

CHAPTER THREE

IN SEARCH OF WHOLENESS

CMC had a great reputation, so that if a project received recognition and support from them then others were likely to join in. It shared information widely through Contact. It had influence with WHO and through that with governmental policies. It offered an important link between the churches over health issues and the allocation of resources. It also took seriously the local contexts, value systems and theologies and reflected these back to the churches in the West.

Peter Bellamy, CMC Commissioner during the 1980s

Some dilemmas

With the publication, in 1979, of the Alma Ata Declaration, "PHC" came of age. There was over a decade of experience of community-based services, and many powerful and effective models of how it might be done. Methodological guidelines were available. Influential groups within the medical fraternities in most countries had become converted to the idea.

The spread of PHC was boosted by a growing concern about the financial implications of new technologies, particularly in the developing world, where it was difficult to see how these could ever "trickle down" to the majority of the population. From being the radical alternative, it had achieved some kind of official status in the health policies of most developing countries. Books like David Werner's "Where there is no Doctor" were selling in hundreds of thousands. The slogan "Health For All by the Year 2000" provided a focus for the health planners, and an incentive to get on with the job.

For the Christian Medical Commission, in particular, the decade of the 1980s opened with high hopes. The Promised



CMC in the 1980s From left to right:
Jeanne Nemec,
Valerie Medri,
Ann Dozier,
Fernande Chandrasekharan,
Eric Ram (Director),
Reginald Amonoo-Lartson,
Ruth Harnar,
Christa Stalschus,
Jenny Roske,
Cecile De Sweemer,
Maria-Victoria Carles-Tolrà.

Land seemed to be coming closer. The CMC extended family was growing, and there was a powerful sense of fellowship within it. The regional conferences of the 1970s had proved invaluable in helping people share practical community-based examples and experience, as well as a rich variety cultural and religious insights. The medical profession was coming to accept the importance of the community. In many countries, the coordinating bodies were working well, bringing together Christian health care work with that of government and other NGOs. They were asking challenging questions about the role of the church, and about Christian views of healing. *Contact* had come to be accepted as arguably the best vehicle in the world for sharing, on an international level, information and expertise on community-based health care.

The Christian Medical Commission helped articulate the National Rural Health Programme in Southern Sudan

The decade of the 1980s opened with high hopes.



Mayan mother and child in Guatemala who struggle to meet their basic needs.

(PHCP) and also provided links with related programmes and facilities in other countries who had successfully implemented rural health and essential drugs programmes for their rural and urban poor. CMC also provided advocacy opportunities for the Sudan Council of Churches and the Southern Sudan Primary Health Care Programme. As a result of my membership of CMC, I personally learnt much from other countries that have implemented PHC, such as Nicaragua, Indonesia, the Philippines and India.

Oliver M Duku, Episcopal Church of Sudan

PHC had come to be linked with movements for justice, with all the risks that entailed.

But in the general atmosphere of optimism, warning bells were also ringing. In Nicaragua, for instance, where the Sandinista government made the development of community-based health structures a national priority, those who worked in them were often targeted by the US-trained Contra guerrillas. From Guatemala came stories of health workers being abducted or murdered. PHC had come to be linked with movements for justice, with all the risks that entailed in the political polarisation of the 1980s in Latin America.

And what about the more affluent nations of North America, Europe and Australasia? The gap between them and the rest of the world was growing, not shrinking. The health of poor people in those societies was becoming relatively worse.

Another polarisation was developing, too: this time within the CMC family

itself. What about those regions – the Indian subcontinent, for instance – in which the Christian community had developed long-standing, viable, internationally respected tertiary hospitals? Many western mission and development agencies, newly converted to the principle of PHC, now refused to fund the programmes of such hospitals, although these included institutions which had been flagship projects in the past.

Clash of priorities

One example was the Christian Medical College, in Vellore, South India. “CMC Vellore” was, and still is, one of the most prestigious Christian institutions in the world. It was one of the earliest success stories of ecumenical cooperation in medical mission, and the Indian churches themselves managed it. It was also one of the first Christian hospitals to initiate community health as a compulsory element in the training of doctors; and its grassroots involvement in the surrounding rural areas was a legendary part of its own institutional heritage. For decades, it had been the darling of the funding organizations.

