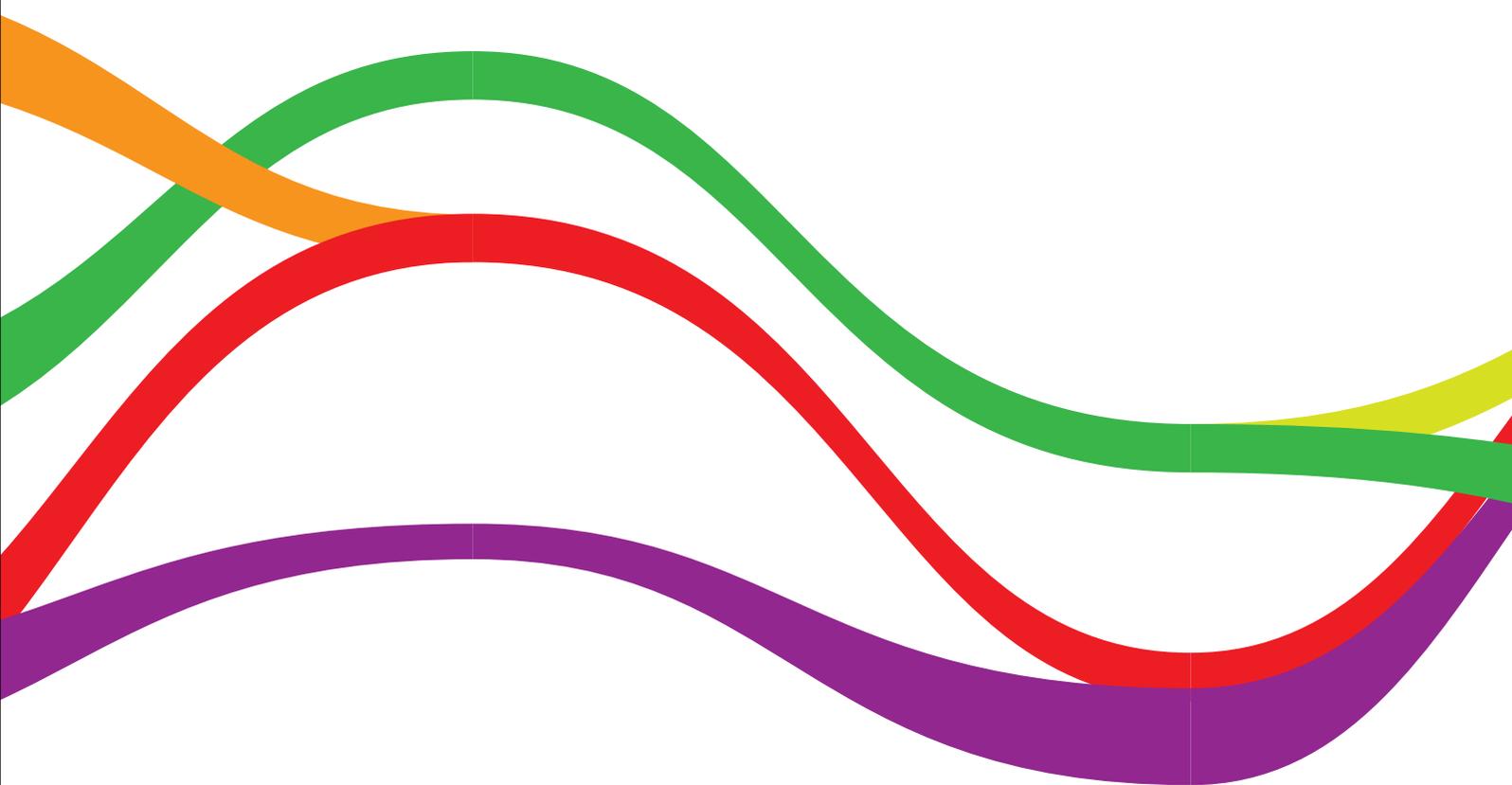


contact

SPECIAL SERIES NUMBER 5, OCTOBER 2018



Primary Health Care Revisited



Contact Special Series Number 5, October 2018

Edited by Lyn van Rooyen, Mwai Makoka. Cover design and layout Albin Hillert.

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Primary Health Care Revisited

Contact Special Series No. 5

Table of Contents

| | |
|--|-----------|
| Introduction | 5 |
| <i>Olav Fykse Tveit</i> | |
| 1. Primary Health Care: Are We Faithful to Our Foundations? | 7 |
| <i>Mwai Makoka</i> | |
| 2. The Alma-Ata Declaration 40 Years Later | 9 |
| <i>Odile Frank</i> | |
| 3. Revisiting “Is PHC the New Priority? Yes, but...” | 13 |
| <i>Mwai Makoka</i> | |
| 4. Revisiting “Health Care and Justice” | 15 |
| <i>Gisela Schneider</i> | |
| 5. “Five Challenges to the Churches in Health Work”: Still Relevant? | 17 |
| <i>Bimal Charles</i> | |
| 6. Review: “Primary Health Care and the Village Health Worker | 20 |
| <i>Dan Irvine</i> | |
| 7. Health Promoting Churches: A Case for Congregation-Based Health Promotion Programmes | 25 |
| <i>Mwai Makoka</i> | |
| 8. The Historical Involvement of the Christian Medical Commission and Churches on the Politics of Breastfeeding | 31 |
| <i>Erlinda Senturias and Mwai Makoka</i> | |
| 9. From Disability to New Abilities: Case Studies in Disability Care | 36 |
| <i>Gift Norman, Raji Thomas</i> | |
| 10. Faith in Health: Why it Still Matters | 40 |
| <i>Gillian Paterson</i> | |
| 11. A New Health Impetus for WCC: The Ecumenical Global Health Strategy | 44 |
| <i>Lyn van Rooyen</i> | |



Introduction

A number of significant events in the history of the World Council of Churches (WCC) and its health initiatives are being marked in 2018. It is the 70th anniversary of both the WCC and the World Health Organization, as well as the 50th anniversary of the Christian Medical Commission (CMC), the 40th anniversary of the Alma-Ata Declaration on Primary Health Care, and the start of the 2018–2021 Ecumenical Global Health Strategy.

It is against this background that the WCC is publishing this commemorative issue of *Contact*.

Since 1971, *Contact*, the CMC's flagship publication, has been used to develop what some have termed "a hospital without walls" – a global conversation on all matters of health from a Christian perspective. Primary Health Care was discussed, refined, and promoted through *Contact*.

While we acknowledge changing landscapes, we see that many health challenges remain today. The most important of these is probably the vast inequalities in public health structures and provision between developed and developing countries, and even between the rich and the poor within countries. The vision of equitable health care for all remains just a dream.

In this edition of *Contact*, the conversation continues. This publication revisits some of the seminal articles written in the years leading to Alma-Ata, explores areas of advocacy and programming, visits case

studies, introduces the WCC Ecumenical Global Health Strategy, and looks to the challenges and opportunities in the future.

We have stated that the World Council of Churches wants to be the leading agent of an ecumenical movement of love – that we want to show the love of God in practical actions together. Such an ecumenical movement of love not only means sharing a vision but also identifying concrete steps to move forward.

There is no more appropriate vehicle to address ecumenical challenges and potential than through revitalizing the role of churches in Primary Health Care. Here, as in other areas of concern to humanity, we have a great opportunity to move forward together now in a better grounded, better developed shared vision and strategy.

As the World Council of Churches, we recommit ourselves to playing our role as convenor, facilitator, and catalyst in ensuring health for all. We commit to work with and through our member churches and structures, and with our partners, to strengthen our contributions to the Sustainable Development Goals on health.

Our calling to health and healing, compelled by the love of Christ, is as strong as ever.



Rev. Dr Olav Fykse Tveit
General Secretary
World Council of Churches



1. Primary Health Care: Are We Faithful to Our Foundations?

Mwai Makoka

As we look back at the signing of the Alma-Ata Declaration,¹ and at the developments since then, it is an opportune time to look at the faith foundations for this important declaration.

Since the publication of the first issue of *Contact* in November 1970, one of its principal orientations has been the advocacy of community-based health care programmes. From the beginning, this has been the central focus for the work of the Christian Medical Commission (CMC). The principles of these programmes were adopted by the World Health Organization (WHO) and UNICEF in 1975, under the name of Primary Health Care (PHC).

The World Council of Churches (WCC) participated in the two-year NGO consultation which produced a position paper on PHC in May 1978, and, four months later, the Alma-Ata Declaration, which we are commemorating.² It is clear that the WCC played a significant role in the development and promotion of PHC.^{3 4}

The first International Conference on Primary Health Care was the result of years

of development, even before the 1960s. However, the establishment of the CMC in 1968, and the CMC and WHO's signing of a Memorandum of Understanding on technical cooperation in May 1974, created the impetus culminating in the Alma-Ata Declaration.⁵ The Declaration itself was a universal and bold statement, drawn from WHO's self-understanding as a "world health conscience."⁶

Alma-Ata affirmed that health is a fundamental human right and that all people have the right and duty to participate in the planning and implementation of their (own) health care. Notwithstanding the diverse players in the health sector, Alma-Ata declared that governments are responsible for the health of (all) their people.

The CMC, however, had argued earlier that health is not only a matter of human rights, but also a matter of justice. Traditional hospital-based approaches, where hospitals were doing more and more for the same limited number of patients, was judged to be ineffective and inefficient, and thus unjust.⁷

It is an act of injustice for any government to deny any part of its citizenry health care, or to create or sustain situations where some of its people cannot attain the "highest possible level of health." Yet this is true for some of the signatories of the declaration. Racism, ethnic cleansing,

1 Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, http://www.who.int/publications/almaata_declaration_en.pdf.

2 "Non-governmental Organisations and Primary Health Care." Position Paper. *Contact* 48 (1978), 8-10.

3 S. Litsios, "The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach," *American Journal of Public Health* 94:11 (2004), 1884-93, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448555>.

4 T. Karpf, "Faith and Health: Past and Present of Relations between Faith Communities and the World Health Organization," *Christian Journal for Global Health*, 1:1 (2014), 16-25, <http://journal.cjgh.org/index.php/cjgh/article/view/21/86>.

5 WHO Archives, Fonds Records of the Central Registry, third generation of files, 1955-1983 (WHO.3), file N61/348/77.

6 WHO, Official Records No. 206, Annex 11, 108, http://apps.who.int/iris/bitstream/handle/10665/85855/Official_record206_eng.pdf

7 "Health Care and Justice," *Contact* 16 (1973).

apartheid, and other injustices, in whatever form or guise, have no place in a country that is party to Alma-Ata.

Looking back, Alma-Ata may seem naive for having included matters of “self-reliance and self-determination” and civic participation, and of making the fullest use of available national resources, as these inevitably impinge upon the realms of local and international politics as well as local and international trade.

It is unrealistic and immoral to expect that citizens who are denied meaningful civic participation in other areas of life will somehow be able “to participate individually and collectively in the planning and implementation of their health care.” Indeed, in some countries, PHC workers were branded as stooges of movements for justice, and so they suffered abductions and murder at the hands of both national and foreign governments.⁸

It was expected in the vision of Alma-Ata that the New International Economic Order would lead to a reduction of the gap between developing and developed countries. However, unfair and exploitative international trade practices, such as the merciless plunder of Africa’s natural resources, led to the equally immoral inability of many people to use their “local, national and other resources.”

Little heed has been paid to Alma-Ata’s urging for countries to de-escalate armaments and militarization and to redirect those resources toward human development, including health. Oxfam’s report “An Economy for the 1%” details how the majority of the world’s population has been driven to extreme poverty.⁹ Wars and conflict are still major drivers of the global economy from which only a

few benefit. Global military spending has increased relentlessly for the past 18 years, and in 2017 reached an all-time high of US\$1.7 trillion, a global average of US\$230 per capita.¹⁰

Alma-Ata was positioned for implementation “particularly in developing countries.” Advancing PHC in developing countries, while the traditional hospital-based approach persisted in developed countries, quickly became untenable.

First, the Western approach exercised its “professional domination.” Halfdan Mahler, the WHO architect of PHC, bemoaned in 1980 that doctors had become “medical emperors” with “false grandeur” and a negativism toward PHC.¹¹ This was seven years after Charles Elliott had warned of “professional domination.” Interestingly, Dr Mahler made these remarks in Nigeria, where the medical fraternity was both victim and perpetrator.

Second, the human resource architecture of the health sector did not adjust to the reality of PHC. This had two further implications: the community health worker (CHW) played second fiddle to “professionals,” as described in Chapter 6; and the West (with its hospital-based approach) suctioned health workers from developing countries. The global South has suffered massive brain drain, and minor adjustments, such as codifying international recruitment of health professionals, has had little effect. The whole human resource architecture of the health sector needs to be reviewed at its most fundamental level for PHC to succeed.

8 “The CMC Story,” *Contact* 161/162 (1998), 20.

9 “An Economy for the 1%: How Privilege and Power in the Economy Drive Extreme Inequality and How This Can Be Stopped.” 210 Oxfam Briefing Paper (Oxfam, 2016), <https://www.oxfam.org/en/research/economy-1>

10 Stockholm International Peace Research Institute Report, 2017, <https://www.sipri.org/media/press-release/2018/global-military-spending-remains-high-17-trillion>.

11 H.T. Mahler, “Primary Health Care: An Analysis of Some Constraints.” An address delivered to the special congregation for the conferment of an honorary degree on Dr HT Mahler at the University of Lagos (Lagos: University of Lagos Press, 1980), 10. Mahler speeches/lectures, Box 1, WHO Library, Geneva.

In his article “Is Primary Healthcare the New Priority? Yes, but...,” Elliott correctly predicted that medical historians would hail PHC as a major innovation in medical care. Alma-Ata, with its utopian, even poetic, language, inspired generations, not only providing a universal framework for health policy formulation, but also serving as an ethical compass.

Sadly, we have not always followed the direction shown by this compass.

Even though faith communities make significant contributions to health and provided momentum to PHC, these communities were not explicitly mentioned in the declaration.¹² There is evidence, however, that the suspicion with which UN agencies and governments viewed faith-based organizations is decreasing, and that their assets – ideas, practices, and experiences – that may foster development are increasingly recognized.¹³ ¹⁴ It remains to be seen, however, how much

12 Notes of the Christian Medical Commission. Unpublished.

13 G. Berge, “Recognizing the Role of Religion in Development Cooperation: Experiences and Examples from Norwegian Church Aid (NCA),” *Ecumenical Review* 68:4 (2016), 423–32.

14 C. Benn, “Guest Introduction: Faith and Health in Development Contexts,” *Development in Practice* 27:5 (2017), 575–79, <https://www.tandfonline.com/doi/full/10.1080/09614524.2017.1330875>.

space WHO will create for faith-based organizations.

