China, a vast country with a large population, has witnessed fast economic growth since the late 1970s. However, there still exists an income gap between the eastern and western parts of China. The church in China has grown phenomenally in the past 20 years. Friends both at home and abroad often asked me, “Why was there such a growth?” My observations are as follows,

1. The comparatively relaxed political atmosphere provides enough freedom for Chinese people to focus on spiritual issues. The earlier emphasis on class struggle gave neither time nor energy to search for the spiritual dimension of peoples’ lives.

2. God’s word has spread rapidly because Chinese Christians witness through their actions, as well as by their words.

3. It is estimated that the majority of rural Chinese Christians have come to faith through physical healing.

The growth of the church in China depends on the message of the church. The opening up and adoption of the reform policy in the late 1970s enabled the church in China to do many things that could not be done earlier.

Two examples illustrate this: the Amity Printing Company, a joint venture between Amity and United Bible Societies, which gives priority to printing Christian literature, was established in 1987 and has printed more than 22 million copies of the Bible. This is God’s miracle in China. Such an establishment would not exist if the Chinese government had not opened up and adopted a reform policy.

The Amity Foundation, a Christian initiated organization, aims at promoting health, education, social welfare and rural development, in order to share God’s love with fellow Chinese and to care for the weak — things that ought be done by Christians.

By the end of 1998, 42 million Chinese were still living under the official poverty line. They have neither clinics nor doctors. Women and children do not have access to health care nor do they have provision for basic prevention of diseases. They suffer from illnesses of poverty while poverty leads to further ill health. Amity helps them meet their basic needs by offering medical training programmes at the grassroots level, so that the trainees can go back and serve the local communities. Amity also helps them establish village clinics so that medicines for treating simple illness is easily accessible. The prevalence of faith healing practices in rural areas is considerable. However we encourage the sick to take medicine, because we believe that medicine is also one of God’s creations.

As this issue of Contact goes to press, humankind is moving into the new millennium. At the turn of the century the Chinese church faces the challenge of new leadership and promotion of theological thinking. Meanwhile, we will continue to strengthen our social ministry. We ask for your prayers that through our concerted efforts, our church will grow steadily and accept challenges in the new millennium.

Wenzao Han
President, China Christian Council
Nanjing, China.

Dear Readers,

Twenty-seven years ago Contact 12 (1972), praised the Chinese system because of the stress placed on rural health care, and on preventive rather than curative services. We have put together this issue on health reforms in China, when the world is facing structural adjustment, political instability and fragile economics.

This issue of Contact has several Chinese view-points that look at the effects of market reform on health in China, and the role of the Churches in health care during a period of privatisation and greater freedom. It is their message to readers in other countries. A true exercise in sharing.

Darlena David
PAYING FOR HEALTH
NEW LESSONS FROM RURAL CHINA

Shenglan Tang, who teaches both at the Liverpool School of Tropical Medicine and at the Shanghai Medical University, believes that sustainable health care requires long-term commitment by leaders at all levels of government.

Before the founding of the People’s Republic of China in 1949, the Chinese population was among the least healthy in the world. The great burden of disease resulted in the nation’s poor economic performance. From the 1950s to the 1970s, the health status of the Chinese population improved significantly. The very effective health service ensured that a vast majority of the population received treatment for illness, and help and advice on how to prevent communicable diseases.

Improving health conditions
Success in improving health conditions in China is attributed to two notable achievements. One is the establishment of the cooperative medical schemes in the rural areas, covering the population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Year</th>
<th>1970</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-year population total (millions)</td>
<td>818.3</td>
<td>1201.4</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>61.4</td>
<td>69.4</td>
<td></td>
</tr>
<tr>
<td>Crude death rate per 1,000 people</td>
<td>7.6</td>
<td>7.5</td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate (%)</td>
<td>8%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Under-five mortality rate (%)</td>
<td>115</td>
<td>44*</td>
<td></td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>5.8</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Percent of population over the age of 60</td>
<td>68.4</td>
<td>96.3</td>
<td></td>
</tr>
<tr>
<td>Percent of urban population</td>
<td>17.5</td>
<td>33.7</td>
<td></td>
</tr>
</tbody>
</table>

Notes: * Data based on the 1990 statistics

Sources:

From the 1950s to the 1970s, the health status of the Chinese improved significantly.
INTRODUCTION

With the three-tier network of health care, “barefoot doctors” provided basic health care and organized preventive care programmes in the villages. In almost 90% of the villages. Financed by the central and local governments, local agricultural collectives and individual households, the cooperative medical schemes reimbursed the participants for most of the costs, or provided free medical consultations and preventive services.

Another is that since the early 1950s the Chinese government has developed a three-tier network of health care in both rural and urban areas. In the rural areas, village health stations with 2-3 “barefoot” doctors provided local people with essential clinical services, and organized preventive care programmes. The township health centre is the lowest tier where qualified doctors are stationed. Its preventive care section organized health promotion and prevention activities and its curative care section provided outpatient and inpatient services. At the county level, general hospitals and other preventive health facilities not only provided various health care services to local people, but also offered technical support to lower levels of health facilities. Consequently, the system resulted inremarkable gains in health status at affordable costs.