In 1980, “CMC Vellore” applied for funding to develop its primary health programmes along Alma Ata lines, and a delegation arrived in Geneva to meet a group of European funding agencies. They were under the impression that the deal had only to be formally ratified. Daleep Mukarji, coordinator of health activities within WCC's Unit II until March 1998, was the youngest member of that delegation. He speaks today of the shock of discovering that the funds for the primary health programmes would only be forthcoming if CMC Vellore simultaneously started to reduce its tertiary and research programmes. Something owned by the Indian churches, something of which they were justly proud, had been rejected by a group of northern agencies that they had regarded as friends and allies.

In effect they had little choice. They refused to accept resources that had such strings attached, and went back to India sadder and wiser. But the hurt and anger associated with this incident was

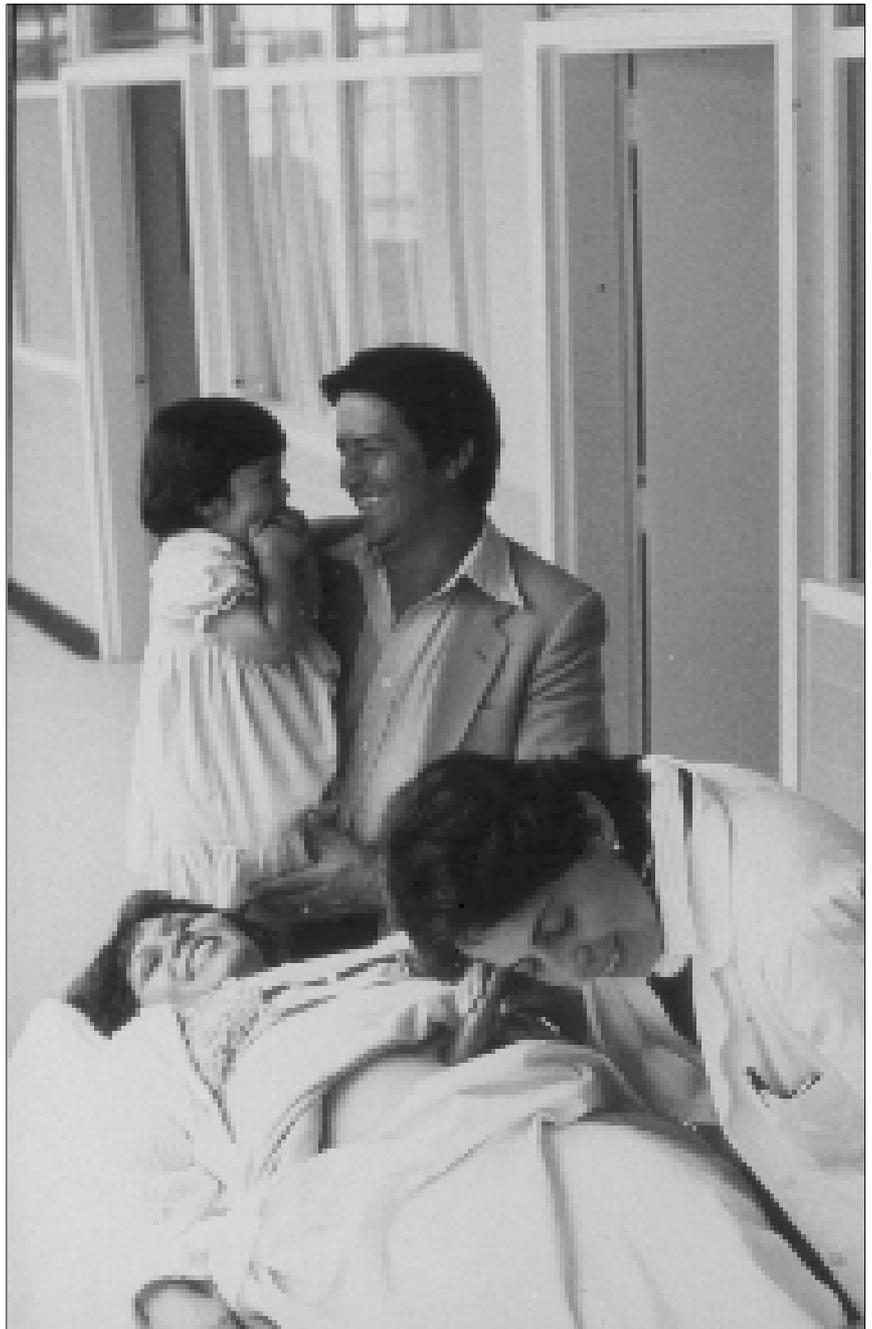
felt by the whole Indian Christian community. Its legacy of bitterness is still alive today.

