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A bimonthly publication of the
Christian Medical Commission World Council of Churches
150, route de Ferney 1211 Geneva 20 Switzerland

Number 77
FEBRUARY
1984

REDISCOVERING TRADITIONAL COMMUNITY HEALTH RESOURCES: THE EXPERIENCE OF BLACK CHURCHES IN THE USA



Also in this issue:

Short reports on

- **The National Conference on the Black Churches' Role in the Healing Process, Atlanta, Georgia, USA, October 1982.**
- **Black Women's Health Conference, Atlanta, Georgia, USA, June 1983.**
- **Women and Health Conference, New York, USA, November 1983.**
- **Consultation on Life, Health and Salvation, High Leigh, England, September 1983.**

EDITORIAL NOTE:

Every family, community and society has its "helping persons"—people to whom others turn for advice and support in times of need and sickness. The following question can be asked within the context of the Black communities in the USA today: to what extent are such natural helpers and healers equipped to prevent and deal with their families' and neighbours' illness and to sustain their health? To what extent do they compete with official health services and to what extent can they complement them?

In rural North Carolina, an innovative project has been initiated by a church—the General Baptist State Convention—which seeks to answer these questions and to mobilize natural social networks among the Black community in support of health and healing, as well as to reinforce people's and congregations' confidence in their ability to fulfil helping and healing roles.

The first article in this issue of *CONTACT* was written by John Hatch, Department of Health Education professor in the University of North Carolina School of Public Health. In 1977, he carried out a demonstration "Black Churches' Project" to test the notion of using rural churches as a focus for health promotion activities. The results were so encouraging that, at the end of 1980, the idea was taken up by the General Baptist State Convention (GBSC) in a "Health and Human Services Project" in which nearly 200 Black churches/congregations, spread over 9 counties, are currently participating. John Hatch describes how the project got underway, the impact it has on helping behaviour and on the community's use of local health services and health self-help efforts.

To our mind, the GBSC project, while only three years old, is noteworthy for several reasons. A case of an industrialized-country church providing the impulse and resources for better-off community members to devote their time and effort towards the improved health and well-being of the entire community, the project is a useful example of the promotion of community

self-reliance in health care. In its substantial commitment of resources and the care taken in planning and coordination for state-wide and regional implementation, the project is somewhat unique in the (relatively short) history of industrialized-country, non-governmental, community-based health care programmes. Finally, in stimulating better-off citizens to become aware of the health problems of their lower-income neighbours, of some of the economic and political factors causing these problems, as well as of what they can do to sustain and enhance their fellow-citizens' health (and, thus, in a certain measure, redress the balance of health resources), the project is an example of community solidarity worthy of careful study.

The past three years have witnessed a sharp rise in unemployment and a corresponding drop in living standards for a large section of the US Black population. There have also been sharp cutbacks in the provision of public health and welfare services to poor people. How have these changes affected the GBSC project? As we have done some time after publishing descriptions of other health projects in *CONTACT*, we hope to be able in a later issue to provide an update on how the Health and Human Services Project is faring and how it continues to progress.

The second article in this issue of *CONTACT* is by Florence Crim Robinson, Fuller E. Callaway Professor of Music Humanities at Clark College in Atlanta. She was the first Black woman in the 116-year history of Southern Illinois University to be given the Distinguished Alumni Award; she also served as music coordinator for the city of Denver and produced a very popular radio programme, "The many sides of Black music". In this article—an edited version of a talk given at a National Conference on the Black Churches' Role in the Healing Process, held in Atlanta in October 1982—Florence Robinson looks at the Black American community's traditional health resources from another angle: that of the power of people's music to refresh, strengthen, give hope, heal and to allow them to survive.

Miriam Reidy

THE GENERAL BAPTIST STATE CONVENTION HEALTH AND HUMAN SERVICES PROJECT

by John W. Hatch with the help of Anne E. Callan, Eugenia Eng and Crutis Jackson *

INTRODUCTION

The legally sanctioned caste-like system existing in the United States from the end of slavery in 1865 until the passage of the Civil Rights Act of 1964 has had a profound influence on the health status of Black people and their access to health and health-related public and private resources. Until quite recent times, Black people had few rights that White people were bound to observe. Education, health care services, governmentally-provided services such as waste disposal, safe water, building and maintenance of streets and roads, housing quality control and even fire protection were usually provided differentially on the basis of race. Sums spent on public services such as education and public hygiene provided to Black people seldom amounted to half the per capita amount spent on these services for White citizens. Professional and technical education was limited in availability and difficult of access. Those with the perseverance to acquire credentials were excluded from the general job market, with the exception of a very narrow group which provided limited professional services to the Black community itself.

The cumulative effect of these limitations amounted to near exclusion of rural Black people from modern health care and health-related services and technology until quite recent times. (This is not to mention the direct impact on Black Americans' health of racism, economic and political discrimination.) Needless to say, people did not sit idly by and wait for better times. In addition to reliance on home-made folk remedies, there were root doctors, faith healers, nursing specialists, burn treatment specialists, midwives, voodoo practitioners and persons who pulled teeth and treated related problems.