<table>
<thead>
<tr>
<th>Period</th>
<th>Political movement and economic development</th>
<th>Health development</th>
</tr>
</thead>
<tbody>
<tr>
<td>1949-1957</td>
<td>• The Three “antis” (anti-corruption, anti-waste, and anti-bureaucracy)</td>
<td>➔ Development of health policies focusing on preventive services and infectious disease</td>
</tr>
<tr>
<td></td>
<td>• The land reform</td>
<td>➔ Many infectious diseases were under effective control and the health status of the vast majority of the population was improved.</td>
</tr>
<tr>
<td></td>
<td>• Establishment of the joint producers’ cooperatives in the rural areas</td>
<td>➔ The employment related medical insurance schemes in the urban areas were established.</td>
</tr>
<tr>
<td></td>
<td>• Public-private joint operation for enterprises and business in the urban areas</td>
<td></td>
</tr>
<tr>
<td>1958-1960</td>
<td>• The Great Leap Forward</td>
<td>➔ Health centres at most of the towns (communes) and general hospitals at the county level were rapidly established.</td>
</tr>
<tr>
<td></td>
<td>• Establishment of commune system in the rural areas</td>
<td>➔ The barefoot doctors began to play an important role at the village level health services.</td>
</tr>
<tr>
<td></td>
<td>• Abolishing of private sector</td>
<td>➔ The Cooperative Medical System (CMS) was first developed in a few villages and townships.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➔ The number of private health clinics declined dramatically.</td>
</tr>
<tr>
<td>1961-1965</td>
<td>• The Socialist Education Movement</td>
<td>➔ The three-tier network of health care in the rural and urban areas was gradually developed, facilitating access to basic health care for the vast majority of the population.</td>
</tr>
<tr>
<td></td>
<td>• Decentralization of agriculture production</td>
<td>➔ The CMS continued to develop in the rural areas.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➔ The health status of the population was further improved.</td>
</tr>
<tr>
<td>1966-1978</td>
<td>• The Great Cultural Revolution</td>
<td>➔ The three-tier network and the CMS had been well established in almost all of the rural areas.</td>
</tr>
<tr>
<td></td>
<td>• Slow development of agriculture production affected development in the late 1960s and a reasonable recovery later in the urban industries</td>
<td>➔ Many health professionals were sent to the rural areas for “re-education” and providing health services to local people.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➔ The health status had significant improvement over the period.</td>
</tr>
<tr>
<td>1978-now</td>
<td>• The economic reform with de facto privatization of agricultural production in the rural areas in the early 1980s and the reform of the state-owned enterprises in the urban areas in the 1990s</td>
<td>➔ The CMS in most of the rural areas collapsed in the early 1980s and had a slow and unsatisfactory recovery in the 1990s.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➔ The cost of health care, particularly in the urban areas grew rapidly and the employment related medical insurance schemes are in financial crisis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➔ The health status of the vast majority of the population continued to improve, albeit slowly.</td>
</tr>
</tbody>
</table>

Sources: compiled by the author
INTRODUCTION

local collective economies and the lack of political backing in China’s transformation from a planned economy to a market economy. The percentage of the population covered by any form of health insurance schemes including the cooperative medical schemes declined dramatically from 71% in 1981 to 21% in 1993. The share of government’s and the collective expenditure on health has greatly declined. An increasing number of people have to pay for health care from their pocket, and some of them cannot afford these medical fees and therefore fail to receive needed care.

Almost all the health facilities are encouraged to generate revenues through **user charges**. Making profits from drug sales is common in most of the health facilities in China. The preventive care programmes, particularly in the poor areas, also have suffered under these resource constraints. It would not be surprising, therefore, that some health indicators have consequently not changed since the mid-1980s, according to a recently published World Bank report.

**Actions being undertaken**

Having recognized these problems, the Central Committee of the Communist Party and the State Council of the Chinese Government convened a national conference on health development in November 1997. The conference called for strengthening rural health services and re-establishing a variety of the cooperative medical schemes. The ministry of health has responded to these problems by urging local governments and health authorities to develop innovative schemes for financing and for delivery of health services.

**Rebuilding village health stations** has been proposed in many rural areas, as a vital strategy for providing basic health care to the rural population. A variety of sources of finance, including World Bank loans, village collectives financing and household contributions have been sought to support the construction of the health stations, to supply needed medical equipment, and to attract skilled staff to work in them. Government and health authorities at higher levels have allocated special funds to help the village stations in one way or another to sustain the health stations.

A **strengthening township health centres**, particularly in the poor rural areas, is another action taken to ensure that the rural population can get access to basic health care of reasonably good quality. In the richer areas, the county and township governments have been requested to support the development of their township health centres. In the poor areas, funds from the central government, and international funding agencies have been sought to support the health centres.

**Re-establishing the cooperative medical schemes**

The above two actions are important and necessary, but insufficient in improving access to basic health care for the rural population. Re-establishing the cooperative medical schemes is an effective way in facilitating people to obtain health care. Many local governments in China, have since the early 1990s, made progress albeit not significantly. The key is how to mobilize potential sources of finance for the
INTRODUCTION

China is planning to strengthen rural health services and re-establish cooperative medical schemes. Our research findings show that, once central or local governments show willingness to subsidize the cooperative medical schemes, individual households would most likely be willing to make their financial contributions. The poor should not be asked to pay premiums to the cooperative medical schemes. The cooperative medical schemes need to define a minimum package of basic health care services it should cover. The package (see box) should include preventive programmes and access to outpatient care and basic inpatient treatment.