The tension between hospital and community, tertiary and primary care has been present throughout the history of the Christian Medical Commission, and indeed of all other agencies concerned with international health. It is a conflict that affects the industrialised world as well as the developing world. In Europe and North America today, comparable decisions – equally painful – have to be made about health priorities. In 1980, given their current criteria for who was in and who was out, the funders, drawn together by the Christian Medical Commission, were simply obeying the letter of their own criteria in placing such conditions on the Vellore application.

New insights

By the end of the decade, however, three things were becoming increasingly clear. The first was the continuing importance of the large hospital itself. In 1988, WHO's Safe Motherhood Initiative identified key roles for the district hospital. The availability of obstetric facilities, for caesarean section for instance, was crucial if maternal deaths were to be reduced substantially. The second was the tendency of influential parts of the medical profession, many of them inherently sympathetic to the PHC movement, to become alienated by the insistence that basic health services did not need doctors. The moral high ground claimed by the PHC agenda could lead to resentment among other health professionals, with the result that they might develop systems that were even more intractably two-tier than before. The third was the realisation that systems that genuinely served the poorest people were never likely to be self-financing, and that the fees paid by better-off people for tertiary medicine were a major potential source of funding for health services in general.

Almost twenty years later, this is still a live debate. There is even more expensive technology around today than there was then, and more people in North



WHO

and South who can afford to pay for high-tech medical care. The problems of poverty are no less pressing than they were then. It is now generally accepted that the two sectors are both here to stay, that they need each other, and that they have to find ways of relating, so that justice and equity are achieved without the sacrifice of excellence and scientific creativity. Making sense of this challenge is something that may need to be considered by WCC's health team in the future.

The increasingly ambivalent attitude to the large hospital is only one of the tensions encountered by the PHC lobby during the 1980s. The hope had been

Safe Motherhood: some women need hospital care if their lives are to be protected during delivery.

WHO's Safe Motherhood Initiative identified key roles for the district hospital.



Diana Smith/WCC

Saradidi showing fruits of income-generation project successes in 1995: villagers had purchased cooking bowls and teapots with the earnings from the goats they had raised.

But community-based programmes do not die quickly or easily.

that national governments would gradually take over responsibility for health infrastructures. But the fact was that during these crucial years, the majority of the countries of the South became further impoverished by massive debts acquired during the 1970s, fueled – as in the Philippines and many African and Latin American countries – by the misuse of capital for personal gain by those who held power. Rich people got richer, but poor people got poorer. The rightness of the primary health agenda seemed so obvious. Yet, it could also be made to look like left-wing resistance, as in Nicaragua, Guatemala and the Philippines.

Mobilising the people to take responsibility and be allowed to have a say in what concerned them was not always easily accepted during the years of the cold war. These were years when we used to say that many large church/mission institutions were like a cemented road instead of the footpath where we should be following in the footsteps of the Lord. Some said that he had turned left off the tarred road!

Hakan Hellberg in
The Vision and the Future, 1995

Furthermore, there were problems in evaluating what was being achieved, and at what cost. Community-oriented health professionals and committed local people were not always good at bookkeeping, or at implementing systems of financial control and monitoring. Dan Kaseje, in *Contact 127*, tells the story of the Saradidi Rural Health

Programme, in a drought-stricken area of Kenya. After a bright start, Saradidi fell apart in the 1980s largely because the people who were interested in organizing its financial affairs – all of them respected figures in the area – had their own interests at heart and not those of the programme or the church. As a result, funders eventually stopped giving money and the project was brought to the brink of collapse.

But community-based programmes do not die quickly or easily. The empowerment and awareness achieved among those involved was still there. Saradidi was restructured, with a new set of principles for management, and with new guidelines for selecting staff. These are much more realistic. They also look rather like a blueprint for a Christian system of management and personnel selection that might work anywhere.

For discussion: Matthew 19, 16-26. Who do you identify with in this story? Why? Doing community-controlled health care requires great sacrifices. What are they?

The Pharmaceutical Programme

The World Health Organization uses a cartoon of a little person pushing a huge stone up a steep hill. He (or it could be she) is about to give up altogether. This is the individual attempting to achieve health. The hill is steep because poverty, poor sanitation and housing, lack of education and so on increase the gradient. The individual has an uphill struggle to stay healthy if the societal conditions for good health are not there. Remove these obstacles and the stone rolls quite easily along the flat ground.

There are other obstacles, though, which are not part of the natural heritage of the poor community. The way in which pharmaceuticals are marketed is one of them. In the early 1980s, many countries experienced serious shortages of drugs. Prices of brand-name drugs were high, and although generic drugs were available, information about their supply was hard to come by, delivery was poor, and unless you were able to buy in bulk, you would not be able to buy them at the best prices. To add to it, pharmaceutical companies

were donating inappropriate drugs to third world countries, where many of these unwanted gifts had to be burnt causing other costs and hazards.