One of the hallmarks of the saving nature of the Lord Jesus Christ was his unwillingness to accept delay in the alleviation of suffering. In Luke 13:10-13, he healed on the Sabbath, arguing that even though the woman had had her disease for many years, it was intolerable to let her suffer one more day in order to be healed after the Sabbath was over.

As we commemorate Alma-Ata at 40, the World Council of Churches maintains that we are part of a creation groaning in pain and longing for liberation. We are also a sign of hope and an expression of the kingdom of God.¹⁵ The call to a pilgrimage of justice and peace demands that the church’s work on health include a “prophetic denunciation of the root causes of suffering and transforming structures that dispense injustice.”¹⁶

We commit to be faithful to our foundations.

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15 Keum (ed.), *Together Towards Life* (Geneva: WCC Publications, 2013), 21, https://www.oikoumene.org/en/resources/publications/TogethertowardsLife_MissionandEvangelism.pdf.

16 Keum (ed.), *Together Towards Life*, 19.

2. The Alma-Ata Declaration 40 Years Later

Odile Frank

This article proposes that, while the health conditions and status of the world’s human population have improved since 1978, improvements have fallen short of the hopes of the Declaration of Alma-Ata,¹ and so far have failed to establish the basis for sustainable improvement. The reason for

this failure is that the operating principles of Primary Health Care, the cornerstone of the Alma-Ata agenda, have been ignored. At the same time, the foundation for the hopes entertained in 1978 has been eroded and the conviction of the importance of human health that inspired them is now undermined. Consequently, progress in human health has taken a slow, parallel service road rather than the high road envisioned in 1978, losing both speed and ground. To get back on the high road

1 World Health Organization, “Declaration of Alma-Ata. International Conference on Primary Health Care,” *WHO Chronicle* 32:11 (1978), 428–30, http://www.who.int/publications/almaata_declaration_en.pdf.

requires a fundamental change in the argument for greater concentration of resources and dedication of effort to lower human morbidity and mortality.

Human longevity has improved since 1978, as has the state of the world's health

The improvements enjoyed by the human population over the last 40 years are notable. Table 1 summarizes vital statistics for the global population estimated around 1978 and projected around 2018.

Even a casual glance reveals that while world population has grown by 60 per cent, all the indicators of health and survival have improved. Most notable are the improvements in the rates of infant and child mortality, which have declined by 64 and 65 per cent respectively. These improvements in mortality at the global level occurred despite substantial setbacks in mortality gains during the period 1978–2018 in Eastern Europe and in Southern Africa, in the latter case due to the HIV/AIDS epidemics.

Notwithstanding these improvements, the language of the Declaration of Alma-Ata, its affirmations, and its messages of urgency and advocacy are as valid today as they were 40 years ago. Only two details age the document. The first concerns the target year of 2000. The second is the language of the reference to the “New International Economic Order.”²

Although the language itself has fallen from use, many of its underlying objectives have not. In fact, the New International Economic Order is still on the agenda of the United Nations. A 2016 Report of the UN Secretary-General³ provides an overview of

2 United Nations, Declaration on the Establishment of a New International Economic Order. Resolution adopted by the General Assembly [A/RES/S-6/3201], 1 May 1974, <http://www.un-documents.net/s6r3201.htm>.

3 United Nations, “Updated overview of the major international economic and policy challenges for equitable and inclusive sustained economic growth and sustainable development, and of the role of the United Nations in addressing these issues in the light

the international economic achievements made in the pursuit of the Millennium Development Goals (MDGs) between 2000 and 2015, and of the challenges remaining for the Sustainable Development Goals (SDGs) between 2015 and 2030. These serve to highlight that the New International Economic Order⁴ remains as relevant today as in the world described in the Declaration of Alma-Ata, to which we still aspire.

Unhappily, however, the failures of the Economic Order have a greater chance of being addressed than do the failures of the state of global health care advocated at Alma-Ata. The reason for this is that we collectively advocate far more successfully for economic growth and prosperity, which are seen as positive contributions, than we do for improved health, which is perceived largely as a cost.

Yet the Declaration of Alma-Ata attempted to counter this view, and did so 25 years before Dr Gro Harlem Brundtland stated in 2003, in one of her final speeches as Director-General of the World Health Organization, that “We have established that health is an important determinant of development and poverty reduction.”

Article III of the Declaration of Alma-Ata stated that “the promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.”

This was a subtly different view to the position that health care is charitably offered to those who cannot afford it themselves – essentially the poor in high- and middle-income countries and the

of the New International Economic Order.” Report of the Secretary-General [A/71/168] (2016), http://www.un.org/ga/search/view_doc.asp?symbol=A/71/168.

4 International Institute for Sustainable Development, “UN Reports on Progress towards New International Economic Order” (2016), <http://sdg.iisd.org/news/un-reports-on-progress-towards-new-international-economic-order>.

| Indicator / Year | 1978 (estimations) | 2018 (projections) |
|-----------------------------|--------------------|--------------------|
| Population | 4,458,412,000 | 7,550,000,000 |
| Crude death rate | 11.0/1,000 | 7.7/1,000 |
| Life expectancy, males | 58 years | 70 years |
| Life expectancy, females | 62 years | 74 years |
| Life expectancy, both sexes | 60 years | 72 years |
| Infant mortality | 85/1,000 | 31/1,000 |
| Child mortality | 124/1,000 | 43/1,000 |

Source: United Nations, *World Population Prospects: The 2017 Revision, Vol. I: Comprehensive Tables (ST/ESA/SER.A/399)* (Geneva: Department of Economic and Social Affairs, Population Division, 2017).

majority of populations of low-income, less developed, and least developed countries. But the subtle difference invited the notion that health was not merely a cost, but an investment, and as an investment, would bring returns. This subtle difference allowed the interpretation that the returns on investment in health could be accounted for in terms of economic productivity and economic growth, not as mere social or humanitarian gains. This was essential as humanitarian gains were not in themselves seen as justifying the investment.

It was also founded on a quasi-universal view that the productivity associated with human labour would be beneficial to the economy, and that there was an underexploited capacity for growth in increased quantity and quality of human labour. Health for all meant a healthier labour force, which implied gains for all from higher human productivity.

Total global health expenditures have risen steadily, albeit not dramatically, at least since 2000.⁵ This was, however, driven mostly by growth in gross national income.⁶ Levels of health expenditures according to national income show largely the same

5 There is insufficient data to define the trend since the time of Alma-Ata.

6 E. Ortiz-Ospina and M. Roser, "Financing Healthcare" (2018), <https://ourworldindata.org/financing-healthcare>.

inequalities today as they did two decades ago. This means that few poor countries can be shown to have improved health expenditures.⁷ Where there has been improvement, there is a clear relationship in developing countries between expenditure on health and the gains to health in measures of morbidity and mortality.

Although it is still a realistic objective to create the "comprehensive national health systems" advocated in the Declaration of Alma-Ata, where it would be possible to ensure health for all, we have done less than we could over the last 40 years. We have tolerated a pace of decline in morbidity and mortality much below what we could have achieved. Instead, we have sought to pursue, at a global level, "good enough" control of infectious diseases to limit mortality, we have advanced treatment of a range of non-communicable diseases with the aid of technological innovations, and we have greatly increased the coverage of childhood vaccination, among other things.⁸

7 J.L. Dieleman, T. Templin, N. Sadat, P. Reidy, A. Chapin, et al., "National Spending on Health by Source for 184 Countries between 2013 and 2040," *The Lancet*, 387:10037 (2016) 2521–35, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)30167-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30167-2/fulltext).

8 We also succeeded in lowering maternal mortality measurably, but failed miserably to address the fundamental issue of sanitation under the MDG agenda.

But we have unequivocally forsaken the fundamental principles at the base of Primary Health Care: to reflect the conditions on the ground and to address health problems through a multisectoral and sustained involvement of the community, leading to “progressive improvement of comprehensive health care for all.” Primary Health Care was conceived to be demand based and proactive, whereas we have complacently offered a patchwork of interventions driven by an amalgam of industrial readiness, geopolitical considerations, philanthropic objectives, and humanitarian sensitivity.

It should not surprise us, therefore, that in the last 40 years we have seen epidemics arising from poverty take on fearsome proportions and shake our beliefs and confidence in public health. This is evident from the HIV/AIDS epidemics, waves of respiratory viral infections, strains of resistant tuberculosis, and cholera and Ebola outbreaks. The health system infrastructure to address them was caught short because of our collective failure to take the high road after Alma-Ata and sharply increase our willingness and the resources to meet its clearly defined purpose.

Although still a realistic objective – and now possibly reinvigorated by the new global health community mission of “Universal Health Coverage: Everyone. Everywhere” – the challenge to finance “comprehensive national health systems” is greater now than it was in 1978. This is because it is no longer so clear that improved health contributes to development through economic growth. Today we see diminishing returns to labour, and the greater and increasing productivity of non-labour factors of production, especially capital. The very future of work is called into question. We see inequalities growing sharply, not diminishing, due to sluggish salaries and

the increased precarity of jobs maintained by widespread unemployment. In contrast, extreme wealth is relentlessly growing everywhere, even in the poorest countries. The projections of this reality appear to be accepted by all. Universal basic income is as much discussed in conservative circles – as a means to cut the intolerable administrative costs of increasing social services, as it is debated in progressive circles – as a means to address the intolerable expected growth in structural unemployment.

Wealthy segments of our societies and our world, and the governments in their debt, were reluctant to invest more in health after 1978, believing that future economic growth would eventually take care of health and reduce the disparities between the haves and the have-nots. It will be no easier to convince them today, when it is projected that “substantive policy interventions” and “concerted action” will be required to achieve “meaningful increases in health system resources” to narrow the gap in health expenditures between well over 90 low- and middle-income countries on the one hand, and the high-income countries on the other. However, this is essential if we are to see the very needed outcomes of better health in the next 20 years.⁹

In the current clash of values polarizing the international agenda, it is critical to steer away from the economic arguments for health and to uphold the fundamental and enduring values that justify universal access to essential health services to ensure Health for All: that health is a human right.

After 40 years, Health for All remains a valid objective, given the poor global health situation and the lessons learned from the two major attempts since 1978 to restart the world’s commitment in the MDG and SDG agendas.

9 Dieleman et al., “National Spending on Health by Source for 184 Countries between 2013 and 2040.”

In this time we have, however, seen an increase in global wealth that can now be channelled with greater collective determination.

Health for All is therefore also a realistic objective, given the expressed will of

governments, the range of financing mechanisms and the demonstrated existence of the necessary resources.

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3. Revisiting “Is PHC the New Priority? Yes, but...”

Mwai Makoka

The term “Primary Health Care” (PHC) entered into the lexicon of the Christian health care ministry in the late 1960s, and by the early '70s was gathering momentum. In July 1975, Dr Charles Elliott presented a paper, “**Is PHC the New Priority? Yes, but ...**,” at the annual meeting of the Christian Medical Commission (CMC) in Zurich. Dr Elliott was attempting “to read history forwards,” however dangerous that exercise always is.

Now, on the 40th anniversary of the Alma-Ata Declaration, we look back at Elliott’s paper.

Instead of pontificating or prophesying, Elliott identified potential pitfalls of PHC and provided thoughts on how these could be navigated or managed to ensure the success of PHC.

He identified five key elements that would be drivers of PHC: frontline workers, relative upgrading of preventive services, a more integrated approach, dethronement of cost effectiveness and efficiency, and the fusing of Western technology with traditional systems. Elliott emphasizes that movement on each of these elements is across a spectrum, and that different countries are moving along each of these elements at different speeds.

Although Elliott feels that the “ball is rolling,” he has questions about its direction and turns to the difficulty of defining the goals of health care. While the goals seemed clear and unified “from

a distance,” ideological differences became more significant as the process evolved and those who thought they were on the same team realized that they had been working toward different goals.

To refocus on the goals of health care, Elliott asked a number of questions.

He questions whether the new emphasis on the democratization of health care has become no more than a new form of professional domination.

Elliott uses the term “democratization of health care,” in a way encapsulating the idea of “health of the people, for the people and by the people”. He was concerned that PHC would simply become a new form of “professional domination” (by doctors). He argued that neither community participation nor the epidemiologist is king, but that what is required is rather a “council of equals” of multi-sectoral and multidisciplinary decision makers.

The motivation for this concern can be summarized as follows:

- It seems as if the priority accorded to health care by villagers is under most conditions rather low, because “a community adjusts culturally and possibly psychologically to a certain pattern of disease.” This means that the services that PHC provides might be based on needs criteria that are not the “felt need” of the community.
- Communities may seem to typically make “wrong” choices on health matters

because they confuse their health desires with their health needs. Clinics, hospitals, and ambulances have thus always featured high on the demand list of communities, even when a sober PHC approach would choose otherwise.

The effect of this is still evident today. While communities may underestimate the effect of disease, leading to poorer choices, epidemiologists or health economists make their judgements based on data (disease and population data) that often disregard intangible community resources and qualities like resilience, values on health matters, or indeed value placed on life (and death).

- Elliott was concerned that the “frontline workers” themselves fell into the “professional domination” trap, rather than developing a unique path and motivation.

This has sadly proven true. The status and position of community health workers (CHWs) have not improved, despite the increasing evidence that they play a central role in PHC. Lack of career path, low remuneration, and disconnection from the “mainline” health sector have dogged CHWs.

Instead of meaningfully investing in and developing the CHW cadre and addressing these concerns, the “centripetal force of the profession,” as Elliott put it, relegated CHWs to the “slumland of the medical townscape.” There was progress in the area of HIV, when non-professional “frontline workers” were engaged: for example, mothers to mothers for prevention of mother-to-child transmission of HIV (PMTCT), expert patients to promote adherence to HIV treatment, or peer educators to promote uptake of HIV testing and counselling (HTC) among high-risk groups. Unfortunately, these have not been sufficiently replicated to control non-communicable diseases, to mobilize blood donors, or to promote health in schools, churches, and so on.

- Elliott argued that professional domination would also be affected by the quality of the services. If the Western and centripetal model of medicine is equated with quality care, it will indeed cause “unrealistic demands for hospitals” and overprofessionalization of medicine. In many countries, the majority of health resources are deployed to serve the minority and the privileged few. This is true not only for clinical services but also for training, research, and human resources.

Elliott argues that greater investment in local and traditional health resources may improve the quality of such services and change community perception and demand.

Sadly, investment in the Western model remains dominant. HIV might, however, once again create models that can be used universally. The rapid increase of people on antiretroviral drugs in under-resourced countries, overwhelming hospital and clinic capacity, has led to exciting innovations such as treatment and adherence clubs.

- Overestimating the effects of disease on a community has led to the persistence of vertical disease programmes. Health and development practitioners focus on the urgency of addressing a serious health problem, while integral human development and strengthened health systems may naturally lead to its reduction.