One function of the cooperative medical schemes is to redistribute resources from those who are healthy to those who are sick. People contribute to protect both themselves and others against the high cost of treating a serious illness. Therefore, if possible, it is important to make participation compulsory in a community.

New lessons learnt from rural China

It is not necessary to wait for economic development for the health status of the Chinese population to improve. Likewise, economic development of a nation does not automatically result in improvement of health status for all. As China itself and regions within other developing countries, such as Kerala in India have learnt, health status can improve even when the national economy is weak and household incomes are low. However, a long-term commitment to ensure the access of the population to health care by leaders at all levels of government is vital in making health development sustainable.

Shenglan Tang, Lecturer in International Health, Liverpool School of Tropical Medicine, Pembroke Place, Liverpool L3 5QA, UK
E-mail: s.tang@liverpool.ac.uk

Health services to be covered by the cooperative medical schemes

- Children under seven get free vaccinations
- Pregnant women get free prenatal and postnatal care and safe delivery of their babies
- All childbearing women get family planning services
- Participants in the schemes get partial reimbursement for medical care expenses

Young woman and child on tricycle in Jiang Pu Country, 40 km north-west of Nanjing.
EXPERIENCES

HEALING THE WEAK
AMITY IN HEALTH AND DEVELOPMENT

Yu Qun, Publications Secretary with the Amity Foundation in Nanjing, China, outlines several creative initiatives Amity has launched to bridge the health care gap between the urban and rural areas as well as the west and east of the country.

In the countryside, the whole family helps cultivate crops on every bit of their small plots.

The social economic reform implemented in rural China since the early 1980s, has widened the gap between the urban and rural areas as well as the west and the east of the country. The household responsibility system has replaced collective agriculture, reducing the role of collective economy. Private clinics have replaced village health stations. The cost of health care service has increased rapidly. Eighty per cent of medical resources are now concentrated in urban areas. Residents in some poor rural areas suffer from shortages of medicine and doctors. The Chinese government has taken a series of measures to ensure better quality and convenient health care services.

Amity in health and development

Amity Foundation is the only nationwide NGO initiated by Chinese Christians among the many organizations now doing social development in China. Begun in 1985, its projects are situated almost all over China. In Chinese the word Amity is translated as “love virtue”. Amity demonstrates love through its interest in the physical, spiritual and health care needs of people. Amity has been endeavouring to meet the basic needs of the grassroots people though the involvement and participation of Chinese Christians.

Speaking of health transition and development in China, Ting Yanren, Associate President of the Board of Amity Foundation commented, “Amity really welcomes the great changes now taking place in health fields in China. With the reform being deepened, more people get accessible and
convenient medical services. The problem is how we deal with those who are left behind.”

Taking advantage of overseas funds and non-governmental resources, the Amity Foundation, hoping to influence the government’s policies and actions, has pioneered new methods of medical training and services.

**Bridging the gap**

Christians involved in health ministries are challenged to respond with creative and effective approaches to bridge the health care gap. In the past ten years Amity has gradually adjusted its strategies and launched a series of projects with “Chinese characteristics”.

**Training of doctors at grassroots level**

Amity has helped to train more than 10,840 village doctors in 14 provinces, mostly in the north-west and the south-west. These doctors provide basic medical services in the rural communities (see page 11).

**Mobile medical services**

In mountainous and remote areas in China, people have a nomadic lifestyle and live in isolated settlements. Two mobile medical teams set up by Amity travel in the mountains to make medical treatment accessible. The teams consist of specialized senior doctors who like doing voluntary work. They visit poor farmers regularly and make diagnoses or do surgery with the equipment in the village or in the township hospitals.

Besides the teams of voluntary doctors, a mobile clinic, a vehicle equipped with modern machines and five to six doctors and nurses serve the herdsmen on Qinghai Plateau in northwest China.

**Church-run hospitals**

To make Christian involvement and participation in society more widely known to Chinese people is one of Amity’s goals. Till the end of 1998, Amity implemented 76 projects in cooperation with churches at the grassroots level in 23 provinces or regions. Among these projects, there are 37 church-run clinics.

Congregations involve themselves in providing health care. From medical consultations after worship, to well-equipped and warmly-welcoming hospitals, such medical centres grow rapidly. The patients include local Christians as well as non-Christians.

Ji Sipu, vice-president of Amity Hospital in Linqu County, Shandong Province, said that besides their own efforts, the success is due to support from Amity, fellow Christians, and the local government. “We need each other,” he added. Their Christian background, good services and low fees have fostered a big demand among the rural folk. The reputation and importance of these hospitals are growing.

**Laid-off workers train as nursing assistants**

With the reform in the big state-owned enterprises, thousands of workers laid-off in the cities have become the worldwide focus of media attention. At the beginning of 1999, Amity started training courses for women who have been laid-off in Nanjing (where Amity is based) as well as in nearby cities. Li Enlin asserts that, “Women between 35 and 50 years who are unable to find work will be trained as nursing assistants in the hospitals. It is planned that thousands of women will receive such training and 80 have already graduated.”

