GLOBALIZATION: WHAT DOES IT MEAN FOR HEALTH?

2 Editorial
3 Introduction
   What does globalization mean for health?
6 National strategy
   Nicaragua: Health in a global era
11 Hospital care
   Challenges to the healing ministry
14 Community-based initiatives
   What does "market forces" economics mean for the poor?
16 Resources
17 Bible study
8 List of back issues of Contact
10 Networking - Useful publications, announcements
From the very beginning, the Christian Medical Commission (CMC), now renamed CMC-Churches’ Action for Health, has emphasized the need to promote the health of all. A major theme has been to seek an alternative to expensive and sophisticated health care systems which are affordable only to a rich minority. In particular, CMC has challenged the churches to open wide the doors of their hospitals and health centres to poor communities.

During the 1970s, the work of the CMC contributed to a shift in thinking at the World Health Organization (WHO). Its pioneers played a crucial role in the Alma Ata Conference in 1978 which defined the target of “Health for All by the Year 2000” as well as the Primary Health Care (PHC) strategy. At the end of the Alma Ata meeting, governments throughout the world committed themselves to providing the services which would meet the needs of the majority.

Sadly, moves to undermine the adoption of the PHC strategy began soon after the meeting was over. The concept was broken up into technical components so that it evolved into a much less effective alternative. At about the same time, debts in the South became an increasing burden forcing governments to accept Structural Adjustment Programmes (SAPs) in return for International Monetary Fund (IMF) loans. These programmes, which form part of the process of globalization, have had serious effects on health.

The term “globalization” itself is still relatively new. It refers to a process in which there is increasing reliance on “market forces” economics and rapid improvements in communications. The result has been to allow international financial and economic institutions, such as IMF, the World Bank and the World Trade Organization, to behave as unquestioned patrons of a whole new set of global rules and regulations. The dramatic and destructive effects of the policies of globalization are plain to see all around us. They have led to an unprecedented concentration of power and wealth in the hands of a small minority, and a widening of the gap between rich and poor. The effects on health are serious.

The introductory article of this issue defines how the process of globalization is affecting health. The second article, a case study of Nicaragua, tells the story of how neo-liberal belief in “market forces” economics has destroyed an effective primary health care programme. Health care in Nicaragua has become once again the privilege of the rich.

The article by Dr Sara Bhattacharji provides a mission hospital perspective. She believes an alternative, “upsidedown” model needs to be created so that we learn to put people at the centre instead of profits. Sierra Leonean Mrs Marion Morgan advocates for community-based health care initiatives which, though threatened by globalization, have brought real success to church health programmes. She offers suggestions on how churches and non-governmental organizations (NGOs) can help break the dominance of the globalized economy, especially as it affects health.

The future is certainly not without hope. Models in health development exist, and communication technology is increasingly available to help put the strategies into practice. Many people around the world are working on new orientations with which to confront the economic and political project of globalization. This issue of Contact aims to highlight successes as well as difficulties, and to provide a reminder of the vitality and validity of the alternatives to globalization in health development.

Dr Konrad Raiser
General Secretary
World Council of Churches
WHAT DOES GLOBALIZATION MEAN FOR HEALTH?

The impact of the globalization has harmed the health of the poor.

Contact editor Diana Smith describes how the policies affect health and provides some of the evidence.

Everyone agrees that the process of globalization has made the gap between rich and poor greater, both within and between countries. This factor alone has had serious consequences for the health of the poor. In India, for example, while the elite and the middle class have grown over the past decade, malnutrition among the children of the poor has not improved, and may have worsened. In sub-Saharan Africa, one of the poorest regions of the world, declining economic conditions have resulted in mortality rates actually rising in some countries. This sad development follows several decades in which mortality rates had declined steadily worldwide.

The ideology of globalization

The ideology associated with globalization is that of “market forces” economics. With the collapse of the socialist system in the former Soviet bloc, belief that the “invisible hand” of the market mechanism must be allowed to operate unimpeded received a tremendous boost. Government action and control is now seen as the cause of inflation, debt and economic recession, while the private sector is promoted as the creator of efficiency and growth. Global and national thinking and policy is therefore oriented towards privatization and liberalization, and subsidization, regulation and protection of national enterprise are frowned upon. Unburdened by government taxes, intervention and regulations, the argument goes, a competitive private sector will stimulate trade and attract foreign investment.

In many countries, governments have willingly adopted the ideology of globalization. In fact, elites often benefit from increased flows of trade, investment and finance associated with liberalization policies. However, in many poorer countries, “market forces”...
Policies have been introduced as part of structural adjustment programmes. Declining international assistance and increasing debt forced many governments to accept conditions imposed by the World Bank in return for loans from the International Monetary Fund. At the same time, all countries face new international trade rules and regulations. These are set by the World Trade Organization in discussions dominated by the interests of the transnational corporations.

How do the policies associated with globalization affect the health sector?

First, reduced overall government spending means government spending on health falls. Since governments are the main providers of mother and child health services, AIDS prevention work, leprosy control programmes and anti-smoking campaigns, these and other primary health care initiatives are particularly badly affected. In government services which remain after the cuts, user charges are often introduced. This method of introducing the market mechanism into the provision of health care obviously makes services less available to the poor.

The privatization of health and hospital services also makes the poor suffer as services become more oriented towards those who can pay. In addition, essential drug policies, which aim to make necessary pharmaceuticals available to all at an affordable price, are threatened by increasingly liberal policies towards pharmaceutical companies. Finally, increasing unemployment and poverty add to the nation's health problems by creating extra demands on reduced government services.

Policies in practice

Considerable evidence exists that public health services have been reduced as a result of the policies associated with globalization. For example, in China today, 15,000 villages are without clinics or regular health workers. Experts believe that in some cases this lack of provision is directly related health system reforms. Dr Li Enlin, director of Amity Medical Directorate in Beijing, says health workers have left their villages and clinics have been abandoned since the opening up of the private health market. Similarly, an in-depth study in Zimbabwe on the impact of country's structural adjustment programme has revealed cuts in public health services and a decline in the use of existing services due to increased user charges.

User charges are introduced in an effort both to reduce government spending and to enhance the working of the market mechanism in health. In theory, the charges increase efficiency and allow health costs to be shared with those who can afford to pay. A system usually exists which allows the poor to apply for the right to free services. In practice, however, applying for clearance to local committees is a tedious process. Poor families ultimately decide either to do without the services or to pay the charges that they can ill afford.