This still reinforces and is reinforced by the underestimation of communities’ resources to deal with their health problems. Community resources or assets, especially intangible resources, have been recognized and leveraged only when they are deemed to advance the agenda of the health and political leadership.

Three years before the Declaration of Alma-Ata on PHC, Elliott proposed fundamental changes to the organization and the orientation of health care for PHC to take root and bear fruit. He also explained how and why the goals of health care had to

be redefined to avoid players “kicking the ball towards different goals,” and to allow for the eventual realization of the vision of Health for All.

On the 40th anniversary of the Alma-Ata Declaration, Elliott’s concerns are still relevant and urgent. These concerns are worth the attention of all health leaders at all levels.

Elliott, a distinguished economist and Anglican priest, made numerous contributions to global health, not only as a member of the CMC but, importantly, through timeless appraisals such as this one. Ultimately, he said that patient and doctor alike need healing so we can forge

a health system that is not subverted into the protection of a profession or an industry, nor indeed a process by which my neighbour is robbed or subjugated into perpetual socio-economic disadvantage.

Forty years later, we can only emphasize Elliott’s call for wholeness, where the relationship between practitioner and patient “becomes rather a relationship between 2 people or groups both of which know that they are less than whole people and both of which are seeking to find a greater degree of wholeness.”

Dr Mwai Makoka is programme executive for Health and Healing, WCC, Geneva.

4. Revisiting “Health Care and Justice”

Gisela Schneider

“Ensuring healthy lives and promoting the well-being for all at all ages is essential to sustainable development”¹ – this is the clear commitment of 193 heads of state who signed Agenda 2030 in September 2015. There is a clear call for universal health coverage, for access to health care for all, and for more justice in health by the year 2030.²

This recalls one of the discussions held in the 1970s, leading to the term “Primary Health Care” (PHC) and the Alma-Ata Declaration.

At the time, there was a real concern for more justice in health care. In developing countries, a few hospitals, often church based, were serving a limited number of people – those who had access

geographically, economically, or socially. The Christian Medical Commission recognized the need for health care to be closer to the people and to be developed by people with their full participation.³

In PHC, health is seen as a human right: governments carry the responsibility for health and health care that would ensure that “all peoples of the world by the year 2000 attain a level of health that will permit them to lead a socially and economically productive life.”⁴

The **Position Paper on Health Care and Justice** was published five years before Alma-Ata, and provided the basis for many of the principles of the Declaration.

It emphasized that the health care system was seen as “ineffective, inefficient and unjust.” Key aspects of this unjust system include a hospital- or facilities-based

1 <https://www.un.org/sustainabledevelopment/health>

2 United Nations, Transformation unserer Welt: die Agenda 2030 für nachhaltige Entwicklung. Resolution der Generalversammlung, verabschiedet am 25 (September 2015).

3 Declaration of Alma-Ata. The Lancet, 2:8100 (1978), 1144.

4 Declaration of Alma-Ata, International Conference on Primary Health Care (Geneva: World Health Organization: 1978).

system, with significant barriers and poor access to care even for those who lived geographically close to the institution, and an inappropriate balance between curative and preventive services. One of the suggestions for increased efficiency was task shifting, from doctors to nurses and community health workers, who can reach more people. It states that these health workers can “care for 90% of illnesses as effectively as physicians”.

In this paper, the Christian Medical Commission highlights the inability of hospitals to meet the “total needs of populations” and thus the need for a health care model in which nobody is deprived of health care due to financial reasons.

It emphasizes that individuals, families, and communities should be at the centre of health care and that in addition to the provision of health care, social determinants of health must be addressed to strengthen the health of the community.⁵

Today we look back on 40 years of PHC. According to the World Health Organization, about half of the world’s population still does not have affordable access to quality health care. Every year, 100 million people are thrown into poverty because they have to pay for treatment they cannot afford.⁶

There have been successful comprehensive PHC projects in the past 40 years. An example is the Comprehensive Rural Health Project in Jamkhed,⁷ where community participation, successful task shifting, and affordable hospital care have made a significant difference in the health status of the target community.

However, structural adjustment programmes of the World Bank in the

1980s and ‘90s led to a lack of public funding in many developing countries,⁸ thereby weakening health systems. The HIV/AIDS epidemic further put enormous pressures on health systems, especially in sub-Saharan Africa.

In spite of these constraints, knowledge of the importance of community participation and involvement increased. Dealing with HIV/AIDS in various communities, especially in sub-Saharan Africa, have shown the impact when communities and people affected by a disease participate in the development of health care.^{9 10}

Pressure by civil society, such as in South Africa, contributed greatly to the availability of antiretroviral drugs (ART) and the increase in treatment opportunities. Over the past 15 years, the number of people living with HIV receiving ART increased dramatically, reaching 19.5 million globally.¹¹ Many factors contributed to this success:

- There was political will at international and, in many cases, national levels.
- Massive investment in research and development of drugs, diagnostics, and research into health systems determined the most effective approaches to care.
- At the same time, the creation of the Global Fund against AIDS, TB and Malaria¹² has had an enormous impact in reaching many people, even in the least developed countries.

8 A. Shah, “Structural Adjustment: A Major Cause of Poverty (2013), <http://www.globalissues.org/article/3/structural-adjustment-a-major-cause-of-poverty>.

9 The Aids Support Organisation Uganda, “Community Based HIV Approaches in Africa, TASO Uganda,” <https://www.ncbi.nlm.nih.gov/pubmed/2488284>.

10 P. Piot, S. Karim, R. Hecht, H. Legido-Quigley, K. Buse, et al., “Defeating AIDS: Advancing Global Health,” *The Lancet* 386:9989 (2015), 171–218.

11 http://www.who.int/gho/hiv/epidemic_response/ART/en

12 <https://www.theglobalfund.org/en/news/2017-09-13-global-fund-partnership-has-saved-22-million-lives/>

5 “Health Care and Justice.” *Contact* 16 (August 1973).

6 [http://www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](http://www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

7 www.jamkhed.org

Despite these successes, disease-specific approaches – which were introduced under the “selective PHC programmes” and further developed under the Millennium Development Goals – have not necessarily had a positive impact on health systems development. The recent Ebola epidemic in West Africa has shown what can happen if health systems are neglected and weak.¹³

Therefore, the call for universal health coverage today is also a call to strengthen health systems. This requires sustainable health services, the need for qualified health workers, access to medicines and diagnostics, health infrastructure, health information, appropriate health policies, and above all appropriate health financing.

At the same time, we need to recognize that sustainable health systems cannot be detached from the local community and that communities must participate in the governance, development, and sustaining of health services in the local context. This is where the original concept of PHC can contribute to universal health coverage. Where communities are involved in the

governance of health services at the local level, they will ensure that there is access, socially and economically, and that the services provided will be meaningful and culturally sensitive.

Churches can play an active role in strengthening comprehensive PHC as part of their healing ministries. Churches have a special responsibility to the vulnerable and marginalized, but should also ensure that they act to strengthen the national health system. In this way churches can contribute to more just health care.

Churches should also be a prophetic voice advocating for access to health for all and holding governments accountable. Thousands of years ago, the prophet Micah said, “And what does the LORD require of you? To act justly and to love mercy and to walk humbly with your God” (Micah 6:8).

Justice in health care is one area where Christians can work within their local community or health care setting, showing love and contributing to more health for individuals, communities, and nations in a very meaningful way.

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13 H. Shoman, E. Karafillakis, and S. Rawaf, “The Link between the West African Ebola Outbreak and Health Systems in Guinea, Liberia and Sierra Leone: A Systematic Review,” *Global Health* 13:1 (2017), 1.

5. “Five Challenges to the Churches in Health Work”: Still Relevant?

Bimal Charles

In his paper “**Five Challenges to the Churches in Health Work**,” Dr John H. Bryant sketches the context of health care in the 1970s, especially in developing countries, and explores the major challenges churches face in health work. During the last four decades, there have been substantial changes in the demography, socio-economic situation, and behaviour that led to epidemiological and health transitions. Health systems across the world

experienced significant changes, including in organization, rising costs, financing and insurance mechanisms, development of high-cost medical technologies, and so on. In spite of this, the majority of the population in developing countries still does not have reasonable access to acceptable, quality health care services.^{1 2}

1 O. O'Donnell, “Access to Health Care in Developing Countries: Breaking Down Demand Side Barriers,” *Cadernos de Saúde Pública* 23 (2007), 2820–34.

2 D. Peters, A. Garg, G. Bloom, D. Walker, W.

Bryant observed that churches were often unaware of both the major problems that needed to be addressed and the relevance and strength of their own resources for doing so. Forty years later, churches have yet to comprehend the magnitude of the problem and their role and potential to make a change in the health of populations.

Bryant highlighted five major challenges to churches in health work: serving the poor, redefining development, promoting social justice, equitable distribution of health services, and development of educational programmes for health personnel that lead to competence and commitment to serve the poor.

On reflection, these challenges are still relevant today.

The commitment and responsibility to serve the poor is the primary challenge Bryant identifies. This biblical imperative is verbalized in the gospel of Luke: "Give to everyone who asks you, and if anyone takes what belongs to you, do not demand it back. Do to others as you would have them do to you" (6:30-31). Christian health care should therefore be built on the love of Jesus Christ, love for others (John 13:34), and equity and justice (Micah 6:8). Caring for "the poor" was the foundation of the earliest mission hospitals.³ Churches have done substantial work in both developing and underdeveloped countries to improve the health of the most vulnerable and poor people. Estimates indicate that Christian health networks contribute between 30 per cent and 55 per cent of health services in African countries, primarily targeting the poor.⁴ The core purpose of Christian health

care should thus be to serve the health care requirements of the poor and the most vulnerable populations.

However, this may be a challenging task for churches involved in health work today. Health systems in developing countries are often competitive and profit oriented, and often exploit the sick and violate Christian principles and values. The health care problems and requirements of the faith sector require a keen and inclusive strategic approach which will not compromise the sustainability of institutions. The existing resources need to be effectively and efficiently used to ensure financial fairness and equitable access to all. Churches should further have strategies to mobilize additional resources through appropriate partnerships with governments, non-governmental organizations, and bilateral and multilateral organizations. These strategic partnerships are critical for promoting and influencing pro-poor policies and programmes at a country level.

Second, Bryant suggests a need for redefining development and its link to health, considering the impact of better health on development and poverty reduction, and conversely, the impact of development on the achievement of health.⁵ This is still necessary today, especially in developing countries. Development is not just economic growth, but includes educational attainment, level of equality, and a productive and healthy population with control over their lives, through understanding their rights. Evidence abounds that the overall health of the population depends not only on medical care, but also on socio-

Brieger, and M. Hafizur Rahman, "Poverty and Access to Health Care in Developing Countries," *Annals of the New York Academy of Sciences* 1136 (2008), 161–71.

3 G. Ferngren, "The Sick Poor and the Origins of Medical Charity," in *Church Health Reader* (Memphis, Tenn: Church Health Centre, 2014).

4 R.C. Kagawa, A. Anglemeyer, and D. Montagu, "The Scale of Faith-Based Organization Participation in Health Service Delivery in Developing Countries:

Systemic Review and Meta-Analysis," *PLOS ONE* 7:e48457 (2012).

5 WHO, *Effective Aid, Better Health: Report Prepared for the Accra High-Level Forum on Aid Effectiveness, 2-4 September 2008* (Geneva: World Health Organization, 2008).

economic and cultural factors.^{6 7} This necessitates a multidimensional and multi-sectoral approach in addressing the social, economic, and environmental determinants of health, and not only the immediate causes of illness and disease. To improve the quality of life in the population, the church should therefore look at health in the context of an overall development agenda.

Dr Bryant further highlights the importance of ensuring equitable access to basic and essential health services through a network of primary health care services. This has become even more relevant in the current health context. The experience of Christian missionaries in developing countries was one of the major influences for PHC; the term “Primary Health Care” was probably first used in *Contact*.⁸ However, in many developing countries, Christian health services succumbed to the competitive market and reverted to a hospital-based health care system with relatively less emphasis on Primary Health Care. It is time for churches to revive Primary Health Care and provide an integrated approach of preventive, curative, and promotive services for both the community and the individual. This will not only bridge the gap between formal service provision and community-based services within households, but also will ensure social justice.

Finally, the churches have a crucial role in providing medical education and developing

the capacity of care providers. Over the years, churches played a pivotal role in medical and nursing education, shaping the practice of medicine. Christian churches were the founders of the earliest medical and nursing schools, both in developing and developed countries, which became the model for others. Medical education for women was particularly promoted and pioneered by churches and made a huge impact in the lives of marginalized women. However, the challenges raised by Dr Bryant are still relevant today. Due to an overemphasis on specialty training, including technological advancements, medical students increasingly focus on monetary benefits and practising in urban settings. To address this, the technical medical education should be redesigned to address the needs of the poor and underserved individuals and communities who are disproportionately affected by health disparities. Technical training that can build the capacity of care providers to provide community-based services in the field of palliative, geriatric, and mental illnesses should be a priority for Christian health services.

Dr Bryant, one of the pioneers of PHC, an active member of the Christian Medical Commission with vast experience in developing countries, provided a strategic direction for churches to develop high-impact and pro-poor policies and programmes. There is no doubt that, even after four decades, his specific guidelines and strategies are still relevant to church health services that want to contribute to achieving equitable health services and social justice.

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6 A. Sheiham, “Editorial: Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. A Report of the WHO Commission on Social Determinants of Health (CSDH) 2008.” *Community Dental Health* 26:1 (2009), 2–3.

7 P. Braveman and L. Gottlieb, “The Social Determinants of Health: It’s Time to Consider the Causes of the Causes,” *Public Health Reports* 129 (2014), 19–31.

8 M. Cueto, “The Origins of Primary Health Care and Selective Primary Health Care,” *American Journal of Public Health* 94 (2004), 1864–74.

6. Review: “Primary Health Care and the Village Health Worker”

Dan Irvine

When *Contact* published “Primary Health Care and the Village Health Worker”¹ in 1975, the global under-five child mortality was 15.6 million per year.² Today that figure has been reduced to 5.6 million, despite a near doubling of world population in the same period. That might be considered a modern miracle – and it is certainly cause for celebration. Much of this success story is attributable to increased immunization rates, saving children from the scourge of measles, pertussis, diphtheria, tetanus, and polio.³ It would therefore be negligent to underestimate progress in Primary Health Care (PHC). The extent to which community system strengthening, including deployment of village health workers (VHWs), has contributed to this progress has proven challenging to evaluate, yet continues to loom large in universal health care strategy.

Health care revolution was in the air in the late 1960s, placing the World Health Organization (WHO) and the Christian Medical Commission (CMC), a semi-autonomous body within the World Council of Churches (WCC), on a collision course that would radically change the trajectory of global public health policy.⁴

In 1967, Kenneth N. Newell became the first director of a newly created division in WHO: Research in Epidemiology and Communications Science. Among the

new division objectives was development of a “rational” approach to health strategy, entailing the “incorporation of epidemiological, ecological and behavioral perspectives into the health service planning process.”