At the turn of the millennium, the Board of Amity has reaffirmed the policy of whole-hearted service to the weak and the poor in China. At the same time, Amity has made new strategies and policies to improve Amity’s work such
Challenges to the health care in China

There is a continuing need to ensure accessible health care facilities in the rural areas, where 75 to 80 per cent live, to develop preventive services and provide clean water for the 40 per cent of rural people who lack it. Many farmers and herdsmen in western China suffer from and even die of diseases that are controlled in the more developed areas of the country. Reaching the nearest medical clinic may require travelling 300 to 400 kilometres, contributing to the inaccessibility of health care. The shortage of doctors is also a problem. Few doctors assigned to work in township medical centres in western China are willing to work there and most eventually find positions in cities or coastal areas. Besides, western China has fewer hospitals and hospital beds.

Epidemiologic transition

Due to the ageing of the population (by 2020, the number of Chinese over 60 years of age is estimated to increase by 90% to some 240 million people) and the change in people’s living conditions, the causes of sickness and death begin to resemble those of a developed country. The cities in particular are experiencing changing patterns of diseases. Instead of parasitic and infectious diseases and high rates of infant mortality, the incidence of chronic diseases such as heart disease, cancer and hypertension is increasing.

The return of endemic and infectious diseases

Although from the 1950s to the 1970s, China achieved great success with respect to the control of tuberculosis, the TB infection rate now is increasing in some provinces, and there are about 6,000,000 TB patients in the country. China has the largest number of blind people in the world, around 5 million, or about 18% of the world’s blind (more than the population of Denmark). An estimated 400,000 Chinese become blind each year mainly because of cataracts — a new case of blindness every minute.

Newer problems

As China opens up to the outside world, the number people with HIV infection is estimated to have reached 5-10 million. In addition, the environmental pollution is gradually becoming severe. In some poor, remote areas, local dwellers suffer from goitre. There are 10 million mentally disabled persons.

China is the largest consumer of tobacco in the world. A 1984 study showed that 61 per cent of the men and 7 per cent of the women smoked. According to WHO’s regional office for the Western Pacific, during the mid-1990s, there were between 500,000-700,000 tobacco-related deaths annually. This is predicted to rise to 2 million by 2025.

Fan Jie, Medical and Health Division, Amity Foundation

as widening the resource channels and strengthening the supervision and evaluation of the projects. We hope that with the effort of Amity and other development organizations in China, the whole nation will get stronger.

Yu Qun, Publication Secretary, Amity Foundation, 71 Hankou Road, Nanjing 210008, P.R. China. Phone: (86-25) 331-7093/ 331-7034/ 331-4118/ 663-8128. Fax: (86-25) 663-1701. E-mail: afn71@public1.ptt.js.cn

Women who have been laid-off from state-owned enterprises are being trained as nursing assistants in hospitals.
WHOEVER enters Chen Zhanyuan’s health station cannot overlook the scroll on the wall in the village doctor’s own calligraphy:

“Searching high and low to relieve people from their miseries!”

On September 1993, seventeen year-old Chen Zhanyuan graduated from a one-year Amity training course for village health workers and returned happily to his home in Xiamei Village, Gonghe County. Ready to cure his villagers from all their illnesses, he waited for days, but not a single person knocked at his door for treatment. The country folk, most of them ethnic Tibetans, were extremely poor. When people fell sick, their only option was to turn the prayer wheel, hoping that the gods would heal them — not because they mistrusted modern health care, but simply because they lacked the money to pay for a consultation in town. Chen Zhanyuan decided to go out looking for people.

And old herdsman named Zhao Youcai suffering from acute rheumatoid arthritis could hardly walk. With Chen’s acupuncture treatment within days the old man’s legs had recovered enough to carry him through the village. From that day on, people started calling on Chen with all their ailments, seeking his treatment and hoping for a cure.

Creating a clinic out of nothing

Flooded with patients Chen was unable to buy even the most basic medicine or the simplest equipment. The seriously ill he had to turn away. He needed start-up capital for a health station of his own. In the spring of 1994, Chen set out for the mountains with a group from his village to dig up Chinese caterpillar fungus, a rare and precious plant used in traditional herbal medicine. Climbing through difficult terrain for days, they searched for the little sprouts of the fungus breaking through the earth. The ground was wet, their feet froze, and their backs ached from the constant bending and digging. To make things worse, altitude sickness overcame them one after the other. At night, Chen treated his group and himself with acupuncture and other methods of traditional healing. Two months later Chen returned home, weighing twenty pounds less but with 4000 yuan more in his pockets. He threw himself into forming mud bricks, felling trees, sawing beams, and purchasing medicines.

Chen’s health station opened in November. He called it “Amity Health Station”. People seeking Chen’s treatment come from at least three other villages nearby. With the radius of the area he serves increasing, he now tends to the needs of a population of 1,300.
Training village doctors

Amity’s training programme, conducted in cooperation with the government health bureaux at provincial and county levels, uses their training centres and resources. The Amity medical coordination office in Lanzhou, capital of Gansu Province in Western China, coordinates the training held at 22 medical schools, selected from the 315 medical schools in China.

The curriculum is modified in keeping with Amity’s training objectives. The training emphasizes prevention, rural hygiene and the administration of village clinics, including the keeping of case notes. It includes one year in the classroom, one semester as internship in a hospital and one month for a community investigation project. Training covers the use of 40 basic drugs and encourages referral of more complex conditions.

