HEALTH FOR ALL

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HEALTH FOR ALL

2 Editorial

3 Introduction
   Take a cue...

7 Interview
   “There are no universal answers”

9 Review
   Health workers — catalysts for change

11 Experience
   Working for health...

13 Wages of globalization

14 Health care in China

15 Fear not the Goliaths

16 Interview
   Empowerment must replace participation

18 Update
   Promises to keep

20 Bible study
   Jesus and the healing of the people

21 Resources

23 NETWORKING
   Useful publications, letters and announcements
Buffers of development?

Credit: Michael Lutzky/UNDP

Ken Newell’s Health by the People describes innovative strategies for primary health care involving community action. Newell drew attention to the fact that poor communities seldom rank health care amongst their top priority needs. Rather peace and stability, food security, water supplies, housing and self-determination are considered more important. The situation nearly 30 years later is little changed.

This issue of Contact revisits some of those who were involved in Primary Health Care (PHC) at that time, while also highlighting current programmes which demonstrate the importance of Health by the People.

According to Hafden Mahler, Director General of WHO — during the period of the Conference of Alma Ata — “Many countries made an effort, but did not commit themselves to peoples empowerment, which was the essence of PHC. People should identify with their own health”.

Carl Taylor, another person deeply involved with the Conference of Alma Ata, explained “Health professionals who have a tendency to feel that health is dependent on them, must recognize that Health by the People is critical to development.”

The Institut Panafrique de Santé Communautaire (IPASC) has attempted to ensure that Health by the People is facilitated by focusing on the re-profiling and training of professionals working at community level so that the new profile matches the skills required by the local definition of health.

A Chilean programme, Popular Education in Health (EPES) has spent 20 years working for health and human dignity. The EPES team is convinced that the educational strategy of promoting the organization and participation of the community contributes to improving the health conditions.

In December 2000, a People’s Health Assembly (PHA) was held in Dhaka, Bangladesh. It was designed to “see the people who remain unseen and to hear the voices of the unheard” – to show solidarity with Health by the People. Sukumar Muralidharan gives us some highlights of the Assembly, which recognized the need to provide a platform for the growing mass of those dispossessed by the onward march of globalization.

A Mayan Kakchiquel doctor, Hugo Icu, has brought us an example from Guatemala of health not being “by the people”. He feels that indigenous Guatamalans are faced with the dehumanization of health, with the loss of the right to health, where what is valued is what you pay.

Health by the People is not only an issue for developing countries. Members of Breckfield and Everton Community Health Action Group, in Liverpool, England campaigned to keep their local community health clinic open when decisions to close it were being made.

Health by the People takes us to the root causes of poverty and disease, and encourages us (health professionals, churches, NGOs) to work with communities in their efforts for justice and their struggle for peace. This is their Health – a human right!

Patricia J. Nickson
Guest Editor
TAKE A CUE, MAKE A DIFFERENCE
COMMUNITY PARTICIPATION IN HEALTH: HOW DOES IT WORK?

The Alma Ata in 1978 made ‘Health for All’ seem to be an achievable goal. But with governments persistently defaulting on their commitments, even two decades later, we are still miles away from our goal. Motivated public participation seems to be the best course now. Grindl Dockery, Lyn Barry with Erica Hedley share how the community can get together to find workable solutions.

The Breckfield and Everton Community Health Action Group, (BECHAG) in Liverpool, England campaigned to keep their local community health clinic open when decisions to close it down were being made behind closed doors by the management. Their tenacity paid dividends and won them credibility and a voice in the decision-making process.

How it all began

We started a community campaign to keep our local community health clinic open. Decisions to close it down were being made behind closed doors by the management at the Community Health Trust (CHT).

People attending the clinic found that time tables had been changed. With cross-checking getting difficult, they stopped coming to the clinic. The Trust used the reduced numbers as an excuse to close the centre down. There were fewer general practitioners (GPs) here than in other communities, yet the area had some of the worst health problems in the city of Liverpool.

The campaign to prevent the community health clinic from closing was the first time that the group had come together. We had meetings with the Liverpool Health Authority, the Community Health Trust and local people. The Health Authority (HA) agreed to let the campaign group research the feelings of the communities concerned and funding was given by the HA and Liverpool Community Voluntary Services. Our campaign group appointed an independent and sympathetic researcher to help us do the research.

Research

Training for the research gave us a lot of confidence and time to get to know each other. For three weeks our research team tramped around the whole area doing the survey, finding out a lot about our own community we didn’t know before. Nearly everyone we spoke to thought the clinic was already closed so we had to keep telling people to go and use it to help stop it closing.

Sharing makes the difference
INTRODUCTION

I joined the campaign group because it made me angry that managers were making decisions on my behalf without discussing it.

We were lucky we had two sympathetic senior managers in the HA who supported us. They also shared some of their problems with us.

Methodology

The purpose of participatory approach is to develop a process that enables the participation of those being researched, leading to individual and collective empowerment.

The first challenge to those who help in participatory research is to avoid taking over, but enable all participants to own and control the planning and conduct the research. People expect the trainer will not only bring greater independence and skills to the process, but also have a commitment to ensuring local people’s voices are heard. (In some situations, exploitation by outsiders to fulfill their own agendas can also occur.)

Local people need to ask specific questions of the trainer before activities begin. This should include who will be making the decisions; what experience/skills does the researcher have; how will they ensure that local people are able to participate in the process; who will own or control the process and its outcome, e.g. reports and academic or professional papers?

The process

A very practical planning framework was applied* to facilitate everyone’s participation and to enable group members to see the progress and to add or make adjustments as necessary. On completion of the analysis and preliminary report, a questionnaire was developed, field tested and edited by the research team.

The survey purposely identified those who most used primary care services in 50 randomly chosen streets and six random households per street. The group then edited and commented on the report with public presentations of the findings by the team to the wider community.