A year later the CMC was formed to assist the WCC in evaluating the performance of church-related medical programs in the developing world, building on field assessments that had commenced from 1963. Three of those assessments – examining alternative community-based methods to address health care in Indonesia, India, and Guatemala, and including the use of VHWs – made their way into Newell’s 1975 publication, *Health by the People*.⁵

Joint analysis between WHO and the CMC led to the 1974 World Health Assembly (WHA) Resolution 27.44, calling for steps to “assist governments to direct their health service programs toward their major health objectives, with priority being given to the rapid and effective development of the health delivery system.”⁶

“Primary Health Care and the Village Health Worker” summarized WHO deliberations leading to the 1975 Executive Board meeting, responding to WHA 27.44, and focused on development of PHC as a means to strengthen national health services. The WHO recommendations at the time were extraordinary, calling for a “new tier of primary care.” They make tacit reference to a largely disadvantaged, marginalized, and vulnerable population without equitable access to primary health care service, as well as a significant funding

1 *Contact* 25 (1975).

2 M. Roser, “Child Mortality” (2018), <https://ourworldindata.org/child-mortality>.

3 E. Zuehlke, “Child Mortality Decreases Globally and Immunization Increases, Despite Unequal Access” (Washington, DC: Population Reference Bureau, 2009), <https://www.prb.org/childmortality>.

4 S. Litsios, “The Christian Medical Commission and the Development of the World Health Organization’s Primary Health Care Approach,” *American Journal of Public Health* 94:11 (2004), 1884–93.

5 K.N. Newell, *Health by the People* (Geneva: World Health Organization, 1975).

6 Litsios, “The Christian Medical Commission and the Development of the World Health Organization’s Primary Health Care Approach.”

and resource gap with which to reach them. They conclude that to address these challenges, health outcome ownership must be cultivated at the community level, health promotion and prevention emphasized, behaviours changed, and community action linked to the formal health system. The contextual approach to design called for a series of “peripheral structures.” There appears to be an underlying assumption that these activities would be cost-effective.

Having established the objective to strengthen community systems to achieve Primary Health Care, the recommendations extend to the description of a proposed Village Health Care Worker system. The leading principles proposed that “All health interventions should be undertaken at the most peripheral practicable level of health services by the worker most simply trained for this activity.” A prescient section follows, describing VHW functionality, considering profile (man or woman who can read and write), supervision (village and health authorities), training (pre-service and in-service), remuneration (cash or in-kind), and role (health care and education, community development, hygiene, referral). The proposed local language-training manual intended to prepare the VHW to address “about 30 current and urgent problems.”

Rather than bridging the health service to individuals, this VHW concept emphasized community responsibility for their health outcomes:

The community development work of the VHW should serve to encourage the village authorities and the village people to show initiative and take interests in any activity likely to improve living conditions in the village. The VHW should first consider what can be done locally with the village’s own resources at the least possible cost.

VHWs were intended to work under the village authorities, and to report to them.

One of their proposed objectives was to catalyse community action. In return, remuneration was to be made by the community, as well as provision of “a hut or a room to be used only for the health activities.”

These strong recommendations from WHO pre-date the Alma-Ata Declaration by three years. But at Alma-Ata, the movement was enshrined in the enduring definition of PHC:

... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.⁷

In the Declaration, community ownership transcends health as a right, to become an individual, family, and community duty.

Primary health care ... requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate.

The early PHC movement was a reaction to the limitations of a purely clinicalized health service delivery system. The proposed “rationalization” of the end-to-end system took a broad perspective on health outcome achievement, considering individual agency, health determinants, and the logistics and cost of practical population coverage. Human rights became a foundation for the new system,

7 Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, http://www.who.int/publications/almaata_declaration_en.pdf.

demanding equity and self-determination. Health care providers expected, in return, to achieve a greater cost-effectiveness through community-level promotion and prevention, as well as community-financed service in part through cadres like the VHWs.

While support for PHC may have waxed and waned in the years between 1975 and today, it is fair to say that with the advent of the Sustainable Development Goals (SDGs) era, it has achieved a new peak. The terminology of PHC persists. The WHO Draft Thirteenth General Programme of Work 2019–2023 states: “Primary health care is indispensable to progress to Universal Health Care and remains central to the unfinished agendas for communicable diseases, and for maternal, new-born, child and adolescent health.”⁸ The work plan is flush with references to promotion and prevention, multi-sector approaches, “whole-of-society” policies, “people-centred” health systems, equity, and “community involvement”. The draft plan document presents a quote from the new WHO Secretary-General, Dr Tedros Adhanom Ghebreyesus, on its cover: “Health is a human right. No-one should get sick or die just because they are poor, or because they cannot access the services they need.” A 2009 evaluation of PHC impact charts a steady increase in the number of new articles published per year in PubMed with “PHC” in the abstract or title, from about 20 articles in 1975 to over 500 in 2005.⁹

It is the emergence of Universal Health Coverage (UHC) as a Sustainable Development Goal Target (Target 3.8), however, that most dramatically realizes the ideal of 1975 today. WHO defines UHC as “ensuring that all people have access to needed promotive, preventive, curative and

rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.”¹⁰ Perhaps the most distinguishing factor between PHC and UHC is the former’s emphasis on individual and community agency. UHC connotes as well a sophisticated government policy of finance mechanisms, insurance, and social protection. In fact, a summary of events leading to the 1975 WHO Executive Board recommendations, and subsequently the Alma-Ata Declaration, should include origins of state-led policies to achieve universal health care coverage, such as the 1883 launch of Germany’s Social Health Insurance system, and the 1948 founding of the British National Health Service.¹¹ Otherwise, the ethos of essential health care provision as a human right, realized through cost-sensitive policy, remains intact.

In the preface to their 2017 global monitoring report on UHC, the WHO and the World Bank suggest: “Never before has there been as much political momentum for universal health coverage as there is right now. And never before has there been greater need for commitment to health as a human right to be enjoyed by all, rather than a privilege for the wealthy few.”¹² The report points to encouraging evidence of UHC progress, stating that “average coverage for a sub-set of nine tracer indicators used in the index with available time series increased by 1.3% per annum, which is roughly a 20% increase from 2000 to 2015.” The most rapid areas of coverage

8 WHO, Draft Thirteenth General Programme of Work: 2019–2023 (Geneva: WHO, 2018).

9 J. Macinko, B. Starfield, and E. Temitope, “The Impact of Primary Health Care on Population Health in Low- and Middle-income Countries,” *The Journal of Ambulatory Care Management* 32:2 (2009), 150–71.

10 WHO, Universal Health Coverage (Geneva: WHO, 2018), http://www.who.int/healthsystems/universal_health_coverage/en.

11 J.B. Bump, “The Long Road to Universal Health Coverage: Historical Analysis of Early Decisions in Germany, the United Kingdom, and the United States,” *Health Systems & Reform* 1:1 (2015), 28–38, doi: 10.4161/23288604.2014.991211.

12 World Health Organization and International Bank for Reconstruction and Development / The World Bank, *Tracking Universal Health Coverage: 2017 Global Monitoring Report* (Geneva, 2017).

increase were in anti-retroviral treatment for HIV (from 2% to 53%) and use of insecticide-treated bed nets to prevent malaria (from 1% to 54%).

Sadly, the report also observes that “at least half of the world’s population does not have full coverage of essential services,” and that “200 million women have inadequate coverage for family planning and nearly 20 million infants fail to start or complete the primary series of diphtheria, pertussis (DTP)– containing vaccine, with substantially more missing other recommended vaccines.” A challenge like malnutrition might be a better proxy indicator for the full intent of PHC/UHC, evoking not only service coverage, but the multi-dimensional determinants of health outcomes, as well as preventative practices such as infant and young child feeding. The 2017 Global Nutrition Report suggests that despite many countries having made progress on targets related to stunting, wasting, and overweight, the world is off track to meet nutrition targets.¹³ About 2 billion people suffer from micronutrient malnutrition; 800 million suffer from calorie deficiency; and 159 million children are stunted.

A 2009 assessment of 36 peer-reviewed studies on PHC impact found that “Reductions in infant mortality (the most frequently studied outcome) attributed to PHC actions averaged about 40%, and varied from 0% to as high as 71% over intervention periods ranging between 2 and 10 or more years.”¹⁴ This conclusion both is compelling for PHC and gives pause as to its consistency in effectiveness. The assessment observes that interpretation of PHC impact is hampered by poor operational conceptualization and

inadequate peer-reviewed evaluation. It also highlights the importance of “accurately measuring variations in the technical quality of primary care delivered. Most of the positive PHC case studies assessed included implementation of VHWs, and VHW success was linked to professional health worker supervision. Conversely, negative case studies cite, for example, effects of singularity of intervention focus (such as sexual and reproductive health) versus “comprehensive” approaches, and “overworked and/or inadequately trained staff.”

In 2008, the International Labour Organization developed a definition for “community health workers”:

Community health workers provide health education and referrals for a wide range of services, and provide support and assistance to communities, families and individuals with preventive health measures and gaining access to appropriate curative health and social services. They create a bridge between providers of health, social and community services and communities that may have difficulty in accessing these services.

The contemporary daunting taxonomy of CHWs has been presented as an impediment to effective harmonization, support, and evaluation of CHW programs.¹⁵ VHWs, as proposed in 1975, would be one loosely defined interpretation of what has become a much more complex concept in frontline health worker cadres. In a census of its program support for over 220,000 CHWs in 2015, World Vision, an international NGO, found that in 48 countries surveyed, 80% of the Ministries of Health had CHW-supportive policies, and that CHWs were addressing in aggregate at least 25 distinct health and nutrition issues, including tasks as disparate as

13 International Food Policy Research Institute, *Global Nutrition Report 2016: From Promise to Impact: Ending Malnutrition by 2030* (Washington, DC: International Food Policy Research Institute, 2016).

14 Macinko, Starfield, and Temitope, “The Impact of Primary Health Care on Population Health in Low- and Middle-income Countries.”

15 Frontline Health Workers Coalition, *A Commitment to Community Health Workers: Improving Data for Decision Making* (2014).

community case management of childhood illness, community management of acute malnutrition, community management of mother-to-child transmission of HIV, and integrated reproductive, maternal, and child health behaviour change.¹⁶

A 2007 review paper commissioned by the WHO to examine the state of evidence for CHW programs echoes the PHC assessment conclusions:

... CHW's can make a valuable contribution to community development and, more specifically, can improve access to and coverage of communities with basic health services. There is robust evidence that CHW's can undertake actions that lead to improved health outcomes, especially, but not exclusively, in the field of child health. However, although they can implement effective interventions, they do not consistently provide services likely to have substantial health impact, and the quality of services they provide is sometimes poor.¹⁷

The assessment cites weaknesses in training, task allocation, and supervision that need to be addressed. Dr Henry Perry's 2013 "A Brief History of Community Health Worker Programmes" also cites these issues, and adds challenges of CHW remuneration and incentive, continuing education, integration with the health system, logistical support for supplies and medicines, and acceptance by higher-level health care providers.¹⁸

In 2013, the USAID-funded Healthcare Improvement Project finalized a tool with

which to assess CHW program functionality, in the process systematically reviewing the factors that are most critical for CHW program success.¹⁹ The resulting framework responds well to the challenges cited above. Fifteen areas of functionality emerged: recruitment, role, initial training, continuing training, equipment and supplies, supervision, individual performance evaluation, incentives, community involvement, referral system, opportunity for advancement, documentation and information management, health system linkage, program performance evaluation, and country ownership. It is amazing to see the extent to which the 1975 recommendations predicted and advised this scope of functionality. And yet as consistently assessed, addressing these factors comprehensively has proved elusive. For example, in a World Vision assessment of CHW functionality within its own supported program in Mozambique, on a four-level scale ranging from "Non-Functional" to "Highly Functional," the program was found to lie between "Partly-Functional" and "Functional."²⁰ This means that CHW functionality was suboptimal across the majority of the assessment areas. This is a common story.

Suboptimal functionality, along with the diversity of CHW program types, makes evaluating the impact of CHW challenging. These effects are noted in a 2015 systematic review of CHW program cost and cost-effectiveness.²¹ Noting the limitations, that review found CHW programs both to be cost-effective and

16 M. Cisney, *Expanding World Vision's Impact through Community Health Workers: A Global Census of Progress to Scale* (World Vision International, 2015).

17 U. Lehmann and D. Sanders, *Community Health Workers: What Do We Know about Them? The State of the Evidence on Programmes, Activities, Costs and Impact on Health Outcomes of Using Community Health Workers* (Geneva: WHO, 2007).

18 H. Perry, "A Brief History of Community Health Worker Programs," in *Developing and Strengthening Community Health Worker Programmes at Scale: A Reference Guide for Programme Managers and Policy Makers* (USAID-MCHIP, 2013).

19 L. Crigler, K. Hill, R. Furth, and D. Bjerregaard, *Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving Community Health Worker Programs and Services*, rev. version (Bethesda, Md.: University Research Co., 2013).

20 M. Ernesto, *Mozambique Readiness for CHW/ttc Programming* (Mozambique: World Vision, 2012).

21 K. Vaughan, M. Kok, S. Witter, and M. Dieleman, "Costs and Cost-effectiveness of Community Health Workers: Evidence from a Literature Review," *Human Resources for Health* 13:71 (2015), doi: 10.1186/s12960-015-0070-y.

to reduce coverage cost in reproductive, maternal, newborn, and child health; tuberculosis; malaria; and other health priority areas. The importance of this analysis cannot be overestimated in light of a current annual global health financing gap of \$33 billion,²² and an estimated need for 40 million new health and social care jobs globally by 2030 to achieve universal access.²³

Authors of the 1975 *Contact* article would be alarmed at the 2007 WHO review finding that

the concept of community ownership and participation is often ill-conceived and poorly understood as a by-product of programmes initiated from the centre. Evidence suggests that CHW programmes thrive in mobilized communities but struggle where they are given the responsibility of galvanizing and mobilizing communities.²⁴

22 Global Finance Facility (2018), <https://www.globalfinancingfacility.org/introduction>.

23 WHO, *Global Strategy on Human Resources for Health: Workforce 2030* (Geneva: WHO, 2016).

24 Lehmann and Sanders, *Community Health Workers*.

Three factors are highlighted as contributing to these challenges:

- 1) institutionalizing and mainstreaming community participation;
- 2) sustaining volunteerism for long periods; and
- 3) community financing.

