African Regional Conference on the Churches' Role in Health and Wholeness. Gaborone, Botswana, 15-19 October 1979, 1-12. 46f. (CMC/79/12).

Introduction

CMC Study/Enquiry Programme

From CMC's inception in 1968, a search for the "connections between health, being human, the community and the kingdom of God" were part of its appointed task. In April 1977, the goal of "action/reflection studies on the Christian understanding of health and healing,… predominantly oriented to perspectives emerging from local communities in various parts of the world," was again emphasized by the full Commission, meeting in England, and specific strategies for carrying out this mandate were provided. The Commission asked that the Study/Enquiry take a multidisciplinary approach (i.e., enlist the contribution of various disciplines, WCC departments, and focus on the many components of health and wholeness); that it promote reflection on health and healing; gather perceptions from local communities on health and wholeness; and promote information sharing between caring communities.

In the first stage of implementing these strategies, CMC began gathering information by writing to a wide range of individuals and organizations, some of whom were already known and others having been suggested by members and friends of CMC. Initially, the greatest response came from Africa, with information on traditional medicine and healing. This geographical imbalance was later partially reduced, although many countries are still very little explored as far as the Study is concerned. Other issues which emerged as focal points in this initial information-gathering phase were the Healing Community and Human Values in Bioethical Issues.

Information was received from African correspondents on such subjects as herbal medicine, the important role of the congregation in healing, traditional medicine and the practices of traditional healers in caring for the mentally ill. In addition, responses yielded interesting insights on attitudes in traditional African society towards the aged and handicapped people. Considering that traditional medicine still represents the only form of health care available in many parts of the world, these responses led CMC to hope that more could be learned about how traditional and Western medicine could be *integrated*, in spite of the cultural taboos and some Christian teaching against a number of indigenous healing practices which were also mentioned in some responses. The responses, in fact, indicated that new medical and theological attitudes may be forming about the possibility of such integration and that, by sharing information between persons directly involved in the confrontation between the two forms of healing – medical personnel, local church leaders and missionaries – the CMC Study/Enquiry could promote helpful clarification and understanding.

The next step in pursuing the Study/Enquiry was to share information, put people in touch with one another, exchange reference material, draw attention to innovative projects and thought-provoking studies. As this phase progressed, and information gath|ering continued, it became clear that the three subject areas of Traditional Medicine and Healing, the Healing Community, and Human Values in Bioethical Issues,

are all closely interrelated. Parallels between interests and concerns in developing and industrialized societies were also identified, e.g., the need for, and applicability of, primary health care in both kinds of society.
By the time the newly-mandated Study/Enquiry was one year old, another common denominator had emerged, i.e., the concept of "*wholeness*". There seemed to be a growing realization, in many diverse groups and areas, that to experience healing is to know wholeness, and an increasing identification of one with the other. Wholeness was brought into a wide variety of situations and contexts and assigned a variety of meanings. Some of these were:

- wholeness in a theological context ("I am come that they might have life, and have it abundantly" [John 10:10].)
- wholeness as exemplified in an approach to healing (i.e., one which looks at the sick person as a physical/psychological/spiritual whole, that is able to recognize wholeness in the elderly, the physically handicapped, as well as to recognize handicaps of mind and spirit in those who have no apparent physical handicap. This concept of wholeness comes naturally to African traditional medicine. In a society where harmony with one another and with nature is considered essential to good health, traditional healers naturally treat people as whole persons).
- wholeness in a social context (e.g., where the necessity of attacking the fragmentation of society and the many components – social, economic, political and cultural – of injustice is integrated into development policies and programmes, based on people's participation and responsibility).

