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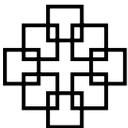
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Witnessing to Christ today

Promoting health and wholeness for all

A contribution towards the Christian healing ministry compiled by a study group on mission and healing from the World Council of Churches (WCC), Geneva, Switzerland, and the German Institute for Medical Mission (DIFAEM), Tübingen, Germany.



**World Council
of Churches**



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Foreword

Today, Christian churches play an important role in the field of health and healing through their provision of conventional health care, as well as a wide range of spiritual approaches to healing.

The global health situation at the beginning of the third millennium is alarming. While countries in the global North spend huge amounts of money providing high-tech medicine for their citizens, many people in resource-limited settings still do not have access to basic health care. These people also bear an unjust burden of disease, and tens of thousands die every day of diseases that can be treated and often cured. In this regard, the contribution of Christian churches to health care is sorely needed. Already, churches and faith-based organizations are important health providers in many countries. This is especially the case with regard to people in remote areas and in resource-limited settings, and with marginalized groups in these and other places.

In addition to these examples of the engagement by Christian bodies in health care, in many churches, especially the fast-growing churches of the global South, spiritual healing is becoming increasingly important. These churches seek to provide healing through prayer, blessing, the laying on of hands, and anointing with oil.

However, many inside and outside the churches are not so confident that the churches' engagement in the field of health and healing is essential to their mission. Some argue that the churches should only be involved in health care provision if there are no secular health providers available. Also, whilst others insist exclusively on the use of 'spiritual' means to overcome illness, many question whether Christians today should still seek to overcome illness through this approach.

Against this background, the World Council of Churches (WCC) and the German Institute for Medical Mission (DIFAEM) wish to contribute to an understanding of the healing mission of the church today.

Both organizations are engaged in the field of mission and healing, and have a long history in dealing with questions about the Christian healing ministry.

Since its inception, the WCC has regarded issues related to health as part of its core work. Health care and theological questions on health and healing have been on the agenda of WCC programmes on mission, as well as those dealing with justice and diakonia. For many years, the WCC's Christian Medical Commission guided the organization's work on health and healing. In 2005, the world mission conference in Athens, Greece, considered the theme, "Come Holy Spirit, Heal and Reconcile: Called in Christ to be Reconciling and Healing Communities," and strongly reaffirmed the healing mission of the church.

DIFAEM has over 100 years' expertise in promoting Christian health care in resource-limited settings, and today provides health-related consultancy services to faith-based partners engaged in public health issues. DIFAEM has been a partner with the WCC in worldwide discussions on the healing mission of the churches since the mid-1960s, and a leader in the promotion and implementation of the concept of primary health care.

In 2007, the WCC and DIFAEM jointly called for a "study group on mission and healing" to follow up the Athens mission conference. This study group was subsequently mandated to work on the Christian understanding of the healing mission of the church, and to promote Christian engagement in the field of health. The members of the group are theologians and medical professionals from four continents and various denominations.

The objectives of the group include:

- to clarify the holistic and integrated nature of Christian mission and healing, based on biblical theology;
- to demonstrate ways in which Christian communities can contribute towards health and healing in contemporary contexts.

The study group on mission and healing has compiled this publication, which offers a section on the theology of health, healing and wholeness (Part I), and case studies on health and healing (Part II).

It is our wish to reaffirm the healing mission of the church, and to encourage churches, plus Christian communities and organizations, to engage in this ministry, and thus take part in God's mission of transforming the world.

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(On behalf of the study group on mission and healing)

Part I:

The foundation: ecumenical insights into health, healing and the nature of the healing community

Why do Christians have a healing ministry? The healing mission of the church

The healing practice of Jesus

What do the healings that Jesus performed, and his command to Christians to heal, mean for today? What is the Christian understanding of health, healing and wholeness? Christians of all denominations ask these questions, and are concerned about the involvement of churches in the provision of health care services, and the relationship between faith and health.

The Christian understanding of health and healing, and the Christian healing ministry is related to our Christian understanding of salvation. Biblically speaking, salvation is related to the realisation of God's kingdom, i.e. the "new creation" that the Hebrew prophets announced and expected as "shalom". Shalom can be described as an ultimate state of reconciled and healed relationships between creation and God, between humanity and God, between humanity and creation, and between humans as individuals and as groups or societies. Every single act of healing is a sign of the realisation of shalom.

The source and subject of healing and reconciliation is the triune God, who is Father, Son and Holy Spirit, and who is present and active in the world. Missiology refers to this as *missio Dei*.¹ Jesus is the core and

¹Missio Dei (mission of God) as a term and concept became increasingly popular in the church from the second half of the 20th century, and is a key concept in missiology. Missio Dei stresses that mission is primarily an activity of God rather than an activity of the church. Mission is a movement from God to the world. It is God who is the subject of mission, and the church takes part in God's mission to the world.

centre of God's mission, and he is the personalisation of God's kingdom. The Son came into the world to offer salvation, and to witness through his life, deeds and words to the ways in which God cares for humanity and creation.

Jesus affirmed that with him the time of salvation had begun. For example, he said, "The time is fulfilled, and the kingdom of God is at hand" (Mark 1:15). Jesus did not only teach the good news but also healed people, and these healings were visible signs that the kingdom of God was "at hand". When Jesus turned to the sick, the poor, the outcast and the marginalized, people saw and experienced the kingdom of God as a present reality.

The incarnation of God in Christ affirms that God's healing power does not save us from this world but is active in the midst of this world with all its pain, brokenness and fragmentation, and that healing encompasses all of human existence.

Healing was not only a central feature of Jesus' ministry but also something in which he wanted his disciples to participate. He asked his followers to continue his work, and endowed them with the authority to do so. The missionary instruction in each of the first three (synoptic) gospels connects the proclamation of the word of God with deeds, and explicitly mentions the healing ministry: For example:

He (Jesus) called to him the twelve disciples and gave them authority over unclean spirits, to cast them out, and to heal every disease and every infirmity ... These twelve Jesus sent out, charging them ... "Preach as you go, saying, 'The kingdom of God is at hand.' Heal the sick, raise the dead, cleanse the lepers, cast out demons." (Matt. 10:1,5,7)

The evolution of the healing practice of the church

Was Jesus' call to be involved in his healing ministry directed exclusively to the apostles and those disciples who were with Jesus, or does it, alongside his command to preach and to teach, apply to the whole church and all Christians?

With God's incarnation in Jesus, the time of salvation in its full sense has irreversibly begun. This is also the time of the beginning of the church, and the time when the Holy Spirit, whom Christians also believe to be active in the world, has equipped the church with charismata of healing as signs and foretastes of the new creation. Therefore, we regard the healing ministry as valid for all times, and we expect healing to take place today.

The early church took Jesus' healing ministry seriously, and Christianity presented itself to the Mediterranean societies of the time as a healing movement; the final chapter of Mark's gospel, which was probably added in the second century AD, reflects this. Many writings of the early church fathers also affirm the centrality of the church as a healing community, and proclaim Christ as the healer of the world.

Over the following centuries, the churches' perception of salvation changed, and this affected their understanding of their healing ministry to the degree that the churches increasingly limited the consequence of salvation to the healing of the soul. Theology addressed a human being mainly as a sinner at risk of losing eternal salvation, for which the remedy was the healing of the soul. Consequently, the churches overemphasised their ministry to preach and to teach, and increasingly interpreted their ministry to heal as a command to care for the sick and needy according to the example of the Good Samaritan in Luke 10, and to do the works of mercy outlined in Matthew 25. As a result, it was through Christian initiatives that many health facilities for the care of the sick and elderly were built.

Alongside these developments within the churches, advances in medicine led to a separation of medicine from religion; this resulted in medicine making a universal claim on health matters. As a consequence, within the churches and with regard to medical science, the churches became increasingly indifferent to the thought that a holistic healing ministry should be an integral part of their being.

In the middle of the 20th century, the member churches of the World Council of Churches (WCC) interpreted their healing ministries in various ways: In the industrialised countries, many churches by then seemed to have handed over their involvement in the field of health and healing to the medical sciences. In the newly independent countries of Africa and Asia, some churches were unsure whether to continue their engagement in the field of health or to leave it to the new governments. However, many churches continued in their healing ministry and even claimed a superiority of healing through prayer over medical approaches.

In this situation, the WCC and the Lutheran World Federation called for a consultation to be held at the German Institute for Medical Mission in Tübingen, in 1964. This event emphasised the healing ministry of the churches, and the need to look at its theological foundations. A further consultation took place in Tübingen in 1967, and in 1968 the WCC established the Christian Medical Commission (CMC), and gave it a mandate to lead an ecumenical discussion on health, healing and wholeness, and to develop an understanding of the Christian healing ministry for the present time.

What now follows is a theological discourse on the healing mission of the church reflecting the ecumenical discussions, which took place all over the world.

Part I of this publication is based on six documents:

- The Healing Church: The Tübingen Consultation 1964, World Council Studies No. 3, WCC, Geneva, 1965.

- “Healing and Sharing Life in Community”, in David Gill, ed, *Gathered for Life. Official Report, VI Assembly WCC, Vancouver, Canada, 24 July-10 August 1983*, Geneva, WCC and Grand Rapids, Eerdmans, 1983, pp. 62-70.
- *Healing and Wholeness: The Churches’ Role in Health: The Report of a Study by the Christian Medical Commission, WCC, Geneva, 1990.*
- *Facing AIDS. The Challenge, the Churches’ Response. A WCC Study Document, World Council of Churches, Geneva, 1997.*
- *A Church of All and for All: An Interim Statement, World Council of Churches Central Committee Document No. PLEN 1.1, WCC, Geneva, 2003.*
- *The Healing Mission of the Church, Preparatory Paper No. 12, World Mission Conference, Athens, WCC, Geneva, 2005².*

²In the interests of readability, direct quotations from these documents in the text are not marked as such.

What is health? What is healing?

“There are insights concerning the nature of health which are available only within the context of the Christian faith ... The church cannot surrender its responsibility in the field of healing to other agencies.” This courageous and, at that time, surprising statement of the 1964 Tübingen consultation was the starting point of worldwide discussions by Christians about the meaning of health, and ways of healing.

In the 1970s and 1980s, from around the globe, ten regional grassroots consultations on “Health, Healing and Wholeness” wove a tapestry depicting their understanding of health. The major thread throughout the fabric was the insight that health is more than physical and/or mental well-being, and that healing is not primarily medical.

A comprehensive understanding of health

The ways in which health and healing are defined, and sickness and illness explained, depend largely on culture and conventions. In ecumenical mission circles, culture is usually understood in a broad sense as something that includes not only literature, music and arts but also values, structures and a society’s worldview, plus ethics and religion.

It is especially when religion, a worldview and values combine that this impacts people’s specific understanding of health and appropriate ways of healing. Since culture varies from continent to continent, and from country to country, or even within countries and groups of people, there is no global common understanding of health and of the main causes of sickness and illness, or how to approach health issues.

In western societies and in western medicine, the predominant notion of health is that it is the absence of physical and/or mental disturbanc-

es. In many other societies, health is determined by the existence of an inner and outer balance (harmony), and disease is considered to be caused by a lack of such a balance. A harmony of mind, soul and body, and of one's relationship with the environment and with other human beings plays an important part in maintaining health. Disturbances to this harmony lead to disease, and the goal of treatment for disease is to restore harmony. In most traditional cultures, healing is part of a socio-religious system in which the power and meaning of life are to be found in the relationship one has with one's own self, with other people, with the physical environment, with the invisible world of spirits, and with God. Treatments, therefore, must deal not only with particular aspects of a sick person's body but also with issues related to God or the spirits, and the social context of a patient's life.

This understanding of health corresponds with an anthropology that is rooted in the biblical-theological tradition of the church, which sees a human being as a multidimensional unity. Body, soul and mind are not separate entities but are interrelated and interdependent. Therefore, health has physical, psychological and spiritual dimensions. The individual is part of a community and society and, therefore, health also has social and political dimensions. Further, because of the interaction between the natural environment (biosphere) and individuals or communities, health has an ecological dimension.

Such a comprehensive understanding of health challenges any understanding of health as something that is simply about having a strong and functional body, and enjoying mental well-being. Rather, it leads us to an understanding that people with chronic physical or mental sickness, and who cope with their ailments and live in harmonious relationships with their fellow human beings and with God, may be healthier than those who are physically and mentally healthy but have little awareness of, for example, the meaning of their lives.

These insights led the CMC to offer in 1989 the following definition of health to the WCC central committee:

Health is a dynamic state of well-being of the individual and society, of physical, mental, spiritual, economic, political, and social well-being – of being in harmony with each other, with the material environment and with God³.

This definition of health is reminiscent of the World Health Organization's (WHO) 1948 definition:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Yet, the CMC definition of health goes beyond the WHO's definition in three aspects:

- The well-being of the individual is seen in direct relation to the way society is constituted; the ecumenical partners made this explicit by specifically addressing different elements (body, mind, spirit, economy, politics, and society).
- The CMC definition assumes that health is not a static concept by which we can distinguish between those who are healthy and those who are not. Rather, every person is constantly moving between various levels of maintaining health and fighting infection and disease; hence the use of the term “dynamic state”. This kind of process-oriented understanding of health is similar to concepts characteristic of more recent debate of and research into the factors that promote health (salutogenesis).
- The CMC definition strongly emphasises that alongside social, medical and economic factors, one's relationship to God is also a vital category. The definition thus accords as much worth to the spiritual factor in the understanding of health as it does to other factors, and addresses the neglect of religious aspects that can exist in certain areas of clinical medicine. In its implications, the CMC definition is also a criticism of certain circles where religious healing is practised as the only way to health, and the medical, scientific or social factors needed for recovery are disregarded.

³The WCC approved this definition and published it in, *Healing and Wholeness*, 1990.

The CMC definition of health is to be understood as providing a concept of wholeness that reflects the biblical vision of shalom, which characterises the kingdom of God. Therefore, we understand wholeness not as a static balance of harmony but as a living-in-community with God, people, and creation. Individualism and injustice are frequent barriers to community building, and therefore to health. In this understanding of wholeness, all dimensions of life are included.

Of course, nobody anywhere on earth will at any time be healthy/whole in all of these aspects of health. Health, in the sense of wholeness, is a condition related to God's promise for the end of time. However, as Christians, we believe that with the coming of Christ God's Kingdom on earth has begun, and is visible now. Whenever and wherever dimensions of good health become a reality, we may discern signs of God's kingdom on earth.

Such a comprehensive understanding of health has consequences for an understanding of the church's healing ministry. Alongside the practice of medicine, practical caring, psychotherapy and counselling, the Christian duty to the sick also includes the addressing of explicitly spiritual needs, as well as working for justice and peace. Such diverse activities are all part of God's work in creation, and God's presence in the church.