Even where government policy does not stipulate that patients should be charged fees, tight government health budgets result in the introduction of informal charging. As government funds and supplies to hospitals become more sporadic, health workers may have little option but to begin charging patients for drugs and services. Evidence of the introduction of informal charging exists in several countries of Africa and eastern Europe.
Privatization and the development of the private health sector may also result in relatively fewer health promotion services. Preventive and promotional services are traditionally the domain of the government sector. In Zimbabwe, the structural adjustment programme led to a fall in child immunization.

Perhaps even more worrying is that privatized services mean more health providers are directed by the profit motive. A recent meeting of Health Action International was told that private health workers in Uganda were feeling obliged to provide injections to demanding patients for fear of losing customers. Prescriptions for the most effective, safe and economical drugs were rare.

More than 120 countries worldwide rely on essential drugs lists, but implementation of related policy requires government involvement and strict control and regulation of the pharmaceutical companies. Reduced government intervention associated with the opening up of markets to foreign investment makes enforcement of essential drugs policies more difficult. It may also threaten local manufacture of generic drugs. In Lesotho, health experts feared that liberalization policies would result in a foreign take-over of the country's drug manufacturing enterprise, and a reorientation of production away from generics and towards drugs offering higher profit margins.

Secondly, the job insecurity and unemployment created by globalization presents its own health problems. According to UNCTAD's 1997 Trade and Development Report, almost all countries that have undertaken rapid trade liberalization have seen unemployment grow and wages drop for unskilled workers. For many people, unemployment means living in poverty, and no work means no access to health services. Low-paid health workers often lose their jobs as governments cut health spending. Globalization may bring in new industry but benefits to employees are often restricted by "no strike" clauses and lack of government regulation on working conditions. Everywhere, unemployment and poverty are associated with declining living conditions and a rising incidence of mental illness, alcoholism, tuberculosis and sexually-transmitted diseases. These additional health burdens weigh heavily on reduced government services.

Hope for the future
Nevertheless, globalization has brought with it important communication technology which is helping to share a wide range of health information rapidly. Of particular importance in the struggle for health for all is the use of this technology by groups monitoring unethical marketing practices in pharmaceuticals, pesticides and powdered baby-milk. By providing evidence to governments and international trade negotiations, some abuse of power by transnational corporations may be averted.

At the same time, there are signs of a change in thinking at the international level. The World Health Organization has launched a revival of its "Health for All" strategy, and is involving nongovernmental organizations in discussions (see page 16). This development may help to strengthen the relative position of WHO against the power of the World Bank, IMF and World Trade Organization. At the same time, the World Bank is taking a new line on the role of governments. Its latest World Development Report makes much of the need for an "effective state" with policies and programmes which "ensure the benefits of market-led growth are shared, particularly through investments in basic education and health". Maybe, at last, thinking is changing and more emphasis will be given to health and the quality of people's lives.
NICARAGUA: HEALTH IN A GLOBAL ERA

Health care in Nicaragua provides an extreme example of the effects of globalization on health. Ms Maria Hamlin Zuniga, who is global coordinator of the International People's Health Council, tells how her country has been drawn into structural adjustment programmes and privatization, and describes the effects of the policy changes on health.

Nicaragua, a small, Central American country with a population of 4.2 million people, is one of the poorest countries in Latin America, second only to Haiti. It is also one of the most highly indebted, with outstanding loans of six times the value of the Gross National Product. Despite all this, during the ten years of the 1980s, the commitment of the Nicaraguan Government to the Alma Ata Declaration demonstrated the success of the principles of primary health care (PHC).

The revolutionary period
In 1979, the Sandinista Liberation Front triumphed over the 40-year dictatorship of the Somoza dynasty. The new revolutionary government defined health as a right for all people, and as the responsibility of the state and the organized population. During the decade of the 1980s, a National Unified Health System provided free and universal health care to broad sectors of the population. Both the commitment to PHC and the effectiveness of the community-based health campaigns were praised by the World Health Organization. Through massive immunization and education campaigns, community volunteers changed the concept of health for a few in the elite to health for all. New facilities were constructed, personnel were trained and an essential drug policy established. As a result, polio was eradicated and health indicators, including child mortality, improved dramatically.

The Nicaraguan experience during the 1980s provided a model of health and development to which others could aspire. However, it was not allowed to prosper. During the entire period, the Nicaragua Revolution was subjected to a devastating counter-revolutionary war. This armed intervention was supported financially and ideologically by the government of the United States of America. Although there was a growing need for funds for defence, the Nicaraguan government continued to give priority to social programmes — health, education, and social welfare. Maintaining the services was not easy due to delib-
erate attacks on health facilities and schools and against health and education workers.

The Chamorro period
With the people worn down by the experience of armed conflict, the elections in 1990 resulted in the defeat of the Sandinista Revolutionary Government. It was replaced by a broad, coalition government led by Violeta Chamorro de Barrios. Her government, which promised an end to the war and a restoration of economic stability, was supported by the US and other countries interested in bringing Nicaragua into the process of globalization. The new Nicaraguan government’s economic office was committed to the implementation of neo-liberal economic policies defined by the World Bank and the International Monetary Fund (IMF).

The constitution of Nicaragua states that the Nicaraguan people have the right to health and that the basic conditions for health promotion, protection and rehabilitation must be established. The Chamorro government’s National Health Policy, elaborated in 1993, recognized health as a basic right of the population and stated that people should have access to integral health care. However, the policy stressed the opportunity for people to select their health services, opening the sector to private provision of health care.

The so-called “modernization” of the health sector in Nicaragua was financed by the World Bank, the Norwegian government and the Nicaraguan government itself. It was characterized by decentralization and reorganization, a proposal for a new Public Health law, and an emphasis on Primary Health Care for the extension of services to the whole population. It also included a programme to improve the quality of care, the participation of the community, and the modernization of information systems.

The Chamorro government began to initiate a wide-ranging process of transformation of the National Health System with a redefinition of the health model. This included the decentralization of services to the municipal level and the search for alternative financial support of the public sector, including fees for service. There was an enormous push in favour of both the private sector and an optional social security system for those who can afford to pay. Rapidly, health was transformed from “a right for all people” into “a market commodity” which was no different from any other.

The present period
Elections in October 1996 brought Dr Arnoldo Aleman, leader of the Liberal Alliance, to power. He belongs to the Somocista, followers of Somoza, the military dictator overthrown by the Sandinistas in 1979. Most of the new cabinet posts have been filled by older (even quite elderly) Liberal Alliance members, many without the necessary experience to carry out their work in the new economic scenario. The new health minister has called for the resignation of the directors of the ministerial departments, as well as the directors of 27 hospitals and the 17 SILAIS (Regional integrated health systems). He has also disbanded the National Health Council which had a broad participation of different sectors of civil society. Most of the personnel being asked to leave are fairly young, well-educated persons who were technically prepared and often recent graduates of the masters programme in the country’s School of Public Health.