Li Enlin, head of medical and health division in the Amity Foundation, explains, “The provincial health bureaux have shortened the training from three years to one and a half years, and have let the trainees master practical skills in the most limited time. To ensure that the graduate really works for his or her fellow villagers, the license to practise is only valid in the particular village. The government is aware that cultivating community health workers is a way to extend the rural health work.”

Amity covers two-thirds of the tuition fees and contributes towards textbooks and maintenance and provides “seed money”, usually needed for the purchase of necessary equipment and basic medicines.

New education methods

Amity with the Huaxi Medical University has produced 210 videotapes, as part of a set of distance educational materials for doctors and health workers at grassroots level. The local doctors are required to take examinations based on the content of the videotapes. Amity has translated and adapted such books as Where There is no Doctor by David Werner and Helping Health Workers Learn by David Werner and Bill Bower for medical workers in rural China. Amity has also developed several posters, videos and pamphlets for the HIV/AIDS projects in south-west provinces, Yunnan and Guangxi.

Coordination

To keep in touch with Amity graduates and provide further professional support, the office publishes The Rural Doctor Quarterly, a Chinese newspaper distributed free of charge to grassroots medical personnel.

Based on an article from the Rural Doctor Quarterly, by Wang Jianshen and Zan Jianqin and translated by Gotthard Oblau, published in the Amity Newsletter. With further inputs from Yu Qun.
In 1949, there were approximately 750,000 Christians in China. Today the official figure is 13 million, although evidence indicates there could be as many as 20-30 million Protestant Christians and an additional 10 million Catholics. How does a person explain what is happening in China? It can only be explained as God’s work.

Prayer for healing

Although born in a Christian family in Shandong Province, East China, 18-year-old, Lu Binjun had no desire to follow her parents' faith. In 1929, she developed a serious health problem. The local doctors gave little hope of her living without the amputation of her leg. Her parents prayed for her and Binjun herself, frightened at the prospect, joined them in prayer. She was healed. For most of the past 70 years Lu Binjun has served as an evangelist, pastor and seminary professor. Dr. Hong Bihua, a retired physician who works with Amity Foundation, was partially blind as a young child. She recalls that when her Christian mother prayed her eyesight was partially restored. Prayer for the sick, continues in the community of faith within China today.

While many urban churches emphasize prayer and physical healing, in rural
Faith and Healing

"Family members of our patients see the love of God demonstrated in how the patients are treated. They ask questions. They ask for Bibles. They come to church. They attend inquirers' classes. They believe."

Hospital administrator of a 40-bed church-run hospital in Hubei Province in central China.

"People know the hospital is Christian because of its name. The hospital is known as a place where the staff are not only competent but they minister to the patient with kindness and love. We are the expression of God's love, loving others for His glory."

A Christian doctor in the city of Dalian in north-eastern China, who with the local churches has started a clinic, a rehabilitation centre and homes for the elderly.

"In 1976, at the end of the Cultural Revolution, my mother became ill. One of the women from her work unit visited her. The colleague told my mother that she was a Christian and would ask the living God to heal her. The woman prayed for my mother. My mother was healed. She believed that the living God healed her. She became a Christian. I am not a Christian but my mother says she prays for me every day."

A young woman.

"Our hospital is called the Jesus Hospital. Many patients come looking for Jesus to heal them. They are looking for both physical and spiritual healing."

A hospital administrator from in Shandong Province in eastern China.

China there is an even stronger emphasis. Some of China's Christian leaders believe that approximately 90% of the converts in rural China come to faith in Jesus Christ through some type of physical healing.

A healed and healing church

A young woman, who was healed after prayer in a church, started a group to "pray for the sick". That group is now one of Jiangsu Province's leading churches. The pastor continues to pray for physical healing because for many, "physical healing" points them to the One who gives spiritual healing.

Downside

Some churches or groups overly emphasize physical healing. They have bizarre meetings. Recently a man died and the Christians in the church would not allow the family to bury him because they believed God would restore the dead man to life. Due to the neglect of sound doctrine stemming from a lack of theologically trained leaders, it is easy for many cults to develop within the Christian community. Despite the potential for misuse, Bao Jiayuan, one of the Vice-Presidents of the China Christian Council says that he receives a handful of requests asking for prayer regarding physical illnesses — cancer, stroke, blindness, blood problems, etc in the various churches where he preaches. On being asked his response, his reply was, "I take the requests home and I pray for each person. As God's servant, I would not think of not praying for the people."

It is unlikely that seminarians, theologians or missiologists can explain the extraordinary and mysterious faith healing and its impact on the growth of the Chinese Church. It can be explained only as the work of a loving and holy God, interested in the total person — physical, mental, emotional, social, and spiritual.

Faye Pearson, Amity Foundation, 71 Hankou Road, Nanjing 210008, P.R. China.
Phone: (86-25) 331-7093/331-7034/331-4118/663-8128. Fax: (86-25) 663-1701
WHOLENESS

Contact asked Li Enlin, medical director of the Amity Foundation why she thought prayer for healing was widely practiced within the church. Excerpts from the interview.

Contact: Why is there such a difference between rural and urban areas regarding spiritual healing?

Li Enlin: It is mainly related to the access to medical care. Urban areas have hospitals with sophisticated medical equipment and well-trained medical staff. To a certain extent, most urban residents either enjoy free medical care or have medical insurance.

