

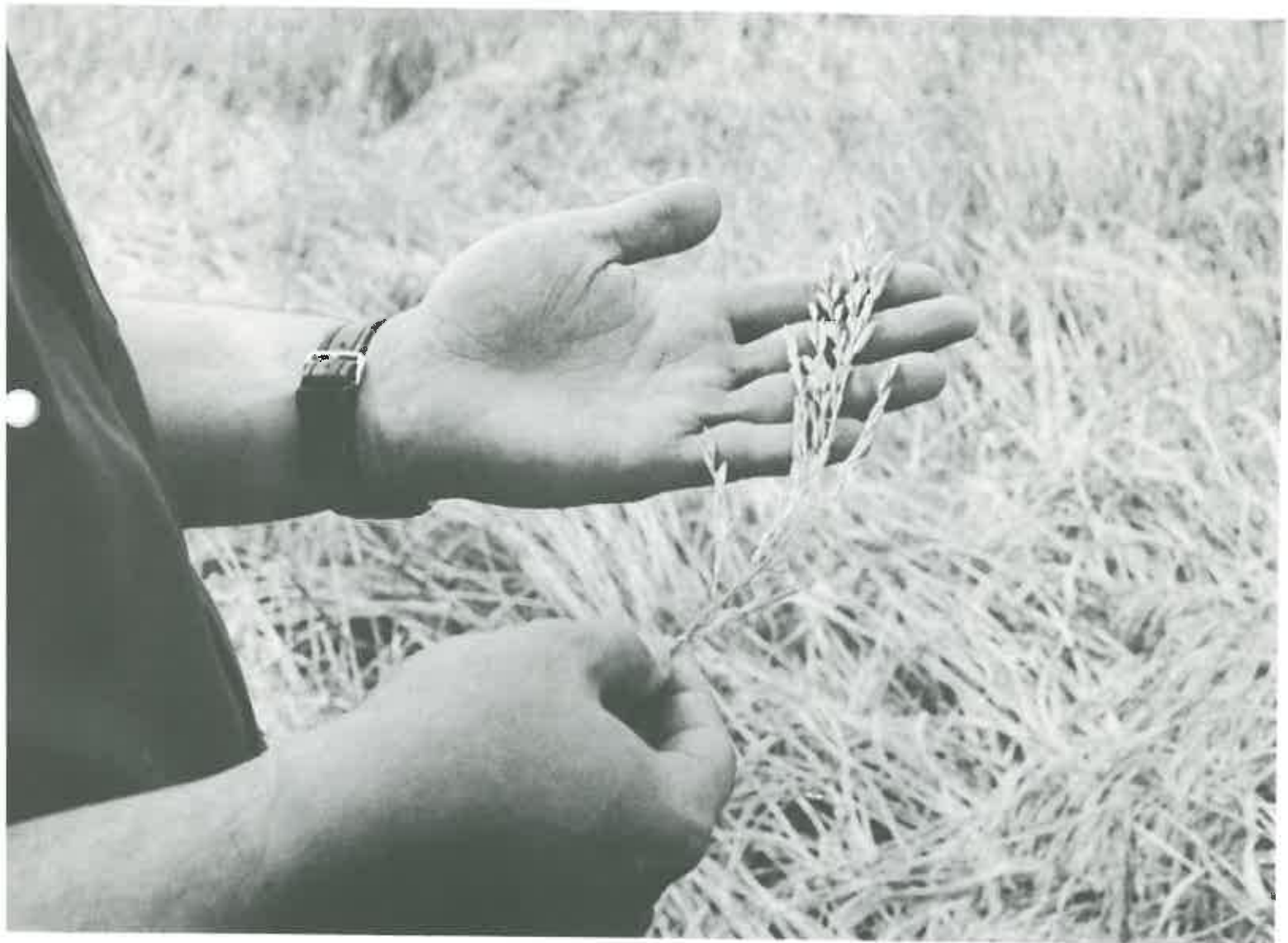


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# Letting People Decide For Themselves



## FOREWORD

What does giving mean? Or perhaps, at the start of this new year, we should first remind ourselves of what it is not. Giving does not mean forcing others to adopt ways of doing things that are not only foreign to them, but sometimes inappropriate. Giving does not mean replacing local traditional procedures with imported modern ones simply because they are imported and modern. Giving does not mean taking away the old and implementing the new to show others apparent improvements.

No matter how formally uneducated people may be, no matter how much building materials or medical facilities wealthier nations may donate, no matter how long medical staff or other personnel sent from industrialized parts of the world may stay, the country and village still belong to its people. "Westerners" usually return to their homes when they have completed their contracts. As guests then, they should remain respectful of all that the local population holds dear.