During the 1990s, the World Bank, the World Health Organization and donor nations made considerable investments in the health sector. These
There is particular concern on the part of personnel working both in government and non-governmental organizations (NGOs) with respect to the position of the government on women’s health and reproductive rights. One concern relates to the fact that the education minister is a member of Opus Dei, a conservative right-wing group within the Catholic Church. Like other members of this group, the minister is against the promotion of gender issues on the grounds that it is "feminist". Such a position is in direct opposition to that of the progressive women’s movement and the Platform for Action of both the Cairo and Beijing UN Conferences. In essence, Opus Dei is against women’s rights, children’s rights and older peoples’ rights (the struggle against ageism) and is in favour of the morals of the traditional family hierarchy, including anti-family planning and anti-divorce measures.

**Structural adjustment**

The implementation of the Structural Adjustment Programme (SAP) in 1990, with the subsequent negotiation of the Extended Structural Adjustment Facility (ESAF), was designed to reduce the extremely high external debt.

The effect of the SAP has been dramatic in all spheres, especially in health and education. Subsidies have been eliminated from services and products of primary necessity. The extent to which health services reach the population has reduced dramatically, and preventive initiatives such as "complementary food" programmes have been abandoned. Coverage in women’s prevention and promotion programmes, such as "Uterine Cervical Cancer Control" for example, is known to have decreased, and fewer women receive prenatal care.

Declining services are bound to adversely affect maternal mortality. According to registries in Ministry of Health, maternal mortality in Nicaragua’s Regional 1 is extremely high: one in every 66 women of childbearing age dies during pregnancy, delivery or the postpartum period. At national level the official maternal mortality ratio ranges...
from 159 to 300 deaths per 100,000 live births, according to Nicaragua’s Women’s Health Network. However, there is under reporting of deaths due to clandestine abortion. An unwillingness to admit that illicit abortion exists results in these deaths being reported as accidental pesticide intoxication or a malaria treatment overdose.

The globalization process
As well as the specific effects of structural adjustment, more general consequences of globalization, such as job insecurity and rising unemployment among the unskilled, also affect health. For example, morbidity and mortality due to violence have been increasing. Recent studies show that 60% of women in Nicaragua have suffered physical abuse, usually from their partners or close family members. According to police reports, the common denominators of this kind of violence are unemployment and the presence of alcohol.

Suicide has also become much more common. National police registers show a total of 176 suicides in 1996, equivalent to an average of 14.6 per month and representing a 33% increase in suicide compared with 1995. In the first half of 1997, 278 suicides were recorded. Most were male (135 compared with 45 female), and 124 cases were in persons under 30 years of age. The principal causes of suicide related to depressive-emotional causes and economic problems.

The economic crisis and prevailing unemployment have also caused the phenomenon of child labour to grow. More than 400,000 children and adolescents in Nicaragua are workers. The government has no defined policy on this issue. By 1996, it was estimated that 30,000 children were on the streets in different cities where they were exposed to grave risks: violence, mistreatment, sexual aggression and drug addiction. The proposed response is to remove the children to detention centres. A return to these policies would mean treating children as the wrongdoers rather than meeting their needs as outlined in the Convention for the Rights of Children to which Nicaragua is a signatory.

The challenge for civil society
What is now needed is for civil society, particularly the social movements, to participate in drafting Nicaraguan social and economic policies. Already, they are using the Platforms of Action developed at UN conferences since 1990 to demand compliance on the basis of these international agreements. Women and men are also discussing alternative development plans and designing policy proposals. Activity covers a variety of fields including environment, education, health, sustainable development, food security, and population.

Recently, in a widely publicized document, the United Nations Development Programme (UNDP) proposed that the new ESAF should take into account the extreme poverty and marginalization of over 80% of the Nicaraguan people. It was suggested that the ESAF should incorporate social adjustment measures as well defining financial objectives so that the dramatic deterioration of living conditions and the profoundly unequal distribution of wealth could be corrected.

As the Nicaraguan government prepares to sign a new ESAF agreement, the people are demanding the opportunity to participate actively in the decision-making process. A variety of dialogues, forums and lobbying activities at the national and international

People sitting in front of their house in Esteli, Nicaragua.
breastfeeding promotion and AIDS. While the Ministry has not revived these Commissions at the national level, there are functional commissions at the departmental (provincial) levels in some areas of the country.

Networking, especially among women, has been significant. For example, the Women's Health Network includes 54 different centres and groups providing educational and health care, and the Women's Network Against Violence involves nearly 200 groups around the country. The Initiative for the Citizenship of Women is actively involving women from diverse sectors of society in programmes of education and advocacy around issues related to social and economic conditions, structural adjustment, human rights, as well as in developing proposals to generate productive employment.

Thus, in spite of the major setbacks since the health achievements of the Sandinista Revolutionary Government, the resilient people of Nicaragua continue to organize and struggle for a society that is supportive of health and a quality of life for all.

Maria Hamlin Zuniga, MPH, is co-founder and director of CISAS, Centro de Informacion y Salud (Center for Information and Advisory Services in Health), Apartado Postal 3367, Managua, Nicaragua. Fax: 505 2 24099. E-mail: cisas@bw.com.ni. She is an activist and coordinator of the Regional Committee for Community Health in Central America and Mexico, as well as global coordinator of the International People's Health Council.

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**Health and development trends in Nicaragua**

- The percentage of households living in poverty has increased from 63% in 1985 to 75% in 1995/6, according to FIDLEG at the Nicaraguan Economic Research Center.
- Gross National Product (GNP) per capita has fallen from US$467 in 1990 to US$438 in 1996.
- Health expenditure has fallen from 5% of GNP in 1989 to 3.9% in 1993.
- Education expenditure has fallen from US$20.5 in 1990 to US$18.50 in 1995.
- Illiteracy among young people under 15 years has increased from 23% in 1990 to 30% in 1995.
CHALLENGES TO THE HEALING MINISTRY

Seeing the effects of globalization on health from a hospital setting, Dr Sara Bhattacharji, professor of community health at the Christian Medical College in Vellore, India, calls for an "upside-down model" to challenge current thinking and present a more positive alternative.