Participation

On completion of the research, the group prepared a presentation of the report for

Where there is a will there is a way
the Health Authority Board. During the research there were several GPs who retired, which meant there were even fewer practitioners in the research area and in consultation with the campaign group. Appointment of new GPs was initiated by the HA. The group members gave a presentation to a group of GP candidates, on the type of attributes they wanted from a new GP in their community, before the candidates went on to their job interview. However, the campaign team declined an invitation to attend the interviews, but were represented by the Community Health Council (CHC) so as to avoid community criticism of the campaign group if the new GP proved to be unacceptable, or the process of joint planning did not meet their expectations.

This is an important point, as managers and GPs often see the appointment of individual community members to sit on committees as an appropriate approach to community involvement, but it often has less than positive outcomes both for the communities involved and other members of the committees.

Listed below are some of the main factors that in our experience are most important in deciding the meaning and reality of the term ‘partnership’.

Partnership implies and suggests equality between partners through:

- Shared visions
- Joint decision-making
- Negotiated priorities
- Shared duties/responsibilities
- Mutual respect/trust of differing knowledge, skills/abilities, needs, constraints
- Real power sharing (this is the tricky one!)

Outcome

The experience of BECHAG five years on indicates some of the serious problems that community projects face in developing partnerships and achieving sustainability. Because of BECHAG’s past history of success in putting the needs of the community first, it is seen as a model of good practice in community involvement.

The problem is that the good practice is being allowed to die because it is being drained by defeat, disillusionment, demoralization and exhaustion.

The result is that fewer people are doing more of the work for no reward. The reality is that work done by an experienced skilled worker takes a fraction of the time it takes a volunteer with no computer or writing, bookkeeping or accounting skills. If we want to get local residents involved, we need to do so by using the skills they have, such as networking and finding the real needs of the community, then train them to be advocates and empower them.

With very few professionals living in the community able to give time voluntarily, we need paid trained people to do the
behind the scenes administrative work. This includes researching, funding, writing up funding bids, servicing meetings etc., thus giving local people time and the backup to recruit other local people, to campaign for local needs and issues. If local and central government want to take the local voice seriously, they need to seriously support that voice.

Conclusion

Despite some positive outcomes of this case study, the longer term process of development raises important issues that need to be addressed.

1. Initially, develop relationships rather than partnerships between the relevant parties.
2. Be realistic about the limitations or possibilities for innovation and creativity within the system, the National Health Service (NHS).
3. Recognize and respond to the different priorities/needs in health between the system (NHS) and local communities. In particular, if the system gives resources and priority to a medical model of health, rather than to a more wholistic social/public health model of health.
4. Recognize that support for public participation remains largely dependent on sympathetic individuals at senior management levels rather than systemic changes.
5. Address the lack of skills and understanding or commitment within the NHS to long-term sustainable development.
6. Work together to develop common understandings and working. Expectations may be unrealistic on both sides, which then affects the type or quality of relationship between all the relevant parties.
7. To avoid confusion, ensure an openness and clarity about what is and what is not possible in terms of resource allocation, the level of community involvement that can be achieved and what role all parties should have in the process. Develop training for health.
8. Local people must be able to discuss and agree the role of any outsiders in community initiatives.
9. The gender roles in community health and social initiatives are usually ignored.

Women are usually the main activists or volunteers in these type of activities.

Where there is no artist.

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Carl Taylor’s advocacy for ‘Health by the People’ is surely influenced to some extent by his early experience in India. Born in India to medical missionary parents and later having served two terms in the 1950s in a remote Christian hospital in India, the need to emphasize for the right to self-determination could not have escaped him. He started the Department of International Health at the John Hopkins and chaired the department for 23 years. He was UNICEF representative in China in the mid-1980s.

Contact: What does health by the people mean to you?

Carl Taylor: It is difficult to give a good example of a programme where health by the people is evident, because we first need be clear as to what the phrase means. The book, Health by the People, edited by Ken Newell managed to illustrate the definition by means of examples, such as China and Jamkhed.

While China illustrates how quickly a world model can collapse when there is no framework for it, the distinctive thing about China in those days was that there was a very strong top-down component under the communist system; but the politicians were smart enough to require the implementation to be done in a bottom-up way, with every locality paying for its own health-care.

Jamkhed, the second example, in contrast to China, rather than collapsing has moved into effecting a scaling-up of its impact. The key component here is “self-help” which was developed through learning and experimenting. This kind of health by the people can become sustainable and the basis for programme growth. One of our biggest problems, as health experts, is that we are always looking for universal answers but we must realize that there are no universal answers, since every local situation is different.

Contact: Can NGOs, government, churches and the people work together?

Carl Taylor: You need the top-down (the government) and you need the bottom-up (the community) but you also need outside influences (the technicians – often NGOs and church-related programmes) who can bring together both the top-down and the bottom-up. Similarly, the polarization between the relative importance of village health workers and doctors is nonsense. We all need to work together in partnership.

Contact: When simplified does it mean we should adopt what WHO has been advocating?

Carl Taylor: Absolutely not. I disagree with what is being said in WHO. We should go beyond the paradigm of primary health care as written out in Alma Ata. I was one of the two outside consultants for WHO. We spent two years working on the background documents for Alma Ata.

In the original document we talked about the three pillars of primary health care,
but these are often forgotten. The first was that the health services being taken out of the institutions and to the communities (accessibility). The second pillar was community participation, but in practice this was replaced by “community manipulation”, totally what “health by the people” is really not all about. The third pillar, which was suggested in the document of Alma Ata was “intersecretorial involvement”. Health cannot be achieved only through the provisions of the health system, but is the whole process of all the influences that determine “health by the people”. Having accepted that, one has to move away from the WHO framework which draws boundaries around the health system.

Contact: Are you disappointed or satisfied with the outcome of Alma Ata?