In the face of this deteriorating situation, CMC collaborated with the European Emergency Drug Stock Committee (EMERSTOC) to encourage church-related purchasing agencies in industrial countries, and corresponding "buying cooperatives" in receiving countries, to work together. Better deals could be made if non-governmental organizations (NGOs) clubbed together at national level to resist exploitative activities by drug companies, and to negotiate much cheaper bulk-buying deals when appropriate. Following CMC Director Eric Ram's visit to Uganda in 1980, a Joint Medical Store was set up by a group of churches.

In 1981, CMC (with the African organization, AMREF, and the Southern Sudan Ministry of Health) organized a workshop to discuss pharmaceutical problems as they affected church-related NGOs. As a result of this meeting, a few community drug stores were set up in rural areas, and consideration given to the development of a drug manufacturing facility in Southern Sudan, on the lines of the ones in Lesotho and in Kigali, Rwanda. The deteriorating security situation and the expulsion of NGOs put a stop to the Sudanese programme, but not before its usefulness had been established.

In December 1981, in Geneva, CMC held a consultation on church-related cooperative pharmaceutical services in developing countries. Participants included Catholic and Protestant church-related donor agencies, low cost essential drug suppliers, joint procurement units and Christian health associations, the World Health Organization, and UNICEF. This group, now referred to as the Pharmaceutical Advisory Group (PAG), has continued to meet regularly every year since. The outcome of their first meeting was the commissioning of the initial survey stage of the Pharmaceutical Programme (PP) in 1982.

Evolution of the Pharmaceutical Programme

- **Phase 1 (1982-1985)** was primarily exploratory, the key priority being supply of essential drugs through "cooperative" pharmaceutical services.
- **Phase 2 (1987-1991)** gave increasing attention to networking and the promotion of the Essential Drug Concept (EDC).
- **Phase 3 (1992-1995)** concentrated mainly on providing support to consumers in developing countries, promoting EDC and Rational Drug Use (RDU), and running training programmes for church groups and agencies.
- **Phase 4 (1996-present)** has two priorities: to build on the work of Phase 3, and to advocate for accessibility to affordable and effective pharmaceuticals for all.

In 1985 the programme called "Getting essential drugs to the people through cooperative pharmaceutical services" was set up. The following recommendations were made:

- CMC should set up a study of traditional and herbal medicines
- A dialogue should be initiated with multinational pharmaceutical companies
- There should be a new code of conduct for drug donations.

At the 1988 Commission Meeting in the Philippines, "TNCs and their role in health and development" formed a major

A CMC meeting in Sudan led to the setting up of a few community drug stores.

Drug store open for business



agenda item. The transnational companies controlled 75% of the world's pharmaceutical market. Their promotional activities created a demand for non-essentials, and poor people often went without food to buy unnecessary, and also unnecessarily expensive, drugs for their families. "To fight the negative effects of TNCs on health, our response has to be transnational. Here churches have a very important role to play," commented Filipino Commissioner Michael Tan. CMC was asked to prepare for a dialogue with multinational pharmaceutical companies, and to produce a code of conduct for drug production and distribution.

The Pharmaceutical Programme is in some ways a model for ecumenical activity

Drug donations are often a sample collection of small packages of many different drugs directed mainly towards treatment of diseases common in industrialized countries.



Model for ecumenical activity

The Pharmaceutical Programme is in some ways a model for ecumenical activity, involving churches in working together on a global issue which has a huge importance to poor people on the ground. Today, the programme is jointly hosted by Community Initiative Support Services (CISS) in Nairobi, Kenya and by WCC in Geneva, with pharmaceutical adviser Dr Eva Ombaka dividing her time between the two. Primarily aimed at the churches and at church-related health personnel, one of its first priorities is the promotion of rational drug use, along the lines of the WHO Essential Drugs Policy. It promotes the use of generic drugs, and advises on the setting up and running of initiatives for the joint procurement of drugs by church health services in each country, with strong encouragement for South-South trade in pharmaceuticals. It also carries out evaluations, facilitates training for pharmacy workers

and acts as an advocate for the use and manufacture of generic drugs as opposed to their more expensive brand-name equivalents. Another concern of the pharmaceutical programme is the exploration of the benefits of herbal remedies and other traditional therapies.