*Cover photo: World Council of Churches*

True giving is selfless. Offering something without the personal interests of self. When one gives of oneself – time and skills – one's will is not being imposed over another's. Giving is sharing, with mutual trust, openness and understanding. And sharing is a two-way process. It is not a charity.

Arnold Lazarus, an eminent psychologist, insists that all persons are persons of worth. "No one," he says, "is any better than anyone else. ...And theologically, all persons are children of God. This is true no matter what one's position, wealth, color or age."

What then does "Letting People Decide for Themselves" really mean? Bringing one's skills, imparting one's knowledge, and caring just enough to let go a little.

The following paper addresses some of the issues that one may confront when assigned to work in a developing country. We hope that as we have been humbled by them, you, too, will be sensitized and find our experiences useful. We will let you decide for yourself.

The Editors



HEKS Fotoarchiv  
**Sharing is caring**  
– and not a charity.

# LETTING PEOPLE DECIDE FOR THEMSELVES

by Eric R. Ram\*, Ph.D.

## INTRODUCTION

Twenty-five years ago I returned to my home in Miraj, India after receiving my training in Public Health from the University of North Carolina. I had the idea of "providing" health services to the villages through a mobile van with a health team. So I began treating the sick and telling people, "This is good for you," and, "That is not good for you". I was shocked, therefore, when I was asked by a man one day to treat his goat, which had stopped giving milk, and by a woman who said I must help save her six chickens, as the rest had died in an epidemic that was raging among the poultry in the area.

I learned then that people have their own priorities where health is concerned, and they may not necessarily be the same as ours. I also learned that the people's own understanding of their problems is intrinsic to health and that they must take the basic responsibility for their well-being. We, coming from outside their community, must have faith in the ability of the people, however uneducated they may be, to do things for themselves, because health cannot be "provided". We must have the patience and imagination to allow the people to find innovative ways of making health services available to them where they are.

It is very easy to open a hospital here, dig a well there, install a water pump here or build a few latrines there and expect people to use them. This makes us feel good. We have done our job and now all the people have to do is use what we've furnished and maintain the new facilities. However, if the people have not been given a chance to understand why they

should use safe water or latrines, or if they themselves have not been involved, things do not work. Our experience has shown that 70 per cent of the water pumps go out of order within a year. So we turn around and say too eagerly, "Aha, you people cannot even do simple things for yourselves". So we decide to manage for them: "Let us provide them with vertical programmes". Unless people participate in and contribute towards decisions which affect them, no amount of outside effort will ever guarantee success of any medical, health or development programme. I have seen people come to the clinics, collect medicines from the dispensaries, and then not use them. They were saving them for worse times. We cannot push medicine down the throats of the people.

I also learned through my twenty years' experience in developing countries, that about 80 per cent of the diseases are preventable and treatable at the village level. The one resource they are rich in is people. They can learn to take care of most of their illnesses. Local people possess a wealth of traditional skills and knowledge.

Traditional birth attendants deliver eight out of ten babies in India and most of the developing world. We trained 176 of them in our service area, and within eighteen months, maternal mortality was reduced to near zero. Traditional forms of healing, such as herbalism, Ayurvedic, Unani, homeopathy, finger pressure and acupuncture have been practised effectively for centuries. The simple procedure of disinfecting wells with bleaching powder once a week reduced water-borne diseases by about 80 per cent. When all readily available resources are tapped, they become a dynamic force which can bring about a change for better health.

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\* Dr. Eric R. Ram is the Director of the Christian Medical Commission.



WCC Photo by John Taylor

... already involved in their own health education ...

As a health professional, the hardest part for me to accept was that they were already involved in their own health care. I was only able to discern the scientific basis of what they were doing – train them to improve their skills and techniques, help them to recognize the danger signals, and identify the risk cases which should be referred to the nearest health centre or hospital.

### **Churches' Pioneering Role**

The ministry of healing in its fullest sense has always been a natural concern of the Church. But somehow, as health and healing have evolved, Christians have come to associate that ministry with certain professional services, which may have very little connection with the life of the congregation. Thus the task of healing has been left in the hands of a selected few, namely doctors and nurses. As a result, the Church, which is the organized and visible expression of Christian discipleship has always had some difficulty in determining how it should respond to the Lord's command to heal. The other imperatives – preaching, teaching and baptizing – have presented no problems.

Over the past 100 years, churches have progressed in answering the call for medical care in many developing countries, and account for a large portion of medical services available in Asia, Africa and Latin America. There are thousands of hospitals, health centres and dispensaries in developing countries related to

the Protestant churches. Similarly, the Roman Catholic Church operates several thousand such institutions. Combined, their annual expenditure totals over \$300 million. In some countries, these mission programmes account for as much as 60 per cent of medical and health care, and most of them are situated in rural areas where they have earned the confidence of the people they serve.