More recently, the removal of legal barriers, the relative decline in racial prejudice and the open-

ing of formerly closed resources have *not* resulted in equal access to services for all, nor have increasing access because of better jobs, government sponsorship of health care services and better knowledge of the modern system resulted in total abandonment of traditional practices that sustained people in earlier times.

Factors such as prior negative experiences with human service organizations coupled with residual racism in service institutions, lack of sensitivity and poor research on patterns of culture in Black communities all serve to reduce health service utilization by Black citizens. Many who meet criteria for services in public health departments and qualify for government support fail to avail themselves of these resources because of their belief that they will not be treated with respect and dignity. While I was growing up in rural Arkansas, there was persistent and strong belief that the local hospitals would expend little effort to save the life of a Black patient. Those entering the hospital were not expected to survive and many did not. Beds for Black patients were located in the basement next to the laundry and the one Black physician in the county was denied staff privileges.

In the state of North Carolina, most Black people are unskilled or semi-skilled "bluecollar" workers or their dependants. The average income for a 4-person family is around \$ 11,000 per year. The inferior health status of Black citizens is most evident in the higher incidence among them of diabetes, hypertension and infant mortality: the death rate for Black people due to diabetes is twice that of Whites, for hypertension three times that of Whites, while the infant mortality rate is 23.2 per 1000 for Blacks compared with 12.2 per 1000 for Whites. These disproportionate rates can be addressed with current medical technology and knowledge. However, in order to improve the health status of Black Americans, it is necessary (although not sufficient) for them to be aware of the need of medical intervention and to gain entry into the health care system.

As pointed out above, a history of segregation and disenfranchisement has created a reservoir of mistrust among Black and low-income

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persons of existing services. Thus, they are more likely to seek advice from within their own social network rather than contacting a local health service provider. Often, particular people are sought out by many within their social network because of their reputation as helping persons. These natural helpers may play a tremendous role in assisting others. The quality of their advice, however, is not always high and their knowledge of resources may be limited. In addition, these natural helpers share the beliefs, attitudes and practices of others in their network. Some of these may actually lead to ill health. For example, the traditional diet of Black Americans is high in salt and fat—a contributing factor for the development of hypertension. If these natural helpers are encouraged to examine their beliefs and practices and are provided with new information, their effectiveness as advice-givers will improve. If brought into contact with local health providers in an informal setting, linkages can be created, heightening the likelihood of a referral. Training natural helpers in the community can increase their knowledge and skill, their familiarity with resources in the community and their awareness of lifestyle changes which will lead to a healthier life.

Using the church as a focus for health promotion

Black people in the rural south of the USA logically turn to the church for help in a variety of situations, including health and illness. For Black Americans, the church has traditionally played a variety of roles, both in providing strength and guidance to individuals and families and in helping the community develop resources to improve health and wellbeing. The

church has a long history as a trusted, respected and effective institution. To understand the role of the Black church in the lives of Black Americans, one must look at its historical role as a source of support in times of injustice and oppression. In Christian teaching, all people are equal before God. In human society, this principal is seldom put into practice. The Black church has recognized that here, in North Carolina, we are far from equal in our housing, our illnesses, our babies dying, our life expectancy, our diet and our access to resources. Based on its realistic assessment of the inequality between Black and White citizens, the Black church has developed a tradition of self-help, self-care and self-reliance.

In 1977, I received a small grant to test the notion of using rural churches as a focus for health promotion activities. The objectives of this University of North Carolina-based "Black Churches' Project"—a demonstration project—were, firstly, to increase by 40 percent the number of people able to provide appropriate responses to basic questions about hypertension, diabetes and maternal and infant care and, secondly, to increase awareness of the value of self-help action roles that the individual, the family and community are able to carry out in support of health improvement—actions such as low-salt, low-calorie diet preparation, weight control, social support and lifestyle changes. Over a 2-year period, 65 volunteers in 23 Black churches were provided with training in these areas. The specific goals were realized and evaluation by community people and health professionals was favourable.

This programme offered a low-cost approach to more appropriate utilization of health care



United Methodist Missions, by T. Fujihira



United Methodist Missions, by T. Fujihira

"... far from equal in our housing, our illnesses, our babies dying, our life expectancy, our diet and our access to resources."



Delta Ministry, Mississippi. United Methodist Missions, by T. Fujihira

The Black church plays a strong role in community development: voter registration by church volunteers.

resources. Integration of preventive and health-promotive functions into the overall structure of the General Baptist State Convention (GBSC) would offer wider impact and sustainability. We therefore approached the president of the Convention.

There are 1,300,000 Black people in North Carolina, out of which 500,000 are members of churches affiliated with the Convention's 63 associations and 1700 churches. The Convention has been in existence since 1867. Since that date until the present time, it has played a strong role in Black community development in North Carolina. It has supported several institutions of higher learning, humanitarian institutions and is recognized as the most powerful Black political influence in the state.