I work in the 80-bed Chad Hospital serving a community-based programme covering about 200,000 people. It is comparable to mission hospitals in other parts of India. At the same time, I am a staff member of one of India's largest teaching hospitals. As a result, I see all the latest developments in the technology of medicine. Today, both mission-type hospitals and major teaching hospitals alike are facing many crises as a result not only of the burgeoning of medical technology but also because of rising costs and the freedom of the market. Let me begin by telling you a story.

Young Shanthi brought her baby girl, Anu, to the village clinic run by the Chad hospital for her booster shot injection. Shanthi is proud of her little daughter and has brought her regularly to the clinic for her immunizations. Her weight on the growth-chart showed a steady increase in those first few months of life. At six months, she was told the next immunization was due when Anu was 18 months, but that Shanthi should continue to monitor her growth at the clinic. Shanthi, who had begun to go out to work to supplement their income, did not find time for this. The little one was active; she sat up and had started to walk. As well as feeding her breastmilk, millet porridge and rice, Shanthi had bought a tin of Cereal for her. She had seen it advertised on the television in the landlord's house. Since it was expensive, she gave Anu just two spoons a day. So, when the doctor at the clinic told Shanthi that Anu's growth pattern was poor and her weight inadequate for her age, Shanthi was upset and puzzled.

Child malnutrition rising
Shanthi's story is by no means a rare event in this area. Approximately half of the children under the age of five years are malnourished. While the more severe forms of malnutrition have declined, mild and moderate malnutrition remain much the same after an initial improvement from the 1970s to the 1980s (see figure 1). Children under six months, who are mostly breastfed, have very low rates of malnutrition. It is between six and 18 months that the percentage of malnutrition increases (see figure 2).

Since the 1970s, there has been a burst of technological development. As a result, food production, material goods

Mild and moderate malnutrition remain much the same.
and the availability of health facilities, especially private services and drugs, have all increased. But Shanthi, and many others like her, stand on the fringes of this development. Globalization with its “free” markets have not improved their lot. While the prices of rice and pulses have increased more than five times, Shanthi's wages have gone up only three times. The public distribution system, a country-wide network of distribution outlets providing people on low incomes with subsidised rice, wheat, kerosene and other essential items, remains basically good. The subsidy for the programme is currently borne by the Government. However, the structural adjustment policy demands that these subsidies be decreased. Health care, on the other hand, is expensive, and the free care offered by the Government is neither accessible nor convenient.

Private, commercial health care
Today, the health sector in India, and in many developing countries, is becoming privatized and commercialized. Church hospitals, set up by missions to serve the poor, now operate within this competitive system. To care for the needy, they must generate resources. Today, resources come from selling quality medicine and the latest high technology. Many hospitals are pushed into getting expensive equipment to keep up with private clinics. Making enough money to maintain the equipment and recover the costs becomes the driving force. Doctors are forced to become business people. Doctor-patient relationships are affected, and the ethos with which these hospitals were started is challenged. While many churches and Christian health institutions are struggling with a few resources, some are so large, rich, and “successful” that I cannot help wondering whether Jesus would feel uncomfortable to be inside them.

While there is undeniably a rising number of “new rich” and an increasing middle class, the numbers of poor have also increased. Malnutrition and common infections like diarrhoea and respiratory illness continue to be major problems. Governments are being forced to cut their spending on health, education, and other social services as part of the programme of structural adjustment. The “safety nets” that previously existed have started to disappear.

Is there an alternative?
Given this reality, what can church hospitals do? How does the church respond to these situations? Is there anything wrong with making medicine into an efficient and well-run business where the rich pay for good quality services that subsidise the poor? Any technology should benefit those who need it. But sadly, once commercialized, vested interests take over, and the poor are always the first to lose.

During his brief time on earth, Jesus paid greater attention to people than to structures and institutions. He often sought out the poorest, the unwanted, and those living on the fringes of society. His brand of economics was: “If you have two coats, give one away.” He focused on loving relationships. What does this imply in today’s world?

Before he started his work, Jesus took time off to think and plan his strategy. The temptations give us some insight into the dilemmas he faced, and they are still relevant for us today. For example, Jesus recognized as a result of one of his temptations that people do not live by bread alone. Today, the market dictates that amassing money
and material possessions is the raison d'être of existence. However, I believe that we are called as churches and institutions to live in poverty – to take no more than is needed, and to give away the extra coat. It means living less affluent, perhaps opting for a lower salary, and consuming fewer imported goods and more of what is produced locally. The specifics of how to respond to this call obviously need to be worked out in each local situation.

Second, Jesus faced the temptation of compelling belief by dazzling people with his extraordinary feats. Today we are compelled to believe that there is only one way forward – the bright lights of capitalism and growth. We must break out of this monoculture and begin to work together, networking across boundaries at local levels as well as internationally. We must affirm that money is not the only resource available. We must turn current values upside down, recognizing other resources that we have and beginning to share them. In offering what little we have to God and each other, we shall all have enough. For those of us working in Vellore, challenging current values may mean working with local government or with others in the health care and other sectors – sharing our time, expertise, experience, and love. Again, each local situation demands its unique answer.

Finally, Jesus faced the temptation of compromising the means for the end. He chose the way that gave importance to both the means and the ends. This approach may mean that we say “no”, as he did, to short cuts to success. We may reach a goal two years later because we choose another way, but that seems to be the way God operates.

Upside-down values?
Jesus deliberately chose the painful way of the cross, and his church and her institutions are called to nothing less. We have to hold up for the world an alternative model; one which places value on people rather than on systems or institutions – a model that calls for each of us to care for the other, where each takes no more than they need, because, like the manna which was freely given, hoarding leads to putrefaction (process of rotting). We need to build communities of people who can take action for their own health, supported by appropriate technology and motivated professionals. Propping up huge, unwieldy structures that are crumbling is useless.

The church and those of us who follow Christ are called as never before – not just to be doctors, nurses, engineers or sweepers but to build the kingdom of God. For me, this kingdom is a principle not a territory. Its values are “upside down” – the first are last, the weak are strong, and the lost are found. The rule of God is revealed in loving relationships. However, its enormous potential for growth may not always be evident. Like the transformation of the grain of wheat, which we cannot see, the coming to fruition of the kingdom is finally in God’s control, not ours. However, seized by the love of this God and his kingdom, we will be ready to sell all we have so that we can possess this pearl of great price.

The challenge for us today is to recognize what is happening. Then, like Jesus, we need to reject the alluring ways of Satan, and to choose to walk steadfastly and courageously in the way of the cross.

In Vellore, challenging current values may mean working with local government or with others in the health care sector.