From 1975 to the present, PHC as well as VHW/CHW programs have been inconsistently implemented, and yet have demonstrated cost-effective impact when implemented well. In this advancing era of UHC focus, it is imperative to move beyond the theory and piloting of PHC and accelerate it systematically and scientifically, with conceptual coherence and with implementation quality. For the most vulnerable populations in the world, in the most fragile contexts, UHC may take a century or more to realize. This sobering conclusion evokes a similar urgency felt by our predecessors in 1975, and might conclude the same recommendation for scaling up PHC with priority.

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7. Health-Promoting Churches: A Case for Congregation-Based Health Promotion Programmes

Mwai Makoka

In this edition of *Contact*, the background and history of Primary Health Care (PHC) have been discussed extensively. Many of these articles have contained references to the role of community health workers (CHWs) and more and less “professional” PHC programmes provided by faith-based organizations. The role of the Christian medical community has been emphasized.

There is, however, a specific asset in faith communities that has not been addressed yet: the congregation or local church. The local congregation is an underused but effective and relevant ally for health programmes.

Three specific examples of congregational programmes will be discussed to reflect on the following questions: Can churches be mobilized to engage in health matters

at the grassroots for the direct benefit of the church members themselves? How would this be different from running church clinics and hospitals? Are there any special advantages of running a health promotion programme at the level of a local congregation?

For these and other questions we turn to Tonga, North Carolina (USA), and Jamaica to learn from three very different courageously innovative health-promoting churches.

1. Health-promoting Churches Partnership, Tonga

The Kingdom of Tonga is an island nation in the South Pacific Ocean on 52 inhabited islands with a total size of 748 km²; 70% of its population of 109,000 lives on Tongatapu, the main island. The Tongan people's demographic origins are Polynesian and Melanesian, with strong tradition and kinship ties, and a Christian heritage. A large part of the population is in the diaspora, especially in New Zealand, Australia, and the United States.

Economically, Tonga depends on remittances from the diaspora and on agricultural exports. Situated within the "Ring of Fire," Tonga has been battered by cyclones and other natural disasters. The effects of climate change are real and frightening, causing rising sea levels and changing weather patterns.

Recognizing the problem

The World Health Organization (WHO) STEPwise Approach to Chronic Disease Risk Factor Surveillance (STEPS) is the recommended surveillance tool for the major non-communicable diseases (NCDs) and their shared modifiable risk factors – unhealthy diet, physical inactivity, tobacco use, and alcohol abuse. These risk factors in turn lead to four key metabolic changes that increase the risk of NCDs: raised blood pressure, obesity, raised blood sugar, and high levels of fat in the blood.

The STEPS survey done in Tonga in 2004 showed that almost the whole population (99.9%) between the ages of 25 and 64 was at moderate to high risk of developing disease. Six out of every 10 adults (60.7%) were considered at high risk: that is, they had at least three risk factors. NCDs accounted for 74% of all deaths in the country.

The government made several efforts to respond to this problem, including the Tonga Commitment (2003), Tonga Strategy for Prevention and Control of NCDs (2004), and Tonga Path to Health, all of which had limited impact. Considering the urgency of the problem, collaboration was sought from the church community, given that the majority of the population are Christian.

Health-Promoting Churches Partnership, Haofaki Mo'ui (Save Lives)

In September 2008, the Free Wesleyan Church of Tonga established a Church Health Committee to serve the health needs of the church. At its first meeting, the committee invited WHO to provide technical support, and it was decided to establish a task force encompassing all denominations to chart a way for a church-wide NCD programme. The task force also included the Ministry of Health and WHO, and was responsible for all the preparatory consultations and proposed governance and coordination structures. The programme was piloted in one village for six months before the official launch in August 2009.

Based in the National Forum of Church Leaders (NFCL), the programme collaborates closely with the Ministry of Health's Health Promotion Unit. It is co-chaired by the chief executive officer of the Ministry of Health and the NFCL chairperson, while Her Royal Highness Princess Mele Siu'ilikutapu is the Patroness. At the operational level, a working committee is chaired by the general secretary of the NFCL.

Programme components

The programme has four main components, based in local congregations or churches:

- **Health Education:** feasting is a notable custom in Tonga; excessive amounts of food are consumed at all social and religious gatherings. To address this, health talks cover healthy foods, healthy cooking, healthy eating habits, how to grow fruits and vegetables at home, and more. Evening education sessions in church halls allow for in-depth discussions. Cooking demonstrations are also held. A food pyramid has recently been introduced to provide more practical guidance.
- **Fruit and vegetable gardens:** churches distribute seeds for members to grow in their backyards to help reduce the consumption of meat and fish. They also form smaller groups that share and swap their harvests, and share with other church members. Some gardeners also creatively intercrop, mixing edible crops with flowers and enhancing the beauty of their yards.
- **Aerobics:** men, women, and even children participate in aerobic exercises in the evening after work hours, led by an instructor and accompanied by lively music. These are held in churches and community centres. The instructor and sound system are provided by the Ministry of Health.
- **Screening for NCDs:** periodic screening is conducted by the Ministry of Health in different churches and includes measurement of blood pressure, weight, height, blood sugar, and cholesterol. Smoking and drinking habits are also documented, and health talks and counselling are provided.

Achievements and challenges

There has been progressive scale-up of Haofaki Mo'ui in Tongatapu. By 2017 the programme was running in 20 congregations. It has also been extended to three other smaller islands, namely Vava'u and Ha'apai in 2012 and 'Eua in 2013.

The second STEPS survey in 2012 showed a slight improvement: for example, 98.7 per cent of the population was at high or moderate risk of NCDs, down from 99.9 per cent in 2004.

Challenges include that implementation of programme activities has not been consistent and standardized across participating churches. Monitoring and evaluation systems are also weak, making it impossible to track progress at individual and higher levels. The early departure of the then WHO country head, Dr Pratap Jayavanth, who played a championing role in the programme, left a leadership gap. Inadequate financial and technical resources have also prevented the programme from reaching its full potential.

Summary

Haofaki Mo'ui has thrived for over eight years and has demonstrated the strength of a grassroots ecumenical movement committed to responding to its lived realities. Strong partnership with the Ministry of Health has been invaluable. Systems strengthening and capacity building, while undergirding the programme with biblical grounding, will further strengthen it.

2. Village Heart Beat, North Carolina, Usa

Mecklenburg County in North Carolina is home to over 1 million people: approximately 48 per cent white, 31 per cent African-American, 13 per cent Hispanic, and 9 per cent other races. There are clear and significant health disparities on racial grounds, and key health indicators are poor in areas (zip codes) that are predominantly inhabited by non-white races.

Village Heart BEAT

The goal of Village Heart BEAT is to prevent cardiovascular diseases through adopting healthy behaviours in high-risk populations and geographic locale. The

acronym BEAT describes the approach of this community engagement programme: Building community capacity; Education for increasing awareness and understanding of cardiovascular disease prevention; Accountability for success, including monitoring individual and partner adherence to programme objectives; and working Together with participant input in all aspects of the programme.

Programme components

- **Health as shared value:** the programme identifies, recruits, and trains congregations. These can already be working independently on health matters, or not. Key leaders are trained as health ambassadors.
- **Create impact at the policy, systems, and environmental level:** churches locally institutionalize evidence-based changes, such as enacting a policy prohibiting tobacco use on the church campus, or on the quality and quantity of food served during church gatherings.
- **Community health leadership academy:** this equips Community Health Ambassadors from local congregations with information and resources or tools on basic health issues as well as chronic diseases. Information about health and human services is included to reduce health inequities in local communities. The modules are divided into two semesters: one on health services, and one on public health and prevention of chronic disease.
- **Competition:** church members from a specific congregation who have cardiovascular disease risk factors form 10-member teams and engage in a 16-week friendly competition to i) improve healthy eating, ii) increase physical activity, iii) promote weight loss, and iv) increase knowledge on cardiovascular disease. The winning team is the one that accumulates the most points by reducing the identified risk factors, including cessation of smoking. The free fitness program is a fun and

healthy competition among congregations which aims to lower heart disease risk factors of participants and the local community as a whole.

- **Measurements:** robust and standardized measurements are conducted before, during, and after the competition, including blood pressure, weight, height, blood sugar, and cholesterol.

Achievements and challenges

Participation in Village Heart BEAT has grown from seven churches (70 participants) in 2013 to 28 churches (280 participants) in 2018. Importantly, retention is almost 100%, with incremental growth in the number of participants: once enrolled, people participate in the programme year after year. Ninety-six per cent of the individual participants in the 2017 challenge registered improvement in at least one of their risk factors.

The programme is a partnership between the County Department of Health and church leaders. It enjoys support in IT, monitoring, and evaluation from the University of North Carolina; publicity from local media houses; technical and material support from the American Heart Association; clinical backup and laboratory services from local hospitals; and sundry support from YMCA and the county commission.

With these achievements, Village Heart BEAT has already won some national recognition as an effective programme to drive sustainable lifestyle change with clinically significant outcomes.

The programme has registered remarkable growth, which poses its own challenges. It also faces the challenge of addressing inclusivity: how can Village Heart BEAT reach other ethnic groups in the county, especially in a community where racial boundaries remain strong.

Summary

Village Heart BEAT is a remarkable demonstration of what can be achieved when church congregations are mobilized at the grassroots for concrete action on health matters. A partnership of mutual respect and understanding between the government health department and the African-American churches has been instrumental in the success of the programme. Collaboration with other sectors has widened ownership of the programme and brought in much-needed expertise and support.

Village Heart BEAT contributes to the Sustainable Development Goals in a remarkably innovative and effective way.

3. Whole-Person Ministry, Jamaica

Contact No. 113, published in February 1990, was dedicated to sharing the experience of the Bethel Baptist Church in Kingston, Jamaica. With the title “A Whole-Person Healing Ministry,” it showcased the Bethel experience as one way in which a church congregation can be involved in health care.

In 1972, the Bethel Baptist Church embarked on a series of theological reflections on the role of the church in healing. Some members had become disillusioned with the mind/body and spirit/matter dualism, which had limited the effectiveness of both Western scientific medicine and the church’s mission, in Jamaica and elsewhere. A whole-person ministry was started in 1974, providing medical, spiritual, and psychosocial services in an integrated manner.

Now, on the occasion of the 70th anniversary of the WCC and the 40th anniversary of Primary Health Care, we revisit Kingston to understand how this ministry promoted the role of the church on health and the implementation of the PHC model.

Jamaica

Jamaica is a Caribbean island nation, 230 km long and 80 km wide (10,911 km²), with a population of 3 million people who are mainly descendants of slaves brought from Africa to work in the sugar fields of British owners. Slavery was abolished in 1838 and the country obtained its independence from Britain in 1962. The legacy of slavery and colonialism, however, continues. A weak family fabric, economic marginalization (especially of the majority youth), emigration of the productive middle-aged group to America and Canada, gun violence, migration to the capital city, and weak community support systems are harsh consequences of Jamaica’s history.

The 1990 publication reported that, whereas Jamaica provides “free” health services to all, the services were inadequate – people queued for hours to receive medical attention, and the waiting lists for surgery and elective procedures were long. Unfortunately, there has been little or no improvement in this situation. Private physicians, hospitals, and pharmacies have mushroomed, but the impoverished majority remains underserved.

Starting a whole-person ministry

After two years of theological reflections, Bethel Baptist Church started a whole-person ministry with a Healing Centre in the church building, providing evening counselling and prayer services. In 1975, a part-time medical doctor was added, and in 1985 it started providing full-week services with full-time professionals in a purpose-built building.

The whole-person ministry is a congregation-sponsored programme comprising medical, counselling, socio-economic, and spiritual care. It uses professional, semi-professional, and non-professional people, largely on a voluntary basis.

Health fairs are held annually. These are week-long events filled with screening for noncommunicable diseases, discussions of various health topics, and surgical and clinical services, culminating in a liturgical healing prayer service on Sunday. These health fairs have expanded beyond Bethel; currently more than 10 denominations hold annual health fairs throughout Jamaica.

Clinic services at Bethel Baptist include daily walk-in outpatient care, counselling, and a pharmacy for both prescription and over-the-counter medicines. Special ministries provide care and support, including bereavement support, women's health, cancer support, prayer and visitation, elderly care, mental health, and support for the homeless.

The congregation is organized into birth month groups, where people born in the same month form one group that provides care and support to each other. The groups have become a strong cohesive factor, promoting intergenerational dialogue and cutting across socio-economic class. The church also runs a school for the disadvantaged, offers vocational skills training and support (such as a business centre where the unemployed learn computer skills, prepare CVs, and write job applications or proposals), and runs a youth internship programme.

This ministry has been wholly funded by the church, with a dedicated budget line. A foundation was also established to champion resource mobilization beyond the church's budgetary support.

Achievements and challenges

This whole-person ministry has demonstrated resilience, as it has survived for more than 40 years. It has established itself in the community at large, and about 90% of the service users are not members of the church. The church has continued to finance this work, although modestly, ensuring subsidized services.

There is limited collaboration among the different churches and congregations, on one hand, and between the churches and the Ministry of Health, on the other. The early guiding documents developed by Dr Anthony Allen and others who pioneered this ministry have not been consistently used and improved upon. The ministry programme has therefore not been developed systematically or standardized, and monitoring and evaluation protocols are still underdeveloped.

Summary

The whole-person ministry at Bethel Baptist Church has thrived over the past 44 years, and the model has been extended to other churches in Jamaica. This demonstrates the resilience and sustainability of a theologically grounded, congregation-based health programme. There is potential for churches to contribute on a greater scale, through both facility- and community-based health care, to achieve universal health coverage in Jamaica.

Concluding thoughts: Is there a role for health-promoting churches in Primary Health Care?

With this knowledge of specific congregation- or church-based health programmes, we return to the questions posed at the beginning of this article.

Can churches be mobilized to engage in health matters at the grassroots for the direct benefit of church members?

The examples clearly show that local congregations can be and have indeed been mobilized. The longevity of some of these programmes proves the sustainability of this model. In spite of the challenges mentioned in each of the case studies, these examples clearly illustrate the significant role that church-based programmes can play in the health of the church's own members, as well as that of the local community.

How would this be different from running church clinics and hospitals?

The clear difference is that these services are integrated into the lives of the faith community as well as the local community. Health-promoting churches particularly focus on prevention and building the capacity of individuals and communities to take responsibility for their own health and well-being. These programmes are particularly efficient when they succeed in building strong partnerships among a variety of stakeholders.

Are there any special advantages of running a health promotion programme at the level of a local congregation?

Although the energy and guidance for health engagement in congregations

mostly originate from Christian health professionals, this is only part of the picture. Programmes based in local faith communities can benefit from, as well as strengthen social cohesion in, the community and provide particular benefits from peer learning. As such, it is important in the health and development of the faith community as well as the broader community.

As we reflect on the Alma-Ata Declaration 40 years on, we would be wise to include congregation-based programs in our faith-based health strategies.