After discussing the "Black Churches' Project" with ministers whose congregations had participated in the demonstration in 1978, the president introduced the idea to the Convention's Social Concerns Committee with his endorsement. In 1980, the idea was approved by the Committee and subsequently adopted by the Convention. The GBSC Executive Board felt that the programme fitted within its overall philosophy of service and development and agreed to the notion of establishing a unit that would focus on health and human services, would train lay volunteers and would continue the service once volunteers had received training.

Aims and goals of the Project

With the overall aim of creating an environment which will be conducive to changing the epidemiological profile of the Black community, the goals of the GBSC Health and Human Ser-

vices Project are, firstly, to identify and train Lay Health Advisors within their churches and, secondly, to create a formal mechanism to implement health promotion activities at the state, regional and local levels of the church. While it is hoped that the training of Lay Health Advisors will increase their technical knowledge and skill as health advisors, another, secondary, objective is to demystify the health care provider-consumer relationship by bringing health care providers and consumers together in a setting which promotes interaction and mutual respect for the unique resources that each has—technical knowledge and community expertise. We hope that, as a result of the Project, church members and health care providers can begin to form a partnership to improve our community's health. Our goals address health promotion from two directions: by training Lay Health Advisors, we hope to have an impact on the grassroots community and, by working within the church structure, we hope to promote health-enhancing changes within the institution to support these grassroots efforts.

Methodology

The GBSC Health and Human Services Project targets the three health problems common among North Carolina Blacks mentioned above: diabetes, hypertension and poor maternal and child health.

Project staff, all of whom are members of the church, include its director who has a Master of Public Health, two health educators, one of whom is also a nurse, and an administrative secretary.

The two goals of the Project—to train local community helpers and to provide an organizational support base for health promotion—are pursued both at the local congregational level, and at the regional and state levels.

Training of the Lay Health Advisors occurs at the congregational level. Project staff and local congregations share in the task of selecting persons for training. Staff explain the nature and goals of the Project and the roles that the Lay Advisor and congregation are expected to play in developing a health and human services presence in the community. While the GBSC has taken a leadership role, members of other denominations are encouraged to join. Participating churches are asked to select persons from their congregation who meet the following criteria: are respected and listened to by a cross-section of the congregation, are good at



GBSC Health & Human Services Project

Lay Advisors enjoy exercise demonstration during training.

getting things done in the church, are in contact with many community people, are asked for advice in health-related matters, are likely to stay in the community and are willing to attend ten weekly training sessions. In addition, congregations are asked to select a man as one of the participants. In our community, men are more likely than women to neglect their health. While health advising is traditionally perceived as a female role, men are more likely to talk with other men about certain health problems.

The ten weekly training sessions start with an introduction to the Project, a discussion of participants' perceptions of their roles and those of their church in promoting health. All sessions are designed and conducted by local health and human service providers, with guidance from the Project staff. Collaboration between church members and health care providers—a principal aim of the Project is thus built into the training. The training is designed to help the Lay Advisors recognize risk factors associated with diabetes, hypertension and pregnancy and to recommend appropriate preventive measures. Sessions on diabetes pinpoint excess weight as a contributory factor, explain genetic predisposition to diabetes and present a number of practical weight control measures. Other training sessions focus on the links between diet, smoking, hypertension and stroke and the need for life-style changes. In the area of maternal and child health, the training stresses the importance of proper medical supervision and social support for mothers during pregnancy as well as of good nutrition for pregnant women and children. The health service providers involved in the

training give Lay Advisors the information they need to be able to refer persons to appropriate community health services, to conduct health information and referral sessions for their congregations and to teach simple self-help techniques such as exercises for expectant mothers, home urine tests and blood pressure checks. Other sessions include skill development in such areas as counselling and using media/audiovisual aids for large groups. A range of ideas of how the church might promote healthful behaviours continually comes up in discussions, including such things as preparing some foods at church celebrations appropriate for people who need to control their weight.

The second major goal of the Project—providing an organizational base for continuing and expanding health promotion activities within the church—is accomplished through working with the GBSC leadership at regional and state levels. We model our approach on that of other successful and long-lasting church activities such as the Sunday School and Ladies Missionary Society. These groups operate independently on the local level with the support and assistance of Convention-level resource persons. The Health and Human Services Project has its headquarters in the state offices of the Convention, allowing its staff access to those in leadership roles. The Convention has recently established a Health Subcommittee whose mandate is to explore more roles for the church in health. The Project staff take every opportunity to meet with pastors and moderators within the church as well as lay leaders, to provide assistance in focusing on health within the church.

The staff coordinate the input of health and human service providers in local communities who serve as resources for the training sessions. In the past, a variety of health and human services providers have been involved in the training: staff of mental health centres, local health departments, departments of social services, hospitals, the Red Cross, police emergency medical services, private doctors and others.