Dr Sara Bhattacharji, Professor of Community Health, Christian Medical College, Vellore 622 002, South India. She also works at Chid Hospital, 632 002 Tamil Nadu, India. Fax: 91 416 32269. E-mail: Abraham@cmc.ernet.in

Figure 2

Main nutrition among under-fives in 1984
WHAT DOES THE "MARKET FORCES" ECONOMICS MEAN FOR THE POOR?

Mrs Marion Morgan is executive director of the Church Health Association of Sierra Leone (CHASL). She says that the success that church health institutions have had in helping the poor via Community-based health care (CBHC) is being threatened by globalization. However, she believes that there is a way forward and suggests what action churches and others should be taking.

When the Alma Ata Declaration was signed in 1978, most people assumed that health delivery services for the poor would improve. After all, by signing the Declaration, governments had adopted the primary health care (PHC) concept which, if properly implemented, would produce the maximum health benefit for the majority. In practice, however, only selected components of the PHC process were introduced. The vital aspect of community participation was often either ignored or given very little attention.

The concept of community-based health care (CBHC) incorporates PHC and focuses on community participation. It adopts a holistic approach to improving the quality of life for the poor. Its relevance and potential for success is based on the active involvement of communities. The people themselves identify their priority needs and find solutions to those needs. The CBHC approach has only recently become popular with Christian health institutions working with poor people. But the impact has been tremendous.

CBHC does not only address physical needs but also spiritual and social needs. In addition to providing basic drugs, it encourages preventive measures and supports income-generating activities which enable communities to become less dependent on government and outside agencies for support. CBHC promises accessible, affordable and appropriate health care to the poor, and encourages individuals and families to take greater responsibility for their health. Sadly, with the emergence of the World Bank on the health scene, the future for church health institutions and other CBHC practitioners is threatened.

Attack on government sector

In the early 1980s, the World Bank and IMF began to encourage poor debtor nations to adopt structural adjustment programmes (SAPs). The aim was to stimulate economic growth that would help cover debt repayments. Typically, SAPs call for reforms requiring the privatization of state-owned organizations, such as hospitals; the removal of subsidies, and reductions in government spending in areas such as education and health. Reforms in the health sector have led to a restructuring of services which has not taken into account the adverse effects of the changes on peoples' lives, and especially on lives of the poor.
As a means of coping with pressures of debt repayment, governments of many developing countries have adopted policies which have not favoured the poor. For example, the Sierra Leone government tried to implement reform programmes including health privatization and decentralization while fighting a rebel war (1991-1996). Privatization became more and more attractive as increased expenditure on arms reduced funds available to support the social sector. The result for the majority of poor people was disastrous.

By 1996, few hospitals in Sierra Leone were functional and low-cost government services had virtually disappeared. This was due to a combination of underfunding, non-funding, vandalism and the brutal treatment of health workers by rebels. Many doctors and nurses were forced to seek "safe haven" outside the country. Over 30% of civil servants were made redundant, including many health workers and teachers. No alternative source of employment was available for them, nor was there any system of social benefits. Real income declined while prices soared, resulting in a general increase in poverty and hardship. An estimated two-thirds of the population of 4.5 million people were living in absolute poverty. Twenty-five per cent of children under five were malnourished, and infant mortality was 163 per 1,000 live births.

Since the military-rebel coup of 25 May 1996, the health situation in Sierra Leone has worsened. There have been reported cases of severe malnutrition, outbreaks of measles, and cholera among the poor. At the end of the year, Sierra Leone came last but one in the UNDP's Human Development Index (173rd out of the 174 countries). Yet, in spite of the harrowing conditions, Sierra Leone was paradoxically reported to have made "massive improvements on macro-economic variables".

The case of Sierra Leone reported above demonstrates why the international health community should be genuinely concerned. In the absence of impartial, external monitoring and reporting, it seems unlikely that access to basic, affordable health care for the millions of poor people scattered throughout the world will increase. This is especially true in the African continent which is plagued with AIDS, massive unemployment, illiteracy, undemocratic governments and corruption.

With the current international support for privatization, profit-driven curative health care is likely to take precedence over preventive community-based health. Belief that the market mechanism is better at health care than the government creates an environment which pushes up drug prices and attracts investors whose goal is profit not service. This is the worst kind of health provider. For centuries, church health institutions have been popular for their not-for-profit services, especially among the poor. But the physical and spiritual care provided by the churches may be forced out of health delivery systems.

What action now?
In order to cope with the challenges, non-governmental organizations (NGOs) in the frontline of community-based health care initiatives need to:

1. Advocate for a meaningful devolution of power from the centre. When
people at the grassroots are involved in assessing their own health needs and finding their own solutions, decentralization of health care management can be effective. Efforts often fail because governments transfer responsibility but not the real power.

2. Establish a Global Health Watch system which will serve to monitor:
   a) the commitments of governments and other providers of primary health care, and
   b) the effects of globalization on the quality of life.

(See reference below).

3. Lobby donor and aid agencies in favour of giving preferential funding to people-initiated community-based health programmes.

4. Address the difficult issue of how to finance community health initiatives. This is particularly important for NGOs working with rural and poor communities who are not covered by any form of health insurance.

5. Research and develop traditional medicines, especially treatments which have already been found to be effective, such as for diabetes, hypertension and malaria.

6. Encourage churches to promote CBHC rather than institutional care.

7. Encourage local church groups and others to persuade governments to involve them in health matters.

The following list of publications provides details of some useful written materials relating to the subject of globalization and health. Unless otherwise stated, these materials are available in English only.

A new global health policy for the twenty-first century: An NGO perspective is the outcome of a formal consultation with non-governmental organizations held at the World Health Organization's Geneva headquarters on 2-3 May 1997. Many NGOs taking part in the meeting expressed a belief that unless and until the spiritual implications and ethical challenges of Health for All were acknowledged and addressed systematically, the achievement of Health for All would be hampered. These issues could best be addressed through a process of consultation with all key players in health, including WHO, NGOs and governments. During the meeting, a Global Health Watch system was proposed which would address the glaring inequities in health. Managed and operated by an NGO group, it would monitor how governments, UN Agencies, including WHO, and NGOs themselves were fulfilling their commitments to Health for All. Report reference: WHO/PPE/PAC/97.3. A catalogue of publications on "Health for All in the 21st Century" is also available. Write to Dr Roberta Ritson, WHO Policy Action Coordination Team, World Health Organization, 1211 Geneva 27, Switzerland. Fax: 41 22 791 4828. E-mail: pac@who.ch