Traditionally, however, most mission hospitals have concentrated their efforts and resources on treating disease and developing technology. Our hospitals have thus become almost synonymous with curative medicine. Doctors and nurses have devoted their time to studying and treating illness, paying little or no attention to the whole person and his or her interaction with society. Many medical colleges continue to train students for practice in which the 'best' care is assumed to be that which applies everything known to medicine to every individual, by the highest trained medical scientist, in the most specialized institution. It has been seen, however, that services provided under this assumption are becoming rather insensitive to the health needs and problems of the community, as medical intervention moves further up the professional ladder.

### **Lessons Learned**

The Christian Medical Commission over the last eighteen years has learned a number of other important lessons through its commitment to the health care needs of developing countries.

- **Each community has a potential resource within itself to promote better health.** Health is a God-given natural endowment, with inherent responsibility, of course; but it should not be a distant promise towards which one need struggle. Thus, health and nutrition education can become powerful agents in releasing this health potential.
- **The provision of medical facilities has minimum effect unless there is adequate nutritious food, safe water, a clean environment and shelter.** These basic needs are interdependent and cannot be seen in isolation.
- **It is the lack of a healthy environment rather than the lack of medical treatment that sub-**



jects the greater part of the world's population to the constant threat of infection.

- Now matter how imaginative or economically viable a health care project may be in the eyes of its designer, it will not take root if it is designed *for* people rather than *with* them. The best way to gain acceptance into the community, change people's attitudes and teach them new methods is to first change one's own attitudes and then enlist the help of men and women directly.
- There is often a considerable difference between people's wants and needs. The problem is, within limited resources, how to match them.
- About 85 per cent of the people in developing countries are outside the reach of hospital-based medical programmes. Much pride is taken in providing quality service to those 15 per cent who go to the hospitals, but the challenge to us is how to make available basic health care to the other 85 per cent.
- Primary health care (covering approximately 70-80 per cent of illness episodes) is more acceptable and better utilized when made available by workers whom the community itself has selected and trained for this purpose. The amount of education these community workers have is not important. They can be trained in basic health care in about ten weeks, followed by monthly refresher courses and supervision. 98 per cent of the workers we trained at Miraj could not read or write, but were able to treat 85 per cent of the ailments in their own community.
- As we expand our Christian understanding of health, healing and wholeness through world-wide studies, we embrace the ideal that health is more than the absence of disease. It is a dynamic state of well-being of the individual and society, of physical, mental, spiritual, economic, social and political soundness. Health is harmony with oneself, with one's fellow beings, with the natural environment and with God. In biblical terms, health is **Shalom** (Isaiah 32:16), a state of right relationships.
- Human relationships, whether at the level of the family, church or community, have greater therapeutic value than applied technologies. Often, congregations and com-



UNRWA Photo

**Making basic health care available where it is needed**

munities are able to select their priests and pastors, but not their doctors. The clergy are "invited" into the community, while medical professionals seem to "invite themselves". Shouldn't the community also choose the doctors and nurses who serve them?



Foto HEKS/S. Andres

**Choosing one's local doctors and nurses inspires confidence.**

## Equity

The World Health Organization (WHO) has reported some improvement in the world's health. And yet, consider the following situations which persist in certain developing countries:

1. A new-born child still has only a fifty-fifty chance of survival.
2. The death rate for women due to childbirth is 1,000 per 100,000 births, while in industrialized countries, it is 2 per 100,000. In other words, it is 500 times higher in developing countries.
3. The average life expectancy is less than 50 years of age, while in the developed countries, it is more than 70 years.
4. Only 30 per cent of the people in developing countries have access to safe water and adequate sanitation.
5. Malnutrition is more a rule than an exception for two-thirds of the world's population.
6. Four-fifths of the world's population are beyond the reach of any permanent form of health care.
7. Nearly 17 million children under the age of five die annually; over five million of them die because of diarrhoea.
8. More than half the world's population live in malarious areas and, although there are no accurate figures, it has been estimated that a million children die of that disease each year in Africa alone.

**The tragedy is that 85 per cent of all these deaths could be prevented.**

Health services are clearly failing to reach most of our world's people. In spite of sophisticated medical advances, it has not been possible to solve the relatively simple and avoidable problems which weigh heavily and constantly on two-thirds of the human race today. Health is recognized as a human right, but also carries with it the responsibility for its universal practice. Fortunately, the global cry for primary health care is being heard, and just and equitable distribution of health services is on the increase.

It must be recognized that the more affluent societies, too, have severe health problems. They are often afflicted with the pervasive challenges of obesity, alcoholism, drug abuse, environmental toxicity and unwanted pregnancies, as well as social malaise and alienation. But when compared with the problems of developing countries, theirs are far fewer.