The Pharmaceutical Programme activities

- **Technical assistance** *The dissemination of technical information via research, newsletters, the distribution of publications and through personal visits.*
- **Training** *The support of training activities relating to EDC (Essential Drugs Concept), RDU (Rational Drug Use) and also drug supply management. PAG keeps church-related institutions informed about courses, and gives some support to staff participation. It facilitates study tours and staff exchanges between partners. And it supports members in organizing workshops at country or sub-regional level.*
- **Research** *Supports the monitoring and evaluation of pharmaceutical activities and resources.*
- **Networking** *PAG offers a global and local forum for networking on current trends in pharmaceutical issues, through organizing North/South meetings, supporting regional meetings, and supporting the representation of church health systems at international meetings.*

Recognising the importance of a global response to what has become a global threat, the 1995 annual meeting of the Pharmaceutical Advisory Group (PAG) discussed the privatization proposals contained in the 1993 World Development Report "Investing in Health". The following year participants met with a World Bank representative and David Werner, author of "Where there is no doctor" to address the effects of structural adjustment policies on health.

In 1997, the PAG addressed the implications of the recent Treaty on Intellectual Property Rights agreement on pharmaceuticals. Late in the day, Health Action International (HAI), WHO and other NGOs have realised the implications of this new global treaty

which has been put together during the Uruguay Round of trade talks which led to the creation of the World Trade Organization in 1995. One of the purposes of TRIPs, as it is called, is to limit the production of generic pharmaceuticals by strengthening patent laws. Prior to this treaty, companies in India have been able to develop their own technologies to produce new drugs within four to six years of their appearance in the world market. Under the terms of TRIPs, India and other countries will have to wait twenty years. There is, of course, a strong argument for protecting markets so that pharmaceutical companies are given time to recoup the costs of development. On the other hand, this move is bound to widen the gap between the health resources available to rich and poor people, and to delay to an unacceptable degree the application of the benefits of new research to the health requirements of developing countries. This is particularly alarming when it comes to medicines developed for newly emerging conditions such as AIDS and drug-resistant TB and malaria.

For discussion: Revelation 18, 8-17. The writer describes the destruction of the great wicked city, which he calls Babylon. Why are the merchants so upset? Can you see any parallels with our world today?

The Baby Killer

Growing up in Barbados, Nita Barrow, who joined CMC as associate director in 1970, said that breastfeeding, until the 1940s, had been "a normal feature of daily life and as the mother went about her work, the baby was kept with her, strapped to the mother's back, slung on her side or just within easy reach, and was fed as required." Meanwhile, bottle-feeding was becoming more common in European and North American societies. This was fuelled, she believed, by the increasing number of working mothers, and by the conviction of many women that breasts were less to do with feeding babies than with sexual pleasure. By the 1970s, there had been a shift to bottle-feeding among Caribbean women, too. Quoting pioneering Jamaican paediatricians, Dame Nita attributed this to vanity, to

pressurising advertising by baby food companies, and to early supplementary feeding which introduced sweetened milk into the diet.

Contact 35, in October 1976 was entirely devoted to the subject, and Dame Nita's article "Breastfeeding – a must or a myth?" was its centrepiece. In it she quoted the Ugandan poet Okot p'Bteke:

*When the baby cries
let him suck milk
from the breast
There is no fixed time
for breastfeeding*

*When the baby cries
it may be he is ill
The first medicine for the child
is the breast.*

The advertising practices of the baby milk manufacturer had recently been the subject for a widely publicised court case, which had become known as "the bottle babies issue". The Third World Action Group was sued by a Swiss company, Nestlé, for publishing a highly critical article describing the company's methods of advertising and marketing baby milk products in developing countries, for example to women in hospital. The article was entitled, "*Nestlé tötet babys*" (Nestlé kills babies).

Contact readers today will not need anyone to spell out for them the benefits of breastfeeding. These are particularly important for poor people who may have to go without other essentials in order to buy expensive baby milk, or who have no effective means of

[The shift to bottle-feeding was attributed] to vanity, to pressurising advertising, and to early supplementary feeding.

A primary health care worker helps a young mother learn breastfeeding



Steve Maines/Unicef

People claimed that PHC was cheap and effective, but where was the evidence?

sterilizing bottles. CMC then set itself the task of raising awareness of these benefits, via *Contact*, via its own networks, and by influencing other agencies. For local groups wanting to take action on the marketing of baby milk and the promotion of breastfeeding, a "how-to-do-it" pack was produced.

