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SETTING OUR PRIORITIES FOR HEALTH

WHO Photo/P. Almasy

1985 Meeting of The Christian Medical Commission

SNAPSHOTS FROM VELDHOVEN MEETING

Photos courtesy Bert Supit

Front row: John Hatch, Aagje Papineau-Salm, Hari John, Judith Ray, Oliver Duku, Bert Supit, Hiromi Kawahara; *second row:* Kodwo Enyimayew, Erlinda Senturias, Deborah Raditapole, Timothy Pyakalyia, Metropolitan David; *third row:* Tony Allen, Belawete Fulakambu, Hildegard Bromberg Richter, Margret Marquart, Al Murdock, Gwen Crawley, Sigrun Mogedal, Peter Bellamy, James McGilvray, Ann Dozier, Ruth Harnar, Rainward Bastian, Dutch Observer; *last row:* Maria Victoria Carles-Tolra, Jeanne Nemec, Béla Bazso, Bishop Sarpong, Reginald Amonoo-Lartson, Don Fergus.

SETTING OUR PRIORITIES FOR HEALTH

1985 Meeting of the Christian Medical Commission

Introduction

Many of our readers may know that CONTACT is a publication of the Christian Medical Commission (CMC) without being aware of the history of this Commission, its relationships to other organizations, its place in the World Council of Churches or of its underlying philosophy in the field of health work.

This report of the January 1985 meeting of the Commissioners of the CMC gives us a good opportunity to relate to all our readers the ongoing concerns which are woven together with our priorities for action to form the richly coloured tapestry of the life of the Christian Medical Commission.

The meeting we describe in this issue took place in a conference centre in the village of Veldhoven in Eastern Holland during one of the coldest months of January ever recorded in Northern Europe. Participants from all over the world found the freezing exterior temperatures balanced by the warm comradeship of the people involved in this meeting of all the Commissions of the World Council of Churches' Unit II.

For the Christian Medical Commission exists as a part of the World Council of Churches. It is called a "sub-unit" and is attached to Unit II, the Churches' Programme on Justice and Service which assists the Churches "in combatting poverty, injustice and oppression; and in facilitating ecumenical cooperation in service to human need and in promoting freedom, justice, peace, human dignity and world community."

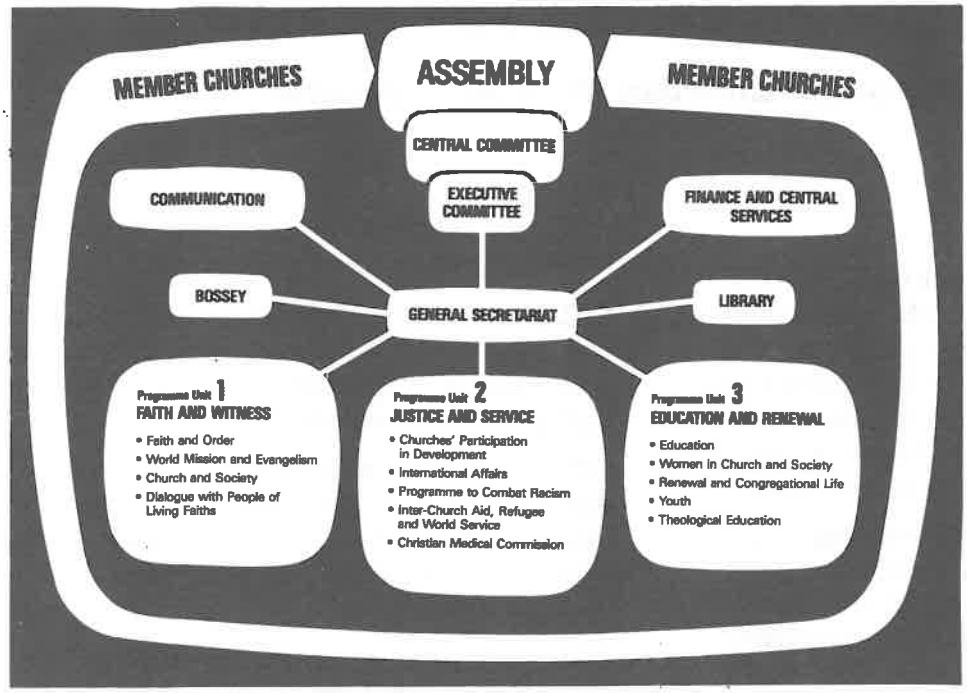
To help in trying to attain theses goals, Unit II is divided into five sub-units, each serving the overall goal through specific programme areas; CMC is one of these sub-units attached to Unit II. Other sub-units of the Programme on Justice and Service are: the Commission on Inter-Church Aid, Refugee and World Service (CICARWS); the Commission on the Churches' Participation in Development (CCPD); the Churches' Commission on International Affairs (CCIA); and the Programme to Combat Racism (PCR). These five Commissions are linked by a living network of themes and programmes as they seek to express the concern of the churches for the relief of human suffering and the promotion of justice and peace:

- CICARWS enables the churches to reach out towards those in need through financial and material support of the programmes on human welfare and development.
- CCPD is an expression of concern for economic justice on a global scale, and its development theory involves not only economic growth but social justice and self-reliance as well.
- CCIA functions as an instrument of Christian witness amid the world's conflicts.
- PCR was established to help the churches move from their convictions about racism into common actions helping victims of racial oppression.

As a part of this larger organization, CMC has seen its role as an advisor to help the churches in trying to answer the health needs of large sections of the world's population, with an emphasis on total human development and community-based health programmes. We strive to enable the churches to act—to act as a voice of conscience on questions of health and health ethics; to act as initiators of innovative health care programmes; and to act as donors to health programmes both within their communities or countries and also internationally.

The meeting in Veldhoven was the first time in nearly eight years that all the commissions of Unit II had met together. Plenary sessions and social contacts at meals and in casual evening conversations helped people from all the sub-units of Unit II to make friendships based on common concerns and commitments and common Christian feelings of brother- and sisterhood.

The overall theme of the Unit meeting was expressed as a "search for peace, justice and the integrity of creation", and members of the CMC found that our ideals and programmes fit easily into this larger view of the work of the whole of Unit II. Meeting together with all members of Unit II also allowed time for members of various sub-units to get together in regional groups to discuss strategies for reaching common goals.



How the WCC works

The CMC recognizes the value of coordinated programmes in health and development work, and our members need to take responsibility for knowing what other groups in their geographic areas are doing.

Smaller groups also met on specific concerns which cut across sub-unit lines: concerns such as food, human rights and women's rights touch every area of work in which sub-units such as the CMC are involved. Those who work in health quickly learn that it is meaningless to try to separate concerns for health from concerns about adequate food, violence against women or justice for minorities.

Several CMC commissioners mentioned the value of holding a joint Unit-wide meeting as a way of becoming acquainted with more of the work of the World Council of Churches and as a spur in relating health work to other concerns for justice and peace. Affirmation of the already recognized reality that health can hardly exist without justice and peace grew throughout the meetings.

The illness-enforced absence of CMC's Director, Eric Ram, from this Veldhoven meeting brought the whole Commission face to face with the inescapable fact of the vulnerability of all of us, even those whose lives are most involved with healing. Commissioner Gwen Crawley writes, **"The absence of our current Director Eric Ram kept us aware of the individual frailities of the wounded healer and helped us face the reality of the limitations of both the individual and collective human and material resources which we bring to our task. So while we were renewed in faith by the synergy of our shared time and worship, we recognized the need to target carefully our resources where they could be most effective."**

Reginald Amonoo-Lartson, Acting Director of the CMC, stood in for Eric most ably, and James McGilvray, first Director of the Commission, attended to help add continuity and give us the value of his long experience with the CMC.

Setting the scene

Early in our meeting time, Reginald presented a brief Director's report which was given to the commissioners for study along with the packet of material which had earlier been mailed to them. As this short paper gives a brief overview of the history and past concerns of the CMC, we quote from it in order to give you, our readers, an idea of "where we're coming from".

"Historically, the work of the Church in health care has concentrated on the individual in a hospital setting. This is still the case in many parts of the world, although the move to a more community-oriented approach is gaining momentum. As developing countries achieved independence and governments began to take over the management of their own health systems, serious questions arose as to how to coordinate their programmes with the work of government agencies and to develop local expertise for running these hospitals. At the same time, rising costs for medical care in all parts of

the world demanded that hard choices be made in assigning priorities in health work.