Questioning the solution: The politics of primary health care and child survival looks specifically at the "new colonialism" of today's globalized economic order. It examines how the international financial institutions have perpetuated underdevelopment by imposing structural adjustment policies on debt-stricken countries. It also discusses the impact of these policies on health and the quality of life of the world's neediest people, and explores how the growing power of the transnational corporations influence public policies and endanger child health. Paperback copies cost US$18 and hardbacks cost US$30 plus US$5 shipping costs. Write to HealthWrights, PO Box 1344, Palo Alto, CA 94302, USA. Fax: 1 650 325 1080. E-mail: healthwrights@igc.org

Third World Resurgence is the monthly publication of the Third World Network. Several issues have focused on aspects of globalization and health (eg Issue No 74 "Globalization and Development" and Issue 68 on "Health care in the marketplace"). Enquiries should be made to: Subscriptions and Marketing, Third World Network, 228 Macalister Road, 10400 Penang, Malaysia. Tel: 60 4 2264505. E-mail: twn@igc.apc.org/twnpen@twn.po.my
GLOBAL VALUES
ACTS 8.4-14

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

Globalization is one of the key words of the present time. Globalization is the product of a world which has been made smaller by faster physical and electronic communications, where no national or local economy is independent of outside forces and where a particular set of political, social and economic theories are held by the powerful. It sounds like the description of an abstract theory but its effects are all too real.

Make a list of the effects of globalization described in the articles in this issue on a country such as Nicaragua, on a church hospital and on community based health care. Spend a few moments considering how you would describe the effects of globalization on your own situation?

In extending their empire throughout what to them was the known world, the Romans were engaged in a process not unlike globalization. The "pax romana" (Roman peace) brought a system of communication, trade and the rule of law to the peoples whose lands they occupied - that is if you saw things from the Roman point of view. It was in this setting that the gospel was able to spread so rapidly in the years immediately after the death and resurrection of Jesus. The system of exploitation and oppression was able to become a means of sharing good news.

The passage for our Bible Study follows immediately after the account of the stoning to death of Stephen, and Saul's vigorous efforts to destroy Christianity.

Read Acts 8.4-13
Instead of ending faith in Jesus, the persecution spread it. Much of Acts is taken up with the remarkable story of the missionary journeys of St Paul after his own conversion. Here we are reminded that there were many others like Philip who were spreading the good news. What does this passage tell us about the words and actions of Philip and their effect on people in physical, emotional and spiritual need?

Read Acts 8.14-24
We would probably want to say that the Holy Spirit had already been at work in the preaching and healing ministry of Philip. However, the arrival of Peter and John raised the issue of individuals receiving the gifts of the Holy Spirit. Simon saw the commercial potential for the power of the Holy Spirit to become a commodity which could be bought and sold.

Even though he was an enthusiastic new convert to Christian faith, Simon did not appear to see anything strange in exploiting the transforming power of God's love - until he was challenged by Peter. History shows that not all Christians have been so principled as Peter. Why was it important that Peter resisted the commercial culture of the times?

Many critics inside and outside the church have said that Christianity is too closely identified with the forces which create globalization. What should be our points of resistance? Where can our resistance be effective?

From the earliest years to the present, the spread of Christian faith has been enabled by developments in communications - from Roman roads to the Internet. In what ways can we transform the deadly effects of globalization into positive opportunities for the health and well-being of all people?
INDEX OF CONTACT BACK ISSUES