Eventually, partly as a result of vigorous and coordinated campaigning by NGOs – in which CMC played a key role – the issue became the subject of a voluntary code of conduct relating to the marketing of breast milk substitutes. WHO, UNICEF and other organizations developed the code in consultation with the industries concerned. At the World Health Assembly in 1981, only the USA voted against the code. Today, promotion and monitoring of infant formula marketing practices are coordinated by IBFAN, the International Baby Food Action Network.

Former CMC staff member Tina Pfenninger, now working for IBFAN, believes that the churches have a crucial role to play as grassroots watchdogs for such unethical marketing, particularly in relation to the health of poor people. It is by reporting abuses, bringing them together into a coherent international picture, and then joining with

allies to campaign against unethical practices that the power of the transnational companies will be kept under control.

For discussion: Mark 11, 15-19. This is the only example in the gospels of Jesus using physical violence. How would he have responded to the above situations? Why does it seem so much more difficult today?

Paying for it

It had originally been expected that primary health programmes would become self-sufficient within a few years. Such expectations proved to be misplaced. In 1987, CMC invited the Ecuadorian Victor Vaca to do a study, which had two main aims:

- To identify the factors that influenced financing and costs of community-based health care programmes, and to see how they operate in selected local programmes.
- To identify the principles of good practice which PHC programmes had learnt from experience, and to distill them in such a way that new initiatives could learn from them.

Victor Vaca toured selected programmes in Indonesia, the Philippines, Papua New Guinea, India, Brazil and Central America. His reports were then put together with other finance-related material from CMC, from WHO, and from DIFÄM in Tübingen. A total of fourteen case studies from eleven countries were reviewed.

Mr Vaca was initially surprised by the absence, in many cases, of accurate bookkeeping and statistical data. People claimed that PHC was cheap and effective, but where was the evidence? Primary health staff had other priorities. It almost seemed that the ethos of primary health care, with its insistence on participation and appropriateness, had an in-built resistance to conventional economic analysis.

The results of this study are set out in detail in the WCC publication "Financing Primary Health Care Programmes: can they be self-sufficient?" (WCC 1987)

The survey reaches a range of conclusions, of which the following may be of particular interest:

Working with health data at EPES, a community-based health organization of the Lutheran Church in Chile.



- PHC programmes cannot be self-sufficient, because their beneficiaries are so poor.
- It is difficult to measure the real cost of PHC because so much of the staff input is voluntary.
- Community financing has to be one source in what should be a balanced financing approach.
- Outside donors often have unrealistic expectations about a programme's capacity for self-reliance, and the time taken to become self-sufficient.
- Well-run programmes have a tendency to grow. Although they may be heading for a degree of self reliance, they will still need additional funding if they are to do so.
- Hospital-based programmes can become self-sufficient.
- By entering into partnership, PHC and existing hospitals can increase each other's effectiveness.

The issue of sustainability is still an absolutely crucial one for primary health care programmes, and there is a section in the next chapter which describes a more recent study. Many agencies still work on the principle that a programme must be able to be self-financing within – say – six years. But who then pays for staff salaries, vehicles and essential drugs? The insistence on sustainability has led to programmes giving preferential treatment to those with money, and turning away poor people who have none. This is a key issue today, when cash is even shorter than it was in the 1980s, and when the principles of privatisation are being vigorously promoted by international agencies.

For discussion: Luke 16, 1-12. What is going on in this strange story? Why does the lord congratulate the steward? In your experience, does the story have anything to say about the problems of sustainable development?

Health, healing and wholeness

In 1975, in Nairobi, the WCC's Fifth Assembly mandated CMC to "serve as an enabling organization to churches everywhere as they search for an understanding of health and healing which is distinctive to the Christian faith".



Bert Demmers/Unicef

Training traditional birth attendants in the role of herbal medicines in Rwanda.

This was to be done by "exploring insights into, and promoting theological reflection on, the Christian understanding of life, death, suffering and health, that these may find expression in the church's concern for health care as a healing community", and by being "alert to the dimensions of healing which transcend the concern with physical pathology and assess the input of spiritual, social, ethical and psychiatric insights". In 1978, in response to this mandate, the Christian Medical Commission embarked on a programme to study Health, Healing and Wholeness (HHW).

Between 1979 and 1988, ten regional consultations were held. They brought together 814 participants (pastors, theologians and health professionals) from 95 different countries. They took place in the Caribbean, Central America, Africa, Southern Asia, South East Asia, Pacific, South America, North America, Europe and North East Asia. A national seminar was held in Egypt in 1980, the current political situation in the region having made it inadvisable to go ahead with plans for a Middle East consultation. Two consultations on death and dying and a third focusing on addiction were held at Bossey, in Switzerland; and a conference on the role of herbal medicines in health was held at Achimota in Ghana.