Regional Meetings

A further step in the exchange of information with the "resource network" being built up was the circulation of a description of the Study/Enquiry to date and, in the Caribbean and Central America, of a questionnaire on the meaning of health and wholeness. Then, in March 1979, the two initial phases of the Study culminated in the holding of two regional meetings – one in Trinidad for the Caribbean and the other in Honduras for Central America.
The objective of holding regional meetings was to test out the level of interest at "grassroots" regional level; to bring people of varying backgrounds but with common purpose out of their isolation – often total – and enable them to share information and experiences, engage in mutual reflection, identify their Christian role in contributing to health and wholeness of their communities, and to be stimulated and encouraged to continue both their reflection and their work. |
Participants in the meetings were selected from the study network of resource people, based on what had been learned of their interests, disciplines, programmes and commitment to a Christian responsibility for health and wholeness. The participant groups at both meetings were remarkable. This was due not only to the broad spectrum of interests and disciplines represented, but also to the fact that, in many cases, people with similar concerns, working in the same region, had no previous knowledge of each other's work, let alone existence. The bringing together of such a mix of people constituted a unique event in both regions and generated an atmosphere of wonderment, joy and excitement at both meetings.
The style of the meetings contributed to prolonging this mood, since it encouraged people to participate fully and contribute to the proceedings from their own experience.

The agendas of both meetings had focal points but were not prestructured. The participants themselves spontaneously identified the issues they wished to talk about. Fears, that the meetings would be arenas for sterile colloquy dissipated when people met with others of like concerns and recognized the mutuality of their interests and needs. At a certain point in both meetings, participants split into broad interest groups to focus on selected issues. There was no attempt to formulate “final” conclusions, but both meetings arrived at a broad consensus of opinion.
The topics identified for discussion reflected the economic and political conditions in which the participants lived and the traditions out of which they grew. This allowed a unique regional flavour to emerge in each meeting. Areas covered included the search for definitions, such as the meaning of “wholeness” and its relation to social justice, or the contribution of people with disabilities to the wider community of those with no obvious handicaps; practical dilemmas, such as the difficulties and possibilities for exercising a healing ministry; and needs: to more closely observe and appreciate traditional healing and folk beliefs and to promote dialogue between medicine and theology.

Background to African Regional meeting

African “resource network”

Some of the responses obtained in the initial information-gathering phase of the Study from resource people in Africa have been mentioned above. Who were the individuals and groups contacted who provided this input? They included representatives of:

- Health, Education and Development Ministries
- Traditional Healers' Associations
- Protestant, Roman Catholic and indigenous African churches and church-related health services
- University medical schools, training institutes and seminaries |
- Hospitals, clinics, health care programmes, both church- and non-church-related
- Christian Councils, both national and regional
- Credit unions

National coordinating agencies for church-related health services.
The selection of people from among this resource network to be invited to the African regional meeting was made with the aim of obtaining as wide and representative a participant group as possible in terms of disciplines, affiliation, geographical location and particular areas of interest.

Questionnaire on Health, healing and Wholeness

In preparation for the meeting, a questionnaire was circulated to the prospective participants. The questions sought to elicit views on the Christian meaning of health and the healing ministry; on how, in what areas and to what extent individual Christians, churches and congregations are responsible, and can become involved in, health work and in promoting wholeness among congregation members and the community at large; and on traditional medicine and traditional healers.
It was hoped that the questionnaire would serve to identify, clarify and crystallize the issues to be studied and would thus heighten the quality of work at the meeting.

Responses to the questionnaire were summarized and included in the background documentation provided to the participants at the meeting.

African Coordinators' Meeting

While the objectives of holding an African regional meeting were identical to those identified for the two prior regional meetings (see under B, pp. 2f.), an additional aim was to bring together the national coordinators of church-related health services in the region. Three coordinators' conferences had been held in the past under CMC auspices: in Limuru, Kenya, in 1970; in Blantyre, Malawi, in 1972; and in Mombasa, Kenya, in 1975.

The objective of these meetings had been to provide the coordinators with an opportunity to discuss coordination of church-related medical work between churches and with national governments. At each of the meetings, reports on the progress of coordination were followed by discussion on topics relevant to the work of these agencies, e.g., communications, innovative experiences in health care, the role of health programmes in general national development, indigenization of personnel, conditions of government grants, the fate of existing church hospitals, the development of primary health care as a top priority and planning for primary health care.