"These questions began to engage the attention of the World Council of Churches, together with theological questions about the Christian definition of health and healing. These two needs—the need for an advisory group on the Church's active role in medical work and the need for a forum on the spiritual aspect of health—led to the foundation of the Christian Medical Commission (CMC) in 1968 with James McGilvray as its first director. Following the Nairobi General Assembly of the WCC in 1975, the CMC became a sub-unit of the WCC Programme of Justice and Service (Unit II)."

As the CMC grew to be an official sub-unit, it functioned within a mandate which outlined clearly its main tasks. These were seen as threefold:

- First, to serve as an enabling body for churches everywhere as they search for an understanding of health and healing distinctive to the Christian faith.
- Secondly, to act to promote innovative approaches to health care for the maximum benefit of individuals, families and communities, especially the deprived.
- Thirdly, to encourage church-related health institutions to plan and coordinate their activities for more effective service.

As the Acting Director's report states, "CMC is thus an 'enabler' to the churches in their efforts to define and develop their healing ministry. In this role, CMC supports the churches worldwide without directly funding or managing health projects. It has, however, provided 'seed money' occasionally to get innovative locally-designed programmes off to a good start."

Some of the new commissioners may at first have had trouble in sorting out the diverse concerns of the CMC. As Tony Allen, commissioner from Jamaica says, "Initially the wide range of concerns and activities of the CMC as expressed in several documents was somewhat bewildering. After making my own schematic diagram, it became clear to me that the areas of concern of the Commission were the most comprehensive that I have witnessed for a relatively small agency. No wonder the impact it has produced since its inception."

The curtain rises

Twenty-three of the total of 26 CMC commissioners gathered from all over the globe to meet with CMC staff and consultants in January 1985 to begin to look at the work the Commission has accomplished in the past seven years (the term of the previous Commission) and to set the direction for the period to come. The commissioners act as advisors for the CMC. They are appointed for a seven-year term from among people familiar with our work. In a very important way, they represent our constituency, the people "out there" whom the CMC tries to serve in its study, actions and publications. (A list of Commissioners and Special Consultants is included in this issue.)

Three of the 23 commissioners present had served a previous term, and they provided necessary continuity for the work of the group. Special Consultants invited were Dr. Margret Marquart, Roman Catholic Consultant representing *Cor Unum* of the Vatican; Bishop Peter Sarpong, a Roman Catholic Consultant from Kumasi, Ghana; and James McGilvray, first

UNICEF photo

Health can hardly exist without peace and justice

Director of the CMC, who related valuable knowledge of the CMC's history.

As it is planned that Commission meetings should be held every year or 18 months, this group of people, many of whom were complete strangers to each other in the beginning, will during their seven-year terms, have time to forge themselves into a close working committee. Commissioner Sigrud Møgedal, from Norway, in evaluating the meeting commented, **"The meeting paid sufficient attention to the history of the CMC to make the new Commission rooted in the past. Yet, the discussions stressed a common sense of urgency to move on to new discoveries and new contributions. The CMC should not become a static institution distributing ready-made answers, but it needs to be 'on the road' along with all the church-related health workers around the world, dynamic and able to respond and interact."**

Although the commissioners represent the problems and ideas of their constituencies around the world—whether these be large church bodies, community health services, or coordinating agencies—much importance is also placed on their roles in working as the voice of the CMC in relaying and interpreting its programmes and priorities. In fact, the Commissioners often act not only as a 'voice' but also as an extra pair of eyes and ears by undertaking visits, in their own regions or while travelling, which the small Geneva staff of CMC could not carry out themselves. They can act as consultants to churches, or to governments or non-governmental agencies.

The work begins

Dr. Erlinda Senturias of the Philippines had already been appointed by the Central Commitee of the WCC as Moderator of the Commission. She is a Medical Doctor and founder and Director of the National Health Concerns Committee of the National Council of Churches in the Philippines who is very much concerned with health and justice. It was she who took the chair at the first day's meeting in Holland, a meeting which was mainly devoted to hearing each Commissioner's "story" as a way of getting acquainted.