Carl Taylor: There is disappointment. It is not what happened in the Alma Ata Conference, but is what happened after that. Alma Ata was in 1978 but by 1984 there was a consensus that emerged among some international agencies to introduce “selective primary health care” - a quick means of achieving selective results, which is appealing to the donor community, but which does little for sustainability, because of its vertical approach. I am a great believer in single focus approach but only if it fills a gap in the existing health system. Most of these selective, single focus efforts have concentrated on their own outcomes and not in building the primary health care infrastructure.

Contact: With stability and economic development almost non existent in many areas, health care system is difficult to sustain. How do you make it work then?

Carl Taylor: I used to think that these conditions were necessary myself. But I have changed my mind and I now think that the greatest opportunities are at a time of crisis. There is an old Chinese proverb using the word ‘Waygee’. ‘Way’ is crisis and ‘gee’ is opportunity. What we need to do is to go back to ancient Chinese wisdom and learn that crisis is the chance that we have been waiting for in order to implement primary health care.

Contact: Would you prefer to put health into the hands of women?

Carl Taylor: When we look at the best examples of world changes, it becomes evident that women have a leading role which includes sustainability. Women’s empowerment and work in the community is sustainable, but the health system is the obstacle. Few health managers want to give up control and especially to give up control to women. If you face that reality then you can really begin to talk about “health by the people”.

Contact: How can we ensure that poor women’s voices, poor people’s voices are heard?

Carl Taylor: I used to think that these conditions were necessary myself. But I have changed my mind and I now think that the greatest opportunities are at a time of crisis. There is an old Chinese proverb using the word ‘Waygee’. ‘Way’ is crisis and ‘gee’ is opportunity. What we need to do is to go back to ancient Chinese wisdom

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HEALTH WORKERS – CATALYSTS FOR CHANGE

The Institut Panafricain de Santé Communautaire (IPASC), established in the Democratic Republic of Congo (DRC) in 1992, now includes three Institutes in DRC (Nyankunde and Bunia) and Ivory Coast (Dabou).

Patricia Nickson writes about the institute which started as a training programme to improve the quality of care at the health centre level and has now expanded to bridge the gap between the health worker and the community through its ‘community determined approach’.

A culturally determined approach

Some would argue that culture and community self-determination are obstacles in meeting the health needs of the community. Others see the community and its environment as being the context to which health care must be adapted. In traditional societies, the clan was self-sufficient. A micro-culture evolved which dictated a way of living to ensure the preservation of the clan. This was health — not confined to a state of wellbeing of the individual, but related to harmony and responsibility within the clan and the wider community. This would have included problems as diverse as the failure of crops, drought, demon possession, sterility, measles or ‘misfortune’.

To ensure that Primary Health Care (PHC) is ‘shaped around the life patterns of the population it serves’, community health workers need to be able to recognize these ‘life patterns’ and understand the cultural context. The concept of health, illness and health care should be seen in relation to each other. Traditional health practices and illness-related decision-making processes should be respected, and the definition of a ‘healthy family’ is crucial in understanding some of the health needs of the community.

Missed the point?

The strategy of community participation was born from the recognition of the limitations of the medical approach and the potential of ordinary people to take responsibility for their own health.

Lip service has been paid to community participation, but in reality the practice has often completely missed the point. The PHC approach insisted that PHC be ‘shaped around the life patterns of the population’, rather than imposing directives, activities and new committees upon the population. Over twenty years of failed “community participation” have passed. Now it is time to change the emphasis to “health professionals participating with the community, facilitating the community to achieve their own objectives”.

Health services should adapt to the cultural needs

The PHC approach insisted that PHC should be ‘shaped around the life patterns of the population’, rather than imposing directives.
A wide gap

Much of rural health care depends on the availability of health centres, which are usually staffed by hospital-trained nurses. Doctors who may visit or receive patients who need a second opinion, usually supervise them. Seldom do these nurses or doctors cope with the root causes of the problems they are trying to tackle, such as poverty, lack of hygiene, poor agricultural techniques, strife within the community, and natural or man-made disasters. As a result, community health, which underpins the health of rural, urban and refugee communities, is often neglected.

There is then a wide gap between the skills of health professionals, trained in hospital environments (even if they are committed to improving the health of communities), and the skills needed to respond to a wholistic definition of health. Thus, the profile of the professional working at community level needs to be re-defined so that it matches the skills required to the local definition of health.

Human resource development

The Institut Panaricaic de Santé Communautaire (IPASC), was created in March 1992 in the north east of the Democratic Republic of the Congo (DRC) to serve Francophone Africa. Its goal was to improve the quality of care at health centre level through a ‘community determined approach’, by training health professionals to fit a new profile which was acceptable to the Government of the DRC. Curricula were designed which would prepare students to fit the roles defined by the profiles. In February, 1998 IPASC expanded its work to West Africa, working with MAP International.

Training

IPASC has established a three year degree course and a four-year diploma course (in DRC) and short courses in Ivory Coast, all of which are designed for community health professionals. A participatory, problem-based learning process is used with the accent on the importance of the relationship between the health worker and the community, and on the facilitation of the community to respond to its own objectives. The course also includes such subjects as natural medicine (ethno-pharmacology), primary veterinary care, agriculture, water protection, conflict resolution, disaster preparedness and refugee health. The final evaluation of each student is done in his/her own programme by a member of the IPASC staff, the respective district medical officer and community members. A follow-up visit for this purpose is arranged one year after the student has returned home (regardless of the country or situation of the candidate).

Conclusion

The community’s role in PHC cannot be written off as ‘community participation’ unless the health service participates with the community and facilitating the community to achieve its own objectives.

In its nine-year history, IPASC has proved the benefits of working closely with the community and facilitating community members to tackle their own health problems.

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In March 2002, EPES will celebrate 20 years of work emphasizing health and dignity. While the socio-political context is different now, the basic elements of the economic model installed during the military regime remain in place. Health care and social security are privatized, and previously welfare-oriented social services remain an important new arena of capitalist accumulation.

The struggle for fundamental human rights such as access to health care remains a challenge in 21st-century Chile. Health now depends on the user’s capacity to pay, which has created a huge abyss between the quality of health care available to the rich and that within reach of the poor. These gaps also extend to sectors within the same city and between cities, as well as in the differing levels of protection available to men and women.