A Technical Advisory Board provides technical assistance to the Project in the areas of training, programme design and evaluation. Representatives from Duke University, Shaw University, North Carolina State University, the Schools of Medicine and Public Health of the University of North Carolina, the State Health Department and the State Office of Rural Health—physicians, epidemiologists, educa-

tors and historians—have developed a collegial role with the Project staff and serve as resource persons for them.

Perhaps the most important people in the Project are the Lay Advisors themselves. In the three years since the Project was initiated, 200 Lay Advisors, coming from almost 800 churches/congregations, spread over 9 counties, have completed the training. These people naturally serve as sources of information and referral for members of their social network. Their reputation as helpful and knowledgeable people makes them a natural resource for people with problems of all kinds. They give this help voluntarily and receive the intangible rewards of helping others.

Mrs Eula Boyd is perhaps typical of the Lay Health Advisors. She is 59 years old and, with a high school diploma, is employed as a food service worker at the primary school cafeteria. Her husband works in the local warehouse operating a fork-lift. They have three grown children and have raised a fourth as their own who is now in high school. Mrs Boyd has been a member of the Spring Street Baptist Church for 29 years and is actively involved with the Ladies Missionary Society and the choir. She is a member of the local high school PTA and an officer of the local home extension club. In short, she is a very stable and active member of her community. Before participating in the training sessions, an average of 5 people a week turned to Mrs Boyd for help. Most either called her on the phone, came to her house or talked to her at church. Younger as well as older people, their problems ranged from how to get to the train station on time or how to prepare for a programme at the church, to problems concerning health and family matters.

Evaluation

The evaluation component of the Health and Human Services Project measures the effects of the training on the Lay Health Advisors in terms of changes in their technical knowledge and patterns of helping behaviour. While we would like to evaluate the impact of the Project on the self-help behaviour of community members, and to measure before- and after-Project patterns of health resources utilization, funds to carry out these activities have not yet been available.

An evaluation of the Project's first year collected demographic data on the Advisors, measured their helping behaviour prior to training, analyzed their level of involvement in

church and community activities, measured their before- and after-training knowledge of the risk factors, etiology and common treatments and referral patterns for diabetes, hypertension and maternal and child health, and studied the characteristics of help-seekers and the nature of the help given.

This evaluation showed that all the Lay Advisors trained in the first year were either employed or retired and had, on the average, completed 12 years of schooling. Their average age was 49 years; the majority were married women active in church and community affairs and they included some professional and business people. The help-seekers all came from the "bluecollar" class to which most of the state's Black people belong. Their average income, for a 4-person family, was around \$ 11,000 per year which means that they are not the poorest group in the community. Their average age was 34 years; they were, like the Lay Advisors, predominantly women but, in contrast to the latter, more than half were unemployed.

The number of helping encounters had almost doubled and the number of those relating to health needs had increased almost 9-fold when measured after the training. In fact, the increase in the total number of helping encounters is almost solely due to the increase in those relating to health problems. Encounters which took place in the church before the training tended to shift to the help-seekers' homes although they took place in a number of other situations as well, for instance, over the telephone.

As hoped, the Lay Advisors' knowledge about diabetes, hypertension and maternal and child health increased significantly; participants with less formal education showed the most progress in comparison with pre-training test scores. Participants' self-perceptions of competency were greatly boosted: prior to training, 82 percent felt there were times when they could not be of much help compared to only 4 percent after the training.

Before the Project, Black people in North Carolina very rarely consulted the "official" health services. The training was designed to prepare the Lay Advisors to become an organized force for promoting full utilization of appropriate health services by providing correct information on their availability and by helping people overcome their suspicion about White health providers and these services. White health-service providers participated ac-

tively in the teaching. This allowed close social contacts between them and Black people—a first for many of the former—and the context in which they could become more sensitive to the health needs of their fellow-citizens. Based on these contacts and, in some cases, negotiation with White health-service providers, the Lay Advisors after training were better equipped to help their fellow Black citizens to overcome their suspicion of health services by assurances that they would be treated with respect. As mentioned earlier, funds to measure the Project's impact on the community's utilization of health resources before and after training have not been available. However, the fact that the health departments of two counties and a rural health centre attribute a dramatic increase in utilization of maternal and child health services and participation in hypertension control to the Project is one indication of its impact on attitudes, both Black and White.

After training, many Lay Advisors initiated health-related activities at their church. Some went to the Family Nurse Practitioner at the local clinic who conducted a MCH care session so that they, in turn, could organize sessions for teenage mothers in their community. Others went to the Red Cross, which had demonstrated the use of sphygmomanometers and cuffs, to become certified blood pressure screeners for their church. Some went to the local health department to organize an infant-car-seat loan programme. Others decided they wanted training on dental health, which had not been covered during the 10 weeks, and contacted the local dentist to conduct sessions with interested church members.