As Dr. Anthony Allen, a commissioner from Jamaica, writes in reflecting on the meeting, "The selection of commissioners allows for a wide representation of world regions and varied backgrounds of disciplines and experiences. Thus, getting to know one's colleagues and sharing views was an education in itself. What emerged was that there are significant factors that vary from country to country in such a way as to radically affect the delivery of health care and the involvement of the Church."

Commissioners also queried their exact role as CMC's advisors. Do they have power to change the direction of the Commission's programme? How do they relate their roles as commissioners to their ongoing work and the organizations to which they are obligated? They learned that, as a body, they can set the direction for the CMC within the guidelines of the mandate given by the Assembly and the Central Committee of the WCC, but more far-reaching changes must be approved by the WCC Assembly. Rev. John Murdock sums up the feeling of belonging to the WCC: "When the question of the role of the CMC in the World Council of Churches was raised, the Commissioners reaffirmed the mutual importance of the Commission and Council to each other."

Concerning their individual roles and relationships, consensus supported commissioner Gwen Crawley who stated, "We all come from different bases. In defining our task we should leave room for each of us to play the roles made necessary by our own situations." It was emphasized during the meetings that although commissioners may come from and represent various church bodies and other organizations, they also represent their own personal histories. In a very important way, individual experience is the most important thing a Commissioner can offer the CMC.

It is essential for the CMC, with a small staff and limited resources, to define clearly its goals and priorities. This fact became very evident during the Commission's five days of discussions. Although many possibilities for action were considered valid, commissioners had the hard task of choosing those most important and most suited to the capabilities of the CMC.

For James McGilvray, who was at the cradle of the CMC, setting the right priorities is in itself a priority in order to avoid getting bogged down in too many activities. While maintaining CMC's commitment to promote primary health care (PHC) and to serve the poorest of the poor moving beyond "equity" to a concern for the *quality* of human life, he spoke of the need to look ahead: to look at changing disease patterns; at long-term planning for manpower and institutions; at how to reach decision-makers;

at how to find and promote tomorrow's models; at how to dialogue with industry, both transnational and indigenous.

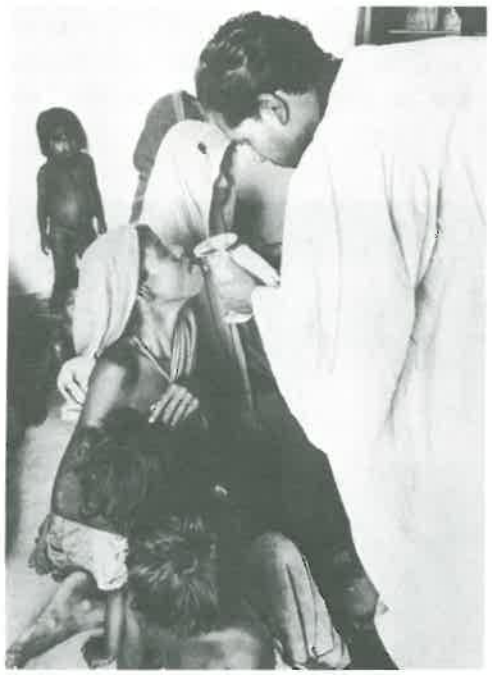
So, the main business of the meeting followed the pattern of examining what CMC has done in the past; discussing commissioners' concerns for the future (based on their own different individual experiences), and then, through long and hard discussion, sifting out the priorities for CMC's attention for the next period.

Identifying priorities

The Commission began work on the important task of choosing priorities for the next period by considering the mandate given the CMC by the World Council of Churches. The first point of this mandate calls for the CMC to serve *as an enabling organization to the churches as they search to understand the theology of health and healing.*

Health, healing and wholeness

During the previous Commission's term, regional studies of the Christian understanding of health, healing and wholeness had taken place in seven regions of the world. The Commission reaffirmed that these studies are of prime importance. If the CMC wishes to remain a pioneering body in promoting health, it must offer meaningful understanding of what it means to be healthy.