Dr Mwai Makoka is programme executive for Health and Healing, World Council of Churches, Geneva.

8. The Historical Involvement of the Christian Medical Commission and Churches on the Politics of Breastfeeding

Erlinda Senturias and Mwai Makoka

One of the recurring themes in the run-up to and development of the Alma-Ata Declaration is that of justice. This was emphasized particularly by the World Council of Churches (WCC), through the Christian Medical Commission (CMC), and other faith-based organizations. In addressing unjust systems and policies, advocacy at local and international levels soon became crucial.

One of the early justice issues is the politics of breastfeeding.

For centuries, breastfeeding, by mothers or wet nurses, was the primary form of nutrition for babies. Milk formulas developed slowly to deal with the unfortunate instances where breast milk was not available. Over time, the use of breast-milk substitutes was increasingly and aggressively marketed. In developing

countries particularly, this proved disastrous. It was clear that the Acceptable Feasible Affordable Sustainable and Safe (AFASS) principles for breast milk substitution could not be met, and more importantly, that financial profit outweighed the health of babies.

In the 1990s, Dr Erlinda N. Senturias, executive secretary of WCC CMC—Churches' Action for Health, recorded the involvement of the CMC and churches in this issue in a comprehensive unpublished article. It is important to review key points of this history.

Early 1970s' warning on the dangers of bottle feeding

The dangers of bottle feeding in the third world became known from the early 1970s. A few voices at medical congresses and in professional journals warned against the way milk companies promoted infant

formulas. In a widely publicized article, "Commerciogenic Malnutrition," Derrick B. Jelliffe denounced the promotional activities of the baby formula companies. The Protein-Calorie Advisory Group of the United Nations System issued a statement on 18 July 1972 emphasizing the importance of breastfeeding and in March 1974, War on Want published "The Baby Killer," an article condemning the advertising methods used in promoting dried milk products.

The rising tide of public opinion

In June 1974, Nestlé sued the Third World Action Group from Berne, Switzerland, for libel. This generated public attention and raised the issue into a grassroots movement.

By November 1974, the lawsuit had generated media interest in many parts of the world. As the case dragged on to November 1975, the Third World Action Group held an international press conference at the United Nations in Geneva, chaired by Ruth Nita Barrow, associate director of the CMC.

The WCC followed the case closely. James McGilvray, director of the CMC, was involved; he monitored the developments within the WCC member churches and regional ecumenical organizations and held discussions with Nestlé executives. The CMC affirmed that its interest was to encourage the infant feeding industry to seriously reconsider the most basic issues rather than just make minor adjustment in their practices.

In the winter of 1974, the Interfaith Centre on Corporate Responsibility (ICCR), a movement of the National Council of Churches of Christ in the USA (NCC), began its own investigation into infant formula abuse in the third world by US corporations. ICCR member groups filed shareholder resolutions with US formula companies requesting precise information on sales and promotional practices. In

January 1975, they met with Bristol-Myers management for the first time.

The day before the verdict in Nestlé's libel case, in June 1976, the company dropped three of the four libel charges: that the activity of Nestlé and other companies was unethical and immoral; that by its selling practices Nestlé was responsible for the death or permanent mental and physical injury to thousands of infants; and that the baby food sales personnel in developing countries were camouflaged as nurses. Nestlé did, however, win on the charge related to the title of the pamphlet "Nestlé Totet Babys" (Nestlé kills babies). Judge Jurg Sollberger fined the Third World Action Group a token amount and declared, "If the complainant [Nestlé] in future wants to be spared the accusation of immoral and unethical conduct, it will have to change advertising practices."¹

Nestlé boycott in the United States

In 1975 Nestlé promised a moratorium on advertising infant formula. However, the Infant Formula Action Coalition (INFACT), a US-based consumer organization, continued to receive reports of extensive advertising by Nestlé from many parts of the world. In July 1977, INFACT, together with Church Women United, launched a US boycott of Nestlé products, demanding an end to all promotion of infant formula. Two WCC member churches, the Presbyterian Church in the United States and the Evangelical Lutheran Church of America, joined the boycott.

On 3 November 1978, the NCC endorsed the boycott. The governing board of NCC called on Nestlé to cease unethical promotion of its infant formula; endorsed the international boycott and instructed all its agencies to observe the boycott; called upon its member churches to seriously consider the issue; called on all Christians

¹ Quoted in A. Chetley, *The Politics of Baby Foods: Successful Challenges to an International Marketing Strategy* (London: Francis Pinter, 1986), 45.

and persons of goodwill to join the boycott; and called on the US government to refuse to support the promotion of infant formula at home and abroad.

Advocating internationally and at the grassroots

In observance of the International Year of the Child, the CMC published an article in *Contact*, edited by D.B. and E.F.P. Jelliffe: "Improving the Nutrition of Mothers and Young Children – Recommendations for the International Year of the Child from the International Union of Nutritional Sciences (IUNS)."² The article emphasized the superiority of mother's milk: providing the best nourishment for the baby, protection from infection, biological child-spacing, and emotional bonding between mother and child. This publication served as a background document for the WHO meeting on Infant and Young Child Feeding held from 9 to 12 October 1979.

This was the first time that NGOs were full participants in such a meeting: participants urged WHO to develop a strong international code on the marketing of breast-milk substitutes. Another key outcome was the founding of the International Baby Food Action Network (IBFAN), which was tasked to more closely coordinate the work of member groups to sustain grassroots pressure.

The CMC served as a resource to many action groups such as ICCR, INFACT, IBFAN, and the Geneva Infant Feeding Association (GIFA), and also provided support to people from the developing world to participate in these activities.

Studying the activities of transnational corporations

Inherent in the concern with the marketing and promotion of infant formula in the third world was an interest in the activities of transnational corporations (TNC). In an effort to understand the baby formula TNCs

– their practices, the effects of their activity, their political and economic structures – and with an interest in finding ways of limiting or influencing their activities, the WCC engaged a full-time consultant and established a broadly representative TNC Task Force.

The task force maintained the WCC liaison with UNIAPAC, an international Christian union of business executives. Stuart Kingma participated in the discussions on the baby food issue with the TNC executives at the UNIAPAC discussions in Fontainebleau and Wolfsberg in 1976 and 1979.

The 1980 General Council of the United Methodist Church (USA) authorized the General Council on Ministries to establish a task force to study the infant formula controversy.

Collaborating with WHO in drafting the International Code of Marketing of Breast-Milk Substitutes

The CMC participated in a number of WHO meetings in which the code was drafted, debated, and redrafted. In May 1980, the CMC participated in the World Health Assembly (WHA) as the only NGO accredited to speak on the code. The CMC's oral submission was presented by associate director Stuart Kingma. He urged that the WHO Director-General be given a mandate to prepare a definitive code of marketing of breast-milk substitutes, in consultation with all parties concerned, to be presented to the World Health Assembly of 1981.

Similarly, in the WHA of May 1981, the CMC made another submission emphasizing that, for the majority in developing countries, formula milk is not sustainable economically and hygienically, with a serious toll in infant morbidity and mortality. During that period, the CMC was the coordinating body for the NGO Group on Primary Health Care. On 21 May 1981, the 34th WHA voted 118 to 1 to adopt a code of conduct designed to restrict the

2 *Contact* 50 (1979).

promotion of infant formula and other breast-milk substitutes and to encourage breastfeeding. The United States was alone in voting against the code.

Monitoring code compliance

After the 1981 adoption of the code, Nestlé took little action to change its marketing practices. An international boycott organized by Action for Corporate Accountability, IBFAN, and International Negotiators for Baby Food Code Compliance continued against Nestlé. In 1982, Nestlé established a monitoring body, the Nestlé Infant Formula Audit Commission (NIFAC) to look into the violations of the code. Robert Campbell, general secretary of the American Baptist Churches, who was also a member of the WCC central committee, and Dean Philip Wogaman of the Wesley Seminary of Washington, DC, served on NIFAC.

The boycott ended in 1984 with the four-point agreement between Nestlé and the boycott organizers. The International Association of Infant Food Manufacturers (IFM), established in 1984, became a recognized NGO representing infant food industries in WHO. Nestlé officials met with WCC general secretary Emilio Castro on 16 July 1987, reporting that IFM had developed guidelines compliant with the WHO code which would replace NIFAC in monitoring the code. Nestlé executive Helmut Maucher confirmed that this also applied to the WHA resolution of May 1986, and reassured the WCC delegation that Nestlé would not make money unethically. The said resolution was a ban on baby milk donations to maternity hospitals, voted in favour by 92 countries, opposed by the US, and abstained by six baby milk-producing countries. A month earlier (16 April 1986), the European Parliament had adopted the code.

Monitoring of the code continued, mostly by action groups in the different countries, especially those affiliated with IBFAN.

Christian health-coordinating agencies organized by the CMC in Africa and Asia-Pacific were sent copies of the code to implement in church-related hospitals and health programmes and to monitor violations by milk companies.

Struggling for health of infants and children

On 14 February 1989, Birgitta Rubenson, programme secretary of the CMC, reminded the various constituencies that “our struggle for health for the infants and children of the world continues,” as breast-milk substitutes were still routinely available.

Noting the decline in breastfeeding and the continuing increase infant mortality in developing and industrialized countries, the CMC published “Breastfeeding for Life.”³ This article brought to the attention of the readership the materials published on the subject by WHO/UNICEF and action groups like IBFAN and GIFA. It also noted the citizens’ groups joining the boycott of Nestlé in Ireland, Switzerland, the Netherlands, Germany, Sweden, and the US. Although several manufacturers disregarded the code, Nestlé was targeted because of its major share of the market.

In October 1989, during the IBFAN 10th anniversary held in Manila, the renewed international boycott of Nestlé was launched in front of the Nestlé office in Makati, Philippines. Action groups began to solicit signatures of people willing to endorse the boycott.

Erlinda N. Senturias, programme secretary of the CMC, who participated in the IBFAN 10th anniversary celebration, brought back disturbing information from the Ministry of Health’s Maternal and Child Health Unit in the Philippines. She highlighted practices of infant formula industries circumventing the code and the difficulty the ministry encountered in the legal processes of suing national code violators in the Philippines.

Reporting back to WHA on the Status of Code Monitoring

Dr Senturias also brought this matter to the attention of the 43rd WHA meeting on Infant and Young Child Nutrition and Status of the Implementation of the International Code of Marketing of Breastmilk Substitutes on 11 May 1990. She cited specifically that “large quantities of infant formula continued to flow into health institutions through the so-called ‘booking scheme’, in direct circumvention of [the code]”.

“Booking” allowed company salesmen to charge supplies delivered to the hospital as a credit purchase on the understanding that payment would not be collected. “Booked sales” were then written off as bad debts. Thus, the manufacturer not only evaded prosecution for furnishing free supplies, but also enjoyed a reduced income tax because of these so-called bad debts. Dr Senturias called on WHO to ensure strict observance of the code to stop “business as usual.”

Alliance building with NGOs and WHO/ UNICEF

The CMC hosted various meetings with Geneva-based IBFAN and received people from the field to get updates on the current status of the code, as well as deliberating on issues of common concern such as breastfeeding and work.

The CMC also participated in the formation of the World Alliance of Breastfeeding Action (WABA) in February 1991, and subsequent meetings and initiatives. Contact featured an article on “Improving the Health of Working Mothers and Their Infants”⁴ and announced the formation of WABA. The CMC participated in the executive briefing on the Baby Friendly Hospital Initiative (BFHI) by WHO/UNICEF in Netherlands in September 1991 and endorsed this initiative, while calling for legislations that would enable mothers to breastfeed at their workplaces and for longer maternity leave. Another meeting

on BFHI took place at WHO headquarters in May 1992. At that meeting, the CMC asked what was preventing the infant formula industries from lifting the free supplies unilaterally, unequivocally, and universally. The representatives of the industry did not respond.

Continuing the pressure

In July 1991, the Synod of the Church of England called for a boycott of Nescafé until Nestlé ended free supplies; the World Alliance of the Reformed Churches disinvested from Nestlé shares early in 1993. These initiatives were important steps in pressuring infant formula companies, notably Nestlé, to really change their marketing practices for now and for generations yet to be born.

Sadly, there are still many examples of unjust manufacture, sale, and promotion of formula milk. Here are just a few: in the 2008 Chinese milk scandal, infant formula was contaminated by melamine, causing at least six deaths as well as illness in 300,000 babies⁵; Lactalis, a French company, admitted that its infant milk formula may have been contaminated by Salmonella for 13 years before the product was withdrawn in February 2018⁶; as recently as July 2018, at the 2018 World Health Assembly, the US voted against a resolution on promoting breastfeeding.

We are frequently asked whether the boycott should continue. Dame Nita Barrow of the CMC (and later the first female governor-general of Barbados), reminded us that insistence on the promotion of breastfeeding is not enough: we need to look at the factors which led to the change in the original practice of infant feeding and take the necessary actions.

5 Y. Huang, “The 2008 Milk Scandal Revisited,” *Forbes Asia* (16 June 2014), <https://www.forbes.com/sites/yanzhonghuang/2014/07/16/the-2008-milk-scandal-revisited/#19ab0bc84105>.

6 E. McKirdy, “Baby milk powder could have been infected with salmonella for 13 years” (2 February 2018), <https://edition.cnn.com/2018/02/02/health/lactalis-baby-milk-powder-salmonella-intl/index.html>.

It is clear that the advocacy of faith communities in the politics of breastfeeding should continue. We must continue to uphold the health of infant and children and be part of that biblical vision: “No more shall there be in it an infant that lives but a few days ... (Isaiah 65:20). The song of Mary gives this promise and hope for those who continue the struggle: “He has

filled the hungry with good things, and the rich he has sent empty away” (Luke 1:53).

Original unpublished article written in the 1990s by Dr Erlinda N. Senturias, executive secretary of WCC CMC–Churches’ Action for Health.

Abridged and edited by Mwai Makoka, programme executive for Health and Healing, WCC, Geneva.

9. From Disability to New Abilities: Case Studies in Disability Care

When the International Conference on Primary Health Care developed the Alma-Ata Declaration in 1978,¹ there were a number of key considerations. The most important of these was probably emphasizing health as a fundamental human right and reiterating that health is a state of “complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.”²

The Christian Medical Commission (CMC), and the faith-based sector in general, framed this as health being an issue of justice. There was significant emphasis on

the need for quality health care among the most marginalized.

If there is one part of the population for whom this has been particularly challenging, it is probably people living with disability (PWD). They are often the most marginalized in society, and access to health care is extremely challenging. The nature of their condition also limits the chances of “complete physical, mental and social wellbeing.”

How, then, can Christian health care organizations provide optimum care for this vulnerable group?

We visit two very different projects from India: programme of Bangalore Baptist Hospital; and the Department of Physical Medicine and Rehabilitation, CMC Vellore.