From a comprehensive health perspective, we see that what is called “development” in our country depends on damage to the environment, the glorification of individual success, the weakened negotiating position of workers to obtain adequate salaries and poor working conditions.

**EPES Blueprint**

EPES’s educational approach is described in its mission statement as “Promoting a health education strategy based on the participation of poor communities...” in order to enable people to improve their living conditions.

The core of EPES’s work has been the formation, training and permanent accompaniment of community health groups, mostly women, who are trained as community health promoters. Health groups supported by EPES have engaged in a wide range of initiatives to deal with problems and needs related to their communities’ health, such as family violence, child sexual abuse, HIV/AIDS, pollution, mental health, drug addiction, adolescent sexuality, menopause and breast cancer, among others.

In addition, EPES has designed and distributed educational materials for health training and developed systematizations and research studies on key issues dealt with by the institution.
EPES’s work is based on the identification of the lack of basic rights as an underlying social and political problem, as well as on stimulating the organization of the community for the defence of its right to health. EPES education policy is based on the principles popularized by the Brazilian educator Paolo Freire and these include:

- Education is never neutral.
- Training content should be relevant to the situation.
- Needs and conflicts of communities being served to be kept in mind.
- Pose problems in order to find solutions.
- Reflection and action are inseparable.” (Calvin and Toro, 2000)

Lessons learnt

EPES focusses on improving the health conditions of women. It stimulates processes of change at the level of the individual and the group. It emphasises on the acquisition of new skills to empower women to care of their own health and that of their communities.

Further, EPES believes that it is important to:

- Bring clear, precise education and information to the populace in accordance with its needs.
- Work with health services at the local level to induce improvements in services and make them more accessible to the populace.
- Construct a positive environment, which contributes to the maintenance of preventive health behaviours, in which organization and participation of the community play a central role.
- Construct an organizational model coherent with the mission and based on the principles of democracy, justice, efficiency and participation and in which institutional leadership is collective.
- Improve programme planning, follow-up and evaluation processes.

Given the current reductions in foreign development cooperation with Chile and a decrease in the number of NGOs, EPES’s principal problem is its dependence on international financing. Each year, the staff must work harder to cover funding shortfalls, generating insecurity among staff and threatening institutional objectives.

Community-based organizations such as EPES should network with regional, national and international coordinators to promote “Right to Health”. Global problems require a response which is anchored in local needs by keeping in mind the impact of these international policies. We also need to encourage initiatives to combat the lack of respect for people’s rights. There is a need for EPES to influence local authorities and find tangible solutions to problems regarding women’s health.

We continue to believe that Health for All need not be a Utopian vision but a reality. Education, organization and the struggle for rights remain a means of transforming human consciousness and putting human needs and dignity at the top of political priorities.

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My name is Hugo Icu, and I am a medical doctor of Mayan Kakchiquel origin, from Guatemala in Central America. The Spanish colonized and dominated us for over 500 years and now Spanish is the national language. As indigenous people we maintain our own visions about life, health and treatment. We have a rich history of traditional medicine, which has been passed on from generation to generation.

We lived at war for over 36 ears. This has left 1,50,000 dead, 2000,000 orphans and 60,000 widows. And as a result, our lifestyles are out of gear. We have been trying to reverse these structural problems but are checkmated at every step.

Health care reform in Guatemala has been promoted since 1991 by advisors of the Interamerican Development Bank (IDB) and successive governments. The IDB has been the most important financial institution in the strategic support of the health service, but now it works on the World Bank principles. This change began in 1997 after the signing of the Peace Accords, which proposed a reorganization of the health sector. The objective was to privatize health care. President Arzu’s government set new guidelines and redefined the functions of the Ministry of Health and Social Security. The new ‘Health Code’ now offered primary health care through the Integral System of Health Care (SIAS) - a network of voluntary health workers on contract.

The population is divided into jurisdictions of 10,000 inhabitants, which are “enterprises” offered to private institutions. The services provided by the private entities are supposed to meet requirements determined in a vertical manner with budget allocations averaging to $5 per person per year!

Consequently, the present health system is a very fragile set-up. If the volunteer fails, the system fails. It also limits government accountability and helps the government to get away with low budgetary allocations for health.

In the cultural context, our traditional resources and practices have been ignored totally. Most reforms are duplicated from the Chilean and Colombian models. In addition, the new ‘vertical approach’ has little relevance to our needs.

Further privatization of health care has absolved the state from responsibility and paved the way for unequal access to treatment. It has also introduced invasive and dangerous diagnostic practices, which destroy traditional practices. Besides, monetary gains have replaced our ethnic values and threatened the traditions of our Mayan heritage by substituting it with individualism and competition.

The Peace Accords in 1996 stopped military aggressions, but our people are still under seize. Globalization has created a divide and highlighted the poverty and disparity of our people.
ACCESSIBILITY

In western China, one of the major stumbling blocks in promoting health facilities especially in the rural areas, is the accessibility factor. With health centres being few and far between, reaching them is not an easy task. Reaching the nearest medical clinic may require a journey of 300 to 400 kilometres.

There is a growing need therefore, to ensure health care centres in the rural interiors where 75 to 80 per cent live. Basic medicines and preventive medical services continue to elude the marginalized and poor. In addition, it is important to ensure the availability of clean water for the 40 percent of rural people who lack it.

Farmers and herdsmen in this area — a vast area inhabited mostly by ethnic minorities who eke out a living growing low-yielding crops or tending yaks and goats — suffer and even die of diseases that are controlled in the relatively developed areas in the eastern part of the country.

THE PRESENT SITUATION

Although, China has achieved great success with respect to the control of tuberculosis, the TB infection rate is now increasing in some provinces, and there are about 6,000,000 TB patients in the country.