WCC photo

Understand the theology of health

Commissioner Rainward Bastian of the Federal Republic of Germany writes expressing his concern for the necessity of continuing studies of health and healing to act as a foundation for other work of the CMC:

> "...The churches have to understand better their call for healing and have to implement it more clearly. Perhaps our understanding follows Dr. Philip Potter's expression: 'Healing has also to be seen in the context of justice, a just relationship with God and our fellow men, enabling real community and reciprocal sympathy.' The Commission is challenged to help the churches to find and take this path of healing. How can, out of one's own experience of healing, the needs of others be met? How can Christians make transcendent the community of all, in order really to replenish community-based services with life and make them beneficial for all?"

Given these deeply held convictions about the study of health and healing, a priority was set by the Commission: To continue regional meetings on the meaning of health, healing and wholeness. The next regional meeting will be held in Europe in 1986. It is entitled the *European Regional Consultation on the Christian Witness to Health and Healing and Building Community,* the last phrase reflecting the importance attached to the idea of community as a source of strength. As an example, Rev. Béla Bazso spoke of the service committees within local congregations in Hungary, which will be the site of the European consultation. Several of the commissioners from Europe who are members of its Preparatory Committee, met together at Veldhoven to discuss the next steps and to hear John Hatch give an account of the recent North American regional meeting, the first to be held in an industrialized country. One of the points emphasized there was the need to adapt primary health care from Third World to First World settings.

The first round of CMC regional meetings will end with the North Asia consultation which will include Japan, Korea, People's Republic of China, Taiwan, Hong Kong and possibly Vietnam. No date has yet been set for this meeting, but Dr. Hiromi Kawahara of Japan anticipates great interest in such a consultation and promised to begin negotiations about the time and place. Dr. Kawahara is the founder of the Asian Health Institute.

Full value of these regional consultations is realized when participants have a chance to reflect upon them and learn what insights others have found to the sometimes confusing frontiers of the theology of health. For these reasons, follow-up of regional consultations was also assigned prime importance by the Commission. The CMC needs to hear from participants in past regional meetings who can tell us what changes the consultations on health and healing may have made in their lives and in their communities. In turn, we can relate these stories of personal and community discovery about Christian concepts of health to other consultations and through our letters and publications. This two-way communication growing out of regional meetings will be a continuing priority.

Commissioners will be helping in many ways with the organization of new regional meetings and the on-going evaluation of their results. Rev. Béla Bazso, for example, is very much involved in helping set up the European Regional Consultation. Many of the present Commission have attended the regional consultations, and for some the meetings were the way they first became acquainted with the CMC.

In writing about the importance of evaluation of the consultations, the Rev. Peter Bellamy, commissioner from Great Britain, said, "The commission meeting made me feel the challenge to reflect theologically on all that is coming out of our regional meetings... I wonder whether we need to give each other more confidence to theologize on practical experience of healing in the churches and through medicine as part of our regular meetings..." Don Fergus of New Zealand commented that "what we are doing as we discuss healing and share our views is practising theology. We should recognize that we are all theologians." To sum up our commitment in this area, Dr. Margret Marquart, one of the Roman Catholic consultants said, "The CMC should continue to seach for what it means to be a People of God."

Primary health care

The directing mandate of the CMC lists as another of its objectives, *"to promote innovative approaches to health care for the maximum benefit of individuals, families and communities, especially the deprived."* The CMC has found these innovative approaches in the ideas of primary health care (PHC), and it has long been considered a pioneer in this field. Commissioners affirmed that support of primary health care programmes will continue to be a top priority and that great efforts must be made to extend PHC to those most in need.

As a group of commissioners and friends of the CMC commented after engaging in pre-Veldhoven planning discussions:

> "As primary health care (PHC) and health for all (HFA) programmes are implemented, it remains likely that the poorest and most powerless, even in poor communities, will not be reached. The CMC, with its commitment to serving the poor, could give special emphases to these people, including: considering how to define and reach the poor and how to assess the impact of programmes on their health and development status."

Our commissioner from Zaire, Belewete Fulakambu, agreed most whole-heartedly with this continuing commitment: "In emphasizing once again primary health care, the Commissioners are meeting the needs of our churches: to engage ourselves fully in the society in which we live, a society of the poor, poor not only in body but in spirit" (translated from the French).

The hard discussions on this priority, therefore, centered not on the concept of primary health care, but on what directions really helpful and innovative approaches to PHC should be taking. As well as concern for promoting and describing good community-based programmes, commissioners called attention to two ways in which the CMC's study could help expand and extend the benefit of primary health care.