However, there have been the following criticisms of the WCC's broadening of the WHO's definition of health:

- It runs the risk of weakening the central principle of an individual's human right to health⁴, as laid down in the preamble to the WHO constitution. Societies could abuse the WCC's concept in order to

⁴There is a human right to health that the United Nations (U.N.) defined as the "right of everyone to the enjoyment of the highest attainable standard of health" (International Covenant on Economic, Social and Cultural Rights, 1966, Article 12). In 2000, the U.N. affirmed the human right to health, and called upon governments to implement it by providing adequate health care systems. However, it is important to note that the right to health, in the sense of a right to access adequate health care, does not imply the right of human beings to be healthy.

give more weight to the health of the nation than to the health of their actual citizens.

- There is a problem regarding the clarity of the WCC's definition, and the demarcation of its limits. It is correct to describe the practice of economics and politics as significant factors for health but to take the next step and talk of economic, political and social well-being, and to call that health, is questionable. This is so, firstly, because it is hard to say what economic well-being entails. Secondly, economic co-existence is not normally considered a subset of health.

Nevertheless, the WCC's definition of health remains helpful insofar as it understands the theological concepts of health and healing in light of the overarching themes of shalom and the kingdom of God. Therefore, if Christianity is to have a meaningful and fruitful conversation about health, it must be able to talk about the often-neglected subject of health in a way that reveals the interrelationship between health and other parts of life that have emerged in the WCC's discussions, and elsewhere. As part of this, the WCC believes that the churches must oppose the isolated focus on individual health and health care, and make it clear that major advances in health can only be achieved through the cooperation with one another of the social, economic and political spheres.

Healing and salvation enriched by insights from persons with disabilities

In recent ecumenical discussions, people with disabilities have contributed valuable insights into the nature of healing according to the Bible, and into ways of understanding healing in our times. The understanding of healing by people with disabilities has enhanced our understanding of the healing mission and practice of the church today.

A reference to an understanding of the history of salvation will enrich a theological statement on healing with respect to disability. Salvation

history is here defined as the self-revelation of God in the past and present through events and actions. From such a perspective, God is understood as one who transforms, empowers, renews, reconciles and liberates creation and everything therein by the presence of Christ and the work of the Holy Spirit. It is against the background of salvation history that an understanding of healing is now attempted.

In Genesis 1:25b, God pronounced all creation as good. In Christian theology, reality, whether it be material or non-material, human or non-human, is to be affirmed as created by God, and celebrated as a gift.

However, Christian theology also knows of the reality of the negation of God's good creation. Sin and evil lead to much suffering, despair and destruction. All negative attitudes, systems and structures that exclude and prevent or contribute in any way to the exclusion of people, in particular those living with disability, mar God's good creation.

There is no final answer as to what might be a theological interpretation of disability within such an understanding of creation and the history of salvation; discernment will vary from person to person depending on family histories and socio-cultural contexts. Theology will continue to struggle with the mystery of suffering until the end of time. In doing so, it must take certain elements into account.

The biblical creation stories affirm that humanity is made in the image of God. This means that each of us is made in the image of God, and all deserve to be equally respected. Such theology has led Christians to advocate for the respect of minorities, and to challenge the wrong images of minorities that society sometimes portrays and publicises. However, the concept of people having been made in the image of God has also led to the assumption that the ideal human being is perfect, and so excludes people living with disability from such an ideal.

Christian theology affirms that the crucified and suffering Christ is the true image of God. This raises radical questions as to what understand-

ing of the nature of God and of human beings we can draw from the creation stories. As the WCC central committee document, *A Church of All and for All: An Interim Statement*, which the Ecumenical Disability Advocates' Network (EDAN, a programme of the WCC) produced, affirms, "At the heart of Christian theology is a critique of success, power and perfection, and an honouring of weakness, brokenness and vulnerability" (§28).

Theology may thus not be able to produce a universally valid definition of disability within the history of salvation, though some consequences can be drawn from the above-mentioned reflections.

Healing refers to actions, attitudes, words, processes, etc., which reflect something of God's empowering, renewing, reconciling and liberating power that is working to reverse the negation of God's good creation. Through the Holy Spirit, this healing power of God transcends all the limits of time and space, and is at work inside as well as outside the Christian church for individuals, as well as families and human societies. The healing power of God is not at the disposal of, or dependant on human agency. We can only discern signs of God's healing, and do so in order also to discern in which direction they point. Healing refers to the original intention of God for creation, to the gift of abundant life in Jesus Christ, and to the perspective of a new earth and a new heaven as promised for the end of time.

The theological contribution of the New Testament healing narratives is to demonstrate or serve as signs of God's salvation history. God wills the acceptance and inclusion of each individual in a community of interdependence, where each supports and builds up the other, and each lives a life to the full and to the glory of God according to his or her circumstances.

According to such a comprehensive understanding of healing, the Christian ministry of healing comprises various and very different responses to health issues. It is important to see that all the differ-

ent means employed are part of God's work in creation and through the churches, though when erroneous methods creep in they must be named as such.

Approaches to health: the church's healing mission

As already mentioned, a holistic view of health impacts upon the understanding of healing and the church's healing mission. With regard to a multidimensional understanding of health, it is obvious that health is not achieved by medicine alone. There are various ways of healing that may complement each other.

Healing through allopathic and alternative medical practices

Allopathic (western) medicine has provided significant benefits to people in economically poor as well as economically rich countries. Accurate diagnosis, immunisation, health education, effective drugs, surgery and other medical means have saved the lives of countless people.

For all these advances, we are grateful to God, and Christian medical mission aims at gradually achieving health for all, in the sense that all people around the globe will have access to quality health care.

However, it has been widely acknowledged that although the 'health industry' produces and uses progressively sophisticated and expensive technologies, such an approach cannot address most of the world's health problems.

Moreover, modern technological advances have exacerbated certain tendencies, viz. to regard the medical approach as an absolute or the only way to health, and to dehumanise those who receive such health care. The approach of modern medicine can result in the loss of many human values, and of the Christian understanding of health, disease and death. Modern medicine can also strengthen the persisting belief that disease is a simple dysfunction of body organs, or the result of

unfortunate accidents that scientific medicine can prevent and/or cure.

Notwithstanding the fact that medical approaches to health have helped in the struggle for access to health care, especially for people in underprivileged settings, Christians must be prepared to critique all the ways that tend to make the medical approach absolute and dehumanising.

There are many other systems of traditional or alternative medicine that governments in different parts of the world formally recognise, and, in some cases, modern scientific medicine also values. These systems need to be acknowledged and strengthened.

For their part, health professionals must recognise that health issues have implications beyond the individual and into the community, which is a social network with many resources and skills that can promote health. Health professionals are challenged to see themselves as part of a broader network of healing disciplines that include the medical, technical, social, psychological and even political sciences, as well as religions and traditional approaches to healing.

The churches' task is to make it clear that health needs to be understood in a broad sense, and that the causes of disease in the world may be not only biomedical but also social, economic, cultural and spiritual. Health is most often an issue of justice, peace, reconciliation, the integrity of creation, culture or spirituality.

Healing through advocating and working for justice

Economic justice

Every woman, man and child has the right to the highest attainable standard of physical and mental health without discrimination of any kind.⁵ Still, in spite of health being a human right, the majority of people in our world do not have access to that right.

⁵ See footnote 3

The main cause of inadequate access to health, and therefore of disease in the world, is economic poverty. Poverty is the result of oppression, exploitation and war. No amount of immunisations, medicines and health education can significantly ameliorate illness that is due to poverty.

Economic poverty is also closely linked to inequities in social structures, which are often feudal or oppressive, and tend to limit peoples' ability and opportunity to experience the economic benefits that poverty alleviation efforts may provide. Those interested in maintaining the status quo perpetuate inequitable social structures, and special efforts are needed to bring about change.

The churches are called to see poverty as a justice issue that must be raised in the centres of power at local, national, regional and global levels. Along with calling for justice, the churches must pressure those in power to commit themselves to a more just distribution of available resources for health both within and between nations.

The prophets of the Hebrew scriptures (Old Testament) cried out against any oppression and exploitation of the poor. Jesus began his ministry by quoting Isaiah's prophecy of liberation for the captives, freedom for the oppressed, sight for the blind, and good news for the poor (cf. Luke 4:16-19). The members of the early Christian church chose to share their possessions, and live a life of mutual dependency and accountability.

Today, the political and economic policies of rich countries disrupt the daily lives of people far away from those countries. The demand for the repayment of international debts cripples the economies of debtor nations. The tragedy is often compounded by the fact that many of the projects for which the debts were created did little to enhance the lives of the intended beneficiaries. Creditor nations are harmed as well, since debtor nations are left without the resources to buy products from abroad. All of these issues impact negatively on health and

wholeness. Christians recognise that the actions of governments and transnational corporations, in their quest for power and wealth, interfere with the bringing about of health, healing and wholeness.

Therefore, Christians must be aware that working for the liberation of the economically poor contributes to healing. This includes advocacy, in the sense of speaking with and on behalf of the marginalized and underprivileged, and strengthening networks and campaigns to put pressure on international organizations, governments, industries and research institutions. Such advocacy must also include all efforts towards the transformation of structures that produce poverty, exploitation, harm and sickness. With special reference to access to health care, the strengthening of health systems is an important task for Christians.

Gender issues and justice

Most 20th-century ecumenical discussions on health and healing did not mention gender as a central health-related issue. Now, at the beginning of the third millennium, we realise that gender injustice is one of the major determinants of ill health. Women, who are often regarded as being of less worth than are men, usually get fewer chances than do boys and men to access education and achieve economic independence. Lack of knowledge, information, and poverty are among the determinants of ill health. In particular, gender injustice increases both the risk and vulnerability of girls and women to HIV infection.

The Christian concept of dignity, which is based on the teaching that all human beings are created in the image of God, challenges every teaching that says women are subordinate to men. Therefore, Christians are called to counteract any discrimination of girls and women, and we need to give more responsibility and recognition to women in our churches and organizations.

Healing through reconciliation and promoting peace

Traditional concepts of health and sickness support the view that dis-

harmony in relationships between individuals or within families leads to alienation, separation and brokenness, and may provoke the onset of mental and physical disease. In traditional societies, the family or a community mediator, such as a village elder, listens to both sides in order to foster reconciliation and help heal broken relationships.

Modern sciences, too, increasingly have acknowledged the importance of harmonious relationships with regard to physical and/or mental well-being. Research has indicated that living at peace with oneself, and having a social network and a harmonious relationship with God might protect people from physical and mental diseases, and may help people overcome disease or cope with chronic sickness. By contrast, broken relationships are often associated with unresolved guilt, anger, resentment and meaninglessness, and these conditions may well be potent suppressers of the body's powerful, health-controlling immune system, while many consider that living in harmonious relationships is one of the strongest things that can help improve immune systems.

Generally, healing can result from the reconciliation of relationships, and this is needed on all levels: On the personal level, healing means reconciliation with one's personal or family history (e.g. the healing of memories), or being able to cope with burdens. Healing in this context means the restoration of a person to his or her community and to God, and living in a way that takes responsibility for creation. Healing has to take place between families, wider groups of people, and nations. In particular, there is the challenge for the church to find ways of being a credible witness to the gospel by working at healing its own divisions.

Deaths due to armed conflicts and other forms of political violence continue to be a reality for many. For thousands in the world, state terrorism through low-intensity conflict, torture, imprisonment and other forms of human rights violations has made the well-being of mind, body and spirit, i.e. wholeness, impossible. The direct or indirect supply of weapons and other means of warfare affects the health of many. In such contexts, promoting peace can lead to healing but the

process of reconciliation can be long and painful, and must include the healing of memories.

All positive steps towards reconciliation and peace are, therefore, important and, in the long run, often effective contributions to the physical, emotional and social health of people.

Healing through the reconciliation of one's relationship with God, and as a spiritual attitude

We are spiritual beings created in the image of God; shalom concerns the body, mind and spirit. From a Christian perspective, every human being should be in a relationship with God, and this comes about through an individual having a spiritual attitude.

The nature of someone's relationship with God varies from person to person. It could include intellectual clarity, an emotional experience, an abstract consciousness of God's presence, and/or an awareness of being a beloved child of God. Ultimately, the relationship is based on an acknowledgement of the presence of God, and is something that provides one with the knowledge that one's life has meaning.

Now, medical science not only acknowledges that a relationship with God may contribute to an individual's health but also is beginning to recognise that the biblical emphasis on beliefs and feelings is an important healing tool.

Repentance, prayer, Bible meditation, the laying-on of hands, divine healing, rituals involving touch and tenderness, forgiveness, the sharing of the eucharist, and a reconciliation of the relationship between human beings and God can all have important and, at times, dramatic physical, mental and social effects.

⁶In particular, many epidemiological studies have suggested that there is a positive relation between faith and health. See, for example, Harold Koenig, Michael McCullough, David Larson, Handbook of Religion and Health, Oxford University Press, Inc., New York, 2001.

Healing through a responsible lifestyle

It is human action that causes a significant proportion of illness in the world. In industrialised countries, over 80% of illness and death is said to be due to destructive lifestyles. This situation is rapidly getting worse as a result of continuing 'modernisation' throughout the world. What we impose on ourselves individually and collectively, whether out of ignorance and greed, or simply through a lack of self-control, causes physical, mental, spiritual and ecological damage that is not best addressed by medical technology. Lifestyles and values that breed individualism are increasingly causing the disruption of social networks and life in community.

God is at work in healing processes

Whether healing occurs through medicine, the changing of harmful structures, peace-building, other means or even through miracles, we believe that God is at work in all healing processes. The spectrum of healing embraces all the above-mentioned approaches, and for all of them we offer gratitude to God, who enables human beings to be God's instruments for promoting health.

Stating that God is at work in all healing processes helps stop Christians playing off one approach to health against another. There are churches and social contexts (particularly in Western post-Enlightenment and modern societies) in which a one-sided emphasis and attention has been given to the achievements of contemporary scientific medicine and the physical aspects of health and healing. Today, a new openness and attention is needed to the spiritual dimensions that Christian healing ministries address. There are churches and contexts in which, due to people holding a particular world view, the importance of the spiritual dimension is highly valued. We can conclude this section by saying that a new dialogue between spiritual healing practices and modern medicine is essential.

⁷ For more details of this approach, see, "Liturgical acts and spiritual means of healing" in the section on "Healing communities/congregations".

Who is practising healing, and how is the church's healing ministry implemented?

Jesus sent his disciples out to preach, teach and heal. Most churches today preach and teach but leave healing to medical professionals. Yet, there are many ways in which churches can be, and in some case already are more involved in healing.