People in developed countries spend US \$250 in the private sector, totalling US \$500 per person each year. On the other hand, for the people in developing countries, health expenditures are in the range of US \$2-7. Thus, people in developed countries spend roughly a hundred times more on health than the people in developing countries, whereas the people in developing countries have far more serious health problems.



WCC Photo by W. Tung

**Will these boys have a fair chance to grow up healthy?**

During my visit to the western part of Southern Sudan not too long ago, some people told me that there are those who, from the time they are born until the time they die, do not receive a single tablet of aspirin or Chloroquin. This is a reflection of the inequity in the distribution of drugs. While some people use too many drugs, a vast majority of the people in the world have access to very few or none at all. It has been estimated by the WHO that 25% of the world's people use 85% of its pharmaceuticals.

Some countries, such as Germany, produce more than 70,000 different compounds of drugs, while the experiences of the CMC show that with about 100 drugs, 95% of the illnesses in developing countries can be treated. WHO, with similar findings, has developed a list of 250 essential drugs.

While it is true that health policy makers in all societies are subject to various pressures as they make decisions – technical, social, economic, political and, explicitly or implicitly, human values issues – the inequity which exists between the health 'haves' and health 'have nots' must be diminished. There is much to be gained in both cross-cultural understanding and enhancing health decisions through careful exploration of the human values that underlie health-related policies in different societies.

Poverty, equity and health policy are often lost from sight in the ordinary course of pursuing the goals of Health For All. By its very nature, the Church can play a special role in regard to these issues that are so expressive of the human condition in a world beset by uneven development and social injustice.

"Health for All by the Year 2000" is a campaign in which WHO is wholeheartedly involved. It is unfortunate, however, that as Primary Health Care (PHC) and Health For All (HFA) are implemented, the poorest – the ones with the faintest voices – may not be touched. We as Christians have been given a special mandate by our Lord to serve them and to serve them effectively, and therefore must find ways and means.

The participants of the CMC's regional meetings for the US and Canada recommended strongly that churches play advocacy roles in helping form national health policies, including action on containment of medical costs and fair and responsible use of medical resources.

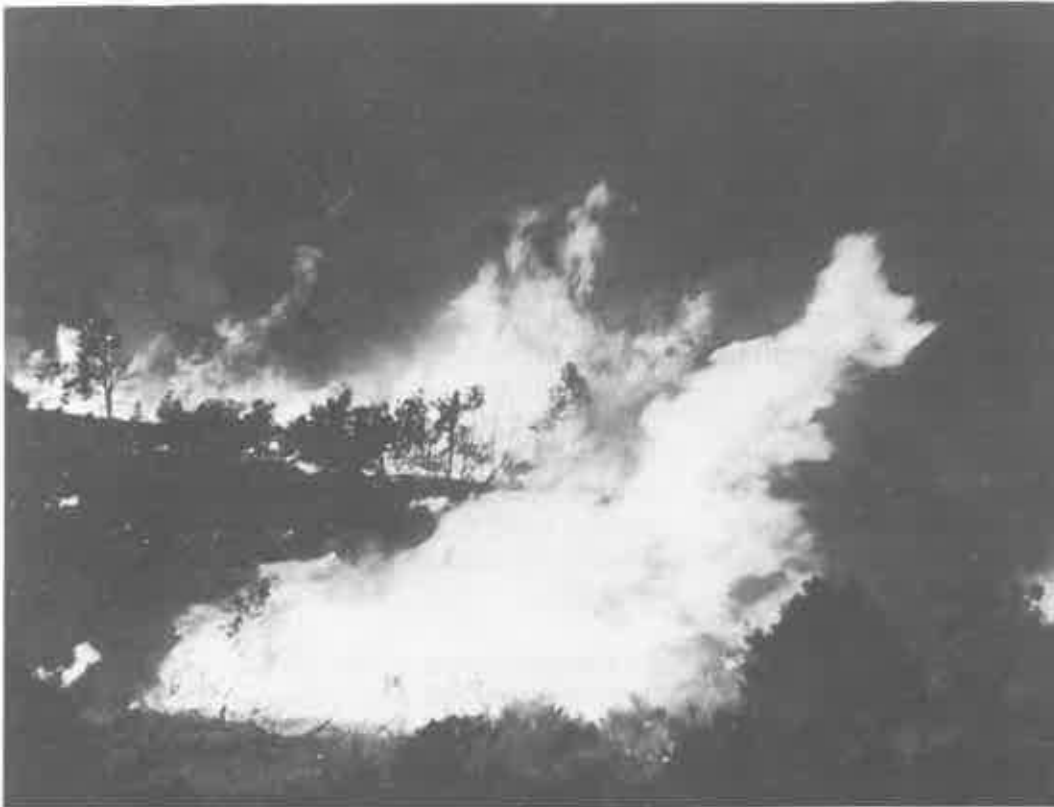
### **Beyond Equity**

**Primary health care as a strategy for health for all is an important step in meeting people's basic health needs and lowering the mortality**