There is now a shortage of doctors, especially in poverty-stricken areas. That and the collapse of the cooperative medical care system have made the medical service for the rural population even worse. Besides, the rural population has to pay out of their own pockets for medical treatment. Due to poverty and the inconvenience of seeing a doctor, seeking spiritual healing becomes the only option for many rural people.

Contact: What is the position of the China Christian Council?

Li Enlin: Visiting and praying for the sick is the common practice in almost all of the churches both in urban and rural China. China Christian Council neither encourages nor discourages the local congregations to show their fellowship in such a natural way.

Contact: What do Chinese theologians think about it?

Li Enlin: Local congregations and those involved in theological education think that “the harvest is large, but there are few workers to gather it in”. While there has been no special theological research on faith healing, some theologians think that expectation of healing is the sign of “poor quality of faith”, due to the shortage of trained preachers and lower education among people.
rural people. Some theologians think that healing is an expression of God’s loving care for the people in need. Most theologians believe we must encourage congregations to seek medical treatment because medicine is one of God’s creations.

Contact: How does the Chinese government react to spiritual healing?

Li Enlin: Freedom of religion has been protected by the Chinese Constitution. “The state protects legitimate religious activities. No person is permitted to use religion to conduct counterrevolutionary activities or activities that disrupt social order, harm people’s health, or obstruct the educational system of the country.”

Contact: Can spiritual healing be combined with community-based health care?

Li Enlin: If community-based health care can provide qualified service, congregations will have one more option to solve their physical problems. The decision is left to each believer to either combine spiritual healing with community-based health care or to choose either one.

This list contains useful publications on the issue of health care in China.

WHO PUBLICATIONS

World Health Organisation
1211 Geneva 27
Switzerland,
Fax: 41 22 791 4167.
E-mail: austinm@who.ch

OTHER PUBLICATIONS

Health in transition: reforming China’s rural health services
IDS Bulletin (Volume 28, Number 1, January 1997, Editors: Gerald Bloom and Andres Wilkes), is a very useful and informative compilation of articles about health reforms in China. Published by the Institute of Development Studies (IDS). Price £9.25 (plus post and packing).

Healthcare in transition: reforming China’s rural health services
Primary health Care, The Chinese Experience, is a report of an inter-regional seminar held in Yexian Country, Shandong Province, People’s Republic of China in 1982. The seminar, jointly organized by UNDP, UNICEF, the World Bank, and WHO, with the support of the Chinese Ministry of Republic Health considered China’s three level health care network; the involvement of the people; health manpower development; and the financing of rural health care. ISBN 92 4 56077 0, 1983.


Primary care
Contact: How does the Chinese government react to spiritual healing?

Li Enlin: Freedom of religion has been protected by the Chinese Constitution. “The state protects legitimate religious activities. No person is permitted to use religion to conduct counterrevolutionary activities or activities that disrupt social order, harm people’s health, or obstruct the educational system of the country.”

Contact: Can spiritual healing be combined with community-based health care?

Li Enlin: If community-based health care can provide qualified service, congregations will have one more option to solve their physical problems. The decision is left to each believer to either combine spiritual healing with community-based health care or to choose either one.
TO DESTROY OR NOT TO DESTROY?
LUKE 9:51-56

The following reflection has been prepared by Chen Xida,
a theologian at the Nanjing Union Theological Seminary, China

The two disciples of Jesus, James and John, want to destroy a Samaritan village by fire sent from heaven. The reason being that the village people did not receive Jesus, whose “face was set toward Jerusalem”.

A reading of the passage makes it clear that the Samaritans rejected Jesus in order to protect him from the danger ahead of him in Jerusalem. But the disciples misunderstood that seeming rejection. They wanted to show their zeal “for the honour of their master” wanting to make everyone submit to their master — like Chinese Emperors who expected absolute loyalty from their subordinates and destroyed all opponents.

Jesus, unlike a Chinese Emperor is determined not to acquiesce to a request to send fire from heaven to destroy the Samaritan village. He did not take the opposition’s power as seriously as his disciples did. Jesus did not want to be treated like a Chinese Emperor who always expects a “yes”. He always gives people freedom to say “no”.

By the Heart

Jesus measures people by their spirit, not just according to their attitudes, opinions or reasoning. Jesus rebuked the disciples for not being able to judge by the “spirit” and “heart”. He says, “You do not know what spirit you are of” (Luke 9:55). The word “spirit” has been translated in the Chinese Bible as “heart” (xin). The Chinese translation of this sentence is, “You do not know what your hearts speak”. Jesus judges people according to their hearts.

Now read Luke 10: 5-37

In telling his disciples the story of the Good Samaritan, Jesus wanted to help them learn how to use their hearts, to appreciate cultures that they do not understand, and to value the life of people who are totally different. Jesus knew that his disciples would fulfil his mission only if their violent hearts learnt to value the lives of people who might even reject them.

Jesus’ strong sense of purpose, “for the son of Man has not come to destroy the lives of human beings but to save them,” (Luke 9:56) did not allow him to destroy the Samaritan village. The Saviour would never bring salvation by destruction.

At the top of Jesus’ agenda is to save lives. It is the only reason for him to “set his face to Jerusalem,” to fulfil his mission, by sacrificing his life on the cross in order to save people.