Further, China has the largest number of the blind people in the world, around 5 million, or about 18% of the world’s blind, more than the population of countries such as Denmark, Finland or Norway. An estimated 400,000 Chinese become blind each year mainly because of cataract. Rapid increase in the ageing population, population growth, the lack of adequately trained ophthalmologists and the absence of modern technologies to prevent and treat blindness are some of the reasons for it.

Several NGOs, including Amity Foundation and Christoffel-Blindenmission are collaborating with the WHO and the Chinese Ministry of Health to actively support eye care.

AGEING

By 2020, the country’s population is projected to grow from the current 1267 million to 1500 million people. The number of Chinese over 60 years of age is estimated to increase by 90% to some 240 million people.

Due to the ageing of the population and the change in people’s living conditions, the causes of sickness and death begin to resemble those of a developed country.

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 remote and poor areas, local dwellers suffer from goitre and there are about ten million mentally disabled persons. ‘Health for All’ is still a distant dream.
FEAR NOT THE GOLIATHS

Oil barons everywhere are a law unto themselves and have little respect for environment or public health. To make matters worse, present day governments have been reduced to paper tigers and often help these global Goliaths by deliberately muzzling all voices of dissent. However, public zeal can go a long way in setting right many wrongs. More so, when the masses understand that ‘Health for the People’ is not just a litany but a basic human right. Sample this.

Petroleum is and has been for Ecuador a main source of income and also a cause of destruction of the environment. Since 1972 international petroleum companies led by Texaco in collaboration with the government owned company Petroecuador, have extracted more than two billion barrels of petroleum, mostly from the Amazon. In the process, billions of gallons of petroleum and toxic waste have been thrown into the environment.

It took the public more than 20 years to lose its collective patience. And when they did, there was no looking back. In 1994, a group of local people and peasants from the Amazon, representing 30,000 affected persons, went to New York and accused Texaco of irreversible damage to the environment.

To keep up the pressure, in 1994 the Amazonian Defense Front (FDA) was established with the support of many indigenous and peasant organizations, to supervise the case against Texaco. Since its foundation the FDA has organized several workshops on environmental issues, reports on oil spills, denouncements, and community meetings for sharing information.

These experiences snowballed to form the Network for monitoring the environment of the Ecuadorian Amazon (RMA). Numerous local and national non-governmental organizations (NGOs) supported the cause to give it added impetus. In 1994, the Centre for Social and Economic Rights published a report about dangerous levels of petroleum contamination in the northeastern rivers of Ecuador. This study highlighted the high concentrations of polycyclic aromatic hydrocarbons (HAP) found in water used for drinking, bathing and even fishing. The contamination levels often ten to 10,000 times higher than the permissible limits set out by the United States Environment Protection Agency.

Not content with these findings, the RMA took it a step further and in 1998 asked the chief of the Epidemiology and Community Health Institute, Manuel Amunarriz, to help determine the impact of petroleum contamination on the health of their communities.

This study, referred to as the Yana Curi Report or ‘Black Gold in Quichua’, tabled alarming facts which can longer be ignored. It revealed that women living near the petroleum wells and stations risked an increase in the irritation of the nose and eyes, headaches, sore throats,
diarrhea, gastritis, fungus and tiredness.

Further, the risk of these women having spontaneous abortions was 150% higher than those not exposed to such polluted environs. Also, populations with a long history of petroleum contamination had a greater risk of having cancer or dying from it.

Affected communities along with the RMA and environment groups from Ecuador are now using this study to underline their complaints concerning petroleum contamination and the health hazards it poses. The authenticity of the report can be gauged by the fact that even the lawyers engaged to fight against Texaco are using the study as evidence before the judges in the USA.

However, so far, there have been no tangible changes in the attitudes of either the petroleum company or the government. But then, the battle has just begun and Goliath is no ordinary enemy. Neither are the people of Ecuador…

Contact: If you were able to reshape primary health care now, what would you change?

HM: Scandinavia, UK, Netherlands, and Canada had all picked up very important issues but among developing countries there were very few which had made a real commitment to Primary Health Care (PHC). Many countries made an effort, but did not commit themselves to the intersectoral approach and to peoples’ empowerment, which were the essence of PHC. The principle was that people should identify with their own health. At the World Health Assembly I suggested that the WHO’s regular budgetary resources should only be used to allow the developing countries to adapt the PHC approach to their social-economic realities. The response was positive but it did not last for more than two months.

I would like to see more of empowering people even though there was some aggressive criticism against PHC and against me personally, because PHC took away power and authority from most of us, and converted traditionally vertical programmes into a comprehensive approach.

Contact: How did you see the role of NGOs and Church related programmes in the PHC framework?

HM: I will be very frank with you on that. Despite my own traumatic relationship with religion, I recognize that NGOs and the church — and particularly the Christian Medical Commission of the World Council of Churches — were the prime players in the PHC movement. One needs to have a ‘missionary attitude’ in order to be trusted by the people, and for them to recognize that you are not there to impose ideas. However, you cannot get anywhere if you are not prepared to discuss policies from the village council level to state government, and here the church was not always so strong. The churches’ present efforts in...
the PHC approach are politically generally ineffective.

I believe it is essential that the church assume a much higher profile and ask itself where it is at the present moment in relation to health. I do not know what will replace the Christian Medical Commission, which was a great success, and which had many extraordinary and charismatic health statesmen. I would be interested in being involved with church leaders to try to help them to understand what the PHC approach is really about. I consider that a real potential.

**Contact:** In 1975, WHO talked about the PHC approach as needing to be moulded around the culture of the people. Yet, by the time of the Declaration of Alma Ata, three years later, that concept had been reduced to ‘community participation’. Do you feel that the original concept lost out to the rather brutal ‘community participation’?

**HM:** I very much agree with you and that is why I climbed on board the empowerment approach with both legs, without hesitating. Because it was better than ‘participation’. ‘Participation’ is always manipulative and particularly when the social mobilization came along. It was just pure manipulation of people, to commit themselves to immunization or whatever the particular issue was. So I must agree with your formulation, and I believe this is utterly essential to understand the PHC approach. We took ‘participation’ because that was the in-word for long time. But I am very much with you.