Based on a comprehensive understanding of health and healing, the role of congregational and non-congregational communities, and faith-based and governmental organizations, as well as individual Christians in health and healing becomes obvious. In this context, we will focus on explaining the strengths and opportunities of faith communities/congregations in the healing ministry.

Healing communities/congregations

Over the centuries, a rift has developed between the work of those with specialised medical training and Christian communities. Until today, those with medical training have often felt that the healing ministry is best left to them. Accordingly, Christians still often understand the ministry of healing in terms of a professional service alone, and as something that has little connection with the life of the congregation.

However, the 1964 Tübingen consultation affirmed that the local congregation or Christian community is the primary agent for healing. Against the background of the need for and legitimacy of specialised Christian institutions, such as hospitals, primary health services and specialist healing homes, the consultation emphasised that every Christian community, as the body of Christ, has a healing significance and relevance.

This view was based on a comprehensive understanding of health and healing, as well as of suffering, sickness and healing, as issues that should concern the entire community collectively. The apostle Paul described the Christian community as “one body” (1 Cor. 12:12-31). If one member of the body is sick, the whole body suffers. Sick congregation members are asked to call for the elders, who will pray for them and anoint them with oil (James 5:13-16). Thus, it is made clear that the sick are and remain essential parts of the community.

At the heart of a congregation’s healing ministry and activity is the ministry of the Word, sacraments and prayer. Over recent decades, awareness has been created of the various health-related strengths of religion and religious communities. It is now recognised that religious communities have many tangible and intangible assets that can contribute to health. The tangible assets include the creation and support of health-related jobs, clinics and mission hospitals, as well as groups visiting sick congregation members, and the provision of counselling services, care groups and health programmes. The intangible assets of a religious community are also essential contributions to health, and include trust, prayer, love, compassion, reconciliation, encouragement, and the giving of hope and a meaning to life.

Sometimes, faith communities are unaware of the assets they have, and so do not take advantage of them. It is important to help faith communities realise that they own resources that can contribute to good health, and to help the communities unearth these assets. As they do so, faith communities can become healing agents, and should recognise that such a ministry will contribute to the realisation of the kingdom of God. There are many ways in which faith communities can be healing communities.

A social network

The way a local faith community receives, welcomes and treats people will have a deep impact on that community’s healing function. The way a local congregation maintains and nurtures a network of mutual

support, listening and care will express the healing power of the church as a whole. Each individual member of a local congregation has a unique gift to contribute to the overall healing ministry of the church.

Even though the secular world stresses independence, we are called to live as a community dependent on God and one another. As members of a congregation, we all have our strengths, weaknesses and burdens, and all of us undergo times of well-being and happiness, as well as times of disease and unhappiness. All are precious in God's eyes, and are of value within a faith community. No one should be considered a burden to the rest, and no one is simply a burden bearer because, "We all bear one another's burdens in order to fulfil the law of Christ" (Gal. 6:2).

A safe and open space

Healing is fostered where churches relate to daily life, and where people feel safe to share their stories and testimonies. Broken, rejected and suffering people need places where they can be comfortable in sharing their pain in an atmosphere of openness and acceptance. The local church can offer a forum where those who are afflicted can, in trust and with acceptance, let down their guard and share their stories. Doing so gives people an opportunity to meet Jesus. In addition, stories of people within the church need to be shared when they present examples of healing.

Creating safe spaces for telling one's story within church communities is a first step through which congregations can become healing communities. To provide a safe space is also to provide an assurance to broken persons that there are warm hands to hold them, and that these hands will be still there even if those being held leave and then decide to return. However small or inconsequential pain and suffering may be, they can never be brushed away. After having been allowed to share their stories, people must also be allowed to live through their pain. It is the church's role to help individuals gradually overcome the power of pain in their lives. There is usually no 'quick-fix' solution.

As an example, despite the extent and complexity of the problem, churches can make an effective healing witness towards those affected by HIV and AIDS. Such people suffer much through social isolation, stigma and discrimination. They long for communities where, with their special gifts and strengths, they are welcomed, and of which they can be a part. The experience of love, acceptance and support can be a powerful healing force that can even influence people's physical condition.

In this context, special reference has to be made to self-help groups, which may include groups for the bereaved or those who share a common serious illness, and Alcoholics Anonymous, as well as groups for drug addicts and the unemployed. Such groups often meet in parish centres, and any parish that is searching for its own healing potential must take them into account. Self-help groups, even though they may not have begun as local church groups and might have come in simply to use the parish hall, should be met with hospitality, interest and love; parish communities must resist trying to monopolise them. Local churches need to support and communicate with these groups. From this, opportunities may arise that can benefit both the parish and the groups.

A true church community is not a closed community; it cuts across class, status and power structures. Its members must risk moving out to identify with people outside the community, and especially with those on the fringe of society. A healing church community will invite in the marginalized and oppressed, and enable them to join the community without judgement. Further, church communities must go to people who will not wish to join the communities but will still be grateful for the care and help they offer. A true healing church community is vibrant and energising; its power steadily gives rise to new communities of healing and fellowship.

Counselling and caring as healing elements

Counselling is a process of empowering a person to make decisions about his or her own life. Counselling may be concerned with many different areas of the life of a person or a family, and can address physical, practical, psychological, social and spiritual needs. Often, counselors are channels for reconciliation (cf. 2 Cor. 5:18).

Christian counselling and care are complementary. While counselling aims at the sharing of burdens and truth, caring is a ministry of being with others and offering practical help. Therefore, care as a means of healing in a congregation can be understood in two ways. Firstly, it is pastoral care exercised as a ministry of presence and spiritual assistance to people in need. Secondly, it is the serving of people in need in practical ways. In both of these dimensions, it is important that those who seek to help are appropriately trained and competent in their respective areas, and that they receive adequate supervision.

Within and outside the fellowship of the congregation, people long for solidarity and caring. This is especially true for those who are physically or mentally ill, or suffer from addictions. Then, there are the lonely, the oppressed and marginalized, vulnerable older people, orphans, and those with social problems such as divorce, unemployment and unplanned pregnancy. In responding to the needs of such people, churches become involved in healing because, for example, having true fellowship with sick people will relieve much of their anxiety, and bring to light the many practical problems associated with a person's sickness. Caring for people by providing food and medicines, visiting the sick at home or in hospitals and hospices, and visiting people in prison are also important and shining examples of Christian care.

Christians caring for people within and outside their congregations must practice their service not only as a duty but also with love and compassion. In doing so, they will truly follow Christ, who identified himself with sick and marginalized people.

A place where charismatic gifts are nurtured and practised

According to the biblical tradition, the Holy Spirit entrusts the Christian community with a great variety of charismata, i.e. spiritual gifts (1 Corinthians 12). Among these, charismata relevant to the healing ministry play a prominent role. All gifts of healing within a given community must have not only deliberate encouragement, spiritual nurture, education and enrichment but also a proper ministry of pastoral accompaniment and ecclesial oversight. Charismata are not restricted to the so-called supernatural gifts that are beyond common understanding or experience. There is a wider understanding through which individuals are seen to have special and sometimes extraordinary talents for helping and healing others. Such gifted people serve by showing love, giving comfort, caring, simply being with somebody, and by offering practical assistance as well as spiritual means of healing.

Liturgical acts and spiritual means of healing

In addition to practical acts of love and service, the congregation is entrusted with sanctified means of healing by its ministry of the Word, the sacraments and prayer with and for the sick. These means and their inclusion in the healing process are special and unique features of faith communities. They include worship, the eucharist, praying for the sick, confession and forgiveness, the laying-on of hands, anointing with oil, and the use of charismatic spiritual gifts. By employing these elements, the congregation joins forces with God in God's healing activity.

The manner in which these healing elements are administered will vary according to the tradition of individual churches, and the condition of the people receiving them. For all Christian denominations and church traditions, it holds true that the worshipping community, and worship itself, can have a deep healing dimension. In many places, special monthly or weekly services are experienced as an authentic witness to God's healing power and care. In such worship, explicit recognition is given to the needs of those seeking healing, whether it be because of the experience of loss, fragmentation, despair, physical illness, or

any other reason. Opening oneself in praise and lament to God, joining others as a community of believers, being liberated from guilt and the burdens of life, experiencing even unbelievable cures, and being inflamed by the experience of singing and of praise are tremendously healing experiences.

At the same time, it must be acknowledged that inappropriate forms of Christian worship, including triumphalistic healing services in which the healer is glorified at the expense of God and where false expectations are raised, can deeply hurt and harm people. Hence, there is the need to have well-trained leaders, who can discern and direct healing ministries.

The majority of Christians consider the celebration of the eucharist (Holy Communion) as the unique and most prominent healing gift that the church in all its manifestations has received. While not all denominational traditions understand the essential contribution of the eucharist to healing in the same way, many churches today are increasing their appreciation and expression of the sacramental aspect of Christian healing. In the eucharist, Christians experience what it means to be brought together, to be made one, and to be reconstituted as the body of Christ across social, linguistic and cultural barriers, even if not yet across denominational divides. Between churches, the remaining division that prevents a common celebration at the Lord's Table is one of the reasons why many Christians have difficulties in grasping and experiencing the eucharist as the healing event par excellence.

The congregation as a place of teaching and of learning together

Congregations need to consider what the Christian understanding of health is, what promotes health, and what causes ill health. They should also discuss how to become involved in transforming society by creating healing communities.

There are a number of ways in which members of a congregation can grow together in their understanding of a healing ministry, and in discovering ways of implementing it. These include:

- Bible study on health, healing and wholeness;
- facilitating the self-discovery of causes for ill health;
- practical health education;
- studying questions of ethics, human rights, justice and peace;
- learning to take personal responsibility for one's own health.

The congregation is also the nurturing ground for young people, and, as part of its mission to the young, the congregation should urgently take on the responsibility of sensitising school and college students to the needs of the vulnerable, and then challenging young people to respond to these needs.

The congregation as an advocate for justice, peace and the integrity of creation

The message of liberation is an integral part of the life of the church. Participating with oppressed people in the building of a just social order is part of what leads to the reign of God, which is life in its fullness, i.e. shalom.

The congregation can contribute to the transformation of structures that produce poverty, exploitation, harm and illness. It can do so by taking its healing ministry into the political, social and economic arenas through:

- advocating for the elimination of oppression, racism and injustice;
- supporting peoples' struggle for liberation;
- joining others of goodwill in together growing in social awareness;
- creating public opinion in support of the struggle for justice in health.

In working for a just social order as it relates to health, healing and wholeness, Christians must promote ethical standards that will protect the environment so that land, water, the air, and other forms of crea-

tion are not rendered useless or harmful to humankind.

The congregation and primary health care

The deliberations of the consultations at Tübingen in 1964 and 1967, and the work of the CMC in the 1970s had a considerable influence on the development of the concept of primary health care (PHC) that a WHO conference in Alma Ata promoted in 1978.

In the years before Alma Ata, it had become obvious that the predominantly curative and so-called Western medical model had failed to solve the world's health problems. It was clear that the majority of human beings did not have access to quality health care, and health seemed to be the privilege of a minority. Alma Ata then presented a concept of health care based on the values of equity, social justice, universal access and solidarity. This "comprehensive primary health care" concept, as it was designated, promoted a community-based comprehensive and intersectoral approach to health based on the strengths of people in local communities. The concept offered the churches a unique chance to be involved in health care and issues of health through the contribution of faith communities in tangible ways (e.g. immunisation programmes, health education), and through intangible assets (e.g. giving hope, encouragement, prayer and social support).

However, the PHC movement, which began with great hope for change, has not been sustained. The tension between high-technology-based medicine on the one hand and primary health care on the other has been detrimental to the struggle for a better and healthier world. While committed Christian professionals have developed outstanding primary health care programmes, the congregational involvement in the PHC movement has been patchy and minimal. Though the PHC movement addressed access and justice issues, it did not do the same with regard to the spiritual dimension of life. The modern allopathic system of medicine has unnecessarily condemned traditional systems of medicine in many countries, and this has created problems in terms of the allopathic system's relationship with traditional health special-

ists. As a consequence, both systems developed in isolation from and in competition with each other. Nevertheless and more recently, governments and allopathic health systems have begun to recognise traditional and alternative approaches to health. Some churches have also become more open to assessing and accepting some of the traditional health systems.

More than three decades after the Alma Ata PHC proclamation, there is a need for the revitalisation of PHC that will include the multidimensional contribution of faith communities to health.

The congregation as a partner in healing ministries

The congregation can offer a unique and irreplaceable contribution to health but it is important that the congregation joins hands with other healing agents within and outside itself.

Every congregation that understands itself as a healing community is challenged to recognise, support and cooperate with healing partners, such as health professionals, families, traditional and alternative healers, secular agencies and communities, and other congregations and faith groups. In doing so, the congregation should always exercise its discernment on the impact of these collaborations in terms of Christian values, the respecting of culture, and the quality of outcomes. The congregation's support is not only important for those working in Christian medical institutions but also for Christian health professionals working in secular settings. As they often carry their burden alone, the latter need to be embraced by a congregation in order to receive the assurance and affirmation that their work is meaningful and important. Some of them may also need pastoral care or healing services for themselves.

A healing community: a community of people who are not perfect but are a sign of hope

A healing community is not a community without problems and suffering but a group of imperfect human beings. It consists of peo-

ple striving together to live with compassion, love and hope despite their many shortcomings. Jesus associated with the marginalized, the downtrodden and the imperfect. Through his willingness to identify and suffer with them and deny himself, he gave hope, restored dignity and created a new community for all. He led the marginalized back to restored relationships, and enabled them to pick up the threads of their lives again, and so helped them to experience community anew.

Being a part of such a fellowship is a continuing process of self-emptying, and requires an openness to sharing and receiving. There is no true community without self-denial of some kind. There is no coming together in community without the sharing of tears. A Christian community is called to be a community of wounded healers.

Being a community of imperfect people, and being part of a creation groaning in pain and longing for its liberation, the Christian community can be a sign of hope, and an expression of the kingdom of God here on earth.

Part II:

Case studies

All over the world, Christians in communities and organizations exercise a ministry of Christian healing, and thus take part in God's mission of transforming the world.

Mission specialists are aware of the various approaches to health and healing that Christian groups and individuals advocate and practice. However, it is clear that a wider public does not know about most of these activities. This is because they are usually not properly documented. Therefore, the joint WCC-DIFAEM study group sees a need to collect and communicate examples of good practice for mutual encouragement, discussion and possible replication elsewhere.

As a contribution to this collecting of examples of Christian healing practice, the study group invited people from different cultures and denominations to share case studies of communities, organizations and individuals that present examples of how a healing ministry might be exercised.

What came out of this process, and now follows, does not pretend to be a comprehensive collection. The case studies do not cover all aspects of the healing ministry, nor was it possible to get examples from all cultures and denominations. Rather, the reader will find a set of very different and particular approaches to health and healing.