When it was decided to conduct an African regional meeting within the framework of the CMC Study/Enquiry, it was felt that this could also be the opportunity for another such meeting of | coordinators. Their reports were, therefore, a part of the regional meeting agenda and are summarized in this report.

Choosing the Site

Given the physical and political obstacles to travel within Africa, the choice of a site to which most African participants would be able and willing to come was of the utmost importance. Two previous coordinators' meetings having been held in Kenya, Gaborone, Botswana was chosen for its political and geographical accessibility. (The fact that the capacity of one of the two existing air routes to Botswana was almost cut off during the period of the meeting was symptomatic of the difficulties of bringing people from allover Africa together in one place.)

The national coordinating agency for church-related health services in Botswana – the Association of Medical Missions for Botswana (AMMB) – was CMC's ecumenical co-partner in the region and took responsibility for all the local arrangements, including choice of venue, accommodation, transport, technical equipment, liaison with government and the Ministry of Health in particular. Cooperation from staff of the agency (and of a special consultant who contributed her services) was maximal and guaranteed the smooth running of the meeting.

Proceedings

The Participants

Fifty-eight participants from 20 anglo- and francophone African nations, five members of the CMC Executive Committee from Africa and other continents, CMC staff members and a number of observers and visitors gathered in Gaborone from 15-19 October 1979 to share with one another their experiences in ministering to the physical, mental and

spiritual well-being of their communities and to seek together ways in which they could better fulfill this role. The meeting was chaired by CMC Moderator Sylvia Talbot. Director Nita Barrow, Associate Director Eric Ram, Secretaries Miriam Reidy and Trudy Schaefer, as well as Elizabeth Wood, special consultant for the meeting, also attended. The CMC commissioners from other continents hoped to be the vehicle for cross-fertilization of ideas to and from their regions.

The participants, drawn from the African “resource network” referred to earlier, included pastors, theologians, health educators, university professors, government officials, traditional healers, doctors, pharmacists, nurses, administrators, social workers, community health workers, credit union officials and representatives of national coordinating agencies for church-related health services.

To briefly identify just a few of the very diverse areas of activity of the participants will convey better than titles or functional labels can the myriad facets of the healing ministry and Christian witness exercised by the members of this group. |

Some of these included:

- a husband and wife team who, after 25 years of medical practice, now work in a purely pastoral capacity in a rural area;
- a young public health worker who is responsible for the health component of a rural development scheme. Among other activities, the health project recruits personnel to supervise village health workers, carries out vaccination campaigns and equips village clinics;
- a theologian who has designed seminary theological courses which include training in mental health and pastoral counseling, and who is currently proposing health education courses for pastors and their wives with the aim of preparing churches to assume responsibility for primary health care;
- a Roman Catholic priest who represents the credit union and cooperative movement in Africa;
- a medical supervisor of a church hospital in an urban slum area who belongs to a large African indigenous church, is a member of its youth movement and is active in sanitation and nutrition education in the church's mothers' movement;
- a social worker in charge of a church boys' home who is also the regional consultant for women's work in her synod;
- a theologian who is the national communications officer of his church;
- a former missionary doctor, now Minister of Health of his country;
- the director of a church centre which cares for young refugees from southern Africa, providing them with food, housing, education and employment possibilities; and
- a traditional healer who is a committed Christian and president of a national association of traditional healers.

For most of the participants of this meeting, it was the first time they had come into contact, in their own region, with others from such a variety of backgrounds to reflect on health, healing and wholeness. The opportunity thus provided to share and the sense of common purpose was felt by all as a source of excitement, encouragement and joy.