**Contact:** Given our political scenario, is it possible to have ‘participation of the health professionals with the community’ to facilitate the community to achieve its own priorities?

**HM:** Yes, I could live very happily with this kind of formulation, if that would start changing things. I believe that this People’s Health Assembly should lead to this kind of consideration. An inter-regional research conducted by sister NGO/church-related programmes should look into the appropriateness of re-defining ‘participation’ and explore how such a change would relate respectively to the political and community arena. This sort of issue we did not discover in the early days because there were no serious attempt made by developing countries to adapt the PHC approach.

**Contact:** How can people’s voices be finally used to shape policies of international organizations?

**HM:** It can be only done if people themselves do it themselves, and it is very important to say that ‘people’ and not populations.

(Those who interviewed Dr Halfdan Mahler on behalf of Contact include: Darlena David, Mary Murray, and Dr Patricia Nickson)

Dr Halfdan Mahler, former Director General of the World Health Organization, graduated in medicine from the University of Copenhagen in 1948 and received a post graduate degree in public health from the same university in 1955. He has logged in long years with different tuberculosis programmes in Latin America and Asia.
While token acknowledgements for the need to provide a platform for the growing mass of those “dispossessed by the onward march of globalization” have echoed through international conferences, rarely have they achieved the resonance they did at the People’s Health Assembly 2000.

With governments constantly defaulting on their commitments, in the late 1980s the top management of the WHO was perturbed by the growing divergence between the realities of the global order and the promise of Alma Ata.

Out of this despair was born a creative response and it was realized, that “purposeful intervention through popular mobilization” is what is needed to achieve health care goals.

The ‘People’s Health Assembly’ came into its own and took up the reins “to see the people who remain unseen, to hear the voices of the unheard.” It challenged the growing sector of non-governmental organizations involved in health care and education to take the initiative in pressuring governments across the globe to attend to their basic obligations.

Among those who were party to this early initiative was Dr Zafrullah Chowdhury, the Bangladeshi surgeon whose contributions towards an alternative health policy are today embodied in the nationwide institutional network of the Ganashasthaya Kendra (G.K).

Appropriately, G.K. offered to host the first global conference of activist groups involved in health. The need to bring on board a variety of participants, with their distinct agendas, delayed the initiative. The format of PHA 2000 depended on a number of parallel sessions at which a whole lot of issues connected to health were discussed. These were then reported back to the plenary session with case studies of individuals trapped in situations where they were denied access to basic health care facilities.

A collection of stories narrated by participants helped to bridge the gap from the general to the particular and expose the difficulties that the poor face.

The Alma Ata declaration was one among a number of initiatives that were taken in the 1970s by the poorer countries to bring their specific concerns to global attention. The goal of “health for all” was in fact recognized as part of the larger task of achieving a “New International Economic Order”.

But seemingly unknown to the authors of the Alma Ata declaration, the Third World ‘debt bomb’ was
rapidly building its explosive force even as these fine words were being written. And when the bomb burst in 1982, it effectively meant the abandonment of all the commitments that had been articulated through the 1970s.

David Werner identified the “McDonaldization of healthcare” as the key factor underlying the transition from “health for all” to “health for none”. He listed three crucial landmarks in this “steady deterioration”. The first came in the decision to abandon comprehensive primary healthcare in favour of a targeted approach. This meant, as he put it, the “depoliticization” of the health movement, when the Alma Ata declaration really sought “social and structural change in the direction of equity as a major element in achieving health for all”. The selective approach, in contrast, “was an attempt to use a few chosen technologies to improve statistics in health while maintaining all the social inequalities of the status quo”.

A second assault came with the adoption under duress of structural adjustment policies in the Third World. Beginning in the 1980s, these policies were a direct response to the debt crisis. They meant the privatization and commercialization of health care and the erosion of the autonomy of families and communities.

The final assault came in 1994 when the World Bank took up, in its World Development Report, the theme of “investing in health” and began a phase of activism in the health sector.

It was therefore no surprise that the World Bank was not a welcome guest at the PHA. Expectedly, the most contentious session in Dhaka was that when Richard Lee Skolnik, a director of the World Bank in the health division, made an effort to articulate his institution’s commitments in the area.

Even as Skolnik insisted that the structural adjustment policies sponsored by his Bank were not responsible for the declining health standards in the developing countries, no one wanted to even listen to what he had to say.

Nevertheless, he valiantly tried to explain that the blame was fully to be borne by the misplaced priorities of national governments, which continued to squander scarce resources in unproductive subsidies for the rich.

David Legge, an Australian political economist, pointed to the cruel ironies of the Bank’s prescriptions of “wealth through growth”, which could be reduced to the prescription that the poor should suffer now for better health in the distant future. The Bank, said Legge, could not plead that its belated discovery of poverty and disease absolved it of the responsibility for all the damaging consequences of structural adjustment.

A conspicuously upbeat note was struck by the Cuban delegation. Despite the economic blockade by the United States, Hafdan Mahler summed the success story “Cuba is an appropriate place for a pilgrimage by activists keen to study how positive synergies could be established among all the sectors that have a bearing on health.”

Sukumar Muridharan from India was among the participants at the PHA at Dhaka.
Jesus saw what people’s lives and relationships were really like. He made them believe in themselves, even when the messages coming from their own culture and society told them that they were no good, and helped them see that health and wholeness could start with them. For people to create healing communities, he said, they do not need special qualifications and special places.

The community described in this story was in Samaria, and the Samaritans were the lowest caste people in Palestine. No respectable Jew would ask a Samaritan for anything, or drink out of a Samaritan’s cup. Women in general were regarded as inferior, but ‘the woman at the well’, as she is called, was particularly stigmatized, having been rejected by a series of men, maybe because she was unable to bear children. As a result, she was forced to go to the well alone in the heat of the day, instead of going with the other women in the morning and evening.