That said, the study group regards the case studies as significant examples that throw light on various aspects of the Christian healing ministry. We also hope that they will encourage others to engage in steps towards health and wholeness for all because, according to the African proverb, "When many little people take many little steps in many little places, they can change the world".

Communities as agents of health, healing and wholeness

Introduction

Communities, whether they be secular or faith based, contain huge assets in terms of what contributes to health and healing, and restoring hope. This assertion is based on the understanding that a community does not consist of independent but interdependent individuals. A community ideally should be a social network of sharing, caring and support that values the most vulnerable in society as most precious.

Based on the vision of a transformed society, a community may enter into a process to become a healing community. As a first step, a community needs to identify the assets that it already has, e.g. influential people, motivated volunteers, natural resources, etc. These are the foundations upon which a healing community can be built. Then, a community's needs have to be identified through listening, discussing and discerning. Only after identifying its strengths and needs can a community mobilise other resources by, for example, promoting volunteering, broadening partnerships, promoting self-help and support groups, and accessing services that can meet special needs.

According to a community's particular strengths and needs, its actions can vary. Some communities focus locally on the inclusion of marginalized people by working against stigma and discrimination. Others look beyond the needs of their immediate community, and work across geographical, religious, ethnic, caste or national boundaries. Some communities focus on economically poor people, whilst others deal with difficult issues such as mental health and aspects related to sexuality.

Faith communities have special assets related to issues of health and healing, and these add value to what they do in both the local and wider community. Faith communities can act holistically by incorporating social, spiritual and economic aspects in what they do. The special healing elements that faith communities contain include prayer, celebrating the eucharist, and their understanding of the importance of reconciliation with oneself, with other fellow human beings, and with God. Faith communities can be a means of healing because they can restore hope, and provide meaning to life.

The many examples of the work of healing communities presented in this section come from different continents, and reveal various aspects of healing. They include an Ethiopian community that offers assistance and relief for people suffering from a neglected disease. The Community Health Department of India's Christian Hospital Bismarck, as well as the Community Development Department of Bethesda Hospital in Yogyakarta, Indonesia, are examples of an intersectoral approach to health for underprivileged people. The case studies from Minnesota, USA, and from Germany are based on the work of communities of volunteers, who take care of sick and elderly people. Bethel Baptist Church in Jamaica provides holistic healing to people in danger of becoming lost in their society. "Users and survivors of psychiatry in Kenya" throws light on the growing demand to recognise the problems that people living with psychosocial disabilities experience.

“Wash one another’s feet”: the community-based treatment and prevention of podoconiosis in Ethiopia

By Christel Ahrens, health adviser for the Ethiopian Evangelical Church Mekane Yesus (EECMY), Western Wollega, Ethiopia.

Podoconiosis: a neglected disease

Many parts of Ethiopia have red volcanic soil that contains silicates. Bare-footed people take up these silicates through wounds or microlesions in the skin of their feet; this induces an inflammatory response so that the lymphatic vessels become obstructed. Therefore, instead of being drained, lymph is retained first in the patients’ feet and later in the lower legs. The disease that results from this is called podoconiosis⁸. This disease is common in the highlands of Ethiopia; its most prominent feature is the development of huge feet, and so it is sometimes locally called swollen-foot disease.

The first symptoms of podoconiosis usually appear in people between 16 to 45 years old but children up to six years old can also show signs of the disease. The condition leads to an itching between the toes, and a burning pain in the feet and lower legs. Gradually, the feet swell, and sometimes do so to an extreme degree. Open sores and ulcers develop, and keloids grow on the feet, which then take on a grotesque appearance. Hence, the other name used to describe podoconiosis is mossy foot. Commonly, diseased feet become infected with fungi and bacteria, and recurrent skin infections often cause a bad smell.

⁸ Podoconiosis comes from the Greek words for “dust” and “foot”.

Podoconiosis is a debilitating foot disease that, in addition to the physical ailments, causes social and economic suffering. The smell of infected skin, and the fact that people usually are not aware of the causes of these symptoms, lead to social isolation and stigmatisation of people with mossy feet. Asked about the cause of podoconiosis, people offer various opinions, ranging from witchcraft to infection transmitted through the use of a container that someone with the disease has already used. Most people are unaware of the real cause of the disease, and this ignorance contributes to the isolation of affected people, who may be treated like outcasts. Children with the disease have to drop out of school; family members sometimes disown their infected children. No one wants to employ or marry someone who has this dreaded disease. Therefore, education about the true cause is the first step towards reducing the stigma associated with podoconiosis.

The disease is prevalent among economically poor people, and mainly women, because they cannot afford shoes. The disease itself aggravates poverty; studies show that affected people lose up to 45% of their productive capacity because of the disease. Being thus impoverished, some people try to earn a living by begging; some even starve to death. In Ethiopia, it is estimated that 500,000 to one million people have podoconiosis.

Improvement of people's physical, social and economic conditions

In 2007, the leader of the Challia Clinic, Haimanot Hunduma, began a community-based programme for people suffering from podoconiosis. Challia is situated 500km west of Addis Ababa, within the Oromia region of Ethiopia. Hunduma had been inspired to act after visiting a Catholic clinic that had experience of treating podoconiosis.

Firstly, Hunduma's programme assessed the prevalence of the disease in the six villages of the Challia Clinic's catchment area. The survey discovered that among a population of 12,000 people, podoconiosis

affected 440. This meant that every 27th person in the area was suffering from this disease. When questioned, some people voiced their fears of what might follow. Some asked, "Do you want to amputate our legs in order to get rid of our problem?" It was clear from people's responses that they had lost all hope for any improvement of their desperate situation.

After the survey, two villages were selected. One man and one woman from each village were chosen, and taught how to treat those with podoconiosis. After the training of these volunteers, the programme had to raise enough funds to cover the expenses the volunteers would incur in doing their work. In ecumenical solidarity, two congregations in the selected villages decided to collect money to cover these costs. Within two weeks, enough had been raised to make the launch of the programme possible.

The main activity for the trained personnel is the weekly washing of infected feet in warm chlorinated water, plus the 'anointing' of feet with oil enriched with the extract of locally available neem leaves to reduce the inflammation of the skin. Some infected people also need antibiotics, at least in the beginning. The programme provides the drugs free of charge and, for a small payment, a local private clinic injects them. This saves people the need to walk long distances to get treatment at the Challia Clinic.

Everyone with podoconiosis from the two selected villages is invited to form self-help groups through which they can share experiences, and offer mutual support. Once a week, the patients come to a health post; each group member has to bring clean water and firewood for the washing of their feet with hot water. The patients who receive foot washing and anointing soon report positive effects. It is wonderful to see all the happy faces of the people who unexpectedly now have a better quality of life.

In addition to this weekly routine, people with podoconiosis are told also to wash their feet thoroughly every evening in order to reduce the exposure of their skin to dust and soil. All patients are provided with socks and leather shoes on a cost-sharing basis to prevent further infection, and villages are encouraged to organize themselves to support those with the disease. As a result, people suffering from podoconiosis are now accepted and respected within their villages, where physical improvement is associated with social rehabilitation.

This programme has some special features and added value compared to the treatment offered at the Challia Clinic. First of all, people have to get to the clinic, and often walk for long distances to do so; this is very difficult for people with podoconiosis. Secondly, at the clinic, which people with all sorts of conditions attend, those with podoconiosis are aware of the stigma they carry in the eyes of some of the foot-healthy people present. By contrast, the service that local non-medical volunteers provide is based in a person's local and now-accepting community, where people are learning to take care of their own health problems. Once a patient's condition improves sufficiently, monthly meetings replace the weekly ones, and supplies of soap and oil are given out.

Eventually, the programme will make an economic impact through the reduction in the number of working days lost because of the disease, and also through the prevention of disability. As the programme is creating awareness of podoconiosis and its causes, and is reducing the attached social stigma, it will have a preventative effect and help reduce the prevalence of podoconiosis in the two selected villages. Hopefully, after one year it will be possible to phase out the project in the two villages; it will then 'travel' to other villages in the Challia Clinic's area.

The people benefiting from the programme are not only deeply grateful to those who serve them but also and especially to God. They regard the programme as the genuine work of God, who always seeks the lost, and promises that those who are the last will be the first.

The podoconiosis prevention and treatment programme reflects an act by Jesus of compassionate care and service for others. Having had supper with his disciples, “(Jesus) poured water into a basin, and began to wash the disciples’ feet and to wipe them with the towel that was wrapped around him” (John 13:5). Afterwards, Jesus told his disciples, “You also ought to wash one another’s feet” (John 13, 14).

In some areas of Ethiopia, the custom of foot washing remains alive; the tradition demands that young wives should wash their husbands’ feet. By contrast, Haimanot Hunduma’s community-based programme to tackle podoconiosis promotes a new and special kind of foot washing.

The service that local non-medical volunteers provide is based in a person’s local and now-accepting community, where people are learning to take care of their own health problems.

Mitra - we believe in people: the Community Health Department of the Christian Hospital Bissamcuttack

By Dr Johnny Oommen, head of the Community Health Department of the Christian Hospital Bissamcuttack.

Mitra: a friend in need

Mitra means friend. Mitra also stands for Madsen's Institute for Tribal and Rural Advancement, which exists within the Community Health Department of the Christian Hospital Bissamcuttack (CHB) in India's north-eastern state of Orissa.

Bissamcuttack is a small town of about 10,000 people in the hill district of Rayagada in Orissa. The Bissamcuttack block has about 315 villages and 85,000 people. Of these, 62% belong to the Adivasi (indigenous) community, and another 16% are Dalits. Therefore, the vast majority of our people belong to historically oppressed and vulnerable communities.

CHB is a 150-bedded mission hospital founded in 1954 by Dr Lis Madsen from Denmark. At that time, people in this remote and mountainous area had practically no access to health care. Dr Madsen began her work by seeing patients on the veranda of the local church. Then, she established a small dispensary, and trained locally recruited staff. CHB grew out of these small beginnings, and today is the main contributor to people's health in our area; the other nearest referral centres are over 200km away. From the beginning, Dr Madsen, who had a deep-rooted commitment to marginalized people, was convinced that it was necessary to go out to people in their communities. She began community-based health care on a small scale, and thus laid the foundations for Mitra. Today, Mitra consists of three pillars, viz. the

Mitra Project, the Mitra Residential School Kachapaju, and the Mitra Training and Resource Unit.

The Mitra Project

The Mitra Project works with about 12,500 people in 53 predominantly Adivasi villages. Our approach is to be with the people, and allow their agenda to emerge in the context of this relationship. By the late 1990s, we had grown disillusioned with the traditional models of community health and development, with their goals and objectives and log-frame-approach grids. From these more or less vertical approaches, we moved to what we would describe as community dreaming sessions and appreciative inquiry. We wanted to know about our people's real desires, and for them to become agents of change instead of objects of others' activity. What emerged from this fundamentally different approach was a four-fold Mitra dream that we still use as a reference point. It is the dream that one day our people will enjoy health for all, education for all, economic security for all, and social empowerment for all. Each of these dreams has simple components, and indicators that we use to measure whether we are getting closer to or further from the dream. Every element of our approach does not take place in all villages, and nothing must happen unless the village decides and asks for it; we work to the maxim, 'No demand, no supply'. All Mitra decisions are team decisions, with the monthly staff meeting being the centre of discussions, learning and planning. An informal council of tribal leaders evaluated our work in 2005 and, based on their own dreams for their people, provided further focus and direction for the next phase of Mitra's work.

Health for all

Six community health nurses spearhead our health-for-all work, and do so with the help of 48 village-level swasthya sevikas, who are women chosen by their villages to serve each community's health needs. The primary health care model we employ follows the World Health Organization's 1978 Alma Ata concept of primary health care,

which is based on the values of equity, social justice, universal access and solidarity. Our health-for-all programme includes mobile clinics, antenatal care, community obstetrics, nutrition, health education, immunisation, malaria control, and health information management systems. Over the last decade, we have seen a halving of the local infant and child mortality rates but there is still a long way to go before we can achieve our dream indicators.

Education for all

Over the last 25 years, we have pursued our dream of education for all in multiple ways. We began with adult education in the 1980s, moved to non-formal child education in the 1990s, and on to formal education initiatives in 1998. At present, our primary focus is an initiative that we call AQTE (Adding Quality To Education). This helps communities improve their government schools by appointing educated, motivated Adivasi young people as village tutors in order to help Adivasi children catch up by teaching them in their mother tongue. This began as an experiment in one village school; the immediate and visible impact created an upsurge of demand for more tutors. Now, there are 19 such teachers serving about 500 children from 22 villages.

Economic security for all

Mitra teams have facilitated the setting up and nurturing of over 50 self-help groups to help provide economic security for their members. Most of these groups consist of 15 to 20 women from a village, who save money together and provide each other with microcredit loans in times of need. Some women have also joined income-generating programmes, while others have chosen to stay with those that offer credit security. In one of the groups, and assisted by Mitra, people set up a community-based health insurance programme.

Social empowerment for all

The concept of social empowerment for all is at the heart of what Mitra does and stands for. All our work has to enhance empowerment and discourage dependence. Mitra has chosen to stand alongside the

Adivasi people; about half of Mitra's full-time staff comes from the Adivasi community. The preservation and promotion of the Adivasi Kuvi language and culture is at the core of the way we work. Thankfully, the community sees Mitra not as an outside agency but as an insider.

Nurturing value-based leadership skills is also part of our work. Over the years, a number of Mitra's paid staff and volunteers have gone on to assume leadership roles in local societies.

New initiatives towards improving health

Mitra is like a churn in which action and reflection, and rootedness and exposure constantly interact with one another. This process constantly throws up ideas and possibilities that are scientific and strategic as much as they are locally rooted and participatory. Some of the new initiatives that have taken off in 2008 and 2009 include:

- a malnutrition reduction strategy that focuses on malaria prevention as its prime thrust; Chloroquine malaria prophylaxis seems to help people put on weight more than food itself (!);
- ageing with dignity is a community-based programme for the elderly in 16 villages; it uses a club membership approach, and is managed by village committees;
- living with sickle cell anaemia (SCA) is a small, self-help-group approach for people with SCA in 50 Mitra villages; this initiative seeks to enable people have dignity and health through awareness and understanding, socio-medical inputs, and health insurance.

Mitra Residential School, Kachapaju

In 1997, a community dreaming session in the hill village of Kachapaju led to the vision of an Adivasi school of our own, where children could grow up within an ethos that reflected their own culture in order

to be equipped to lead their community as educated adults.