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<table>
<thead>
<tr>
<th>No</th>
<th>Date</th>
<th>TITLE/AUTHOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>4/78</td>
<td>Realization of an Integrated Health Services Programme in Rural India - E. Ram</td>
</tr>
<tr>
<td>45</td>
<td>6/78</td>
<td>Appropriate Technologies for Tackling Malnourishment - J. McDowell</td>
</tr>
<tr>
<td>46</td>
<td>8/78</td>
<td>The Churches take a new look at the contributions of people with disabilities in the search for their liberation from isolation - WCC</td>
</tr>
<tr>
<td>51</td>
<td>6/79</td>
<td>In Search of Wholeness Reaching Out to One Another in Caring and Healing - CMC</td>
</tr>
<tr>
<td>52</td>
<td>8/79</td>
<td>Safe Water. Essential to Health - E. Ram</td>
</tr>
<tr>
<td>53</td>
<td>10/79</td>
<td>Community Building Starts with People. A report of the work of an ecumenical health and development agency in Nicaragua - G. Parajón</td>
</tr>
<tr>
<td>57</td>
<td>8/80</td>
<td>The Village Health Care Programme Community-Supportive or Community-Oppressive? An examination of rural health programmes in Latin America - D. Werner</td>
</tr>
<tr>
<td>59</td>
<td>12/80</td>
<td>Nursing: The Art, Science and Vocation in Evolution - R.N. Barrow</td>
</tr>
<tr>
<td>60</td>
<td>2/81</td>
<td>International Year of Disabled Persons 1981 - S. Kingma, N. Acton, J. Steensma</td>
</tr>
<tr>
<td>64</td>
<td>11/81</td>
<td>Aging Today: A Question of Values - J.A. Murdock, M.S. Adisesha, O. Fustioni, M. Skeet</td>
</tr>
<tr>
<td>67</td>
<td>4/82</td>
<td>The Church and Injustices in the Health Sector - J.A. Monsalvo</td>
</tr>
<tr>
<td>68</td>
<td>6/82</td>
<td>Understanding the Causes of World Hunger - F.M. Lappe and J. Collins</td>
</tr>
<tr>
<td>71</td>
<td>12/82</td>
<td>Healing and Sharing Life in Community - WCC, S. Kingma</td>
</tr>
<tr>
<td>77</td>
<td>2/84</td>
<td>Rediscovering Traditional Community Health Resources: The Experience of Black Churches in the USA - J.W. Hatch, F.C. Robinson</td>
</tr>
<tr>
<td>78</td>
<td>4/84</td>
<td>Training Health Workers - L.A. Voight</td>
</tr>
<tr>
<td>79</td>
<td>6/84</td>
<td>The Ceara Experience: Traditional Birth Attendants and Spiritual Healers as Partners in Primary Health Care - J.G. Araujo</td>
</tr>
<tr>
<td>80</td>
<td>8/84</td>
<td>Women and Health: Women's Health is more than a Medical Issue - C. Lyons</td>
</tr>
<tr>
<td>81</td>
<td>10/84</td>
<td>The Church and Health: Reflections and Possibilities - J. McGilvray</td>
</tr>
<tr>
<td>82</td>
<td>12/84</td>
<td>Evolution of a Community-Based Programme in Deenabandu - H. &amp; P.C. John</td>
</tr>
<tr>
<td>83</td>
<td>2/85</td>
<td>Today's Youth: What are their Health Needs? - D. Bennett, N. Kodagoda, S. Denshire</td>
</tr>
<tr>
<td>84</td>
<td>4/85</td>
<td>Answering &quot;Why&quot;: The Ghanaian Concept of Disease - P.A. Sarpong</td>
</tr>
<tr>
<td>85</td>
<td>6/85</td>
<td>Setting our Priorities for Health - 1985 Meeting of CMC</td>
</tr>
<tr>
<td>86</td>
<td>8/85</td>
<td>The Child's Name is Today - D. Morley</td>
</tr>
<tr>
<td>87</td>
<td>10/85</td>
<td>Nurses: A Resource to the Community - R. Harnar</td>
</tr>
<tr>
<td>89</td>
<td>2/86</td>
<td>&quot;I've Made It; You can Make it Too&quot;: Adolescent Fertility. Looking for Solutions to a World-wide Problem - E. Coit</td>
</tr>
<tr>
<td>90</td>
<td>4/86</td>
<td>From Indonesia: Practicing Wholistic Healing - B.A. Supit</td>
</tr>
<tr>
<td>93</td>
<td>10/86</td>
<td>Infant Feeding Today - What's the Best for the Babies? IBFAN and CMC</td>
</tr>
<tr>
<td>95</td>
<td>2/87</td>
<td>Updates on Malaria, AIDS, Guinea-Worm - D. Hilton, D.H. Hopkins</td>
</tr>
<tr>
<td>96</td>
<td>4/87</td>
<td>Enhancing Mental Health Care in the Community - A. Ayyoninde, D.I. Ben-Tovin, G. Nichols, D. Hilton</td>
</tr>
<tr>
<td>97</td>
<td>6/87</td>
<td>Listening and Caring - Towards Healing of Nations - J. Nemec</td>
</tr>
<tr>
<td>98</td>
<td>8/87</td>
<td>National Black Women's Health Project: Empowerment through Wellness - E. Avery, F. Ward</td>
</tr>
<tr>
<td>101</td>
<td>2/88</td>
<td>Health for One Million: Just another Slogan? - L.M. Ephraem and Sister Eymard</td>
</tr>
<tr>
<td>104</td>
<td>8/88</td>
<td>Doing our Best All of Us: Progress with Mental Disabilities - B. Webb-Mitchell</td>
</tr>
<tr>
<td>105</td>
<td>10/88</td>
<td>Health Teaching made Easier: How to create a Manual - B. Rubenson</td>
</tr>
<tr>
<td>106</td>
<td>12/88</td>
<td>Community-based or Oriented: The Vital Difference - D. Hilton, A. Hope</td>
</tr>
<tr>
<td>107</td>
<td>2/89</td>
<td>Essential Drugs: A convincing Concept? - C. Albert</td>
</tr>
<tr>
<td>108</td>
<td>4/89</td>
<td>Justice and Health: Latin America Reality - G. Meyer</td>
</tr>
<tr>
<td>109</td>
<td>6/89</td>
<td>Health, Healing and Wholeness in a wounded World - K. Granberg-Michaelson</td>
</tr>
<tr>
<td>111</td>
<td>10/89</td>
<td>Breastfeeding for Life - WHO/UNICEF, A. Linncare, V. Balasubhramanayan</td>
</tr>
<tr>
<td>112</td>
<td>12/89</td>
<td>Our Land is our Life ... and our Health - VAHS, P. Swan</td>
</tr>
<tr>
<td>114</td>
<td>5/90</td>
<td>Tobacco and Health: Behind the Smoke Screen - C. Corey, J. Mackay, P. Pradervand</td>
</tr>
<tr>
<td>115</td>
<td>7/90</td>
<td>Karak: The People of New Caledonia Struggle to hold on to their Culture .. and their Healing Tradition - E. Senturias</td>
</tr>
<tr>
<td>116</td>
<td>10/90</td>
<td>&quot;We have done it ourselves!&quot;: Community-based Health Care Programme in the Machakos District of Kenya - J. Crowley</td>
</tr>
<tr>
<td>119</td>
<td>4/91</td>
<td>Health in a Search for Wholeness: The Journey of the Medical Mission Sisters - M. Pawath, S. Summers</td>
</tr>
<tr>
<td>120</td>
<td>6/91</td>
<td>Health in the Workplace: It's Everybody's Business - J. Bookser-Felster, L. Wise, P. Marin. IOHSAD, CMG</td>
</tr>
</tbody>
</table>
121 8/91  Children: Agents of Change in the Restoration of their own Rights, including Health - A. Swift (UNICEF), R. de Souza Filho, Z. de Lima Soares, Child-to-Child Trust, CMC, CREARQ Foundation
122 10/91 The Hospice Movement: Providing Compassionate and Competent Care for the Dying -
   C. Saunders, T. Kashwagi, T. Banks, A. Merriman
123 12/91/2/92 Saying No to the Debt - Candace Jagel
124 4/92 Health Development Among the Nomadic Peoples of East Africa - G. Kimirei, E.M. Nangawe, Mark L. Jacobson, A. Wohlenberg, F. Ogulawa, CMC
125 6/92 (Re)Training Doctors for Community Medicine to meet the Health Needs of the Majority -
   E. Senturias, C. Andrew Pearson
126 8/92 AIDS: A Community Commitment - E. Senturias, B. Shenk, CMC
127 10/92 Leadership & Community Participation for Health (Part I) - C. Jagel, M. Sköld, D. Kaseje
128 12/92 Community-determined Health Development: A Vision of the Future from Zaire - P. Nickson, D. Smith
129 2/93 Leadership & Community Participation for Health (Part II) - C. Jagel
130 4/93 Popular Communication for Health: Letting People speak for themselves - INCUSPO EPES
131 6/93 Supporting Women: Fighting Discrimination to improve Health - Gabriela Commission on
   Women's Health, PRODUSSE, Centre for Peace Action, Hedy Banoub
132 8/93 Participatory Evaluation: The Patna Experience - M.-T. Feuerstein
133 10/93 Campaigning for Breastfeeding: Church & Community Action - E. Senturias, D. Smith, D. Arcoverde
134 12/93 Resource Centres: Building Living Libraries - AHRTAG
136 4/94 Writing about Health: Say what you mean and mean what you say - F. Savage and Peter Godwin,
   B. Scott, B. Booth
137 6/94 Coordinating Agencies: Churches working together for Health - S. Kingma, M. Morgan,
   F. Winnubst, D. Mukarji
138 8/94 Community Action for Health: Let's get organized! - International NGO/PHC Group, EPES,
   C. Tusubira
139 10/94 Rational Use of Drugs: Incorporating "Guidelines on Equipment Donations" - R. Laing,
   O.Lanza, F. Mugo Ng'ang'a, P. Brudon-Jakobowicz, E. Ombaka, HAI
140 12/94 Youth and Health: Taking the Lead today for a better tomorrow - Youth to Youth, WORD, N. A. Waithe
141 2/95 Health Care: Strengthening Partnerships to protect the Poor - D. Werner, J. Martin,
   S. Mogedal
142 4/95 Healthier Tourism: Struggling for Development with Dignity - E. Cumberbatch, P. Holden, Jack Bryant
143 6/95 District Health Systems: Decentralizing for greater Equity - WHO, Matomora K. Matomora
144 8/95 Women and AIDS: Building healing Communities - E. Senturias, A. Skjelmervik, Yupu Suta
   (presented by Mary Grenough)
146 12/95 Health financing Crisis: Can Communities afford to pay? - EPES, D. Werner, D. Mukarji, C. Salem, E. Ombaka
147 2/96 Alcoholism and Drug Addiction - What is the Christian Response? - J. Gnanadason, BLESS,
   Prisquias Peters and Darlena David Titus, HAIN
148 4/96 Reconstructing Peace: Together we can overcome Violence - Salpy Eskidjian, Anthony Zwi,
   Elizabeth Sele Mulbah, Natasa Jovicic, Eduardo Campana
149 6/96 Migration and Health: Caring for those in our Midst - Helene Moussa and Patrick Taran, Dr Paola
   Bollin and Dr Harald Siem, White Rakuba, Gabriela Rodriguez, Asian Migrant Centre, Rabia
   Chamoun and Aline Papazian, Mukami McCrum.
150 8/96 Health in the North: Learning from the South - Christopher Benn, Daisy Morris, Kofi Yamgnane,
   David Cowling, Eva Ombaka
151 10/96 Healing Traditions: Finding Answers in Gospel and Cultures - Guillermo Cook and Diana Smith,
   Eugenio Poma, Tara Tautari, Darlena David, Hakan Hellberg
152 12/96 Healing Community: Caring is part of the Curel - David Hilton, Erinnda Senturias, Ricus Dullaert,
   Paul-Hermann Zellfelder-Held, Pierre Strasse, Michael Lapsley, Marion Morgan. Index of Contact
   issues (editions during 1997)
153 2/97 Ethics: Taking Sides in Health care - Christophe Benn, Lucy Muchiri, Sally Timmel, WCC's
   Consultative Group on AIDS Study Process
154 4/97 Indigenous Peoples: Their Health, their Solutions - Erinnda Senturias, International Institute of
   Sustainable Development, Maggie Hodgson
155 6/97 Spirituality and Health: Can our Beliefs help to heal us? - Hans Ucko, Karin Granberg-Michaelson,
   David Gacengpec, P Zacharias and S Bhattacherj, Peter Bellamy
156 10/97 Networking: Linking People for Change - Hari John, Kofi Asante, AIDS Community Action
   Network (ACAN), Catherine Hodgkin, Michael Tan
158 12/97 Sustainability: Models in church-related Health Care - Daleep Mukarji, Sigrun Mogedal, Kofi
   Asante, Patricia Nickson, Marta Benavides, John M Grange