Jesus challenges stigma

Jesus’ actions in this story were astonishing even if the woman had not been a member of a despised race or caste. He was breaking with culture and tradition in so many ways. For a start, the Jews did not have anything to do with the Samaritans, whom they regarded as unclean. Jewish men did not have serious conversations with any women, but this woman, more than others, would have been absolutely untouchable in the eyes of a respectable Jew. By speaking to her, by asking her a favour, by drinking from her cup, and by discussing her sexual history as if it were something he understood and accepted, Jesus was challenging a whole culture of taboos and discrimination and stigmatization.

Jesus broke new ground theologically, too. The Jews believed that the power of God was only present in special holy places, like temples and synagogues. Now, said Jesus, the time has come when God is not limited to special places. God is present in the everyday life of communities. God gives ordinary people the power to change things, and to recognize that their own lives can become a temple for the Lord.

Filled with excitement, the woman rushes into the town to her own people. They must come and meet the Jewish traveller. He has not just looked into her own heart, but now he is saying ‘that even the Samaritan people are acceptable to God.’

Healing and the people

How do we relate this to our own work?

- Jesus challenges the stigma that makes people and communities feel worthless. Even the most stigmatized are able to become agents of change.
- Jesus challenges the idea that you need special places and specially qualified people for God’s healing work to take place.
- Jesus assures us that he longs to be our friend and to use us, both as individuals and as communities, as we really are.
- When people believe in themselves and learn to work together, they can become healing communities.

Question for reflection

1. What practical, spiritual or psychological factors stand in the way of our becoming agents of healing, either as individuals, or as communities?
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WCC PUBLICATIONS

Faith in a Global Economy
by Rob van Drimmelen
This book, a primer for Christians, includes lucid explanations of the major ideas, forces and realities of the world economy today: globalization, international trade, transnational corporations, international finance, employment and unemployment, land and resources, markets and growth.


God and the Goods
Global Economy in a Civilizational Perspective
Bas de Gaay Fortman & Berna Klein Goldewijk
1264-3 100pp, 1998
Sfr12.50, US$8.50, £5.50.
The book examines how in the face of growing poverty, environmental destruction and social disintegration – a global crisis whose roots are spiritual and moral – what does the social teaching of the Christian churches have to offer? What are the challenges and implications of globalization for Christianity and how Christianity can link up with other religions in order to work towards halting present day world crisis.

WHO PUBLICATIONS

Increasing the Relevance of Education for Health Professionals
(Report of a WHO Study Group on the Problem-Solving Education for the Health Professionals
WHO Technical Report Series, No 838
Published in 1993, iv+29pp
(E,F,S) ISBN: 92 4 120838 4
Price: Swfr 8, US$7.20 in developing countries Swfr 5.60. Order no 110 08 38
Explores ways to increase the relevance of education for health professionals as a strategy for improving the quality of health care and increasing access to services. The report, presented in five sections, concentrates on innovations in education that can make learning easier and more efficient while also producing graduates equipped with the knowledge and skills most relevant to priority health problems.

Health Promotion Research: Towards a New Social Epidemiology
Edited by B Badura & I Kickbusch
WHO Regional Publications, European Series, NO 37
Swfr 78/-US$70.20, in developing countries Swfr 54.60. Order no 1310037
A collection of twenty-one state-of-the-art reviews illustrating the ways in which research in the social sciences can improve understanding of the social determinants of health and disease and shape policies that promote health. Examples of specific interventions and their results are also provided.

Health Promotion and Community Action for Health in Developing Countries
By H S Dhillon & L Philip
Explains how the tools of health promotion can be used to encourage community action for health, foster healthy lifestyles and create conditions conducive to good health even when resources are severely limited. Addressed to policy-makers and planners, the book serves as both a call for intensified action and a rich source book of practical methods for tackling a range of problems.