The opening devotions were led by Bishop Walter Makhulu, formerly Africa Secretary of the Commission on Inter-Church Aid, Refugee and World Service (CICARWS) of the World Council of Churches, who had recently returned to his homeland to become the present Anglican Bishop of Botswana. Taking his cue from the theme of the meeting, Bishop Makhulu cautioned the participants against | “putting a straightjacket” on health

and healing, i.e., seeing it only in the context of hospitals, clinics and medical care. He expressed the conviction that health has to do with realizing one's fullest potential, with growing and becoming whole. While suffering is a part of life, it can also be healed, and the healing ministry involves the desire to ensure that people can experience wholeness.
Dr Ian Kennedy, chairman of the AMMB, welcomed the participants on behalf of his agency. The Rev. Albert Lock, speaker in Parliament and government minister, passed a vote of thanks, on behalf of both the church and government in Botswana, to CMC for its contribution to health care in Botswana.

Presentations

Three keynote presentations set the stage for the week's discussions and deliberations: In his opening address on the Christian Concept of Healing, Dr J.A. Stromberg of the Strengthening of Health Services Division of the World Health Organization (WHO), spoke about the importance of *people* (as opposed to programmes, technology, planning, policy or political will) in bringing meaningful health care to the majority of the world's people by the year 2000 – WHO's target year. The necessity of enlisting the totality of available resources in the Primary Health Care effort was another of WHO's cardinal principles and, as Dr Stromberg pointed out, was the principal motive of its interest in traditional medicine, which it now recognizes as a major resource and ally in the struggle for health.
On the one hand, WHO is currently promoting research into the properties and mechanisms of traditional medicine in an attempt to determine its effectiveness and, on the other, is encouraging the integration of traditional practitioners and traditional birth attendants into PHC systems. Dr Stromberg emphasized that these policies are vital since “the resource argument alone is not only insufficient, but immoral. If we cannot prove that there is something inherently effective and valuable in traditional medicine, then we should not endorse or encourage it.” He further stated that, if the approach to traditional medicine is *limited* to an attempt to determine its physical and mechanical properties, although research will yield evidence of effectiveness, only the tip of the iceberg of the healing processes involved will emerge. Dr Stromberg stressed the view that healing involves a great deal more than treatment of physical symptoms and that health itself is a highly complex quality. He used several examples to illustrate the point that health involves the mental, spiritual and physical facets of man in his environment, and that healing, therefore, must address itself to all of these facets and look at the patient as a whole person. In many cases when healing has taken place, the healer will have been concerned with the underlying causes of ill health, in a way only someone with an intimate knowledge of the particular human, social, economic, cultural, political, etc., context obtaining in the case could begin to understand. The healing process may not, therefore, be amenable to any kind | of physical (or other) analysis or research. In deploring the fragmented approach to health care in many societies, Dr Stromberg concluded his address by calling on the participants to face the challenge of thinking about health and healing in a wholistic manner.
In his address on the theme of Traditional Healing and the Church in Africa, Rev. Nyansako-ni-Nku, communications officer of the Presbyterian Church in Cameroon, situated the traditional healer within the fabric of traditional African society which was always a theocratic one, long before the advent of Christianity and still is today, after

400 years of Western cultural invasion. In the African metaphysical world view, every event has a mystical cause. In this setting, the medicine man continues to occupy a central position. While acknowledging the failures of some traditional healers in the fields of chemistry and anatomy, and the existence of some practices of questionable value, Rev. Nku stressed that the genuine African medicine man “symbolizes the hope of society”. The duty of the medicine man is to cure disease, heal, attend to the hidden mystical causes of “ill-luck” and provide protection against evil. Knowing his patients very well, the medicine man sees their lives as a whole. Most frequently, his object is to reestablish harmony in the lives of his patients.

Rev. Nku traced the history of the impact of Christianity in Africa: the impact of the distinction between the sacred and the secular on the African's thought patterns; of the missionaries' insistence that everything African was heathen on African culture and self-esteem. He explained that taking away the traditional objects of African worship – the local deities and the ancestors – had created a vacuum that an abstract, transcendent deity could not fill.