But who then pays for staff salaries, vehicles and essential drugs?

The results of the study are published as a well written pamphlet, entitled "Healing and Wholeness: The Churches Role in Health" (WCC Geneva 1990).

New issues emerged from the different consultations. For example, the Central American meeting highlighted structural injustice and its effects on health. In Africa, central issues were those of traditional healing and African spirituality. In Europe, the absence of effective community was a key concern. Loneliness was a feature of socialist countries, where the state took responsibility for basic needs, and people did not need to help each other. In Eastern Europe, pressure to accept atheistic materialism produced a spiritual emptiness that was the enemy of health. In Hong Kong

A Swedish delegate commented: "We are looking for love in the midst of all this damned security".

and other urban societies, leading causes of death in children were not communicable diseases but injury, poisoning and cancer. A Swedish delegate, from one of the most efficient social security systems in the world, commented: "We are looking for love in the midst of all this damned security".

Inequalities in health

It is not possible, here, to go through the whole of this crucial study. Nor would it be desirable. One of the most important messages is that each political, social and economic context is unique. Nevertheless, there are three general points – issues that affect everyone – which seem of particular importance for a Christian organization to consider. The first is the unequal burden of sickness, disability and preventable death born by different parts of the world. The second is the inequity of resources available to deal with it. The third is the problem of identifying whose understanding of health governs the healing agenda. The following quotations from the study report are particularly relevant here.

Eighty-five per cent of the 450 million people in the world who suffer from disability come from developing countries, which have only 2% of the resources to treat and care for disabilities.

In dialogue about health, there is a lack of a common anthropology, so that it is questionable whether the medical scientists and the theologians/pastors are really looking at the same person. The churches' position on medical-ethical issues arises out of a whole picture of life and its incarnational significance to which the gospel gives meaning.

James McGilvray, first Director of CMC

Is it possible that these observations offer a way round the confrontational "either-or" thinking which created such major divisions during the 1980s? Perhaps the real agenda for healing is political *and* spiritual, moral *and* economic? The reason for the persistence of two paradigms (the medical model and the wholistic model) may be that there are in fact a number of conceptu-

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ally different things going on when a person presents as sick, dying or disabled, and that the people engaged in the dialogue which sets the healing agenda "are not looking at the same person".

We are human beings engaged on a spiritual journey. We are also spiritual beings engaged on a human journey. The churches exist at the frontier between the spiritual and the human. Incarnation, crucifixion and resurrection, the defining concepts of the Christian faith, are not just the most profoundly physical of all experiences, they are also the most powerfully spiritual. In them, the divine becomes human, the human becomes divine. If this is true and relevant, as Christians believe, then the task of the church is not just to promote and pay for Christian health care, but to see the commitment to the healed individual in the healed community as a non-optional dimension of its own life.

For discussion: Luke 13, 10-17. This story is about Jesus' ministry to marginalized people. It is also about the nature of formal religion. What does it say to you about (a) disabled people; (b) the ministry of healing; and (c) the church?

The healing church: in search of a model

Early in the study, the question was asked, "What is unique in Christian health care?" Now we wonder whether we should rather be asking, "What does God require of us as Christians?"

Quotation from report of HHW Study

In the light of the evidence from the HHW study, there was a strong case for the churches themselves and local Christian communities, through their outreach, their liturgy and their way of being church, to become involved with the work of healing and to learn from those for whom healing was already a priority. This came out particularly strongly in the Egyptian and African consultations.

Healing and the building of community, according to the Orthodox view, are part of the basic concepts of forgiveness and the Eucharist (Holy Communion). The final concept of forgiveness is the restoration of a person to the community. It is this

concept that lies behind the pronunciation of the absolution in the Orthodox church, an absolution addressed not to a singular but to a plural object and repeated not once but several times in the liturgy. Why? Because sin shatters the community and forgiveness restores healthy relationships within community.

Egyptian consultation report

In July 1989, when the study was being wound up, the WCC Central Committee met. "Member churches," it said, "must be challenged to make policy statements on their involvement in Christian health care and healing, thus re-affirming the healing ministry of their church." The Committee further noted

.. different things (are) going on when a person presents as sick, dying or disabled ...