As Jesus “went on to another village”, we too must travel on when we meet with rejection. Jesus tolerates objections and rejections if only lives can be preserved.

It seems that our world is full of “right reasons” to destroy lives. We have the “just” wars to protect human rights; we try aggressively to secure our doctrines; we create economic wars to guarantee the financial security and political wars to maintain our power. War seems to be the only solution to deal with differences, obstacles and rejections. Lives are pawns to be destroyed in the marketplace of war.

Questions for discussion

- Have people had enough room to express their opinions and are they allowed to solve problems in their own way?
- Has “heart” been given priority in judging the value of people?
- Is our primary purpose to save lives of people?
Two recently published studies might have considerable consequences on current practices to reduce perinatal HIV transmission. Up to now 25-35% of children born to HIV-infected mothers will receive the virus during pregnancy, delivery or through breastfeeding. Methods to reduce this rate such as antiretroviral drugs or modification of breastfeeding practices are available in affluent countries but are too expensive for resource-poor settings in which more than 90% of HIV-infected women are living. This situation might change.

**More effective drug**

A study looking at the possibility to reduce perinatal HIV transmission with the antiretroviral drug nevirapine was published in September. It showed that a single tablet (200mg) of the drug nevirapine given to the mother at the onset of labour and 2mg per kg to the baby within 72 hours after birth could reduce the transmission rate to only 13.1% after 14-16 weeks. That was almost half the rate (25.1%) of the control group that received the more expensive drug zidovudine. This result is particularly important as the children were breastfed during the first weeks of life proving that the drug had a prolonged effect. This regimen is available at a current market price of US $4. This price might be within reach of many affected women. Policy makers in many countries will have to consider very carefully whether wide-spread programmes offering testing and counselling services for antenatal clinics with subsequent nevirapine treatment for HIV-infected women wherever they live.

A study in South Africa found that babies who were exclusively breastfed had a lower HIV transmission rate than those who were not breastfed or babies who were given mixed feeding.
The antiretroviral drug, nevirapine might be an affordable and acceptable option to reduce perinatal HIV-transmission in HIV-infected women.

**Influence of breastfeeding practices on HIV-transmission**

Another interesting study examined the influence of breastfeeding practices on HIV-transmission. This study compared the influence on three different patterns of infant feeding on perinatal HIV transmission within the first three months of life: no breastfeeding, exclusive breastfeeding and mixed feeding including water and other liquids. The result was that those who were exclusively breastfed had a lower transmission rate (14.6%) than those who were not breastfed at all (18.8%). The worst method was mixed feeding with 24.1% HIV-transmission.

**Appropriate infant feeding practices**

As this result might have considerable implications on how to advise women at risk for HIV infection on appropriate infant feeding practices, the WHO, UNICEF, and UNAIDS have published a joint statement on current policy guidelines. After the publication of this study, available at: http://www.unaids.org, they confirm the importance of the findings of the research team in South Africa but issue a warning that the results of this study are preliminary and need to be confirmed. Therefore they do not see the need for a change in their current policy emphasizing that all women should have access to HIV testing and counselling services and receive full information about all possible options for infant feeding. If the women choose to breastfeed which is still the best method under most circumstances, then exclusive breastfeeding is to be preferred and should be maintained for 3-6 months. This is certainly reasonable advice and the study might help to dispel fears of women who currently refrain from breastfeeding because of worries that they might transmit the virus through their breastmilk.

Both studies show that there is a lot of research going on at the moment that might help to find cost-effective and practical ways to reduce perinatal HIV transmission. Now more than 1600 children are infected every day with the deadly virus, which is completely unacceptable, as methods to prevent this disaster are known. There is hope that in the future preventive therapies and methods will be available and affordable to all women wherever they live.

**References**

All God-fearing and health-minded people must close their ranks and tenaciously defend and preserve the concept of PHC as advocated in the Alma Ata declaration. Though the slogan “Health for all by the year 2000” is more than 20 years old, the field of plant medicine — ordained by God, the greatest designer — which the majority of human races depend upon is under-developed. Our centre has made a unique and significant success in curing many diseases using plant materials.

Peter Dumoga
Ethno Botanical Research and Medical Centre
Ammasaman
Ghana

Overall I became a different professional and a different person because of Contact. Through reading Contact from 1975, I heard about Jamkhed and about the importance of breastfeeding. I read about many interesting experiences, about popular education and about the growth chart. Trying to apply what I read gave me both great satisfaction as well as leaving me frustrated. I designed the first breastfeeding educational campaign for Colombia in 1976 and designed and supported the implementation of a nation-wide growth-monitoring programme in 1978.

But what I consider the most important, not being a person affiliated with any specific church, is that every issue of Contact brought me the support of people whose lives were dedicated to making the world a better place for those most in need. Contact brings the inspiration to keep me alive and going. Contact is an important way for me to keep in touch with what is happening in health issues all over the world. Thank you for that.

Maria C. Bustillo
Barranquilla
Columbia

I often recommended articles from Contact to fellow students at Harvard who were searching for alternative, people-centred approaches to international health and health care. There is a wealth of experience, wisdom and knowledge in the back issues of Contact that is hard to find anywhere else! Contact has played a critical role in providing a space for dialogue, debate and education on issues related to the health of the poor and the ongoing struggle to reach health for all.