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## RESOURCES

INDEX OF CONTACT ISSUES

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<table>
<thead>
<tr>
<th>No Date</th>
<th>TITLE/AUTHOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>14012/94</td>
<td>Youth and health: Taking the lead today for a better tomorrow - Youth to youth in health, WORD, N. Waithe</td>
</tr>
<tr>
<td>141 2/95</td>
<td>Financing health care: Strengthening partnerships to protect the poor - David Werner, World Bank, WHO, Sigrun Mogedal</td>
</tr>
<tr>
<td>142 4/95</td>
<td>Healthier tourism: Struggling for development with dignity - Edward Cumberbatch, Peter Holden, Jacky Bryant</td>
</tr>
<tr>
<td>143 6/95</td>
<td>District health systems: Decentralizing for greater equity - WHO, Matomora Matomora</td>
</tr>
<tr>
<td>144 8/95</td>
<td>Women and AIDS: Building healing communities - Erlinda Senturias, Anne Skjelmerud, Yupa Suta (presented by Mary Grenough)</td>
</tr>
<tr>
<td>145 10/95</td>
<td>Tackling malnutrition: Can community initiatives work? Kenneth Bailey, David Morley, IBFAN</td>
</tr>
<tr>
<td>146 12/95</td>
<td>Health financing crises: Can communities afford to pay? EPES, David Werner, Daleep Mukarji, Carl Salem, Eva Ombaka</td>
</tr>
<tr>
<td>147 2/96</td>
<td>Alcoholism and Drug Addiction - What is the Christian Response? - J. Gnanadason, BLESS, Prisquilas Peter and Darlena David Titus, HAIN</td>
</tr>
<tr>
<td>148 4/96</td>
<td>Reconstructing Peace: Together we can overcome violence! - Salpy Eskidjian, Anthony Zwi, Elizabeth Sele Mulbah, Natasa Jovicic, Eduardo Campana</td>
</tr>
<tr>
<td>149 6/96</td>
<td>Migration and Health: Caring For Those In Our Midst - Helene Moussa And Patrick Taran, Dr Paola Bollin And Dr Harald Siem, White Rakuba, Gabriela Rodriguez, Asian Migrant Centre, Rabia Choumou And Aline Papazian, Mukami Mccrum</td>
</tr>
<tr>
<td>150 8/96</td>
<td>Health In The North: Learning From The South - Christoph Benn, Daisy Morris, kofi Yamgnane, David Cowling, Eva Ombaka</td>
</tr>
<tr>
<td>15110/96</td>
<td>Healing Traditions: Finding Answers in Gospel and Cultures - Guillermo Cook and Diana Smith, Eugenio Poma, Tara Tautari, Darlena David, Hakan Hellberg</td>
</tr>
<tr>
<td>152 12/96</td>
<td>Healing Community: Caring is part of the Cure! - David Hilton, Erlinda Senturias, Ricus Dullaert, Paul-Hermann Zellfeder-Held, Pierre Strasse, Michael Iaplesys, Marion Morgan</td>
</tr>
<tr>
<td>153 2/97</td>
<td>Ethics: Taking Sides in Health Care - Christoph Benn, Lucy Muchiri, Sally Timmel, WCC Consultative Group on AIDS</td>
</tr>
<tr>
<td>154 4/97</td>
<td>Indigenous Peoples: Their Health, Their Solutions - Erlinda Senturias, International Institute of Sustainable Development, Maggie Hodgson</td>
</tr>
<tr>
<td>155 6/97</td>
<td>Spirituality and health: Can our beliefs help to heal us? - Hans Ucko, Karin Grangverg-Michaelson, David gacencegi, P Zacharias, Peter Bellamy</td>
</tr>
<tr>
<td>158 12/97</td>
<td>Sustainability: Issues in Church-related Health Care - Daleep Mukarji, Sigrun Mogedal, Kofi Asante, Pat Nickson, Marta Benavides, John M Grange</td>
</tr>
<tr>
<td>159 2/98</td>
<td>Globalization: What does it mean for Health? Konrad Raiser, Diana Smith, Maria Hamlin Zuniga, Sara Bhattacharji, Marion Morgan</td>
</tr>
<tr>
<td>160 4/98</td>
<td>Community-determined Health Care: The experience of rural Cameroon - Patricia Nickson, Rub N Eliason, Protestant Church of French Polynesia and Hiti Tau, Rakiya Booth</td>
</tr>
<tr>
<td>161/162/98-9/98</td>
<td>The CMC Story - Diana Smith, Gillian Paterson</td>
</tr>
<tr>
<td>163 10/98</td>
<td>Trade or Health? - Eva Ombaka, James Love, Darlena David, Christoph benn, Erlinda Senturias, Patricia Nickson, Eunice Santanathan, Jonathan Gnanadason, Gwen Crawford</td>
</tr>
<tr>
<td>165 6/99</td>
<td>Facing Death: discovering life! Can we strengthen our response? Rainward Bastian, Veronica Moss, Sr. Mary Grenchov, Lazarus Koech, Peter Bellamy, Usha Jesudason, Elizabeth Schlunk, Christina de Vries</td>
</tr>
<tr>
<td>166 9/99</td>
<td>Reforming Health in China: strengthening the weak? - Wenzao Han, Shenglan tang, Yu Quan, Fan Jie, Wang Jianshen, Zan Jianqin, Faye Pearson, Li Enlin, Chen Xia, Christoph Benn</td>
</tr>
</tbody>
</table>
Dear Editor,

I have been receiving the magazine Contact since 1986. Our hospital is involved in some CBHC and we found that in our community alcoholism is a major problem. Most families are affected by it. In order to help the community we started awareness and counselling programmes.

We realize we are meeting a need and God is blessing our work. Since we could not find any teaching materials on alcohol/drug abuse readily we printed some pamphlets and used Contact issue no. 147.

Our print order in English was about 500 prints and Kiswahili 500. We trust we would have acknowledged your contribution by writing to you about our work.

M Tarus Lekkerkerker
CBHC Nurse, Reformed Church of East Africa, Medical Department, Plateau Mission Hospital, P.O. Box 724, Eldoret Plateau

Dear Tarus,

We are encouraged to hear that Contact is more than just a health magazine. Contact as the name suggests is intended to be a contact point for information sharing. We try very hard to disseminate information and illustrate them with experiences so that grassroot health workers will find it useful. Your letter is an inspiration to us. Keep up the good work and keep reading Contact!

Editor

Contact - more than a health magazine

Communication and Reconciliation-Challenges facing the 21st century Edited by Philip Lee.

The call to reconciliation involves a call to communicate, with candour, persistence and sensitivity. The eight essays in this book explore these various angles of communication in the search for reconciliation. The stories come from all over the globe and the recurring image each time is that of communication with a human face – one that genuinely cares for the “other” as one’s neighbour.

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Contact Solidarity Appeal

Contact is expanding, rising to the challenges of regionalization and strengthening the network of health workers.

Will you help us in this? A donation of just US $10/British Pound 8/SFr 18/Rs. 460 will enable one more health worker to receive Contact free of charge.

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ANNOUNCEMENTS

Achieving Results: Brazil’s Strategic Response to the AIDS Epidemic, October 9, 2001: Organized by the Technical Seminar Series by the Management Sciences for Health, it is a part of series held at the National Press Club, 529, 14th Street NW, Washington DC, USA. It focuses on topics of immediate interest and members of the international community will have the opportunity to learn from international health experts.

The Second World Assembly on Ageing, April 8-12, 2002: Scheduled to take place in Madrid, Spain, the United Nations’ Secretariat has already begun to facilitate the important process of bringing the Long-Term Strategy on Ageing, for the World Assembly on Ageing. Watch out for more information.

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CMAI Platinum Jubilee Celebrations, November 8-10, 2001: The Christian Medical Association of India will celebrate 75 years of serving the sick and the marginalized when members from far and near will get together for the Biennial Conference at New Delhi.

Contact deals with various aspects of the churches’ and community’s involvement in health, and seeks to report topical, innovative and courageous approaches to the promotion of health and healing.

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