Mitra and a cooperative of 16 hill tribe villages jointly envisioned this school, and worked together on a plot of land in the middle of the forest to make their dream come true. The school opened in July 1998 with 31 children. Today, the Mitra Residential School, Kachapaju, which is also lovingly called “Mrs K” after its acronym MRSK, is an Adivasi school providing education from grades 1 to 5; it has 143 children and nine staff. The school aims to offer its children the best possible education in an atmosphere that reflects the culture and wisdom of the Adivasi community. We begin by teaching in Kivu; gradually we introduce the children to Oriya and English, and even some spoken Hindi. The school follows the government curriculum but education at “Mrs K” overflows far beyond the walls of the classrooms to include topics such as nature, health, drama, crafts and much more.

The Mitra Training and Resource Unit

In 1997, we stumbled across an innovative way of controlling malaria that evolved from our struggle with this one disease that accounted for one-third of the deaths in our area. Before we knew it, we were inundated with requests from action groups and non-governmental organizations (NGOs) in Orissa and beyond for assistance and training. This led to the formation of the Mitra Training and Resource Unit by a community health nurse in 2000. The unit takes lessons learnt from the field, and shares them with other groups and individuals through training, consultancy and publications. Over the years, we have shared our expertise in primary health care, malaria control, HIV and AIDS, epidemiology, reproductive health and other subjects with governmental and the non-governmental groups. At present, we are part of a technical think tank that the government has set up to look at issues related to health sector reforms.

Mitra: a way of life

Mitra is an experiment in evolution, with one foot in the grassroots reality of village life, and the other in the world of science, health, education and development. We are constantly brainstorming, dreaming and reflecting, and out of this melting pot come ideas and programmes. Many dreams never translate into action; most often we are disappointed with ourselves and fall short of our own expectations. We are conscious that what we do is minuscule compared to what needs to be done, and even what we should be doing.

However, through all the years of Mitra's existence, we have been confident that it is the people of the villages themselves who have the solutions to their problems. We believe in these people and their strengths. At the core of Mitra is our relationship with the 12,000 people living in 53 villages around us; this is the foundation of all we do. Together, we are able to unearth issues and needs, and discuss possibilities. Then, we act together. The action and reflection that takes place during this process feeds back into our relationship, and we all grow together. Our work is our life. For us, Mitra is much more than a programme; it is a concept, a philosophy, and a way of life.

Through all the years of Mitra's existence, we have been confident that it is the people of the villages themselves who have the solutions to their problems.

Community-based healing: community development by Bethesda Hospital, Yogyakarta, Indonesia

By Paula Hartyastuti, director of the Bethesda Hospital Community Development Unit, Yogyakarta.

The vision and mission of Bethesda

The Bethesda Hospital Community Development Unit (CD Bethesda) is one of the extramural units of Yayasan Kristen Untuk Kesehatan Umum (YAKKUM: the Christian Foundation for Public Health). YAKKUM is a church-based organization mandated to carry out health services to realise its strategic vision: “To be a service organization which actively promotes the healthy and prosperous lives of humankind and its environment as a manifestation of God’s salvation”. Accordingly, YAKKUM has a twofold mission:

- to promote a healthy and prosperous quality of life for all levels of society without distinction as to race, nationality, religion, beliefs, class, culture or gender;
- to promote a holistic and healthy environment for the welfare of the people it serves.

Hospital without walls

With an understanding of health as a state of complete physical, mental and social well-being, we promote a holistic approach to health and healing. In addition to curative hospital services, we see the need to work within and with the community in order to address the root causes of health problems. We call this approach a ‘hospital without walls’ service.

It is more than 30 years since the World Health Organization at Alma Ata in 1978 declared that the causes of ill-health were complex, and to be found mostly out in the community. The WHO statement stressed that poverty and political injustice were among the causes of increasing health problems.

Today, not much has changed; the determinants of ill-health still need to be addressed. Poverty, globalization, climate change, communicable diseases, HIV and AIDS, and unjust policies all contribute to the increase of health problems. Many people living in remote areas have little access to public transport, and no access to quality health care. Often, these people have had no education, and are poor and oppressed. Their human rights are not respected, and they are most vulnerable to situations of conflict and natural disasters.

To address these problems in the area it serves, CD Bethesda encourages vulnerable groups to be aware of the strengths they have and to use them to solve their problems. The strategy used is a comprehensive and community/congregation-centred approach. CD Bethesda is a facilitator that encourages communities to identify their problems, and try to find solutions. Capacity building is done through education and training in order to increase skills and knowledge, change harmful attitudes, build awareness, and to organize, campaign and network with other stakeholders.

Examples of community empowerment

1. Pluralistic communities forming strong united groups: the practice in Java and Lombok

Jesus Christ offers empowerment not only to his followers but also to all communities regardless of race, social status and culture. Jesus said, "I give you a new commandment: love one another; as I have loved you, so you are to love one another." (John 13: 34). This is the foundation upon which we must build our relationships not only as individu-

als but also as pluralistic communities.

In the pluralistic communities of Java and Lombok, sometimes it is difficult for minority groups to be accepted. CD Bethesda often faces this situation when it arrives in an area dominated by a group that is not Christian.

CD Bethesda goes with honesty and integrity to communities. It adopts a low profile, and tries to involve other faiths and religious figures in its work. Although we believe God is the source of healing, we do not emphasise Christian doctrine in the communities but attempt to accommodate other faiths. Therefore, the involvement of different religious leaders from, say, the Muslim and Hindu faiths, is very important.

Our way of working to bring empowerment to the pluralistic societies of Java and Lombok includes the establishment of community-based health committees. These committees include Christians, Muslims and Hindus from across the social spectrum, and can include professionals (teachers, government officers, etc.) plus lay women and men.

Usually, the members of individual groups are united in a common search for health for their communities. This helps people overcome differences and change their way of thinking and attitudes, and to be transformed into a group of people held together by a spirit of unity. The result can sometimes be that groups who usually will not accept anything from Christians begin to talk to and cooperate with Christians. It is important, therefore, that CD Bethesda staff members who work in multi-faith communities themselves have an open approach and attitude.

Such openness does not only apply to one's involvement with people of different faiths and social status; it also includes having the same attitude towards groups of people suffering from discrimination, such as people living with HIV, AIDS and leprosy, and sex workers. Treating

such people as having the same worth and rights as others brings about change. For example, those whom CD Bethesda helps to live openly with HIV and AIDS are willing to serve people with the same condition. Likewise, former TB and leprosy patients also volunteer to work with other patients.

Even though CD Bethesda does not openly display the Christian symbol of the cross in the pluralistic communities where it works, the unit's desire and ability to accommodate differences and to be accepted by the pluralistic communities is like being "salt and light" (cf. Matt. 5:13f) for the community. Thus, God is seen as being at work.

2. Churches as healing communities in East Indonesia and Timor-Leste (East Timor)

East Indonesia is a dry and not very fertile region. The health status of its people is poor due to malnutrition, the lack of sanitation, and scarcity of water. Incidences of communicable diseases like TB, malaria and filaria remain high.

In East Indonesia, CD Bethesda has carried out its work of providing access to health services in remote areas through the local churches. Because 89% of the region's population is Christian, though other traditions are also strong, community transformation through churches is the best strategy for bringing about real change.

CD Bethesda's work in response to the community health problems of East Indonesia CD Bethesda aims to control TB, malaria and filaria, facilitate water and sanitation provision, provide essential medicine in remote areas, and develop herbal and alternative medicines. We are also involved in supplementary feeding programmes for pregnant mothers and children, and assist income generation and capacity building through education and training. In our work, CD Bethesda cooperates with secular community-based organizations that operate in these areas, and actively seeks to achieve greater effectiveness through working with others.

The experience of the churches' involvement in health provision in East Indonesia has been very good:

- the churches have become more open to the problems their communities and congregations face;
- the involvement of church 'health cadres' in controlling communicable diseases, e.g. by screening for malaria, filaria and TB, has led to increased health;
- the churches are committed to increasing the awareness of health problems through preaching on the topic in worship services, and to promoting a comprehensive approach to health, including spiritual elements, as well as working for improved health through reducing poverty and advocating for human rights;
- the churches contribute to the breaking of harmful cultural practices; for example, the local custom is for funerals to take place one week after death, and since bodies are not stored in cool places during this time, hygiene-related problems can arise; although the government encourages people to break this tradition, communities prefer to hear this message from the churches.

Climatically and agriculturally, Timor-Leste is the same as East Indonesia: dry and difficult. Whilst its health-related problems are similar to those of East Indonesia, an unstable political situation makes things even worse and more complicated.

In Timor-Leste, CD Bethesda works with nuns, whose convents mostly have clinics associated with them. In cooperation with the nuns, CD Bethesda helps to strengthen the clinics' management structures, and encourages them to implement a comprehensive approach to health that includes the social and economic dimension of healing.

The government of Timor-Leste works with the churches as they implement their health policies. For our part, we believe it to be a good strategy to cooperate with the government in promoting a holistic approach to health by creating healing communities.

In cooperation with the government and secular organizations, CD Bethesda has developed many programmes. Among these are community-based screening for the detection and treatment of TB and filaria, programmes for healthy housing, income-generating for patients and their families, communicable disease-prevention work, and the promotion of good health for mothers and children through supplementary feeding, plus courses in herbal and alternative medicines.

Our work in Timor Leste has had some interesting results:

- the convents have committed themselves not only to becoming more involved in the clinics associated with them but also to implementing a community/congregation-based multi-sectoral approach to health; while the clinics take a predominantly curative approach, our community involvement approach has proved important for the creation of a community-based and comprehensive approach to health;
- the government previously did not accept the concept of primary health care with strong community involvement, or the use of alternative approaches such as acupuncture and herbal medicine; now the government supports the inclusion of these approaches in the provision of health care;
- the government appreciates the churches' and congregations' contributions to holistic healing, and is willing to cooperate with them;
- programmes implemented in particular communities have then been established in others;
- the model of a healing community that the nuns have promoted has inspired secular communities to have a strong sense of solidarity, and to help each other.

To be a community organizer is a calling

In the work of salvation, Jesus Christ was not only a teacher but also an adviser, analyser and organizer. In this regard, Jesus taught several lessons that can be applied to community organizing:

When you go to a town or a village, find someone worthy enough to have you as their guest and stay with them until you leave. When you go to a home, give it your blessing of peace (Matt. 10:11).

I am sending you like lambs into a pack of wolves. So, be as wise as snakes and as innocent as doves (Matt. 10: 16).

You are like salt for everyone on earth. But if salt no longer tastes like salt, how can it make food salty? All it is good for is to be thrown out and walked on (Matt 5: 13).

Then, there are words of advice from St Paul:

God has also given each of us different gifts to use. If we can prophesy, we should do it according to the amount of faith we have. If we can serve others, we should serve. If we can encourage others, we should encourage them. If we can give, we should be generous. If we are leaders, we should do our best. If we are good to others, we should do it cheerfully (Rom. 12: 6–8a).

The words of Jesus and St Paul tell us that in serving the community we should not be so much worried about equipment and costs but with living with the people in their communities. There, we are to be friendly and careful, to be salt and light, to build and maintain unity, and to act with expertise.

CD Bethesda considers working with communities a calling and a blessing. Therefore, our work must spring from genuine love. We must be loyal and ready to face any risk; we have to encourage communities and congregations to embrace the spirit of self-participation in order to solve their problems. Nothing can be a substitute for these things in the process of empowerment and service.

People who are marginalized and excluded have our special attention. As community organizers, we listen to the stories, experiences and

complaints of people living with such diseases as leprosy, filaria, HIV and AIDS, and we try to give such people hope and strength. We demonstrate that we are not afraid of contracting diseases by coming into contact with them. Thus, our patients and their families accept us.

A community organizer is a role model for the target groups with which he or she works because the organizer promotes a comprehensive approach to healing that includes physical, mental, social and human rights dimensions.

We are used to walking long distances to reach the areas where people do not have access to health services. This reveals the inner commitment of our staff members. We do not work solely for money but out of a love for everyone, especially those who are poor in any way. Working for community development is a spiritual task that calls for a deep commitment to serving the poor. However, there is a long way to go in the establishing of healthy and healing communities, and there are many obstacles to be faced during the process:

- in most communities, paying for expensive traditional celebrations is considered to be more important than investing in health or improving the economy;
- there remain strong traditions that see women as inferior to men; for example, staff members of the community-based organization Organisasi Rakyat are still mainly men, although most beneficiaries are women; therefore, creating gender awareness is an important part of our work;
- the dukun (indigenous traditional healers) can be empowered by acquiring medical knowledge, such as acupuncture, but they do not want to remove the element of magic from what they do because the local culture still believes in magic.

Healing is a process

There are some prerequisites with regard to community transformation. Among these are having an awareness of the situation and a clear vision of the healing task. Healing is a process, and there are obstacles on the way, such as the culture of the community. In areas with strong churches (East Indonesia and Timor-Leste) the process of transformation includes Christian elements, such as Bible study. In multi-faith communities we work according to the theory of empowerment, without including elements of any particular spirituality. However, Christian values influence the design and the implementation of all our programmes and activities.

Community-based healing is an approach that should be recommended to all church organizations, and developed and used by them not just in our part of the world but everywhere.

In addition to curative hospital services, we see the need to work within and with the community in order to address the root causes of health problems. We call this approach a 'hospital without walls' service.

What do we mean by healing?: Healing communities in Minnesota, USA

By the Rev. Lawrence M. Pray, Minneapolis, Minnesota.

It was in August that I first met Marsha; she was in her twenties. At first glance, one would never have suspected cancer; she looked fit and strong. Earlier in the summer, Marsha had noticed a small white node on her foot. Concerned that it would not go away, she visited her doctor in Denver. A biopsy revealed it was a malignant cancer; further tests revealed it had spread through her body.

She returned home to Minnesota, moved into her parents' home and began chemotherapy that quickly sapped her strength and began to change her body. Soon, walking became exceedingly difficult. Scarcely able to recognise herself in the mirror, Marsha fought despair with prayer, the hope of healing angels, and visits to the clinic and cancer specialists in Minneapolis.

Who helps? What helps?

I did what pastors do in such a case; I visited Marsha nearly every day, and spent time with her parents and brother. In worship every Sunday, our congregation held Marsha in God's healing light. She decided that she should become a member of the church, and we received her with open arms. When she could no longer get out of bed, we arranged for a special lift that could move Marsha from the bed to her wheelchair. One evening in early October, I wondered if we might take a walk around the block. She knew, as we all did, that the cancer was relentless in its pursuit, and that the chance of a cure was ever so slim. Whatever we could do to escape its clutches might be a good thing, and a walk around the block would free her from the confines of the

bed. Marsha readily agreed. We lifted her from the bed, helped her into the wheelchair, gave her a blanket, and wheeled her down the ramp that Marsha's brother had constructed for just such a purpose. Outside, the air was wonderfully cool, the leaves that were just beginning to fall were fragrant, and the stars were just beginning to appear in the sky. As we made our way down the road, there was a small bump each time we crossed a seam in the sidewalk. The steady rhythm of the bumps, the steps and even our breaths soon gave themselves to prayers. With each bump, we prayed:

Thank you God.

