact readers this Christmas.

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 16,000.

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