WCC Photo by John Taylor

**A health professional willing to deal with poverty**



LRCS Photo

**Diseased trees die quickly;  
and forest fires do not stop at  
national borders.**

**and morbidity rates of several common diseases. But, there is more to life than this. We must strive to improve the quality of life. People as individuals and communities must retain or regain human dignity, have control over decisions which affect their lives, avoid dependency and develop self-reliance. These are the goals which must permeate all stages of socio-economic development, including primary health care.**

Health is only part of human well-being. Health benefits from and contributes to overall development. In addressing health problems at any socio-economic level, it is important to plan and work in concert with other sectors. In dealing with the very poor, it is imperative.

Serious efforts to deal with ill health at the poverty level must necessarily address the needs of education, income, environment and sanitation. Trust in the people must be in evidence, as well as a realistic hope to gain control over their own health and destinies.

### **Need for Appropriate Training**

The developing countries train their doctors and nurses at great cost and with tremendous sacrifice. However, they still prepare them to conform to 'academic' standards, which have little relevance to the actual pressing health

needs. My country of India has the dubious distinction of being the number one exporter of doctors and the number two exporter of nurses, while the Philippines holds the same distinction in reverse order. Every year, 15-30 per cent of the graduates emigrate to the West. It is also interesting to note that over three-quarters of the world's immigrant physicians can be found in only five countries – the United States, Canada, Great Britain, Australia and the Federal Republic of Germany.

What we need today is a new type of physician and nurse who think in terms of 'health' rather than 'disease' – who are willing to work among the rural poor and deal with their poverty, who go beyond the individual to include the entire family and community, who are wil-

While flying at altitude of 35,000 feet from one side of Europe to the other, one can see the pollution emanating from one country and drifting to its neighbors. One can see the forests ravaged by acid rain. Clouds drift and streams flow, regardless of borders – often heavily "guarded". These barriers cannot stop the poisons in our air and water.

Interdependence in Europe is obvious, and yet people are not able to agree on joint preventive measures to benefit all. Here again, the Church must take a lead in advocacy to form national health policies affecting necessary changes.



ling to involve the people in their own health care, and who attempt to use local resources as much as possible. Those who apply techniques of prevention and health promotion are not limited to curing.

Are there schools of medicine and nursing which are prepared to train this new kind of health practitioner to meet today's needs?

In recent years, some innovative studies of basic health services have been conducted around the world, and the effective implementation of primary health care looks promising.

These studies show that about 80-85 per cent of basic health needs could be met by locally trained, indigenous people. With a proper referral system to the nearest health centre or district hospital, difficult cases could be handled without straining the system.

One example of an innovative approach to community health care is from Great Britain: There has been such a considerable growth of Patient Participation Groups, that they are now associated with the General Practitioners and have formed a national association convening annually.

By now, it has become very clear that health is not only essential, but is at once an instrument for and a product of development.

### **The Finland Experience**

In spite of the availability of some of the best medical facilities in the world, Finland also had, until recently, the highest known incidence of heart disease. In 1971, the people in the province of North Karelia, alarmed by the prevalence of heart-related ailments, petitioned the government asking for help. A study conducted by WHO revealed that more people died from, or were incapacitated by, heart attacks and strokes than anywhere else in the world. Modern technology had not made a dent in that problem until local people were entrusted, through health education, to contribute to its solution. This process elicited changes of attitude and health practices by everyone involved. And over the next 10 years, the rate of heart disease in North Karelia dropped by 22%. In the rest of Finland, heart attacks and strokes have decreased by 12%. Consequently, Finland is now only number 3 for the rate of heart disease, with Scotland in 1st and Northern Ireland in 2nd place.

### **Dilemma of Medical Services in the West**

Some people in developing countries tend to think that medical care in the West is best and they would, therefore, like to adopt it as their model. But its superiority is open to question.

In the West, medical costs are generally rising so steeply that even the wealthiest are finding



UNICEF Photo / P. Almasy

**Basic nutrition taught by local volunteers, using local resources.**

them difficult to bear. At the same time, global standards of health are not being maintained. For instance, life expectancy, after once reaching a peak, has now again decreased; cancer rates are rising; cardiovascular diseases are rampant; drugs, alcohol, cigarettes and traffic accidents kill more people today than did all epidemics combined in earlier days; the aged, in spite of the availability of diagnostic tools and complicated technology, are largely unattended and uncared for. I do not believe that such a model of Western health care is suitable for a country such as India, or other less developed countries.