Perhaps the most important impact of the Pro-

ject has been in helping community people to better understand the roles they are able to play in promoting and maintaining health. Twenty-five years ago, a high percentage of births occurred in the home. As increasing numbers of people have been able to pay or qualify for government assistance, management of pregnancy and delivery have come under the control of professional care-givers. Similar trends exist in the care of elderly people and persons with chronic conditions. Increased access to the modern health care system has caused uncertainty as to what, if any, role should be played by persons who formerly provided counsel and advice to family members and neighbours. The Project has assured them their importance and reinforced the tradition of cooperation among family and neighbours by helping to define roles that are complementary rather than conflicting with modern health care practice and services.

The issue of empowerment, i.e., encouraging people to fight institutional and societal policies and practices which bar them access to health and health services has not been directly addressed by the Project. Our programme is using a soft approach in addressing these problems. The church is the most important organization for community development in rural Black populations in North Carolina. The Civil Rights movement of the '60s drew its leadership and core support from churches and the church continues to encourage group solidarity and political participation as an essential element in the continuing struggle for equality.

Our experience has indicated that the vast majority of publicly supported health service organizations are anxious to increase utiliza-



United Methodist Missions, by T. Fujihira

A helping encounter.



GBSC Health & Human Services Project

Lay Advisor checks fellow congregation member for high blood pressure.

tion. They often do not recognize the major barriers created by professional and institutional characteristics, but focus on client characteristics. The Health and Human Services Project provides Black citizens with knowledge of available health resources and encourages them to establish contact with the relevant agencies. Better-off Black citizens who are able to challenge patterns of service but who seldom use public health services, are being enabled by the Project to learn of the disparity in health status between Black and White populations, of tax-supported resources known to be effective in reducing morbidity and mortality. These persons are now becoming involved with health care providers and helping them to recognize patterns of interaction with clients perceived negatively by their lower-income neighbours. In discussing the mission of tax-supported health services and agencies, the Project encourages local citizens to find out the number of Black people

employed in them. How this knowledge is used is determined by each local community. The GBSC President and Executive Board hold several meetings annually with the state governor to discuss issues facing Black people. Health and health-related services are viewed as high priority by these persons. Support from the state health department and its related agencies to the Project has been strong.

The GBSC Health and Human Services Project is demonstrating the role of the church in the health of its members. It has received enthusiastic support from churches, the academic community and others interested in improving Black people's health. The church has developed structures to continue to raise the health question for its leaders and members. These will evolve over time and continue to enable the community to develop new and innovative ways to meet its needs. ■

THE HEALING EFFECTS OF BLACK MUSIC

by Florence Crim Robinson *

Music, like all the other arts, reflects and gives shape to the sum total of people's experience. So, our music, the music of Black people in America, is different from anyone else's because our experience in this hemisphere has been different from that of Africans and even from that of other people in the Western hemisphere of African descent. When we talk about Afro-American music therefore, we are not talking about African or Western music. We are talking about something that is totally unique because we are a unique people.

All Black American music, whether secular or religious, has been part of the essence of our people, ever since our beginnings in this country. According to B.B. King, the great blues singer, the blues began when the first whip was taken to the first slave on the first slave ship. And our music has always been a form of healing. We have used music very successfully as a kind of survival mechanism in the extremely hostile environment in which we were forced to live.

In traditional Africa, music had two main functions. The first was to connect visible and invisible worlds, the world of man and the world of the supreme being who Africans always knew existed. The African did not understand many things in nature, but music helped to make these unknown forces clearer. The second function, and music was always functional, was to bring people together. African music was group singing or something that required group participation. So, it fostered a spirit of cooperation. Cooperation that began in musical activity carried over into all other activities. Even today, most Africans don't think of music in terms of participants and audience. Everyone is encouraged to be a participant, and this is true in most black churches in the USA today where music is participatory for the entire congregation.

In Africa, music was used for all the important events in a person's life. There was special music when a baby was born, for coming-of-

age ceremonies, for death or marriage and for every festival—harvest, victory and battle. And, of course, special music was used for healing. Still today, music is set aside to be used in the event of illness and the powerful effect this music has is uncanny. Several years ago, a student from Zimbabwe gave me some examples of music for illness. I didn't understand the words but the very sound had a soothing, almost mesmerizing effect.

Mahatma Gandhi said: "All true art is an expression of the soul. The outward forms of the art have value only insofar as they are expressions of the inward spirit of man." In a vast number of spirituals, hymns and gospel songs that have been sacred for many generations, Black church music has kept alive our history and our spirit. From the cries and chants of the slaves and our field hollers down to the present day's songs of worship, the soul-penetrating strains of Black music have all played a profound role in shaping the destiny of Black people in this country. Through an examination of the continuity and development of our music, we can accurately trace Black thought, philosophies and action. If we had preserved all the lyrics and all of the music that has been composed since we came to this continent, we would have the complete history of our thoughts, our aspirations and emotions.

Our music was once judged naïve and simplistic. But nothing that is part and parcel of the soul of people can be naïve. As a matter of fact, when Martin Luther wrote his hymns, they were derided in the same way by his contemporaries. It could be that, as our music is examined in closer perspective, its effect on people and on the church will be recognized as being as profound as that of some of the great hymns of the Reformation.