Help me God.

Thank you God.

Help me God.

Thank you God.

Help me God.

We went around the block, and then returned to the house grateful for the walk. I suspect we both sensed it might be the last time that Marsha would see the stars or feel the blessing of night's cool air. Over the next few weeks, Marsha's life became increasingly difficult. I found it increasingly difficult to facilitate communication between Marsha and her family, and between Marsha and God. We were all doing everything we knew how to do, and yet it all felt inadequate. Healing seemed to be outside the province of prayer.

What was true of pastoral care was also true for the hospital and clinic. Their efforts were equally inadequate. I realised we needed to reach out in other ways. Early in my ministry, I learned that there is always somebody to call when guidance is needed. Over the years, I have found that to be true many times.

Mutual assistance in a group

Somehow, I had learned of a cancer support group at a hospital about 45 miles away. I called and asked if I might attend on my own to see if it might be useful; they said I would be welcome. On the appointed day, I drove to the hospital and found my way to a small lounge in the cancer ward. There were about eight people seated around a small table that had a single white rose on it. In turn, the people introduced themselves, and each introduction revealed a bit of that individual's walk with cancer. One man had been diagnosed years earlier and was doing just fine, so he came to the group as a way of supporting others. Another was awaiting test results. Still another was about to begin a different kind of therapy. There was a sense of goodwill and camaraderie amongst the group.

Then, the staff introduced themselves. It struck me later that this had happened after the patients' introductions. Experience, not expertise, was the primary teacher. One of the staff was an oncology nurse. Another was a social worker, and a third was the hospital chaplain. The genius of the group suddenly became clear. If someone wondered why he or she was losing his or her hair, or why fatigue was so deep, the nurse would describe the side effects of the various therapies. If someone was not sure how to share the cancer with his or her children or spouse, the social worker would affirm that cancer affects the entire family as much as it does the patient. The social worker knew that right relationship is an intrinsic part of healing, and affirmed how difficult stress-filled communication could be. And the chaplain was there to address the spiritual dimensions of disease. He joked that if anyone wondered how God fitted into the puzzle, he would surely have the answer.

As the hour passed, I noticed that no one person was the designated facilitator. Sometimes a patient would speak, sometimes the nurse would bring up a topic, and sometimes the chaplain would sense a silence and say something to get the dialogue flowing once again. The

whole process seemed effortless. In a sense, we were a congregation helping each other carry the burden of cancer. Our purpose was not to find a cure or make a diagnosis. Life with cancer was our focus; learning to live with it was our purpose. As the hymn says, “Blessed be the ties that bind.” The depth of connection between us was pleasing, useful and beautiful.

At the end of the hour, one of the people pointed to the rose and asked, “Who should we give it to today?” There was a brief but attentive silence as everyone gently looked around the room. Someone said, “Let’s give it to Don.” And others responded, “Yes, let’s give it to Don.” And that’s just what they did. I later found out that sometimes the flower is given to the person who clearly has the greatest need, and sometimes to the one that everyone was just glad to see. At other times, someone whose insights had blessed the gathering receives the rose. There was never a vote; receiving the rose was not a matter of winning or losing. It was not something to be attained; it was simply a gift. Everyone just ‘knew’ who should receive it, and the decision was not that of any one person to make.

A rose for Marsha

I left the meeting inspired, and quickly told Marsha and her parents all about it. She agreed that trying to attend would be a good thing. We all also knew it would be a difficult trip. Marsha did not have much strength, and a two-hour drive would be exhausting but it was something we could ‘do’. Also, to be in the presence of those who understood both the hopes and fears of cancer might prove to be a blessing. We began to arrange for the trip. We found a van that had a wheelchair lift and, when the day arrived, the four of us headed north across the Minnesota farmland to the hospital.

When we arrived, the hospital staff helped Marsha get out of the van, and then we headed up to the lounge. Marsha asked that she be

allowed to attend the meeting without her parents; there were some things she wanted to talk about that she might not be able to share if they were present. Her parents graciously accepted. The group welcomed Marsha into their circle.

Although the group certainly recognised that Marsha was not far away from death, their faces and words spoke not of grief but of companionship. They were fluent in the language of experience. Story after story flowed across the table that once again held a white rose. The man who identified himself as a “talker”, talked. The man who came to the gathering to “check in”, checked in. The woman who knew how to surrender her life into God’s hands without giving up shared her story. When it was Marsha’s turn to speak, she spoke.

At the end of the hour, the group thanked Marsha for coming, and said they hoped to see her again despite the distance. When it came time to give the rose they gave it to her. I could not tell if they gave it to Marsha because of the gravity of her condition or because they always gave a gift of hope to a first-time participant. It did not matter; Marsha received her rose with a depth of gratitude.

We drove back home thankful for the respite the trip had provided. It was not long after that voyage that Marsha died. Cancer, that most selfish of diseases that wants more and more and more until there is nothing left, ran its full course. We were left with the assurances of the resurrection that transcends death.

Healing should not and need not be a lonely experience

Not long after Marsha’s death, I moved to another church. I had resolved to replicate the cancer group in whatever church I served; it was not difficult to do. People are living with cancer in virtually every town and perhaps every congregation in the world. Starting a group would just be a matter of finding a social worker who wanted to spend

an hour or two a month with a group of cancer patients, and a nurse who wanted to do the same. I should not have been surprised that, when given the opportunity, volunteers came forward. Some were from the church; some were from the town. All wanted to help. It did not take long for our church to be known as the place with the cancer group. It became a ministry to the whole town. When I moved to yet another church, we also set up a cancer group there, and it too became a ministry to the whole town. When people returned from hospital visits with the news of a malignant tumour, or with medications that so deeply affected their lives, they knew we would be there to support them with a depth of compassion. Healing became not a programme but a core ministry of our church.

There are so many stories that run through my mind as I write these words. I think of the 85-year-old woman who attended one of our groups to offer encouragement to the younger women, who were facing breast cancer as she had done 30 years earlier. She was such a beacon of hope. I think of the way that the group helped people without insurance learn how to obtain the care they needed. I think of the man with pancreatic cancer who, three years later, credited the group with his very survival. I think of the “Migrating to the Light” quilt one member made: its patches of red spoke of anger; the green ones spoke of the quilter’s envy of others who did not have cancer. There were black patches for despair, blue for serenity, and white for hope. We always knew it would be a good meeting if there were a mixture of laughter and tears. The cancer group was a time for life.

All of this has led me to a simple thesis: healing both should not and need not be a lonely experience. Its corollary is equally simple: hospitals and clinics desperately need the help that churches can provide. We do not live out the implications of our diseases in the corridors of hospitals; we live them out in our churches, our homes, and in our communities. The people who formed Marsha’s cancer group were as integral to her walk with cancer as were the doctors.

By their very nature, congregations have a calling to tend to the needs of the sick. When they do so, they are drawing from the deepest traditions of Christ's healing. Christ could not have been more explicit: "I was sick and you cared for me." (Matt. 25:36).

The 'more than' of healing

What do we mean by healing? We mean more than the chemistry of chemotherapy as it searches out cancer cells. We mean more than scanning the body in order to diagnose what is wrong with us. We mean more than an operation that fixes what is wrong. We mean more than placing the burden of healing on one set of shoulders. We mean more than just weathering a medical storm.

In answering the question, 'What do we mean by healing?', we emphasise the art of healing that involves the deep sense of connection inherent in the life of congregations. We mean the gift of hope that is best given in the language of experience. We mean the thread of coherence that refuses to relegate a person's life to a single moment in time. We mean the act of finding ways to create a healing community. We mean the blessing that can be given when we assemble together to share each others' lives.

I deeply believe there is not a single church that should not have a cancer group. I believe the same holds true for groups related to strokes, diabetes, addiction, or any other condition that catches the attention of a congregation. I also believe we live in a time in which we as churches have an unparalleled opportunity to reclaim our historic role as healers.

Who is today's rose for? It is for you. Thanks be to God.

Healing should not and need not be a lonely experience.

Faith and health in a Jamaican healing community: the story of Bethel Baptist Church

By E. Anthony Allen, MRC Psych, M.Div., consultant in whole-person health and church-sponsored health ministries, and former director, Bethel Baptist Healing Ministry.

Congregation-based whole-person healing ministry

In 1974, a new paradigm, or new way of understanding and practice, began both in health care in Jamaica and in the ministry of faith and health at Bethel Baptist Church. This model is called the congregation-based whole-person healing ministry approach. It was developed to reverse the influence of the mind-body and spirit-matter dualisms, which have limited the effectiveness of both Western scientific medicine and the church's mission in Jamaica.

Our approach sees that central to health is a wholeness or harmony between body, mind and spirit, and between the individual and the human environment, the natural environment, and God. Health is also a development issue, and healing seeks the liberation of the socially and economically marginalized.

The Bethel Baptist Healing Ministry provides services that are whole person in nature, comprehensive (being promotional, preventative, curative and rehabilitative), and community based (working with under-served communities, and the general community in which the church exists, as well as the local congregation). Our personnel are mainly lay volunteers, who are mostly non-professionals in the areas of health and social services.

Unique features

At Bethel Baptist Church, health promotion is a priority; the entire church population is included and served. Various activities are undertaken within the umbrella of the church. These include education for women and men in healthy lifestyles, family planning, and care for the elderly. Exercise is stressed in “fitness and wellness” classes. Sports and table games provide recreation and leisure activities. There is a “health corner” for working members of the public, who use our church weekday cafeteria, whilst the under-served use our soup kitchen. The church also runs a family life programme within the congregation through lay leaders, who offer counselling on preparation for marriage. We have marriage enrichment and parenting education groups, with follow-up support given to people who decide to have their children dedicated in the church. “Family Month” presentations deal with topics such as family living, ageing, separation, divorce, retirement and domestic violence. Special support and counselling is provided to common-law couples, where at least one member is seeking church membership.

Our preventative services include maternity monitoring and child immunisation, plus dental, vision and medical screening. Counselling, prayer and referral are provided for people with newly detected illnesses. Special health fairs and a health week offer additional screening and health education for the public. A mentoring programme provides for the total development of young people at risk. In the area of crisis intervention, a bereavement group supports people experiencing the traumatic death of loved ones. Training has been provided for those lay people who support others affected by death and suffering.

Our Healing Centre provides curative services on a multidisciplinary basis to the surrounding population, the congregation and our under-served communities. Waiting patients participate in a morning prayer service. Counsellors screen new clients, and note, frequently with the aid of a holistic assessment questionnaire, mental, spiritual, social and

physiological concerns. We then refer people, as appropriate, to the Healing Centre's medical doctors, psychological counsellors, prayer counsellors or the church's social worker. A visiting ophthalmologist provides specialist services. Outside the Healing Centre, a first-aid kit is available for all who use the church's several facilities. We provide training in first aid and lay counselling for use in the home, church and community. The church also runs a pharmacy.

The centre's rehabilitative services include a volunteer care team led by a community nurse and a church staff member. There are outreach services for the elderly, people confined to their homes, the mentally ill, and persons and their families living with HIV and AIDS. What we offer includes holistic care as well as referral to and advice from mental health and other specialists from within the church and elsewhere. The Baptist denomination also provides health care training for rehabilitation work.

Community outreach services are offered to three nearby low-income communities and certain rural villages. These services include a participatory learning and action approach for problem solving, and the promotion of self-help development efforts. Activities associated with this approach include a basic (kindergarten) school, a "kids club", swimming classes, a youth homework centre, adult literacy skill training, health care assistant training, environmental programmes and community advocacy. A bakery provides employment and dignity for members of a rural community.

A summer employment programme for our inner-city young people provides job and life skills training, as well as employment and a gateway to future work opportunities. Health promotion and screening, including health fairs, are offered to the youth, and they are also included in the church's health week and healing Sundays.

Sunday services, a Sunday school, and an evangelism programme provide for the spiritual aspects of our whole-person ministry. Conflict mediation efforts and dialogue bring together rival communities.

A special prayer ministry for divine healing is carried out within the congregation and its related communities. Here, recovery from an illness, which is beyond medical understanding, may occur. In our worship services, there is intercession for healing. A group meets weekly to pray for the sick. There is also a deacons' prayer group, plus house prayer groups, emergency telephone prayer chains, hospital visits and home visitation. All these pray for the sick, individuals with personal problems, and the elderly who are confined to home. Healing Sundays are held annually to emphasise divine healing for the whole person as part of the church's ministry and worship. Church members are divided into birth-month caring groups, who support each other in times of distress, and celebrate in times of joy. The laying on of hands can take place spontaneously as the Spirit leads us as we pray. There is no specific use of liturgical forms involving anointing with oil, as this has not been part of our Protestant Baptist tradition. However, we have used anointing on occasions. In our services, people come forward for pastoral and congregational prayer.

The crisis of HIV and AIDS

Serving people living with HIV and AIDS is important to our congregation. Several lay people have received training in counselling, basic health care provision and offering support.

A special AIDS policy stresses a commitment to complete inclusiveness in all aspects of church life (e.g. baptism and holy communion), non-discrimination, the best possible church-wide information, direct services, and the ensured participation in the life of the church of those living with HIV and AIDS. Efforts, such as talks, displays and drama presentations, are made to dispel the myths and discrimination concerning the diseases. Our HIV and AIDS services are seamlessly a part of our promotional, preventative, curative and rehabilitative programmes in our congregation, the Healing Centre, and in our community outreach. In all of this, strict confidentiality is maintained. Nev-

ertheless, at times, individuals will disclose their status in educational groups as a way of creating mutual openness. Awareness and basic support training is provided to all HIV and AIDS healing ministry workers, as well as to leaders of other church departments. This policy has resulted in a work model that has interested the Jamaica Baptist Union and other Caribbean churches.

The church as a healing community

Bethel Baptist church seeks to offer certain aspects of healing for the whole person directly through a special healing ministry team. Nevertheless, as has already been indicated, the church congregation is organized so that the whole church is one healing community through the involvement of the whole church, and virtually all of the groups associated with it, in this special ministry.

It is largely through volunteers that this healing ministry is exercised. We do have 17 paid staff but there are over 50 volunteers involved directly in the ministry. Many more volunteers come from associated groups.

The church has developed networking and advocacy with outside governmental, non-governmental and service club agencies in what we call, “a healing partnership for the under served”.

Prayer is the basis of this ministry. We seek to be dependent on the empowerment and daily guidance of God, who makes us whole and binds us together; we also trust in God’s healing activity. Thus, weekly groups meet to pray for our ministry, and our intercessory prayer ministry is one of the cornerstones of the church.