### **There is no Healing Where There is no Sharing**

Every act of sharing is a commemoration of Christ's sharing himself with a broken world, healing and redeeming. The Christian emphasis is on the giving of one's self, of bearing one another's burden. We come from different backgrounds, and whether rich or poor, we all have something to share: our knowledge, skills and culture. We read in I John 3:17-18, "If a man who was rich enough in this world's goods saw that one of his brothers or sisters was in need, but closed his heart to him or her, how could the love of God be living in him? Our love is not to be ... more talk, but something real and active".

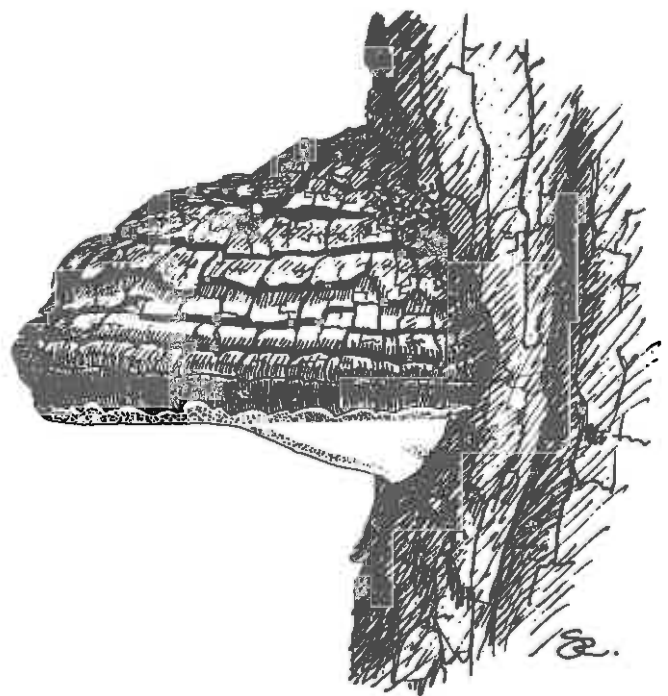
In this interdependent global village, we are summoned to share ourselves. We have to find new ways, where giving and receiving are equally important, where we go beyond the band-aid approach and help people stand on their own feet, so that they can realize their health potential and enjoy the fullness of life.

In 1979, soon after I joined the CMC, the first regional meeting on the Christian Understanding of Health, Healing and Wholeness was held in Trinidad. Since then, we have held nine others in various regions of the world, the most recent being in Budapest in September of this year. I would like to share, in addition to my earlier points, some insights gained from these gatherings, which further enhance our understanding of health, healing and wholeness:

- **The inter-relationship between body, mind and spirit are inseparable.**
- **The importance of knowing WHY: Why is**

someone I love sick? Why me? Being sensitized to the person as a whole, and not to a patient as an ailing organ, is essential to lasting healing.

- **Through wholistic medicine we have learned the importance of these relationships.** Paul Tournier, who passed away in October of this year, was a man of exemplary action, who built relationships in a devoted effort to develop what he called the "third dimension of medicine".
- **Role of ancestors:** In traditional societies, the place of ancestors receives very high priority, particularly in Africa. They provide a sense of tradition, continuity and belonging. How do we keep that alive? How do we maintain the respect and appreciation for what our ancestors, elders and teachers have given us, while feeling free ourselves to move ahead, to change without guilt?
- **Role of family and community rituals:** Many traditional rituals, which promote healing, are confessional, reconciling and purifying. But, there is also a negative side to them. Traditional communities are very conservative and provide little opportunity for those who are different. The premium is on conformity and, in the process, some valuable and innovative persons can be hurt or lost.



Drawing by Sinikka Rossi, in "Mirau and his practice", by Raimo Harjula  
**Phellinus sp., a woody fungus growth on the trunk of a tree, is used to treat headaches.**

- **Importance of traditional healing methods, especially herbal remedies:** I visited the Philippines and India recently, where I saw a new drive towards 'natural' medicine. Community health workers were learning the medicinal value of herbs for treating fever, cough, diarrhoea, jaundice, high blood pressure, cholesterol, arthritis, and other diseases, with apparently good results. In addition to these remedies being found locally, they are available at low cost. Homeopathic and Ayurvedic medicines generally have no side effects and more and more people are using them.

In North America, we also see a growing movement towards 'wholistic' and 'natural' medicine. People in the West recognize that more research is necessary. Should we standardize the dosage of herbal medicines? How do we integrate the best of both systems – Western and traditional?

James McGilvray, former director of the CMC, related how a flock of geese fly in 'V' formation. He explained that the 'V' enables each bird, except the leader, to find an uplift in the vacuum created by the bird ahead of it. The lead bird quickly tires and its place is then taken by another, while it moves down the line to recover. Flying in this formation, the flock can achieve speeds of more than 100 km an hour and travel almost twice as far as a single bird. If, for any reason, one of the birds must descend to the ground, another will go down to help it.