In 1871, a Black choir, the Fisk Jubilee Singers, made a triumphal European tour. In that year, the Czech composer Anton Dvořák, before the première of his *New World Symphony* (the one that has as its theme the spiritual "Going Home"), said: "The most beautiful and varied themes are the product of the soul. They are America. They are the folk songs of America and composers must learn this music. In the

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Negro melodies of America, I discover all that is needed for a great and noble school of music."

After Europe had recognized the power of Black music, America suddenly awakened to the realization that here, within her own borders, was an indigenous, unique and unexploited treasure. Whatever their musical aspects, it has always been the meaning of the spirituals that makes them so valuable. There is not a Black American alive who, if he is honest with himself, cannot identify with at least some spiritual, some gospel song. You think about the old sorrow songs like "I been 'buked and I been scorned", "I wish I'da never been born", "Oh, Freedom", "Lord, I'll never turn back", and you know the power that these songs had. They were the best expression of the slave's deepest yearnings and they speak with finality against the legend of the contented slave.

This music, I am convinced, and music generally, was one of the strongest of all the survival mechanisms used by Black folks. During the Civil Rights Movement, some of the young folks were discovering blackness and they us-

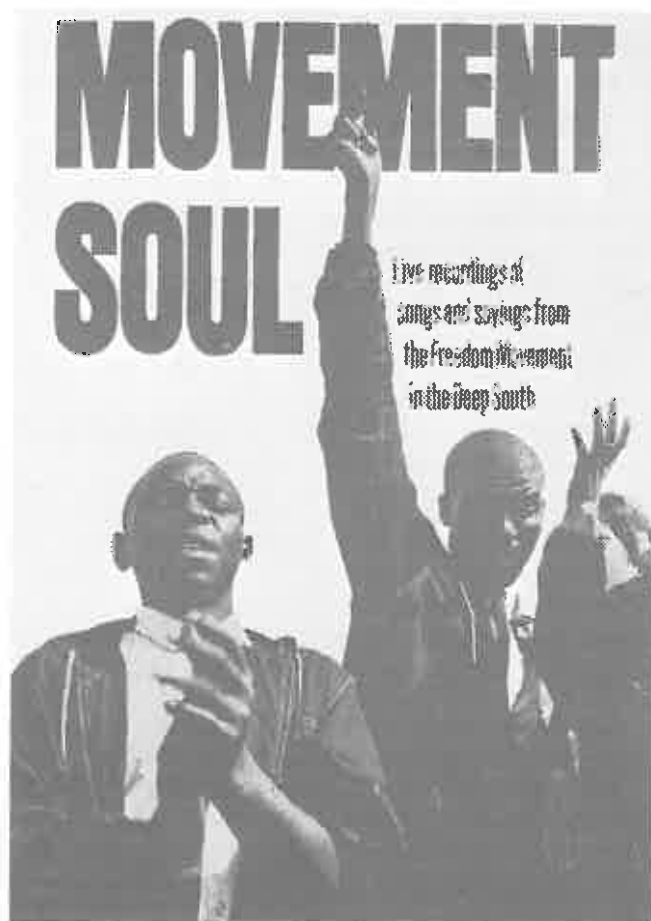
ed to sing the freedom songs as if somebody had just written them. My great-grandmother used to sing all those songs, as her great-grandmother had sung them to her: songs about the promised land, escape, the crossing of the River Jordan, about the train that is always going somewhere—the gospel train—moving from one place to another. These themes occur and reoccur in spirituals because Black people needed to keep them constantly in mind in order to keep on hoping. It was this hope of heaven that kept the Black folks alive. And it was this same kind of power that has been a part not only of our healing, but also of what has kept us well, a power that may be the secret ingredient of our strength as a people.

There were and are other Black survival mechanisms, such as our sense of humour or our ability to sort of take things easy. Even some characteristics normally thought of as uncomplimentary may have been and may be part of the whole Black survival mechanism. Not being on time, for instance. In the old days, you wouldn't exactly leap up in the morning to go out and work 16 hours, and you wouldn't hustle through the day to do whatever you

NCCUSA, by K. Thompson



WCC, by J. Taylor



by Danny Lyon

Music: "always a form of healing" and "one of the strongest survival mechanisms of Black folks".

were supposed to be doing. It was not that we lacked an appreciation of time. It was simply that, in many instances, time was not valued because of the way it was going to be spent. I am also convinced that the ability to laugh when the going gets rough and to laugh at oneself has helped us. Also, we were very good at negotiating the "system", doing what needs to be done at the particular time and in the particular circumstances.