WHO photo

What direction for PHC?

First, commissioners felt from their own experiences that PHC cannot be successfully established in an area without reference to the already existing health care resources there. Primary health care does not exist in a vacuum. Whether these already existing resources be hospitals, church or other non-governmental programmes, or government-run projects, the PHC programme should relate to them, integrate with them, impact upon them. **CMC must study and talk about successful examples of PHC integrating with established health services and describe how the various health sectors can complement each other.**

Secondly, and somewhat related to the first point, commissioners noted the need for expansion of successful primary health care models and the frequent difficulty of increasing the scale of good programmes. Things which work very well in small, community-based projects become unwieldy, bureaucratic or impossible if the projects move to a larger scale. **All of us need to study ways and means of increasing the impact of PHC by increasing the numbers of people involved. It is not that small programmes are not good, but with so many more still to be touched by even the most basic health services, how can we begin to reach out to them faster?** Commissioner Gwen Crawley from the United States wrote to us about her understanding of these points:

> "While we recognized the importance of continuing to foster innovative approaches to primary care, we saw ourselves working harder to replicate our learnings and expand them through coordinated church-related bodies rather than one by one. We acknowledged that community health care does not stand alone, it must be backed up by the services of clinics and hospitals for the 20% of illnesses beyond its scope. For this reason, the role of the hospitals cannot be forgotten as they can and should play an essential role in referral, education and support within a truly comprehensive and integrated system of health care."

These important questions promise to play a major part in the CMC's continuing priority of promoting good models of primary health care. Commissioner Don Fergus also emphasized the necessity of relating the concepts of primary health care to those in the industrialized world. Western models of medicine have not succeeded in bringing many to full health, and in a larger sense the deprived can include all those who are not touched by God's healing grace. Affluent societies, too, have deprived persons and communities who have needs beyond those covered by existing health and welfare services. Commissioner Peter Bellamy, speaking of his experience of working in inner-city Birmingham and in psychiatric hospitals, commented, "Many of the systems we have created actually *disable* the poor."

WHO photo

Relate PHC to the industrialized world

Reconciliation

Both these important points of discussion involved questions of working with local and national governments, both for coordinating services and expanding models. As Sigrun Møgedal said,

> "A number of dilemmas in health care were touched on, and some of them found their way into the list of priority concerns for the Commission. Working with the government is one of the dilemmas, where conscious and planned coordination may be essential in most parts of the world, while almost impossible in others. The need to find a way from community initiative to structured health services and secondary care is another. Do linkages strengthen or hinder community action and control?"

Deborah Raditapole commented on the good relations she experienced between a church-related coordinating agency and government for production and distribution of drugs in Lesotho. "The role of the churches can be complementary, not competitive, with government," she affirmed. A number of other examples were cited by commissioners where church-related health care agencies aided in developing national health care programmes at various levels, avoiding duplication of time and resources. However, other commissioners expressed personal concern about working with oppressive governments; some who had lived through the experience of government constrictions and conflict affirmed that roles of reconciliation were the most appropriate for the CMC. Commissioner Oliver Duku from the Sudan mentioned that it is important for the CMC to help people to help themselves when governments cannot provide sufficient health support.

The CMC exists as a non-governmental agency, and as such, it shares the privileges and burdens of standing outside close relationships with governments. In some cases, this gives the Commission added authority and respect as a non-political body. In other regions, the CMC finds it works best simply to cooperate closely with other agencies which are themselves in contact with the government. The commissioners recognized that the question of what kind of relationships we develop with governments will be a continuing dilemma and will continually vary from country to country.

Traditional Remedies

Another interesting discussion of the Commission reinforced CMC's concern for studying traditional ways of healing and herbal medicines. Hildegard Bromberg Richter described the successful experience of her primary health group with herbal remedies in Brazil. Hiromi Kawahara, too, reported that the Asian Health Institute teaches Asian medicine, especially acupuncture and herbal medecines, with good success. It appears that the CMC has a role to play in encouraging reliable study of various traditional kinds of healing and in reporting the results of such study for better use of traditional remedies by all.