This is an apt example of interdependence and caring – a system in which people support each other. Where there is sharing and caring there is healing. And in a cooperating group, each member makes greater strides forward.

We must be prepared to become the leader when needed, but also be willing to move to the sideline when that time comes, too. This is an important concept of interdependence.

## How can Christians in the North Act Responsibly in an Interdependent World?

This is a question for each of us and we should explore various possibilities together.

- In supporting the churches in their overseas medical missions, a new thrust is needed in community-based health care programmes, away from big hospitals, and towards making health care available and accessible to the greatest number of people at the most reasonable cost. In this regard, donor agencies should also examine their role and priorities.
- As medical and health professionals, we need to recognize the interdependence and inter-relatedness of body, mind and spirit and thus develop realistic, practical and wholistic health care programmes. Likewise, the interdependence of various groups in Northern societies requires our attention: the poor, the elderly, the disabled, the jobless, young people, the homeless, refugees...
- For business people, industrialists and stock-holders, who have international ties with trans-national corporations, we see a special responsibility. It is towards those brothers and sisters, men, women and children, of less developed countries who are deeply affected by these industries. Are pharmaceutical companies, for instance, exporting the essential drugs needed there or are they delivering the non-essential and more expensive ones? How do we balance profit with social responsibility?
- As concerned Christians, it is our duty to be **informed** – to read, to look and **see**, to ask questions, listen and **hear** the answers and then **act** on them, to travel to developing countries and poorer sections of industrialized countries – remaining open to the needs of all. We live in an interdependent world. What happens to them out there affects us here and the reverse is also true.



WCC Photo by John Taylor

**What happens to him affects us all.**

## **Conclusion**

Healing is an essential ministry of the whole Church in proclaiming the Kingdom to all God's people. Where there is no healing, there is no church. Our own well-being is bound up with all who are rejected and marginalized

from society, in particular the poorest of the poor – the powerless. The Church must remain responsive to the health needs of those people, paying particular attention to the appropriateness of its approach. To act responsibly to local needs, the old ways may have to change and in some cases die.

# The Earth

If the Earth  
were only a few feet in  
diameter, floating a few feet above  
a field somewhere, people would come  
from everywhere to marvel at it. People would  
walk around it, marvelling at its big pools of water,  
its little pools and the water flowing between the pools.  
People would marvel at the bumps on it, and the holes  
in it, and they would marvel at the very thin layer of gas  
surrounding it and the water suspended in the gas. The  
people would marvel at all the creatures walking around the  
surface of the ball, and at the creatures in the water. The  
people would declare it precious because it was the only  
one, and they would protect it so that it would not be hurt.  
The ball would be the greatest wonder known, and people  
would come to behold it, to be healed, to gain knowledge,  
to know beauty and to wonder how it could be.  
People would love it, and defend it with their lives,  
because they would somehow know that their  
lives, their own roundness, could be  
nothing without it. If the Earth  
were only a few feet  
in diameter. \*

*\* Author Unknown*



## USEFUL PUBLICATIONS

**Taking Sides, The Choices Before the Health Worker**, by Dr. C. Sathyamala, Nirmala Sundharam, Nalini Bhanot. Asian Network for Innovative Training Trust (ANITRA), 320 pages.

This is a book by and for community health workers in India. The first 234 pages are used to show how and why disease and ill health are a result of poverty and exploitation, factors which modern medicine largely ignores. The "choice" is whether a health worker in a rural village will change the focus of her work to spend a major part of her time in the village, understanding and dealing with the root causes of ill health rather than simply treating patients as they fall ill. The last seventy pages give specific advice on how a health worker can identify with the groups of people who are most oppressed and assist them, through developing an understanding of the reasons for their oppression, to begin to exercise control over their lives.

This book is highly recommended for health workers of all levels, disciplines, and countries.

**Available from:**

B-7, 88/1  
Safdarjung Enclave  
New Delhi 110029, India

**Price:**

Rs. 70 per copy, plus postage  
Rs. 35 per copy, plus postage, as subsidized price for those who cannot afford to pay the cost price.

**Essential Action to Minimise Disability in Leprosy Patients** by Jean M. Watson, MCSP, 1986. 32 pages.

This booklet summarizes the main "action" sections from the manual, "Preventing Disability in Leprosy Patients". Most leprosy disability follows damage to nerves, and prevention of this disability is the subject of the booklet. Topics include sites of nerve damage, direct effects, levels of disability, plan of action to prevent disability, baseline disability records, how to test for and fill in the baseline disability record, and advice for patients, including care of eyes, hands and feet.