Karen Anderson
EPES
Casilla 22-Correo 44
El Bosque Santiago
Chile

slide set shows how to diagnose and treat serious ear diseases which cause a discharge of pus or collection of wax or blood in the ear. The set which has 24 slides and a written commentary is available from TALC, P.O. Box 49, St Albans, Herts AL1 5TX, UK. Price: £9.00 (plus VAT if applicable) including postage and packing.

A Resource Guide on HIV Health Promotion in Prisons
The third in the National HIV Prevention Information Service’s occasional series of Resource Guides, HIV Health Promotion in Prisons (ISBN O 7521 1769 6), is a six-page guide designed to alert health and education professionals to the key resources required for developing HIV health promotion in custodial settings. It has contact details of key individuals, agencies, publications, websites and education resources relevant to work in this area. Other publications include, Guide 1 Antenatal HIV testing policy (ISBN 07521 1587 1) and Guide 2 HIV health promotion with African community groups in England (ISBN 07521 1670 3)
Free from Marston Book Services, P.O. Box 87, Osney Mead, Oxford, OX2 ODT, UK. Telephone: +44 1235 435 565.

LETTERS

Plant medicine

Inspiration, support and education
REMEMBERING MABELLE AROLE

Mabelle Arole, pioneer in community health, former Commissioner of the Christian Medical Commission (CMC) of the WCC, and friend and advisor to the ecumenical family passed away in India, at the age of 64, on 27th, September 1999. Mabelle greatly enjoyed her work in CMC and the contributions she was able to make even after her term as Commissioner was over.

Mabelle and her husband Raj Arole, after completing their studies at the Christian Medical College, Vellore, worked in several mission hospitals. They realised that the needs of the poor were not met by working in a hospital. After completing their Masters of Public Health at Johns Hopkins University in the USA, they returned to India and began the Comprehensive Rural Health Project (CRHP) in Jamkhed. Mabelle’s vision was to make this area a true “shalom” – true wholeness and health for the people of this area. Contact issues 10 and 129 describe the Aroles’ work at CRHP.

She held various leadership positions and received many awards, including the Ramon Magsaysay Award and Paul Harrison Award for outstanding work in rural areas. Along with her husband, she co-authored the book Jamkhed about their experiences in Jamkhed. In a very lucid language, she shared her experiences with primary health care. Her work was instrumental in the spread of the community-based primary health care movement to Latin America, Africa, Southeast Asia, and other parts of the world.

Her work in empowering women and communities stands as a witness to believing in the potential of humankind and bringing out the “image of God” in every person. Her quiet, gentle spirit and words of wisdom will continue to inspire women and men all over the world. We thank God for Mabelle Arole’s gift of healing. She is survived by her son Ravi, daughter Shobha and Raj, her husband.

Mabelle’s mission in life was:

The Spirit of the Lord is upon me, because he has anointed me
To preach good news to the poor.
He has sent me to proclaim freedom for the prisoners
And recovery of sight to the blind,
To release the oppressed,
To proclaim the year of the Lord’s favour.

Luke 4.18-19

CRHP’s address is: Comprehensive Rural Health Project, Jamkhed, Ahmednagar 413201, Maharashtra, India. E-mail: jamkhed@wizard.net

World Breastfeeding Week

WABA (World Alliance Breastfeeding Action) produces a series of publications for the World Breastfeeding Week (1-7 August) — colouring and comic books for children, postcard, calendar, poster, action folder and banner. Contact readers can use or adapt the WABA materials to produce their own T-shirts, mugs, balloons, songs, skits or any other material for the World Breastfeeding Week 2000.

WABA, P.O. Box 1200, 10850 Penang, Malaysia. E-mail: sec@waba.po.my. Website: http://www.elogica.com.br/waba

Contact is the health and community development magazine of the World Council of Churches. The publication deals with various aspects of the church’s and community’s involvement in health, and seeks to report topical, innovative and courageous approaches to the promotion of health and healing. Contact is published by a partnership of the World Council of Churches (WCC); Christian Medical Association of India (CMAI); German Institute for Medical Missions in Tübingen (DIFAM), and Medical Coordination Secretariat of the Netherlands (MCS). It is published four times a year in English, French and Spanish. Present circulation is approximately 15,000.

Articles may be freely reproduced, providing that acknowledgement is made to: Contact, the publication of the World Council of Churches. A complete list of back issues is published in the first annual issue of each language version. Editorial Committee: Rainward Bastian, Christoph Benn, Manoj Kurian, Cherian Thomas, Darlena David, Christina de Vries, Elizabeth Moran. Editor: Darlena David; Design: Gurmeet Singh; Mailing List: Susamma Mathew. Printed on woodfree paper by Impulsive Creations.

Mailing list: Christian Medical Association of India, 2, A-3 Local Shopping Centre, Janakpuri, New Delhi 110 058, India.

Tel: 91 11 559 9991/2/3, 5521502. Fax: 91 11 5598150. E-mail: cd.cmai@vsnl.com

Contact is also available on the World Council of Churches’ website: http://www.wcc-coe.org

The average cost of producing and mailing each copy of Contact is US $2.50, which totals US $10 for four issues. Readers who can afford it are strongly encouraged to subscribe to Contact to cover these costs.