1 Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, http://www.who.int/publications/almaata_declaration_en.pdf.

2 Declaration of Alma-Ata. International Conference on Primary Health Care.

“You Raised Me Up!” Case Study from Bangalore Baptist Hospital, India

Gift Norman

For the poor, getting timely and affordable medical care is an ordeal. When one has to choose between food on the table and paying to see a doctor, the poor would naturally choose the meal, unless the illness is life threatening.

Overcoming disability and becoming a champion

Forty-four-year-old Shaifullah’s life was shaken not once but three times. Hailing from a small village in Devanahalli Taluk in Bangalore Rural District, his story underlines the struggle and misery the poor face if they fall ill and have to seek medical care.

While working as a labourer in the field, I had a small cut on my right foot. I didn't bother much about it and it got infected. I went for treatment from a clinic next door. When there was no improvement, and my leg began to turn black, I rushed to a bigger hospital. It was too late and the doctor told me that the gangrene had spread and my leg was amputated.

Then I began working with the support of crutches and fell again while trying to balance myself. I had an injury on my other leg and the same cycle followed; neglect and difficulty in accessing a good hospital. My worst fear came true! By the time I ended up in a hospital, my other leg also had to be amputated. Moving around became impossible and I began rolling beedis (cigarettes) at home for a living. Disaster struck again and I developed an infection in both my hands; my left hand and two fingers on my right hand had to be amputated. It was a hopeless situation.

It could be seen as a chance meeting: Shaifullah attended a camp for persons with disabilities organized by the community health team from Bangalore Baptist Hospital. The Empower team conducts camps every Tuesday across the Bangalore Rural District for PWDs.

Shaifullah believes, however, that this "chance" meeting was God's providence. It changed his life. The Empower team counselled Saifullah and his wife and made them believe that there was still hope and life beyond all they had been through. They helped him set up a convenience store and gave him a tricycle so he could move around.

If you meet Shaifullah now, it's hard to believe all that he's been through. He exudes such joy and confidence. His store is doing well and his son is back in school. The years of struggle and perseverance

have transformed him into a champion for other PWDs in his village. "It is all about how you choose to live," says Shaifullah. "You either invite doom and failure into your life, or push away negativity and take on challenges with a smile. You raised me up," says Saifullah when we meet him and his family.

Our role in empowering people with disabilities

The Community Health Division (CHD) of the Bangalore Baptist Hospital Society (BBHS) provides comprehensive rehabilitative services to people with disabilities in 1051 villages of the Bangalore Rural District, with a population of about 1 million. The Directorate for PWDs and Senior Citizens Welfare, Government of Karnataka in India, invited CHD to be its implementing partner to establish the District Disability Rehabilitation Centre (DDRC) for the Bangalore Rural District. The opportunity to reach out to about 40,000 persons with disability in the district was something we could not ignore.

The main activities include, but are not limited to, building local capacity, improving access to information and rehabilitative services, home-based rehabilitative therapy, facilitating access to government benefits, sensitization and advocacy on disability rights, and providing low-cost assistive aids and appliances from the Prosthetic and Orthotic workshop. Learning hubs enable children with developmental disabilities to access much-needed therapy. A small band of multi-skilled staff goes out into the villages providing services at the doorsteps of people with disability.

A picture of progress so far

In the period 2014–2018, 8800 National Disability ID cards were distributed and more than 1,441 assistive devices were provided. By March 2018, 180 children

with developmental delay and intellectual disabilities were registered for therapy, 40 modified toilets were built, 22 livelihood projects were initiated, and there were 172 early identification and needs assessment camps.

However, the statistics are not the most important part of the story. Our business is touching lives and raising people up! Our reach extends to 1051 villages; what a joy to see people like Shaifullah, who has beaten the odds. Munikrishnamma (who used a wooden plank to drag herself around the village) now believes in miracles; she cheerfully moves around on the tricycle she was given. One-year-old Yashwanth,

who was bedridden and in a vegetative state, has learned to sit, stand, and walk; the blind duo of Krishnappa and his sister Bagamma now live in dignity – with a toilet at home.

We are called to raise people and touch lives. We are indeed privileged to be chosen by God to be his instruments. Our motivation is to share the love of God as we walk with the most vulnerable every day. Reaching out to those who have nothing to give in return is the greatest joy in serving God.

Dr Gift Norman is deputy director and head of the Community Health Division, Bangalore Baptist Hospital, India.

From Brokenness to Hope and Healing: Case study from the Department of Physical Medicine and Rehabilitation, CMC Vellore, India

Raji Thomas

The department of Physical Medicine and Rehabilitation (PMR) at CMC Vellore had very humble beginnings and is the lasting legacy of one woman's fearless dreams, inspired by apparent brokenness.

Dr Mary Verghese, the founder of the department, joined the college as a medical student in 1946. An accident at a picnic with her fellow interns caused a spinal cord injury and resulted in paraplegia. With no rehabilitation services available in the country, she underwent rehabilitation in the Royal Perth Hospital in Australia, where she was trained to be independent from a wheelchair. Her burning desire to start rehabilitation services in India led her to pursue higher studies in Rehabilitation Medicine in New York.

Returning with the highest post-graduate qualification in the specialty, she started the Department of PMR and the Rehabilitation Institute on 26 November 1966 – the first of its kind in the country for patients with severe disability.

Patients soon started coming for rehabilitation from all over the country –

children with cerebral palsy, patients with spinal cord injuries, acquired brain injuries, amputations, stroke, haemophilia, chronic pain, and more.

Her journey came to an end on December 17, 1986, but her vision continues. More than 30 years later, we salute Dr Mary for her vision and faith. She gives us hope and a reason to believe.

Our role in empowering people with disabilities

The services of the Department of PMR and the Rehabilitation Institute are many and varied, and cannot be discussed in detail in a publication of this nature.

Patients go through several stages of rehabilitation to become independent, involving many aspects, including physical, spiritual, social, and vocational care. This is made possible by a multidisciplinary team. The patient and family actively participate in the decision-making process and form an integral part of the rehabilitation team.

The emphasis in the programme is on building the patients' confidence and teaching skills for a life beyond disabilities.

Patients who are substantially and permanently disabled are helped to make the best use of their residual capacity and to lead lives that are as full and productive as possible.

Weekly team meetings with the patient and family provide opportunities for broader goals and integrated interventions. All team members work together; the cohesive team enables comprehensive patient care and better functional outcomes.

Team members and activities include the following:

- the medical team, including physiatrists (physical medicine and rehabilitation physicians), addresses medical problems which are complications of the disability;
- the Gait Analysis Lab focuses on understanding the dynamics of movement;
- nursing staff introduce the patients to a different, but worthwhile, way of life, teaching care but also helping patients to understand the diagnosis and ways to cope with it;
- physiotherapists work towards strengthening muscles and employ compensatory strategies to improve mobility with appropriate appliances;
- occupational therapists focus on enhancing function by training independence in activities of daily living, cognitive retraining, and use of assistive aids;
- speech therapists work to improve speech and communication, introduce use of augmentative communication methods, and ensure safe swallowing;
- the psychologist assesses neuro-behavioural and cognitive issues and provides counselling through the period of grief with input from the psychiatry team;
- the engineers, prosthetists, and orthotists fabricate modular, low cost, light-weight orthoses and prostheses to assist weak muscles and replace lost limbs;

- social workers are a vital connection between the patient, family, rehab team, and community: they assess socioeconomic and vocational background and environmental accessibility through home visits so that contextually appropriate goals can be made, give vocational guidance, and educate about rights, responsibilities, and social security benefits.

In addition to the normal in-patient services,

- A dedicated paediatric rehabilitation unit treats young children in a holistic, yet friendly, manner and provides guidance on schooling opportunities and training for life skills.
- Vocational rehabilitation opens new economic avenues such as tailoring, bicycle repair, basket weaving, and cane work, which enable patients to lead full and productive lives.
- Additional psychosocial support is provided by the chaplain and chapel in the heart of rehab; group therapy sessions; experience sharing by alumni; celebration of national days and festivals; picnics; and art therapy.
- Sport is a way to regain fitness, boost self-esteem, and restore personal dignity.
- Community services, including home visits, support groups, and annual rehab festivals, address the need for long-term follow-up of these patients and help the team to get feedback from patients and families, provide social and recreational activities for the depressed and lonely, and ensure efficient, cost-effective follow-up.
 - Vellore Community Based Rehabilitation (CBR), located in the slums of Vellore and supported by the World Health Organization (WHO), raises awareness in the community of the problems and abilities of disabled, with the help of local volunteers using locally available resources. Activities include an annual CBR fair, injury prevention and life skills programmes in schools, road safety

projects for college students, and various sensitization programmes.

- The department is recognized as a WHO Collaboration Centre for development of Rehabilitation Technology, Capacity Building, and Disability Prevention. Guidelines have been prepared for care of patients with disability in the community, and WHO fellows have received training in various disciplines.
- The department runs an MD course in PMR, bachelor courses in occupational therapy, physiotherapy and prosthetics and orthotics, a diploma in prosthetics and orthotics, and a master's in physiotherapy.
- Research output is enhanced by the strong clinical base, collaborative studies, and community programmes.
- The pursuit of a cure for spinal cord injury and reports of cell transplantation led to a spinal cord injury regeneration lab in the Rehab Institute.

Our role in empowering people with disabilities

The Golden Jubilee of the Rehabilitation Institute, on 26 November 2016, celebrated the remarkable achievements of this service.

Nine hundred patients from all over the country are admitted annually for average periods of two to three months, and 21,000 patients are seen as outpatients annually.

10. Faith in Health: Why It Still Matters

Gillian Paterson

Not losing the plot

The publication of the Alma-Ata Declaration in 1978¹ was a watershed moment for the World Health Organization (WHO), spelling out its ground plan for the remainder of the century and beyond, and cementing

1 Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, http://www.who.int/publications/almaata_declaration_en.pdf.

In spite of these remarkable achievements, the demand for this service is still great, with a long waiting list of six months to one year.

Further expansion is in progress to increase the number of beds and the area available for the different therapies. This work was expected to be completed in October 2018.

The Department of PMR and the Rehabilitation Institute continue to strive to fulfill God's calling in the healing ministry.

Dr Raji Thomas is professor and head, Department of Physical Medicine and Rehabilitation, Christian Medical College Vellore, India.

Conclusion

The needs of people with disabilities, who are often marginalized, denied their basic human rights, and subjected to the most unjust behaviour, are served in remarkable ways by these two very different programmes. This can serve as motivation to faith-based organizations to embark on their own pilgrimage of justice and peace, identifying ways in which they can care for those with disabilities. Although they are resource and labour intensive, programmes addressing the needs of people with disabilities can truly bring justice, hope, and new life to individuals and communities.

its already close relationship with the World Council of Churches (WCC). For WHO, it was a prophetic breakthrough in public health thinking; for WCC, it was a particularly joyful initiative, resulting as it did from a close relationship between leaders at WHO and the Christian Medical Commission (CMC), great-grandparent to today's health desk. The two organizations had worked in tandem, with WHO exploring the philosophical and political

base for its future involvement in world health and CMC forging a theologically coherent framework for its own engagement. This journey was summarized in the special double issue of *Contact* (No. 161/162) which marked Alma-Ata's 20th birthday.

The two organizations were very much on the same track. Both noted, with concern, the global trend toward health systems that prioritized hi-tech, single-disease, hospital-based care for the few. Both agreed that what was needed, in practice, was a shift toward person-centred, community-based, low-tech systems that would be relevant to the many. WHO's response was the radical shift, spelled out in Alma-Ata, from vertical, top-down systems to a new focus on primary care. Meanwhile, WCC, after a structured process of theological reflection on its own historic role in health care, was energetically promoting a shift from hospital-based care in cities to primary care delivery in rural as well as urban communities.

For WCC and its partners, a bonus was the sense that the contribution of religion to health systems had at last been recognized, and the voices of its member churches were heard in policymaking and planning. Many religious organizations did play prophetic roles in developing community-based models of healthcare, trusted by the people, and naturally operating through the kinds of links and networks that were familiar or on their doorsteps. No surprise, then, that the WCC should recognize some form of primary health care (PHC) as the obvious way to achieve Health for All.

From contemporary accounts, it is clear that Alma-Ata represented some kind of a new dawn: for WHO, because the world seemed suddenly to have got it about the need for a reorientation of health care; for WCC, because here at last was a recognition of the role played by religion.

But despite the excitement, not everyone shared the dream. Health services were still being driven by economic, technological, and political forces. Support for new epidemiological initiatives was more readily available to top-down, single-disease programmes than for people-led, community-based projects. Disappointingly, it had become evident that PHC had turned out, in practice, to be an obstinately secular movement: not just because of political wariness of organized religion, but because many of its supporters had not taken on board the motivational link between health, healing, and the grassroots spirituality of communities and families.

Let us fast-forward to 2008. WHO is celebrating Alma Ata's 30th anniversary by publishing the report PHC: Now More Than Ever, with Archbishop Desmond Tutu speaking at the launch. The archbishop refers his audience to a Mel Calman cartoon in which God is seen searching fretfully around for something lost. "I'm getting old," God is saying. "I seem to have lost my copy of the divine plan."

Today, once again, we are at a crossroads. What, then, is the narrative – the "divine plan" – that could form a basis for our thinking, planning, and activity over the coming years? What are the signs of the times that create the context for our reflections on these questions? What, with our global networks and our historic role in health care delivery, do the WCC and its members have to bring to the table?

Setting the record straight

In 1998, I was asked by the British agency Christian Aid to do some research with the rather clumsy title of Churches' input to basic health and education in five countries of sub-Saharan Africa. The countries it would cover were Ghana, Malawi, Kenya, Tanzania, and Zimbabwe. Today, this would be regarded as a form of mapping.

In the '80s and '90s, the dominant development paradigm was a secular

one. Desirable change, if it happened at all, would happen in spite of organized religion, not because of it. Official data would routinely fail to document the contribution of religions. Governments were supposed to be responsible for delivering basic health services. NGOs became a threat if they tried to set up alternative systems. By the late '80s, the contribution of religion was so suspect that some well-known religiously based charities were reported as planning to remove the word Christian (or other) from their titles.

The first thing I did was to get hold of the most recent country-specific reports, published regularly by the UK government's Department for International Development (DfID). Tanzanian and Zimbabwean reports made no mention at all of religion, or indeed of any faith-based assets. The other three contained one mention each of Christian mission, which was characterized as something that happened deep in the past, before the country outgrew it. And yet when I visited (say) Malawi or Ghana, I was to find that as many as half of all interfaces with health or education services took place in faith-owned hospitals, clinics, or schools.

So, the Christian Aid report was published, and I went to DfID with our deputy director. We presented them with a copy. There were spectacular differences, we said, between the facts on the ground and their own country reports. Their jaws dropped. "If that were true," they said, "we would have known it."