Rev. Nku expressed the hope that the church would recognize the importance of traditional healers in African society and asked the participants to help in promoting meaningful dialogue between the church and traditional healers, in giving the healers a sense that their healing abilities are a gift from God, and in bringing the churches to regard the traditional healers as collaborators in the common effort for health. If we believe in the historical revelation of God to his people, Rev. Nku reflected, then genuine traditional healing practice can be just as much a divine instrument to liberate God's children from the oppression of disease as is modern medical practice.

A similar point about the African global view of life was presented in greater detail by Prof. Natalis Bele-Binda, professor of anaesthesiology at the National University of Zaire, in his paper on African Traditional Practitioners and Traditional Medicine. On the theme of the African concept of health and wholeness, Prof. Bele-Binda affirmed that, for the African, disease and infirmity cannot be divorced from a global vision of the world and of life. Life is seen as a continuous cycle in which death to the world of the living is rebirth into the world of the dead (the ancestors), and vice-|versa. In the African world view, God intends each living being to complete these cycles without interruption. Any interruption, such as illness, infirmity or premature death, is not caused by God, but by man or the spirits of the ancestors, through evil spells or as a result of the evil done to others which is revisited on the evil-doer and his descendants. Because of this global view of life and health, African traditional medicine addresses itself not only to the body, but also to the spirit, the social context, etc. The traditional healer (who is quite distinct from the sorcerer or fetishist) sees his patient as a whole person, an entity with physical, psychological, social, cultural and metaphysical dimensions, and does not reduce him to a single one of these dimensions.

Another participant, Dr J.A. Nartey, himself a traditional healer and the president of the Healers' Association of Ghana, also spoke on the topic of African traditional medicine and traditional healers. Dr Nartey expressed the view that indigenous traditional medicine is an ideal, God-given medicine for Africa and presented many convincing arguments in support of this claim. He also differentiated clearly between the genuine traditional healer and the sorcerer (witch doctor) or fetishist, and outlined the standards set and maintained within his Association for the practice of traditional medicine.

On a different topic – that of Primary Health Care – Dr Colin Forbes, CMC commissioner, paediatrician and former lecturer at the University of Nairobi, used vivid

imagery to bring this subject, about which so much has been said and written, back to human, intelligible terms. Focusing on the African rural child, Dr Forbes identified his most basic need as being the need for love. Love means providing that child with all his basic needs, such as good food, clean water, adequate shelter, education, health care, etc. – a list only too familiar, Dr Forbes pointed out, to all those involved in providing health care in rural areas of developing countries. The list of the conditions which are likely to kill that child before his 5th birthday was, Dr Forbes made clear, just as depressingly familiar to those concerned with, and responsible for, people's health. As he expressed it, the practice of PHC being the sole means for bringing health care to the majority of the world's populations in the foreseeable future – and, therefore, to that same child – it was essential that continued support be given to the principle and practice of PHC.

Two other participants, Fr Emmanuel Kibirige and Mr J.L. Anang, gave short descriptions of their work: the former of the goals and activities of the Ecumenical Working Group for Human Development in Nairobi of which he is African coordinator and which belongs to the World Credit Union Movement, and the latter on the courses and extramural activities of the Good News Training Institute in Accra which was formed to serve the churches in Ghana, and whose main objective is conscientization of people on the burning issues of Christianity. |

Coordinating Agency Reports

Representatives of 16 national coordinating agencies for church-related health work in 12 African countries[1] attended the regional meeting in Botswana and presented brief reports on the progress of coordination between churches and with government in their countries. Each coordinator, using an information form, based his/her report on the following parameters: aims and objectives of the agency; number of hospitals, health centres and dispensaries and staff; percentage of church-organized medical services in the country; government involvement in these in terms of funds, staff, formulation of policy; church involvement in PHC; relations with traditional and faith healers; and training programmes. Some of this data was combined into table form and was later used by one of the meeting work groups in their discussion on Financing of Health Care and Training (see p. 42).