As already mentioned, we seek to be an inclusive community in which the marginalized, such as people from low-income communities, the mentally ill, and persons living with HIV and AIDS, are healed into

community life and the mainstream workforce. Most of all, we seek to introduce those who come to us, or those to whom we go, into an inclusive relationship with the healing Christ.

We are grateful to God for giving our members the opportunity to exercise the stewardship of their natural talents and gifts from the Holy Spirit in obedience to Christ's call to us as disciples, "to preach the kingdom of God and to heal the sick" (Luke 9:2). Over the past 30 years, our ministry has stood the test of time, as many report transforming benefit and thousands continue to experience the healing of God through medicines, people and miracles. The congregational-based whole-person healing ministry model at Bethel has spread to most denominations throughout Jamaica. We believe that every church in some way, however small, can be a healing community for those whom Christ loves.

Our approach sees that central to health is a wholeness or harmony between body, mind and spirit, and between the individual and the human environment, the natural environment, and God. Health is also a development issue, and healing seeks the liberation of the socially and economically marginalized.

Volunteers supplementing professional health care: diaconal groups in the church district of Tübingen, Germany

By Hanne Schmid, consultant, diaconal groups, Diakonisches Werk, Tübingen, Germany.

Doing a little more

In Germany, most people who are sick or in need of care have access to a web of professional help. Our system of health and nursing insurance usually covers the cost of professional help. However, compassionate care and human closeness are not provided as insurance benefits, and insurance companies cannot be sued if they do not provide them. The fact is that, despite the sophisticated German insurance system, many sick and elderly people live in social isolation, and long for people to care for them.

Ten years ago, this situation gave birth to the foundation of diaconal groups, made up of volunteers, in the Protestant Church district of Tübingen, Germany. Women and men, who were open to this new idea and intended to join such a group, took part in a training course that taught them some of the skills needed for this kind of caring. Only after such a course did the participants decide whether or not they wanted to serve in a diaconal group.

Today, diaconal groups are at work in thirteen parishes within the church district. The groups supplement the professional care that is already provided for elderly and sick people. The profiles and activities of these diaconal groups vary according to the situation of their parishes. However, the members of all the groups have at least two things in common: they are motivated by their Christian faith, and everyone has the goal of helping people in need as well as helping the helpers. The

groups provide a well-appreciated addition to professional services, and are examples of healing communities.

Providing help to people in need

Visiting is one of the diaconal groups' main activities. Sick, old and disabled people are visited at home, or are accompanied when they attend parish services or events. Thus, people feel that they belong to a congregation and do not become or feel isolated. Their relatives also get some time off so that they can do necessary shopping and other personal things. Moreover, caregivers are relieved to know that there is some support on which they can draw. Parish leaders also benefit from the groups' activities because without the groups, the leaders would have to do all the home visiting themselves.

The approach of the groups understands that preaching the gospel and diaconal work belong together. In following Jesus, a Christian community knows that it has to take care of and support sick people in the wider community.

Holidays without suitcases

A shining example of the work of the diaconal groups is the "Holidays without suitcases" project. Each year, and over a number of days, the elderly, disabled and even mentally ill people are collected in the mornings and taken home in the evenings. For these 'holiday makers', the days are a highlight of their year, while their relatives, who are with them for the rest of the year, can enjoy time free from care and responsibility.

Other activities of the diaconal groups include special services for sick and disabled people, who cannot attend Sunday church services on a regular basis. Members of the groups collect people from their homes,

and take care of them during the services. Afterwards, snacks and beverages are offered, and this provides the chance for sick people to come into contact with parish members, to interact with others, and to revitalise former relationships. The groups also provide cassettes of the services, which people can listen to at home. The diaconal groups visit those who are newly widowed, take care of immigrants living in hostels, and organize informal meetings for elderly people.

Mutual support among the group members

The members of the diaconal groups have regular meetings to keep their spirits up. At these gatherings, the members receive the addresses of new people in need, and tell each other about their experiences. They also pray for the people they are helping, and share some details about their own lives and concerns. If a group decides not to be active in the community for a time because, say, members of the group themselves are heavily burdened, then, group members meet to share their own burdens. So, instead of being exclusively a helpers' group, a group can become a self-help group for a while.

Four times a year, group leaders meet to discuss matters related to the groups' activities, and to receive information about further training. Thus, the existing diaconal groups network among themselves and benefit from their various experiences.

The relationship to the local parish

Diaconal groups grow out of the parish, and remain very much a part of the parish. This ensures that a larger community accompanies and sustains a diaconal group socially and spiritually. All of those who benefit from diaconal groups know about the context and background of their work.

The activities of diaconal groups vary. However, all of them show in specific ways how, in and through a community, a web is being formed and sustained that can hold and support people in need.

Preaching the gospel and diaconal work belong together. In following Jesus, a Christian community knows that it has to take care of and support sick people in the community.

Helping people with psychosocial disabilities live fulfilling lives: Users and Survivors of Psychiatry in Kenya (USPKenya)

By Susan Keter, chairperson, USPKenya.

For many in Kenya, being diagnosed with a psychosocial disorder (mental illness) signifies the end of active and productive living. It can also mean the end of a career and meaningful relationships. Many people living with these disorders neither receive proper information about their illness nor the support they require to regain control of their lives.

In 2007, some people affected by psychosocial disabilities established Users and Survivors of Psychiatry in Kenya (USPKenya) as a registered non-governmental organization (NGO). These people wanted to support each other through their experiences, and to assist others similarly diagnosed. Their vision was and is, “a world in which people with psychosocial disabilities are not only treated with honour and dignity but also realise their potential”.

As a national user movement, USPKenya offers membership to mentally ill people and their carers, and to community-based organizations (CBOs) that support them. USPKenya also welcomes as members those it believes can assist the organization achieve its objectives, such as professionals who are able to provide expert help and psychosocial support to other members.

Against stigma and discrimination

The situation of people in Kenya who are affected by psychosocial disabilities is serious because there is widespread misunderstanding and

misinformation about mental illness. Many people still believe that the mentally ill are themselves to blame for being ill. Often, mental illness is seen as being caused by sin, curses, the abuse of various substances, or other wrongs that mentally ill people or their families could have committed. People affected by mental disorders rarely receive the understanding they need, and have always received sub-standard treatment in Kenyan society. Even today, they often do not have access to information about their conditions, and are kept in the dark concerning possible treatment regimens.

Mentally ill people continuously receive harassment, criticism, blame and ill-treatment from those around them. This aggravates their illness and hinders their recovery. There are even cases where caregivers and family members persuade patients to discontinue the use of medication in the belief that self-will is all that is required to recover. Many people still equate being mentally ill to being immature. We have witnessed cases where mentally ill people repeatedly relapsed due to harassment from their family members and caregivers.

USPKenya provides education about the true causes of mental illness, as well as about preventative measures and available therapies. It also advocates for affected people's right to have access to quality treatment, and to having their human rights respected despite their illness. We have also learnt that it is not enough to educate mentally ill people about their illnesses; if we leave family members and caregivers out of the education, mentally ill people have little chance of recovery.

As a result of the education we provide, people are slowly beginning to understand that mental illness is a legitimate medical condition like any other illness, and one does not suffer from it because of having done something wrong.

Holistic therapy for mentally ill people

Through USPKenya, mentally ill people learn about treatment regimens, and are encouraged to participate in their professional treatment through talking to psychiatrists and psychologists, and asking relevant questions. Patients learn about the various causes of mental illnesses, about available medical treatment, and the importance of adhering to treatment. We also educate our members about the need for psychosocial support and the prevention of mental disorders.

In addition, people with mental illness are educated about healthy lifestyles through the promotion of practices such as having a wholesome diet with regular meals and enough fluid intake, and engaging in daily physical exercises. Patients are introduced to stress-coping mechanisms, such as avoiding the bottling up of issues that have caused offence, and venting their feelings in a healthy manner by, for example, writing down how they feel and then destroying the records. We also encourage people to discuss things with those who have offended them, to seek counselling support, and to compose a poem or a song about their painful experiences and to use them as lessons for others. Our members learn how to cultivate a positive attitude towards life so that they avoid boredom, take up hobbies, develop supportive relationships (social support), and stay in touch with their spirituality. We also encourage group therapy and the use of art, such as drawing or painting, to express one's pain and trauma.

Religion and mental illness

There are people who appear very religious, and many others who think God must have spoken to them and so listen to them with awe, and even repent, only to realise later that someone's mental illness was manifesting itself through religious zeal. Some people talk constantly about religion, and tell all and sundry how Jesus is coming back soon and that they need to prepare for his return. They accuse others of

being possessed by the devil, and constantly harass them to repent. However, after such patients have been treated for mental illness and stabilised, they stop speaking in these ways and begin talking about other things, such as supporting their children's academic work, starting income-generating activities to support their families, and making other contributions to society. This is one area that is not very well understood, and much still needs to be done to help people discern when someone is being genuinely religious, and when they are being overzealous about religion as a manifestation of mental illness.

Sometimes, signs of mental illness, e.g. delusions and hallucinations, are regarded as signs of being possessed by evil spirits. It is not understood that these symptoms are caused by the way an illness affects a person's brain function, and that they can be controlled with medication.

At times, people affected by mental illnesses will, as a result of their illness, use abusive language or do things that are contrary to their faith. In such cases, it is necessary to separate sin from being mentally ill. People have to learn that the person showing these symptoms of mental illness does not have to repent but needs treatment.

Caring for the carers

There are mentally ill people who are so severely ill that their carers have to deal with their day-to-day needs, including giving them their medication, taking them to the doctor, accompanying them to meetings, and assisting them in every way possible, including feeding and personal hygiene. Sometimes, the carers even have to communicate on behalf of the people for whom they care. As a result, many carers themselves end up with mental disorders due to the extreme stress of taking care of the mentally ill. Therefore, if carers are to provide the right kind of care for their loved ones, it is important for them to receive the psychosocial support and information about mental health

that we offer. We cannot wait until carers develop mental illness before they qualify to become members of USPKenya because, if we were to do so, the people whose interests we are serving would be unlikely to receive proper care from their carers.

Community-based activities

Part of our programme includes holding meetings out in the community to educate people about mental health. We encourage people to bring those affected by mental illness so that they can access treatment.

Moreover, we encourage stabilised mentally ill people and their carers to form local groups in their communities. USPKenya is a national resource to such groups all over the country, and we support them as they begin income-generating activities, e.g. bead work, detergent making, farming projects, and the rearing of poultry and dairy goats. We also encourage people to take part in group therapy, and learn how to advocate for mental health.

As people diagnosed with mental illness and their carers share details about their experiences, they encourage others with the illness, and this means more healing can take place.

Stabilised mentally ill people, and carers who are involved in these projects are often engaged in other activities in the community, and the training and mentoring they receive in the course of working with us benefits these other activities as well. Also, skills learnt by stabilised mentally ill people through income-generating activities are useful for the whole community because neighbours and others emulate them.

Raising public awareness

Public education about mental health as a way of promoting mental health for all is one of our major tasks. Through education programmes, such as participating in conferences, radio and television shows, interviews, the provision of resource materials, and workshops to share experiences, we enable service providers to understand what people living with mental illness go through, with all the misunderstanding and mishandling they experience. By providing such firsthand experience from users and survivors, we educate service providers to handle their patients with more sensitivity.

Our work of increasing the general understanding of the prevention and recovery programmes that are available for the mentally ill acts as a powerful advocate for improved mental health for everyone.

Signs of transformation

The most prominent and important sign of transformation that the work of USPKenya achieves is seen in the change that takes place in the lives of the mentally ill; many of our members become self-confident, and their self-esteem improves. They regain control of their lives, and actively participate in their treatment. They begin contributing in group discussions, and doing something useful. We have seen some members, who, when they joined us, could only sleep throughout the meetings, become elected officials in their community-based organizations, and on the national USPKenya board.

There is still a long way to go but we at USPKenya believe that every person living with psychosocial disability deserves understanding and support. We will continue in our efforts to help these people realise their potential, and to live fulfilling lives. Every person who benefits from our work encourages us to continue in our efforts to promote the rights and interests of people living with mental illness.

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Lessons learnt

The case studies in this section on communities as agents of health, healing and wholeness have taught us a number of lessons:

- it is possible to teach communities to take care of those members who are sick;
- education, and economic and social empowerment are related to health and healing;
- a mutual support group is of immense value to those who suffer and are in pain, and is part of the healing process;
- the power of prayer in its different forms is a healing force;
- even with the best insurance schemes, human care and love is still the best healer;
- the church community can effectively liaise and work with a pluralistic society.

Innovative and transforming responses to HIV and AIDS

Introduction

For the past 30 years, HIV and AIDS have changed the world. AIDS has killed 25 million people, and HIV and AIDS affect every fibre of society. Churches especially have been challenged to respond to them as stigma, discrimination and judgmental attitudes were common across denominations and churches. However, churches were also among the first to offer care and support to people living with HIV and AIDS (PLWHA) long before the arrival of antiretroviral therapy (ART). HIV and AIDS have taught us that churches and society at large must address issues, such as sexuality, openly, and that the biblical principles of forgiveness, love and compassion, as well as a general respect for one another, are essential in order to fight the diseases.

Today, the face of AIDS has changed. Treatment is possible and, where once there was death, today there is life and hope. However, access to such treatment is still limited; only four out of 10 people needing treatment can access it today, and for every two people who receive treatment there are five newly infected. Stigma and discrimination are still widespread, and we all need to work together in fighting HIV and AIDS. How the church and its healing ministry responds to HIV and AIDS will prove whether we have properly understood what our healing ministry should be.

The case studies presented here are just a few examples of Christian communities responding to the HIV epidemic in an innovative and comprehensive way. Some of the communities have years of experience, and began caring for PLWHA long before the advent of ART. These groups have established effective home-based care programmes, and found new and innovative ways of financing their work.

In another situation, a church realised that people in the local community were dying, and responded with a total community approach. The empowering of young people, PLWHA and other volunteers in care and prevention has led to transformation in this community.

Similarly, reaching out to a forgotten community has broken down walls of silence, and allowed an effective prevention programme to be established among a neglected group. Also, and beyond the Christian faith, collaboration with other faith-based organizations has made a difference, and allowed the voice of faith-based organizations to be heard widely.

HIV counselling and testing combined with spiritual guidance to Maasai communities around Moshi, Tanzania

By Maja Kohler and the Rev. Dr Günter Kohler, project coordinators.