Palestinian boy in Ahli Arab Hospital





John Taylor/WCC

Kinshasa: Children worship at the Kimbanguist Church.

and its board, thus making close interaction and serious discussion necessary. Apart from this structural aspect, many of the key hospital staff and personnel are active as elders, deacons, or as members of the Sunod board. In this way the close relationship of church and health work is possible, and it is easy to look at health from another perspective than the strictly professional.

Bert A Supit, in *Contact* 90, April 1986

Dr Supit goes on to describe the effects on the GMIM churches of this involvement. Part of their 50th birthday celebrations included the establishment of a clinic in a group of very poor villages, and a big group service at which several doctors preached about the healing Christ. The hospital staff, together with the Church Lay Training Department and the Theological Faculty, put together a discussion booklet called *The Healing Church*. Over 500 hundred members joined in this discussion process, to prepare themselves to communicate the message to the 560 congregations of the GMIM church. A booklet containing sermon notes and bible study material was also produced, with additional suggestions for practical involvement such as health insurance schemes, latrine building or weighing programmes. Short courses for members of the congregation were held in the hospital itself, and the long-established Diakonia fund was rethought and revived.

...Congregations are now ready to take action, but the technical skills to act are lacking. The increasing demand for knowledge and skills is more than PHC staff has time to provide. Thus the expectations, which have been raised by our programmes, cannot always be immediately met, and this may lead to frustration in some cases.

Bert A Supit, in *Contact* 90, April 1986

The GMIM experience is just one example of the changes that can take place in local church life when healing is taken seriously as part of the agenda. But although others will recognise in it aspects of their own predicament, the challenge to the churches of Sulawesi, as everywhere, were specific to its own context.

that this implied "the de-professionalisation of health care and healing and the building of the care-giving capacity of every member of the congregation." A striking example of this kind of involvement comes from the Minahasa area of the island of Sulawesi in Indonesia.

The healing task of the church had been gradually given over to professionals.... We have become aware of the incompleteness of working in isolation or of trying to represent the whole church in our work. Therefore we have tried to build up a strong interaction with church leadership. Where many health programmes in the Indonesian churches adopted a foundation as their legal working base, the GMIM (Minahasa Evangelical Christian Church) Health Service opted for direct government by Sunod

There was a strong case for the churches themselves to become involved with the work of healing

The findings of the grassroots consultations are a "tapestry depicting their understanding of health. The major recurrent thread throughout that fabric is the fact that health is not primarily medical. Although the health industry is producing and using progressively more sophisticated and expensive technology, the increasingly obvious fact is that most of the world's health problems cannot best be addressed in that way. The churches are called to recognise that the causes of disease in the world are social, economic and spiritual, as well as bio-medical. Health is most often an issue of justice, of peace, of integrity of creation, and of spirituality".

From "Health, Healing and Wholeness", WCC 1990

For discussion: John 17, 25-26 (or the whole of this chapter). Jesus asks that after he is gone the love between himself and the Father may be reflected in the love his disciples have for each other. What implications does this have for our churches?

A new realism

Surveying CMC's experience of the 1980s at its Bridgetown, Barbados, meeting in 1993, Dr Rainward Bastian spoke of a feeling of disillusion and sadness. The high hopes of the 1970s had not been realised. It seemed that there was a limit to what global and national programmes could achieve. In Europe, a new nationalism was becoming apparent, with disastrous effects on health services, and on other countries of the world. All over the world, the budget constraints on health ministries had increased. Many of the coordinating bodies had gone into crisis, their outstanding successes of the 1970s dwindling, and ecumenical collaboration weakening. The process of inculturation, the coming together of traditional and Western methods, had been slower than expected. This was especially true in Africa, where it was linked with the continued dependence on foreign staff. The spread of community-based and congregation-based health work had also been slow. In the North, instead of learning from the experience of the South, community cohesiveness and mutual responsibility had, on balance, decreased.

Dr Bastian was not alone in reaching the end of the 1980s with a sense of sadness. There were others who,

looking back on the pioneering days of the late 1960s and early 1970s, wondered what had gone wrong. The great ideas of those early days had only partially been realised. "It is time," said Dr Bastian, "for a new sense of realism."

The next years were to be a time for reassessment of the past, and for the setting of new priorities; for looking back on past triumphs, but also forward to a renewed vision of what a global ecumenical health network can contribute to the ongoing story of the people of God.

Exodus 16, 1-15. This is a powerful story. Imagine, in turn, that you are Moses; the children of Israel; and God. How, in each case, would you feel? Why does God respond in the way he does? Do you have moments when you wonder why you ever got involved with the work you are doing? If so, how do you respond to such times of uncertainty?

Traditional health practices in the Philippines.