Erlinda Senturias, our Moderator, pointed out that traditional remedies take on even greater importance in areas where drugs are not easily available or are too expensive for most people; and in such areas, use of traditional medicines can give people more self-reliance. It appears that the CMC will continue to help pioneering efforts to study traditional healing and support exchange of information about old ways of healing made new again.

Bishop Sarpong, our Roman Catholic observer from Ghana, reminded us that it is most important for health workers, particularly those who are trained in Western methods, to understand the traditional beliefs of the people with whom they are working. Although one cannot always agree with the traditional beliefs that people hold about health, one can understand these beliefs and respect the people who hold them. Timothy Pyakalyia of Papua New Guinea agreed but also gave a warning about the harmful nature of the beliefs in magic and spells which infest some cultures—surely the

WHO photo

Alternative forms of healing: A community mental health clinic in the Philippines

role of the CMC is also to move people into patterns of love and reconciliation in their lives.

Summing up the directions that most CMC Commissioners seem to be moving on the concept of PHC is the comment on health written by Ivan Illich which Hildegard Bromberg Richter sent to us after the meeting: "Voices are being raised asking for alternative, varied, decentralized forms of medicine as a social experiment. In this view, health exists independently from health services, not just in easy access to them."

Support of coordinating agencies

The third focus of the mandate of the CMC centres upon *helping those involved in church-related health care to join in planning and coordination of their activities for more effective service.* In fact, although much remains to be done in this field, the CMC has been successful in enabling various churches, particularly in Africa, to work together through setting up of ecumenical health agencies, comprising both Catholic and Protestant programmes. The Private Hospital Association of Malawi (PHAM) was one of the first of these ecumenical coordinating agencies, started with CMC's help in 1965. Other associations such as VHAI (the Voluntary Health Association of India) and CHAG (the Community Health Association of Ghana) are good examples of the way CMC has encouraged cooperation of various private health agencies for better service to the whole health sector of a country.

Commissioners recognized the value of these agencies for the regions where they function and also the important example they have set in showing the way for joint action on health by church agencies in other countries. The promotion and support of coordinating agencies will be a continuing priority for the CMC. Commissioners from Latin America pointed to the need for such inter-church coordination in their part of the world. The CMC stands ready to help promote the development of health coordinating agencies wherever the churches feel that this would be desirable.

Existing coordinating agencies often grew from local churches, but after several years of independent action, they may have grown away from the churches to which they originally related. The Commission feels very strongly that we must help with strengthening the ties between health coordinating bodies and local churches. The benefit is not only one-way when local congregations and agencies working for health become re-introduced. In many communities the Church can act as a leader in encouraging the necessary attitudes and understandings that promote successful PHC programmes. Deborah Raditapole of Lesotho urged us to promote cooperation and brotherhood among the churches; when these aspects are lacking, coordination in health work is difficult. As another example of promoting coordination, commissioner Judith Ray reported after our meeting that the Canadian Council of Churches had decided to establish a task force on health.

WHO photo

What kind of medical training?

CMC is also part of the NGO (non-governmental organization)/WHO/UNICEF collaborative programme on PHC. While allowing full freedom to participants, this programme stresses coordination with WHO and UNICEF, among member NGOs and with governments and private agencies in various countries.

Curriculum development

Throughout our discussions, the Commissioners raised a common concern about the negative effects of excessive "medicalization" of health care. As Rainward Bastian noted, "There was a uniform critical attitude *vis à vis* a health care system that is being commercialized and which is one-sidedly under the influence of technical-scientific developments which do not take the patient seriously. More and more a medicine should be developed which has in mind the responsibility of the individual for his/her health, which understands health as a common good, which has to be preserved and attained by all, even by the lowest level of society."

One way of moving away from the medicalization of health is to support training of doctors, nurses and pastors to serve the needs of the community where they will be working. Too often, medical and theological training stress the *delivery* of care in a technical fashion. Despite beginnings of recognition of the isolating effect of highly technical health care and the realization that hospital-based Western-style medicine will only be available to the few for many years to come, medical teaching institutions continue to turn out doctors and nurses who *treat* patients in an abstract, disease-oriented way. Commissioner Hari John told us how she and her husband took years to unlearn the errors of their medical school education while setting up a community-based programme in India. She said, "The present medical education does not prepare doctors to serve in rural India." The same indictment could be made about medical schools in all parts of the world which prepare doctors to serve the rich, the educated, the powerful.