We'd expected this. For the fact is that this narrative (created by the absence of religious assets from official data) was widely accepted, if not actually encouraged, at a policymaking level. National governments had no incentive to question it: they were often short of resources to run their own services. Religious assets are easily overlooked when they are located in poorer, more deprived rural areas.

This was not deliberate misrepresentation. Rather, it was part of the cultural and ideological mindset of those decades, reinforced by embarrassment at the long-standing historical alliance between colonialism and Christian mission. There was concern, too, about hidden agendas that could include conversion, the privileging of particular groups, or the dilution of professionalism with superstition. For governments struggling to build national infrastructure, it was convenient for religiously backed organizations to keep a low profile. Further, resistance to religion was commonplace in international organizations. In Kenya in the late '90s, I met one of WHO's regional directors. "Churches," he said, "are a complete nightmare to work with, because they have so many priorities that have nothing to do with health."

Mapping as advocacy

In the end, it was the African Religious Health Assets Programme (ARHAP) and its partners that started to put some verifiable figures on the claims we were making back in the '90s. God was back in the picture, with UN agencies and others exploring ways to engage more closely with faith-based organizations.

Had they suddenly seen the light? I doubt it. Rather, it is the fact that additional capacity was urgently needed if the world was to reach its development goals. "And behold," said the policymakers, "this capacity exists, under our very noses, in the long-ignored networks of faith-inspired health assets." In 2007, Kevin de Cock (then director of the HIV and AIDS department at WHO) said, "Faith-based organisations are a vital part of civil society, and must be recognised as *essential contributors* towards universal access efforts."

And yet his statement raised further questions. Was it the quantity of care that made them such "essential contributors"?

Or was it the fact that secular organizations were, at some level, getting it wrong? Many today argue that health care delivery cannot be effective unless understandings of health connect with people's deepest beliefs, their understanding of the meaning of being human, and the meanings implicit in the "healthworlds"² they inhabit. And what if the time has come to reclaim the concept of spirituality? Or to challenge those who treat religion as a problem?

For the fact is that the majority of people in the world do have a religious faith. Their beliefs and practices do sometimes block change. But also, they can be powerful motivators of human well-being and reconciliation. So, any movement focused on grassroots meanings of health must take the faith life of the people seriously.

But we need to resist allowing ourselves to be co-opted into national and international systems, where we provide more of the same, and whatever is distinctive in our contribution is downgraded to what Ugandan theologian Emanuel Katongole calls "the post-modern celebration of difference, which at the same time renders difference ineffectual or inconsequential."

The question, then, becomes this: Given the context, given the signs of the times, what is the distinctive contribution we can make? It is a question that should be foremost in our minds as we increasingly take our place at the tables around which international conversations about health happen.

The signs of the times

In November 2001, WCC convened in Nairobi a meeting of African church leaders, inviting them to draw up an ecumenical plan of action for responding to HIV/AIDS in Africa. This, we imagined, would include education, access to treatment, prevention, and so forth. Instead, to our astonishment,

the hundred or so participants agreed, without a single dissenting voice, that the priority for the churches must be the eradication of stigma. They did not recommend that the churches should abandon their historic role in health care and education: far from it. However, they felt that church leaders had a unique role in the response to the epidemic. They were respected; they were believed; they had the ear of their congregations. The most effective thing they and their members could do, in response to HIV/AIDS in Africa, would be to face up, honestly, to the beliefs, systems, and attitudes that stood in the way of effective action.

This might not make them popular: stigma is often reinforced by powerful links between culture and religion, Christian ethics and local custom. It might not be comfortable, either: it is never easy confronting one's own most fundamental beliefs and attitudes, or those of one's neighbours. But this commitment led to a string of influential initiatives, notably the foundation of the Ecumenical HIV and AIDS Initiatives and Advocacy (EHAIA), INERELA+, collaborations with other religions, and the ongoing work of the Ecumenical Advocacy Alliance.

The decision to engage with HIV-related stigma is important, because it provides an example of Christian leaders accepting blame for what is past and developing unique and targeted responses that are distinctively theirs, and in the process developing powerful exercises in advocacy and public education.

So, what today could be the global signs of the times that might invite the distinctive response of a newly constituted health desk at WCC? Maybe demographic shifts toward more elderly people, resulting in an escalating pressure on health services? Migration, and the 70 million people said to be on the move? Disability? Climate change and its human consequences? A global shortage of health care professionals?

² For background on the idea of healthworlds, see P. Germond and J. Cochrane, "Healthworlds: Conceptualizing Landscapes of Health and Healing," *Sage Journals* 44:2 (2010).

WCC will answer this question in its own inimitable, time-honoured way, and in consultation with its friends. Arriving at that answer is one objective of the present conversation.

For since Alma-Ata, there has been progress. As churches, we understand better how we relate to different socio-economic and political systems, as well as the importance of dialogue across the boundaries of religion. There is a greater respect, in the secular world, for the capacity of religions to contribute to global activity, just as there is more appreciation of the need for religious voices to be heard in the corridors of power. It has become more

difficult to ignore the importance of faith in the healthworlds we inhabit. And so on.

We must pray, then, for discernment, for the gift of the Spirit, which is wisdom. And in the words of Gerard Manley Hopkins, the Welsh poet and Catholic priest,

And though the last lights off the black
West went

Oh, morning, at the brown brink
eastward, springs —
Because the Holy Ghost over the bent
World broods with warm breast and
with ah! bright wings.³

Dr Gillian Paterson is a research fellow at Heythrop College, University of London.

3 G.M. Hopkins, "God's Grandeur," 1877.

11. A New Health Impetus for WCC: The Ecumenical Global Health Strategy

Lyn van Rooyen

The role the World Council of Churches (WCC) played in the establishment of Primary Health Care (PHC), particularly through the Christian Medical Commission (CMC), has been reiterated throughout this publication. Many authors emphasized the continued and increasing need for PHC to ensure health for all and just health care systems.

It is 70 years since the formation of the WCC, 50 years since the CMC was formed, and 40 years since the meeting in Alma-Ata. This was an opportune time for the WCC to reassess its work in health. Dr Isabel Apawo Phiri, WCC deputy general secretary responsible for Public Witness, explained, "The work on the ecumenical health strategy will form part of the broader WCC's framework of the Pilgrimage of Justice and Peace."

It is clear that the ideals and dreams of Alma-Ata have not yet been fully reached and that an increased and concerted effort is necessary to revitalize PHC.

The process of developing a WCC Global Ecumenical Health Strategy started with a meeting in Lesotho in February 2017. At this meeting, Dr Mwai Makoka, WCC programme executive for Health and Healing, said, "The World Council of Churches believes it is time for the church to reaffirm the role it has played over centuries as leader in global health, and to consolidate efforts towards health and healing for all."

Dr Phiri challenged participants in her opening address: "So much has changed, and yet so much remains the same. Global public health structures have changed, yet gross inequalities still exist – between developed and under-developed countries, between rich and poor, and the vision for equitable health care still lies in the far distance. Primary health care remains a task unfinished." But she also gave hope: "As part of a creation groaning in pain the Christian community can be a sign of hope and an expression of the kingdom of God here on Earth. The Holy Spirit works

for justice and healing in many ways, and we are called to embody Christ's mission together. Our strategic plans should reflect this, also with regard to strengthening our fellowship and its capacity."

The Ecumenical Global Health Strategy 2018–2021, approved by the WCC's executive committee in Geneva in June 2018, reflects this challenge and the hope that the WCC and member churches will seek to continue the Lord's healing ministry.

The introduction reminds us that God said, "I am the Lord who heals you" (Ex. 15:26). It further highlights that "The Lord our God revealed Himself as a healer very early in the Bible narrative, later affirmed by Jesus Christ. The Church through the ages has sought to follow those footsteps, albeit with different degrees of understanding and ways to express that healing ministry."

The strategy builds on the history of the WCC's CMC and is based on specific theological perspectives on health and healing.

The Christian view of health is embodied in the concept of "shalom" – wholeness, peace, health and prosperity – an experienced reality among God's people. Diverse traditions of theology teach that Shalom was lost in the Garden of Eden; sickness, ill-health and death became a constant reality and reminder of humanity's fallen state. Salvation thus was seen to include the restoration of health and the alleviation of suffering. Moments and acts of Shalom were manifested in God's guidance for preventing and limiting the spread of diseases (e.g., Leviticus 12ff), curative acts by prophets (2 Kings 5:1-14), curative agents such as leaves (Ezekiel 47:12) or indeed resurrecting people from death (2 Kings 4:32-35).

Fulfilling the Scriptures, Jesus Christ proclaimed that he had come so that people may have life, and life in abundance (John 10:10). He restored

people to health and wholeness – spiritual, physical and social, and he charged and empowered his disciples to preach, teach and to heal (Matthew 10:7-8). This theological understanding positions health and healing, not as a minor matter in the life of the Church, but as part of its very existence.

Healing is neither outside the gospel mandate nor simply a means towards evangelization. It is at the very heart of the gospel mandate.

The health strategy is in line with the WCC's mandate and contributes to the WCC's strategic objectives.

The Overall Goal for Health and Healing is to foster health and wholeness for all, and the expected outcome is that churches are strengthened as healing communities.

The strategy has five specific objectives:

1. To promote scientific and ethical reflection on health matters from a Christian perspective: to convene and coordinate informed and experienced individuals to critique, analyse and provide best advice on global health matters from a Christian perspective to Churches and ecumenical organisations, governments and development actors in order to promote human dignity in policy.
2. To promote theological and biblical reflection on health and healing: to promote and facilitate theological and biblical reflection on health and healing through contextual Bible studies, training and other church programmes.
3. To promote the health-promoting churches concept: to support church congregations as healing communities to take holistic action on health, especially health promotion and disease prevention, in collaboration with other actors.
4. To strengthen documentation of ecumenical health work: to strengthen sustainable mechanisms of documenting the work of ecumenical partners on health

and healing to enable evidence-based decisions at all levels.

5. To support advocacy, networking and capacity building for ecumenical engagement on global health: to support and strengthen sustainable ecumenical engagement on global health through effective networking, advocacy and capacity building at regional and global level. Advocacy by WCC member churches among other activities would include monitoring, budget allocations and implementations for health services in their countries.

The WCC objectives and specific health strategy objectives can be graphically represented as in figure 1.

At the meeting in Lesotho, Dr Makoka said,

The WCC remains steadfast in its commitment to health and healing for all, and has recently reaffirmed

that health and healing were a central feature of Jesus’ ministry and of his call to his followers, and as we learn in ‘Together towards life,’ it is the Holy Spirit who “empowers the church for a life-nurturing mission, which includes prayer, pastoral care and professional health care on one hand, and prophetic denunciation of the root causes of suffering, transforming structures that dispense injustice and the pursuit of scientific research on the other.”

This strategy is an invitation from the World Council of Churches to member churches and faith communities to join in the journey to finally reach the goals of Alma-Ata and to promote health and wholeness for all.

Lyn van Rooyen is a member of the HIV Strategy Group of the World Council of Churches’ Ecumenical Advocacy Alliance and an independent consultant.

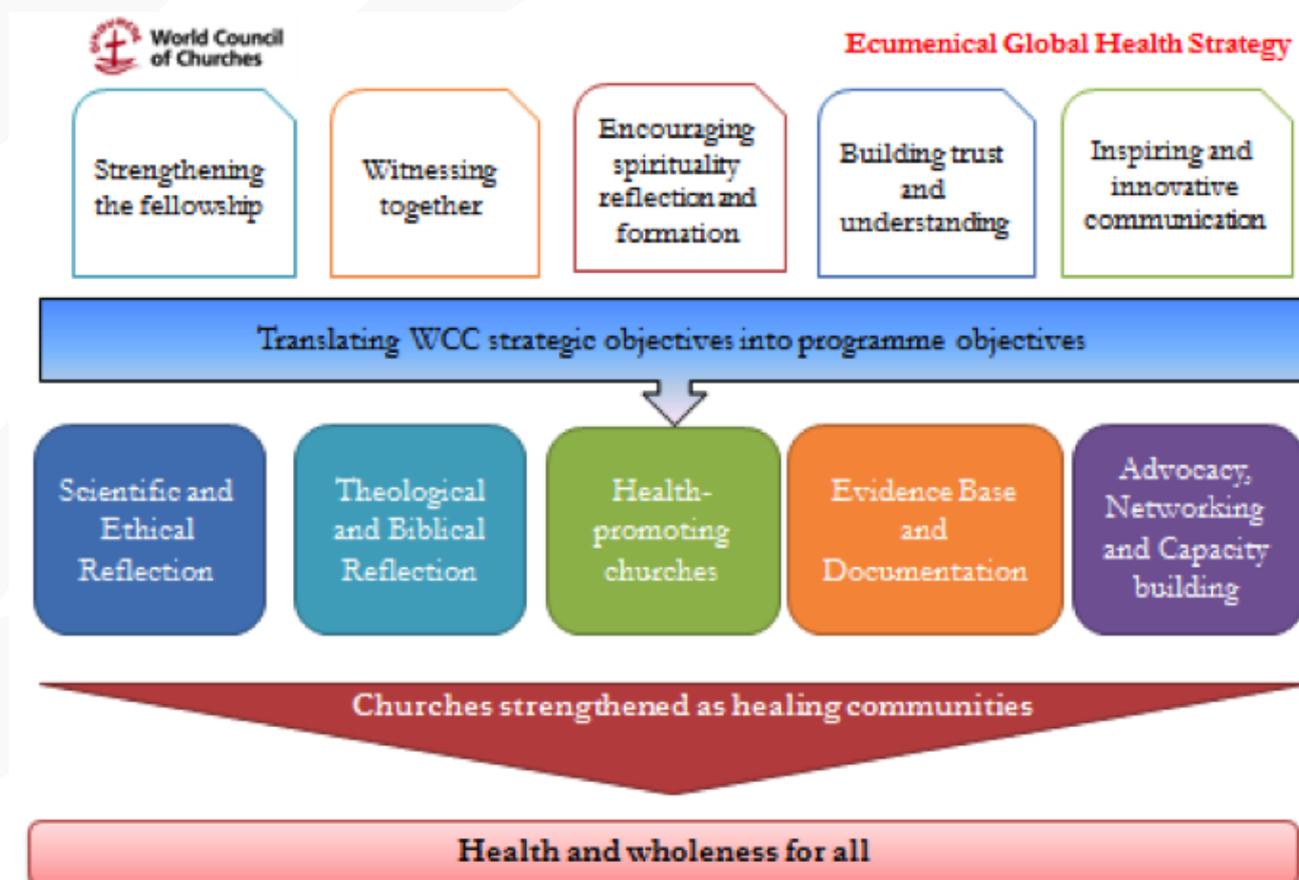


Figure 1: WCC objectives and specific health strategy objectives.



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