**Available from:**

The Leprosy Mission  
50 Portland Place  
London W1N 3DG, UK

## CMC NOTES

**Institute of Child Health**

The Tropical Child Health Unit of the Institute of Child Health, has set up a course for Teachers and Planners of Community-Based Rehabilitation Workers. A new Resource Centre has also been developed for community-based rehabilitation material. Professor David Morley would be interested to hear from anyone involved in community-based rehabilitation programmes and happy to provide information on the new course and the Resource Centre being developed.

**More information from:**

The Tropical Child Health Unit  
Institute of Child Health  
30 Guilford Street  
London WC1N 1EH, U.K.

The **University of Leeds** in the U.K. offers a "Diploma in Health Education in Developing Countries". This nine-month training course is designed for experienced field personnel and provides both theoretical and practical aspects of education and communication methods applied to health, nutrition and population programmes. Course participants specialize in these fields within an overall context of health education and primary health care.

**More information from:**

Dr. John Hubley  
Department of Health Education  
Leeds Polytechnic  
Calverley Street  
Leeds LS1 3HE, U.K.

"Nursing Development for Primary Health Care" and "Operations Management Development Services" are two courses currently being offered by the **MEDEX Group** of the **John A. Burns School of Medicine, University of Hawaii**. Since 1972, the MEDEX Group has assisted developing countries to improve the management of their health services. Activities focus on strengthening management systems at the operations level where PHC services are delivered, and providing management training for operations-level health personnel. The nursing course includes programmes in leadership development, nurse educator preparation, training community health workers and health assessment training. The management course covers development of management training materials and curricula, management operations manuals and strengthening supervision.

**More information from:**

The MEDEX Group  
John A. Burns School of Medicine  
University of Hawaii at Manoa  
1833 Kalakaua Avenue 700  
Honolulu, Hawaii 96815-1561, U.S.A.

**TO YOU AND YOURS**

★ **- OUR READERS AND FRIENDS**

WE WISH YOU A TIME OF REJOICING AND HAPPINESS DURING THIS SEASON  
IN WHICH WE CELEBRATE TOGETHER THE COMING OF CHRIST,  
AND FOR THE NEW YEAR, MANY BLESSINGS -  
HOPES FULFILLED, PLANS REALIZED, RECONCILIATION EFFECTED,  
WHOLENESS RESTORED AND PEACE FOUND.

The commissioners and staff of the Christian Medical Commission.

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## CMC NEWS

**Dr. Ruth Harnar** came to the CMC 2 years ago bringing with her many years of experience. Her commitment to community-based nursing and health care have proven to be an invaluable contribution to the work of the CMC.

During her time with us, in addition to touring CMC-related coordinating agencies in several countries, where she was able to encourage development of community-based health projects, nursing schools and the healing mission of the Church, an honorary degree of Doctor of Divinity was conferred upon Ruth in May 1985 from the Christian Theological Seminary in Indianapolis, Indiana, USA.

"I most appreciate the unequalled opportunities I have experienced to widen my own horizons and capabilities," she says. "These have included getting to know more about nursing and community health in many countries, but even more important, experiencing the many challenges facing churches and ecumenical movements around the world. I hope I can make a continuing contribution as an individual in the future."

Although you may not always find her at the following address, Ruth would be happy to receive mail in care of:

**Mr. Robert Harnar**  
P.O. Box 675 / Cedar Crest  
New Mexico 87008 / USA

**Ms. Sanda Freeman** adds her experience as writer and editor to the Christian Medical Commission as from 1 October. She is our new Editorial Assistant of **CONTACT**, replacing Ann Dozier, who has joined her husband in settling into their new home.

Before coming to Switzerland, Ms. Freeman taught English to foreign businessmen in southern California, where she also pursued nutrition studies and began editing and contributing articles to health-related magazines. She writes occasionally for the monthly magazine **UN SPECIAL**, where she created a vocabulary-game column, "Flexibles", currently in its 4th year. Most recently, she has been free-lancing with the Red Cross League and the World Health Organization.

As CMC welcomes Sanda, we say many thanks to Ann Dozier for her dedicated and talented service.

**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 26,000.

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 bi-monthly bulletin of the Christian Medical Commission of the World Council of Churches.

Editor: Eric Ram (Director). Editorial Assistant: Sanda Freeman. Editorial Committee: Eric Ram, Reginald Amonoo-Lartson, Ruth Harnar, David Hilton, Sanda Freeman, Jeanne Nemeč. The rest of the CMC staff also participate actively in choosing topics and the development of materials. Mailing List: Fernande Chandrasekharan. Printer: Imprimerie Arduino. Correspondence: CMC/WCC, PO Box 66, CH-1211 Geneva 20, Switzerland.

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