The Commission saw an exciting challenge for the CMC in promoting new curricula for training doctors, nurses and theologians which would speak to ethical issues, human values and relationships in health care. With help from our constituencies, we should be able to find and make known curricula teaching the ideas coming out of our studies on health, healing and wholeness—curricula which promote primary health care not as "second-rate" medicine but as a way for communities to attain self-directed health. This priority for action promises to be a most rewarding commitment. Promotion of creative curricula can also help extend the impact of PHC more rapidly by training the doctors and nurses, theologians and pastors, who will in turn be training large numbers of health workers and church workers during their careers.

Communication

Commissioners recognized the importance of CONTACT as a means for drawing together the network of those who share the concerns of CMC. CONTACT through its bi-monthly appearance in the mail may seem to be simply the *sending out* of information and concern; but the CMC considers it as a network, a medium of cross-fertilization of good ideas, in short, as a way of keeping in "contact". Therefore, it is important to us to hear from readers about their needs for information, their reactions to articles, their own experiences. All of you who write can be assured that every letter you send us is carefully read and shared.

CONTACT now is published in more than 26,000 issues in four languages and is distributed to more than 100 countries—and of course, we know from our readers that usually each issue is passed along to several other people and often is carefully saved for later reference in health posts and village clinics.

As well as acting as the link holding us all together, CONTACT was assigned the important task of relating to special groups whose needs the CMC considers of prime importance, but whom we cannot serve with full-fledged programmes. The elderly, young people, the disabled, the mentally ill, the addicted—for all these and many other groups, CMC can act as a clearing house of information, directing those in need toward programmes, ideas and publications which will serve them.

Here, too, commissioners have promised to help the Geneva staff by alerting us to interesting experiments and "stories" they find in their travels for health work. Through them we hope to continue to publish inspiring articles about work from all over the world. For example, commissioner John Hatch has already contributed to an issue about "The Healing Power of Black Churches in America" and Hari John with her husband has written about their

experiences in setting up a community-based programme in South India.

Healing congregations

Arising out of our concern for local congregations and from all of the preceding priorities for action is the Commission's desire to find and promote models of healing communities and congregations. Even while we are engaged in trying to understand what health and healing mean, we can see these processes in dynamic action among all kinds of groups, in all areas of the globe.

Those people committed to assigning greater meaning to health than simply the absence of disease are creating community in ways that can shed light upon all our work. For this reason, Commissioners also expressed the need to be aware of what WCC's Unit I (Faith and Witness) is finding as it journeys along paths parallel to ours in searching for understanding God's actions in the world.

As the CMC mandate states, "Since the caring and healing congregations have been recognized to be the key to implementing appropriate furthering of health care, attention must be given so that they can be found, so that others can learn from them, so that they are supported and encouraged where already existing and so that such congregations are created where they do not exist."

Conclusion

The priorities set in the 1985 Commission meeting were based on the judgement and experiences of our Commissioners' long combined work in the field. The goals set forth in this list of priorities extend to such depth of understanding, such urgency of calls to action, such breadth of geographic coverage that the CMC will be very involved in trying to live up to them before our next meeting of evaluation and goal setting in 1986. Our new commissioners wholeheartedly accepted the challenge of listening, speaking, and acting for us, and we also hope that many of our friends around the world can continue to help in many ways as they have in the past.

The setting of priorities for action which came out of the Veldhoven meeting is in no way a permanent definition of the CMC. We need to be, as Sigrun Møgedal said, "on the road, dynamic, able to respond and interact." Many of our priorities may seem rather the posing of questions than a handing out of answers. This constant questioning, willingness to change ways of acting, openness to admitting mistakes might seem erratic. But as one becomes acquainted with the ideals and the work of the Commission, one finds behind the dynamic surface the solid foundation, the example of Christ the Healer, a standard of caring and wholeness to whom we can refer all our works.

Dear Readers: As we have said, your comments and stories are important to us. Please write to us about innovative health work you know of, so we can tell others.

NCCUSA photo

A concern for local congregations

THE CHRISTIAN MEDICAL COMMISSION

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* Commissioners unable to attend Veldhoven meeting.

** Appointed after the Veldhoven meeting.

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