Contact n°169 - February - March 1998

19
USEFUL PUBLICATIONS

Health, Everyone's birthright
During 1996, Christian Medical Association of India brought together Christian agencies in India working for Primary Health Care. The discussion was highly stimulating but also involved the development of practical thinking for the future. This small book provides a report of the consultation, including an assessment of how the healing ministry can be 'rebuilt', the rise and fall of primary health care, and the development of a strategy for the future. Christian groups involved in health care anywhere in the world are likely to find the publication very useful reading. For further information, write to Dr Cherian Thomas, General Secretary, Christian Medical Association of India (CMAI), Plot No.2, A-3 Local Shopping Centre, Janakpuri, New Delhi 110 058. Fax: 91 11 559 8150. E-mail: cmaidel@glased01.vsnl.net.in

Child Health (Second edition)
One of the most popular publications of the African Medical and Research Foundation (AMREF), Child Health, has been reproduced as a greatly expanded new edition. Specifically written for health workers in Africa, the book covers child health and diseases, and the care of children from conception, through pregnancy, birth, infancy and childhood. New chapters cover care of the newborn, tuberculosis, HIV infections, diseases of the child, and child abuse and neglect. Information on new developments including chloroquine-resistant malaria and some new anti-tuberculosis and anti- helmithic drugs is also provided. Emphasis is given throughout to the community-based health care approach. Write to AMREF, PO Box 30125, Nairobi, Kenya (copies available at 360 Kenyan shillings), or to TALC, PO Box 49, St Albans, Herts AL1 5TX, United Kingdom (price £8.00 plus £2.75 postage and packing or £3.75 airmail).

Understanding HIV and AIDS
This lively, easy-to-read and well-illustrated publication is the result of a project by Health Action Information Network (HAIN) in the Philippines among medic nurses and midwifery schools. The chapters address the major issues involved and answer the most common questions asked in the HAIN workshops. Copies of the manual can be purchased from HAIN. Please write to them for details: HAIN, #9 Cabanatuan Road, Philam Homes 1104, Quezon City, Philippines. Fax: 632 927. 67 60. E-mail: hain@mnl.seqwel.net

ANNOUNCEMENTS

Tropical Institute of Community Health
Courses leading to recognized certificates and post-graduate degrees and diplomas will be available at the Tropical Institute of Community Health which opens in Kenya, Africa on 2 May 1998. Courses focus on utilizing capacities and resources within the community. For further information write to Dr Dan Kaseje, General Director, CISS International, PO Box 73860, Nairobi, Kenya.

Contact - past and future
The final issue of Contact produced from Geneva will feature the "CMC story" (Contact 161 June-July 1998). We hope that this will provide an exciting and heart-warming reminder of the 30-year history of both CMC and Contact. During 1998, the World Council of Churches will discuss with partners the possibility of producing Contact from elsewhere.

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 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.

Editorial Committee: Kofi Asante, Balseep Mukarji, Simon Oxley and Diana Smith; Editor: Diana Smith; Design: Michel Paysant. Printed on recycled paper by Irprimerie Arduina. Mailing list: Fernande Chandrasekharan. All correspondence should be addressed to: CMC/WCC, P.O. Box 2100, CH-1211 Geneva 2, Switzerland. Tel: 41 22 791 03 61. E-mail: dgs@wcc-ccoe.org

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.