The coordinators provided useful input for the general discussions in the form of a broad overview of the degree of church involvement in health services in Africa, on both national and regional levels. They, in turn, benefited greatly from the sharing with others involved in different dimensions of health and healing, with new perspectives to offer: different insights and perceptions on health, healing and wholeness.

Group Discussions

The participants in this meeting themselves identified the subject areas for discussion and joined the discussion groups of their choice. The topics identified were similar to those examined in the earlier meetings and are all central themes of the CMC Study/Enquiry, e.g., Wholeness, the Congregation's Role in Healing, Primary Health Care, Government/Church Relationships, Financing of Health Care. The participants'

[1] Botswana, Cameroon, Ghana, Kenya, Lesotho, Liberia, Malawi, Sierra Leone, Tanzania, Zaire, Zambia and Zimbabwe/Rhodesia.

approach to these themes was, however, conditioned by the African social, cultural and economic contexts from which they came. Two additional topics – Traditional Healing and the Christian Concept of Healing in an African Setting – were particularly relevant to, and for, the region.

The group discussing Traditional Healing reflected on the complementary nature of traditional and modern medicine and on traditional practices as products of their socio-cultural environment. Re-evaluation of traditional medicine by scientific methods and pharmacological analysis, standardization of dos-age, and training, education and integration of traditional practitioners into health services were recommended by this group. The need for collaboration and mutual openness between the church and traditional healers was stressed.

Health and health care were defined in terms of a “wellness-illness” continuum, and also of adaptation to environmental | challenges by the group studying Primary Health Care (PHC). Attention focused on the means for implementing PHC, the function of the village health committee and village health post, and on the expanded role of nurses in rural PHC clinic situations.

On the topic of Wholeness, this group agreed to disagree on whether to emphasize the “perfection” vs. the “harmony” aspects of the state of wholeness. Faith – of the healer, the patient and the community – was seen as a vital element in the ministry of healing, and it was felt that greater efforts were required to reach those who do not ask for help. The special role of the Christian community in healing is to add a spiritual dimension to health care to help people become whole.

The injustices in health delivery systems; church efforts to correct them and barriers against such efforts; and possible future directions for church health services were subjects covered in the discussion on government/church relationships. A number of recommendations concerning increased integration with government programmes, the formation of coordinating bodies of church-related health services and the means for continued Christian witness where integration with government services has taken place were made by this group.

The discussion on the Christian Concept of Healing in an African Setting drew on Biblical references to the nature of Christ's ministry before attempting to define the Christian concept of healing, which was related to concepts of harmony and peace (“shalom”). The African traditional concept of healing was seen as involving the restoration of harmony in the many elements and dimensions of a person's life, including local deities and the spirits of his ancestors. Recognizing the fault on both sides for the lack of understanding between the church and traditional healers in Africa, the members of this discussion group called upon the church to actively seek understanding, to embrace what is good and wholesome in African traditional medicine, and to emphasize its teaching ministry in order to bring its members to spiritual maturity.

The local specificity of health care needs in rural areas and the importance of teaching improved farming methods and environmental sanitation in these areas were topics which received particular attention from the group discussing Health Care in Rural Services. That the household is the basic unit for development and self-reliance was the main point coming out of this discussion, and the responsibilities of various members of the households were enumerated.

The group discussion on Financing Health Care and Personnel produced a number of recommendations highlighting PHC, rural-area needs and the training of auxiliary personnel, particularly in a wholistic approach to health.

The Congregation's Role in Healing was seen to be in areas such as taking special caring responsibility for the sick, the handicapped, alcoholics and drug addicts ("to go where others will not go"); recognizing the healing gifts of congregation mem|bers; showing the example of a healthful life style; sharing health knowledge; becoming involved in work in health institutions and ministering to health personnel; and working towards the healing of divisions within the wider African "congregation".
The fruits of the individual group discussions were borne back to the plenary meeting in summarized form by individual group rapporteurs, and participants were able to share some of the thoughts of other groups and to engage in some further discussion on points of particular interest. The individual group reports are to be found in Section IV of this report.