So, our folklore and our music have kept Black folks going. All our songs have special meanings at particular times for certain people. In the days just prior to the Civil War, men were put to death for refusing to stop singing the song "No more auction block for me". W.C. Handy in his autobiography "Father of the Blues" said that whenever "March on along, I'll see you on the Judgement Day" was sung when he was a child, his father always cried and he never understood why. When he became a man, he finally asked and his father told him that this song was being sung when he'd seen his brother, who was sold to a different master, for the last time. Or think of the power of "We shall overcome" in the '60s. And any Black person would be able to identify with songs like "We'll stand the storm".

We talk about music therapy as a new career. There is nothing new about music as a source of healing. Among the hieroglyphs on the tombs of the pharaohs, there are pictures of official musicians who played when members of the pharaoh's family were sick or troubled, in order to soothe the responsible spirits. I want also to remind you of a story you know very well.

"But the Spirit of the Lord departed from Saul, and an evil spirit from the Lord troubled him.
And Saul's servants said unto him, Behold now, an evil spirit from God troubleth thee.
Let our lord now command thy servants, which are before thee, to seek out a man, who is a cunning player on a harp; and it shall come to pass, when the evil spirit from God is upon thee, that he shall play with his hand, and thou shalt be well.
And Saul said unto his servants, Provide me now a man that can play well, and bring him to me.
Then answered one of the servants, and said, Behold, I have seen a son of Jesse the Bethlehemite, that is cunning in playing, and a mighty valiant man, and a man of war, and prudent in matters, and a comely person, and the Lord is with him.

Wherefore Saul sent messengers unto Jesse, and said, Send me David thy son, which is with the sheep.

And Jesse took an ass laden with bread, and a bottle of wine, and a kid, and sent them by David his son unto Saul.

And David came to Saul, and stood before him: and he loved him greatly; and he became his armour-bearer.

And Saul sent to Jesse, saying, Let David, I pray thee, stand before me; for he hath found favour in my sight. And it came to pass, when the evil spirit from God was upon Saul, that David took a harp, and played with his hand: so Saul was refreshed and was well, and the evil spirit departed from him."

1 Samuel, 16, 14-23.

So I suppose David may have been the first music therapist.

There are many institutions and large churches which today are combining music therapy with their religious music programmes. Music's power is now again being recognized and people who are skilled at using music in healing are finding employment all over the country. Music therapists work with human disabilities, both mental and physical. They work in hospitals, schools for the handicapped, correctional institutions, nursing homes, sometimes in private practice. They use music to make the patient feel and behave better.

I think that music used in the healing process is of particular significance to us as Black people because we relate very well to music: we can be reached with music when we can't be reached in any other way.

It has been said that Negro spirituals speak of life and death. The same is true of the hymns and gospel music that followed. "Our music in many ways has been a voice, sometimes strident, sometimes muted and weary, but the voice of a people for whom the cup of suffering over flowed in haunting overtones, majesty, beauty and power."

The music of Black people has been used to soothe and to heal for generations. How appropriate the words of the old song:

"There is a balm in Gilead,
To make the wounded whole;
There is a balm in Gilead,
To heal the sin-sick soul"

A National Conference on The Black Churches' Role in the Healing Process was held from October 6 to 9, 1982, at the Martin Luther King Jr. Center for Non-Violent Social Change, in Atlanta, Georgia, USA; it was sponsored by the Interdenominational Theological Center (ITC) in Atlanta and the Christian Medical Commission (CMC) of the World Council of Churches (WCC), Geneva, in association with the National Council of Churches of the USA.

Men and women from five states participated. They included nurses and physicians, pastors and laypeople active in their congregations, teachers and social scientists, and represented many denominations.

The Conference grew out of an increasing sense of urgency within the Black churches to find ways in which they, together with their communities, could come to grips with the problems of ill health and poverty afflicting these communities.

The Conference was planned around daily Bible studies. Greetings were presented by representatives of local churches, the ITC and the Sullivan School of Medicine. Mrs Coretta King welcomed the participants on behalf of the Martin Luther King Center while Dr Sylvia Talbot, CMC Moderator, brought greetings from the WCC General Secretary and drew the parallel between the Conference aims and agenda and the CMC Study on The Christian Understanding of Health, Healing and Wholeness. The CMC (then) Associate Director Eric Ram also participated in the Conference and delivered a keynote address on "The Congregation as the Healing Community". Other keynote addresses included a paper on "The Healing Effects of Black Music", reproduced in this issue of CONTACT. A multimedia presentation "Hurting-Healing", four workshops, common worship and meals provided the setting in which participants could reflect on health issues facing Black churches in the US today. Among these were the theological and Biblical bases of understanding health, healing, wholeness and the meaning of the healing ministry for the Black Christian health professional; the relationship of health and healing to justice, peace, liberation and the implications of this for church health and welfare activities; and the healing role of the creative arts, traditional medicine and its practitioners.

Conference participants shared a common conviction that "Like every racial or ethnic group, the Black community has the innate ability to deal with its own ills, to restore itself to wholeness... This is the challenge... As the only institution in the com-

munity owned and controlled by Blacks, the Black church... has a special responsibility to interact in a dynamic and directed way with the Black community so that needs can be met."