Resolution

Another outcome of the week's sharing and study was the passing of a resolution concerning the formation of an "*African Christian Health Commission*". The aim of creating such a body was to allow the initiation and maintenance of regular contacts between Christian bodies in Africa concerned with, and responsible for, health and healing. The resolution clearly reflected the participants' desire to continue the type of exchange which had taken place at the meeting and to open up new avenues for such exchange.
Coming at the close of the meeting, this proposal was subjected to vigorous debate on the pros and cons, the means, purposes and structure of such a body. Relationships of the proposed committee to bodies such as the CMC in Geneva and the All Africa Conference of Churches were discussed at some length before it was voted to accept in principle the formation of a committee and to give the three Africa-based CMC commissioners (two of whom attended this meeting) the mandate to further explore the possibilities for creating such a body. Subsequent to this meeting, the formal resolution was sent to CMC with a view to open a debate on the ramifications of the proposal.
The text of the resolution is as follows:

> "This regional consultative meeting recommends that there be a permanent committee for Africa, composed of representatives from national coordinating agencies and interested and dedicated Christian health workers. This committee shall be responsible for continued promotion of the interests of church health activities in Africa in close cooperation with the Christian Medical Commission and other interested bodies. The name of the committee shall be African Christian Health Commission – ACHC." |

Conclusions

The diversity of the participant group at this meeting has been mentioned in an earlier section of this report (see pp. 5-7). People came, not only from many different countries of Africa, from diverse cultural, linguistic, ethnic and professional groupings, but also with diverging ideological convictions. To the extent that all came wishing to reflect on, and exchange thoughts on, health, healing and wholeness from the Christian perspective, they also had much in common.
But many different approaches to this subject were evidenced. Some participants saw health care and medicine as a biologically-based science, to be practiced with the Christian motive of service; for others, health care and the healing ministry is closely allied to the notion of wholeness; others were struggling to relate medical and theological concepts learned from other cultures to attitudes and practices native to their own cultures and to establish where they themselves stood in relation to both; others

again found no conflict between the principles and practice of traditional methods of medicine in their own cultures and their Christian convictions and were successfully and responsibly practicing traditional forms of health care.
Two factors were equally responsible for fomenting a process of exchange, confrontation and the emergence of a feeling of “unity in diversity” at this meeting. Both the diversity of the group and its common interest in, and desire to explore, the theme of *the* Christian understanding of health, healing and wholeness were the catalysts which activated an exciting meeting “chemistry”.
In the exchanges between people with differing views, many pet theories and cherished beliefs were challenged. But such confrontations took place in an atmosphere of trust and openness in which defensiveness was felt to be unnecessary and discussions could be carried through until all participants felt they had learned something important from the exchanges. Many people of differing views began to listen to each other in a positive way. An example were the exchanges between the Western-trained medical personnel and the traditional medical practitioners, in which the place in health and healing of faith, on the one hand, and of scientific fact, on the other, were mutually explored.
The therapeutic effects of such sharing, mutual reflection and confrontation were felt by many of the participants, particularly those who work in often total isolation from others with like concerns and goals. The possibility of discussing areas of deep common interest was a source of great refreshment to those to whom such opportunities come rarely. Furthermore, for many participants working in different regions and aspects of the healing ministry, this was a first opportunity of learning of other attitudes, approaches and programmes in this area of which they were unaware. |
It was with a feeling of unity in diversity, through their Christian belief and its relationship to health and healing, that the group expressed their appreciation for the opportunity, provided by the Botswana regional meeting, to meet for mutual reflection and sharing. Their desire to continue such exchanges was clearly expressed also in the final resolution concerning the formation of an African Christian Health Commission (see p. 12).