* * *

The National Women's Health Network of the USA, founded in 1978, is "the nation's only public interest organization devoted exclusively to women's health." The Network's membership totals 11,000 individuals and 300 health organizations nation-wide. It has provided a model of self-help activism and cooperation in the area of health which, in 1980, inspired the foundation, by its Georgia chapter, of a "Black Women's Health Project". The principal aim of the Black Women's Health Project is "to empower Black women to make health care decisions, to control factors affecting their physical and mental health, and to reduce the health-threatening disparities and inequalities of American life".

In June 1983, the Black Women's Health Project together with the National Women's Health Network sponsored a **First National Conference on Black Women's Health Issues** whose theme was "I'm Sick and Tired of being Sick and Tired". The theme "symbolizes not only the struggles and suffering of Black women, but also our commitment to seize control of those conditions which affect our lifestyle and health." Held in Atlanta, Georgia from June 24 to 26, the Conference focused on:

- Education of Black women about health care and health facts.
- Cultural and historical perspectives on health.
- Self-care skills and health promotion.
- Public policies that impact on health access.
- Establishment of a health network among Black women.

In support of these objectives, sixty workshops addressed those chronic health conditions and social issues that impact disproportionately on Black women, their families and communities, including hypertension, diabetes, cancer, lupus, domestic violence, stress, maternal and infant health, teenage pregnancy, elderly abuse and occupational and environmental health. Keynote addresses looked at "Black Women and Health Care in the 80s", "The Politics of Substance Abuse", "The Impact of US Health Care Delivery on Third-World Women" and "The Process of Empowerment" (of Black women).

Conference activities allowed for formal and informal dialogue among the 1000 health consumers, practitioners, educators, scholars, policy-makers

and students who attended the conference. In addition to the workshops, daily activities of yoga, meditation, films, self-help demonstrations and exhibits not only entertained but were designed to promote cultural understanding and emotional wellness.

* * *

The major purpose of a four-day **Symposium on Women's Health** on the theme of "A Woman's Health is More than a Medical Issue", sponsored by the Health and Welfare Ministries Division of the United Methodist Church in the USA, was to explore the political, economic, social and cultural factors affecting women's health. Throughout the Symposium, held in New York from 9-12 November 1983, attention was called to the larger contexts within which women's health concerns need to be addressed: the UN Decade for Women, the WHO goal of "Health for All by the Year 2000" and the CMC emphasis on the church as a healing community.

Some one hundred participants from the US and developing countries met for four days of consciousness-raising, education and sharing. Interspersed with presentations and panel discussions, workshops addressing US women's health concerns and the special needs of particular groups of women, films and slide presentations depicting the situation of women around the world, were communion, worship and reflection on spiritual and theological questions relating to health.

Major presentations looked at the link between a woman's health and her status, psychological, cultural, political and economic factors affecting women's health, the effects of scientific and in-

digenous medicine and health care on women's health, and the church as a healing community. A variety of development education resources produced for, and coming out of, the Symposium are to be made available by its organizers.

* * *

Representatives from some sixty, mainly UK-based, missionary societies and Christian organizations in September 1983 participated in a two-day consultation on the theme of **Life, Health and Salvation—a Call for Decisive Christian Involvement in Health Care**. The Consultation, organized by the Conference for World Mission of the British Council of Churches in conjunction with the Evangelical Missionary Alliance, identified Primary Health Care as essential for the achievement of WHO's goal of "Health for All by the Year 2000". Discussion focused on principal requirements for PHC services and their implications for British churches, missionary societies and aid agencies.

Hakan Hellberg, Director, "Health for All" Strategy Coordination, WHO, presented the challenge of that slogan; Raj Arole, Director of the Jamkhed, India, Integrated Rural Health Project, shared information on this successful community health programme, and Stanley Browne, leading leprosy specialist, looked at the part Christian agencies can play in helping the WHO slogan become a reality. Stuart Kingma attended the consultation on behalf of the CMC.

In spite of the risks to those involved in such work, the need for churches and individual Christians to speak out again socially unjust practices and to urge governments to respond positively to the WHO was stressed.

CONTACT is the periodical bulletin of the Christian Medical Commission (CMC), a sub-unit of the World Council of Churches (WCC). It is published six times a year in four languages: English, French, Spanish and Portuguese. Present circulation is in excess of 25,000.

Papers presented in CONTACT deal with varied aspects of the Christian community's involvement in health and seek to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first issue of each year in each language version. Articles may be freely reproduced, providing acknowledgement is made to: CONTACT, the bimonthly bulletin of the Christian Medical Commission of the World Council of Churches.

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On the average, each copy of CONTACT costs SF 2.50 (US\$ 1.25) to produce and mail, which adds up to SF 15.— (US\$ 7.50) per year for 6 numbers. Industrialized-country readers are strongly encouraged to subscribe to CONTACT to cover these costs. Please note that orders of back issues of CONTACT will be charged at the above rate.

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