Clinical pastoral courses

The Kilimanjaro Christian Medical Centre (KCMC) in Moshi is one of Tanzania's major hospitals. The hospital's chaplaincy department has run clinical pastoral education (CPE) courses since 1972. In the beginning, participants used to be mainly pastors but the target group now includes medical and paramedical staff, and other church-affiliated employees such as evangelists and administrative personnel. The CPE courses use a highly practical approach to enhance the trainees' communication skills. Students go on to the wards to provide pastoral care for patients, and also develop self-awareness in peer group activities. The courses foster the cooperation of medical and paramedical hospital staff with the chaplains in order that holistic care can be delivered to patients and staff.

Since 2004, the CPE courses have included a three-week HIV counselling training element, conducted by nurses, and lately also a three-day introduction to palliative care conducted by the Palliative Care Unit of the Evangelical Lutheran Church in Tanzania (ELCT).

After attending an international seminar on pastoral care and counselling in 2007, the Rev. A. Lyimo, head of the chaplaincy department, introduced the idea of clinical pastoral education, plus the concept of taking a holistic counselling ministry to remote communities not reached by standard medical services or the numerous non-governmental organizations (NGOs) working in the country. The CPE col-

lege began to develop a model of outreach to Maasai communities focused on HIV and AIDS awareness building, spiritual guidance, and HIV testing.

Understanding the Maasai

The Maasai are a minority community spread over the steppe plains of Kenya and Tanzania. They are pastoralists, as distinct from the majority of the population of the region, who are of Bantu origin. Maasai usually do not mix with people from other tribes; they have their own language, which is almost unknown to non-Maasai. The Maasai wear their traditional style of clothing in their own surroundings, and use western-style clothes only when necessary. Many men, especially those who are non-Christians, live in polygamous relationships that allow for men of the same age group to have sexual relations with the wives of their peers. The rural women live in houses built from branches and cow dung, and arranged in clusters (bomas), surrounded by brambles, which provide a secure space for people to keep their cattle during the night. Girls are still ‘circumcised’ or, better put, ‘excised’. From an early age, it is arranged that they will marry someone known to them, and be transferred to their husband-to-be as soon as they reach sexual maturity. Traditionally, schooling was not common because in Maasai culture boys are supposed to tend the goats and sheep, the young men are “warriors” who defend the cattle, and girls must help their mothers until they are delivered to their husbands. Now, schools exist, and some children attend, though that depends on the attitude of the owner of a boma.

Goals of HIV prevention among Maasai communities

Due to their way of living, Maasai are extremely susceptible to HIV infection once a member of the community catches the virus. Awareness of this risk is virtually non-existent among the Maasai, and medi-

cal services, let alone testing facilities, are scarce. Because of this state of affairs, the CPE centre planned to achieve four main goals with outreach missions to the Maasai community:

- to supply basic knowledge about human physiology, the conditions and risks of HIV infection, and ways of avoiding the transmission of HIV, and to provide HIV testing;
- to stimulate and conduct discussions on changes in behaviour necessary for the Maasai community in order for them to survive the HIV pandemic, and on matters of prejudice and social exclusion regarding those living with HIV and AIDS;
- to deliver the message of the Christian faith, to teach the uniqueness and value of each individual, and thus the necessity and the right to say no to dangerous practices even if tradition appears to justify them;
- to explore ways of networking with regard to public health issues, and with a special emphasis on HIV prevention and AIDS treatment.

Preparatory work and establishing a teaching team

Preparatory plans were made with the Rev. Joshua Laiser, a Maasai pastor working near Moshi, and the Rev. Joseph Loserian of Narokawo Parish, which belongs to the ELCT Arusha Region diocese, and is situated in the steppe some 250kms south of Kilimanjaro International Airport (the airport lies between the cities of Moshi and Arusha). The parish is made up of bomas within an area of in excess of 100kms in diameter. The first outreach, in November 2008, was mainly to four bomas around the parish centre but also took in the inhabitants of other bomas nearby.

KCMC hospital provided a car, and the Faraja Diaconal Centre in Sanya Juu also provided a vehicle for a choir, as well as video equipment. In January 2009, the team expanded its activities with the addition of three four-wheel-drive vehicles so that it could go to the 'vil-

lage' of Kimotorok in a more remote part of the parish of Narokawo. Kimotorok consists of a number of bomas, and a very small centre with a store and a dispensary.

After discussions with a public health consultant, a six-day training-of-trainers (ToT) event became the key element of the programme. The parish administration had selected a group of twenty active parish members, plus leaders from women groups and choirs to take a course to become HIV and AIDS educators and counsellors.

The KCMC teaching team had a physician, two nurses, and two pastors. In addition, there was a social worker from the CPE centre for organizational tasks, a technician from the chaplaincy department for the visual part of the awareness-raising training, a pastor and his assistant with cinema equipment, and a group of leaders and young boys from the Sanya Juu Brass Band and Choir. Liaising with the parish of Narokawo had again been done through the Rev. Joshua Laiser, the Maasi pastor, since communicating with the parish pastor proved to be difficult because there are just a few spots in this area where communication by mobile phone is possible.

Project implementation and Maasai culture

The awareness-raising campaign for the general public began in the evening of the day when the team arrived, with the screening in the boma of a video on AIDS. The daily teaching sessions for everybody began the next day from noon to 4 p.m. under the shade of a large tree. Any activities in this area must respect the daily routine of the pastoralists, who have to tend the cows in the mornings or evenings, when they calve, while at the same times the "warriors" are away with the remaining cattle, in search of grazing grounds.

Five women and fifteen men made up the ToT group, and provided training every day both before and after some general awareness-rais-

ing events. For some of the teaching sessions about human reproductive health, people were divided into subgroups of women and men. The KCMC team had been warned beforehand that it might not be possible to discuss some sexual matters, e. g. female genital mutilation (FGM), in mixed groups.

Maasai generally practise FGM in the belief that a woman not having undergone it is not mature. Discussions about female genital mutilation were difficult in the first days of the training; it was one of the outstanding results of the training of trainers that after six days it proved possible to discuss FGM in public, and have some of the trainees openly take a stand against the practice which, among other hazards, increases the danger of HIV infection in women.

The KCMC team offered the possibility for one of its nurses, who holds a licence from the National AIDS Control Programme, to provide voluntary counselling and testing for HIV. Generally, people were reluctant to be tested but after one of the boma chiefs took the test and also allowed his wives to be tested, others joined in. Happily, no one was found to be HIV positive. However, given the fact that the government is constructing two main roads that will meet in the Kimotorok area, there is a high possibility that with the arrival of truck drivers and business travellers in the area, the pandemic might soon reach this remote region. Therefore, prevention through education is more needed here than ever.

Those attending the ToT course took a written examination on the sixth day of instruction, with some people needing assistance with reading and writing. The results showed that the people had been following the training closely. The group elected a chairman and his deputy, plus a secretary and his deputy. The chairman is a boma chief, who used to be a parish elder, and who had been elected to be a warden of traditional ethical rules in the Maasai community of the region (Alaigwanani). This means that he is recognised as a person with mediation responsibilities and authority in the community. The whole

group of trainees was officially recognised, given their responsibilities, and blessed in a Sunday service on the ninth day of the mission. The people pledged to:

- organize HIV and AIDS awareness raising;
- work for the improvement of public health, e.g. by building toilets;
- promote a sustainable environment, e.g. by planting trees.

Monitoring and evaluation

In May 2009, six months after the training sessions, a small group from the KCMC Hospital set out on a five-day tour of some of the Kimotorok bomas to evaluate what had been achieved. The group heard that those trained had met once since the course, and done their own teaching of people in the community. More teaching had not been possible due to the long distances involved, and a lack of funds. The KCMC visitors heard that life for the Maasai pastoralists had become increasingly difficult due to drought. Even so, many bomas had begun to grow maize, some were even using tractors, though there was likely to be little chance of bringing in a harvest in 2009. In two bomas, the KCMC team saw newly built toilets. The group of former trainees explained that they needed to elect a new secretary because the first office holder had left in order to go for academic education. The group also needed to appoint two representatives from a distant boma that had felt left out.

The assistant medical officer (AMO) who had begun working in the Kimotorok dispensary in January 2009, came to strengthen contacts between the dispensary and the group. It was known that the village, when planning to establish a local HIV and AIDS committee, had decided to ask the ToT group to take on this responsibility. The AMO and the nurse working in the dispensary explained that they could not do counselling and testing; the same is true for the flying doctors who visit the region to provide mother and child healthcare, and whom the evaluation group met. The evaluation group urged the village authori-

ties to make sure the airstrip in the region was kept intact in order to allow the flying doctors' aeroplanes to land.

Experience has shown that follow-up visits are necessary for some time in order to establish a stable network of local HIV and AIDS educators.

Discussions about female genital mutilation were difficult in the first days of the training; it was one of the outstanding results of the training of trainers that after six days it proved possible to discuss FGM in public, and have some of the trainees openly take a stand against the practice.

The journey to palliative care provision: Maua Methodist Hospital, Kenya

By Stephen Gitonga, coordinator, Maua Methodist Hospital Palliative Care Programme.

Maua Methodist Hospital in Kenya responded to the HIV pandemic in the early 1990s by launching an aggressive HIV and AIDS educational campaign that focused on the community. Ten years later, this strategy proved not to have had a major impact on behaviour change. Increasing numbers of AIDS patients presented themselves at the hospital. This, and the fact that people living with HIV and AIDS suffered from stigma and discrimination, showed clearly that HIV and AIDS are not only health issues but also socio-economic developmental issues. HIV and AIDS touch all that makes and supports a family. The infection brings suspicion, a lack of trust, studious silence, the desire for revenge, and the linking of it to witchcraft and curse in African settings. Therefore, a comprehensive approach is required if HIV and AIDS are to be contained. This is particularly the case because the main mode of spreading HIV is sexual intercourse, and there is a deeply held taboo in Kenyan society about openly discussing such a subject, which means that a thick cloud of ignorance hangs over the issue. Even today, in Christian circles, people living with HIV and AIDS are sometimes labelled as sinners who do not deserve forgiveness.

Against this background, Maua Methodist Hospital changed its approach to combating HIV and AIDS. We launched a programme to offer practical care, support and the prevention of HIV and AIDS through the use of available resources in the community. To make this approach work, we knew we had to involve and engage the communities themselves in the programme.

Not for but with the communities

In 2001, Maua Methodist Hospital began its Community-Based Palliative Care Programme. Our aim was to help people living with HIV and AIDS, and other life-limiting diseases, and to change the attitude of local people towards those with these diseases. We knew that we had to work not for the communities but with them.

Our first step was to ask communities to openly acknowledge that HIV and AIDS were a problem within their community. Leaders of the Methodist Church in Machungulu, a village of 17,000 people, were the first to speak out and say that their young men were dying, their young women were dying or becoming widows, and their children were dying or becoming orphans, and all because of HIV and AIDS. The people of Machungulu responded enthusiastically to the offer of a programme being established in their village that would have a two-fold objective. The first would be to train volunteers to care for their loved ones dying from AIDS and other life-limiting illnesses at home, and the second would be to provide antiretroviral therapy to women with AIDS. Antiretrovirals prolong the lives of people with AIDS, which means that affected mothers can raise their own children.

Hospital personnel and Methodist Church and community leaders began working together. The church leaders created a place for a palliative care clinic in the church. The hospital began training the senior leadership of the church to accept, support and care for people with AIDS. The next step was to train community members to care for dying family members at home. Providing such care is not always easy because there is often no running water, electricity, furniture, or bed. The hospital training team expected few participants but so many people came that several training sessions were required. Soon, people with AIDS and other illnesses were coming to the clinic in the church. The numbers grew steadily, as those who had attended the training classes walked up to 50 miles to villages to let others know about the clinic, and the hope and support available at Machungulu Methodist

Church. Other communities followed the example of Machungulu, and currently there are over 1,000 people receiving antiretroviral treatment in the area.

Since the inception of the programme, the situation in the area has improved considerably: More than 85 people have been trained in home care, and some of these travel up to 70 miles to train others. Women are receiving antiretroviral therapy. Self-help groups exist, and the thinking about HIV and AIDS has been transformed in the entire region. Attitudes and behaviour towards people with AIDS has changed dramatically.

Maua palliative care model: salient features

The palliative care programme we offer contains a number of important features:

- it is an integrated model, where patients with life-limiting illnesses are treated, and this has led to the breakdown of the stigma associated with HIV and AIDS;
- the communities identify for themselves their challenges, and initiate responses; the hospital then facilitates the further development of the programme and offers subsidised treatment;
- clinics are equipped with basic drugs, and weekly reviews of patients take place;
- local pastors and lay church workers visit the clinic weekly, or when local patients' support groups meet; the hospital chaplains offer support and pray with patients as they wait for treatment;
- patients undergoing treatment, and who have recovered enough strength, are vital in recruiting other patients for testing, and offering treatment and support;
- compassionate care programmes have formed the basis of developing other social initiatives, e.g. orphan care, income-generating activities, kitchen garden initiatives, and groups supporting widows and people living with HIV and AIDS;

- patients and their families are enrolled into the NHIF (National Health Insurance Fund) scheme, and their monthly payments are subsidised by external funds; the whole family gains much benefit from being enrolled into the NHIF, which covers hospital fees payable on admission, and this encourages infected people to admit openly to being HIV positive;
- patients receive invitations to speak to congregations and other fellowships;
- families that have broken up due to the knowledge of their HIV status are being reunited, and accept the need to go to the hospital and/or a community clinic for testing and treatment.

Challenges to HIV and AIDS responses

While being extremely grateful to God for working through us in this comprehensive approach, we still face challenges that to some degree counteract the success of the programme.

Antiretroviral treatment is compromised by the “faith healing” phenomenon and “prosperity gospel” that new and growing sects promote. There are preachers who promise people not only that AIDS can be cured but also that a cure is possible solely through faith and prayer without any medical treatment being necessary. We are in dire need of adequate theological responses to misleading articles regarding HIV and AIDS that feature prominently in print and electronic media. Sound theological statements are also needed regarding the full integration of repentant polygamous families and HIV positive people into church communities.

Harmful and destructive cultural practises, such as female genital mutilation, pose another challenge. In some areas, female circumcision is promoted as a ritual necessary to becoming a “full woman”. Such practices increase the vulnerability of girls and women to HIV.

Great things happen

Our burning desire is to see quality care provided to patients and families of people with life-limiting illnesses so that added value can be given to the remaining days of those who are sick. Eight years of experience with the Maua Methodist Hospital's Community-Based Palliative Care Programme have shown that communities are ready and willing to share their commitment and resources in tackling their social and health problems. We believe that community involvement is the practical way to deliver palliative care services in an era when the cost of receiving care is high. This approach proved essential as we engaged with both the senior and grassroots leadership of churches, and people living with HIV and AIDS in formulating inclusive and acceptable policies for dealing with HIV and AIDS. One interesting aspect of the community involvement in the programme is that trained and dedicated volunteers provide the necessary link between the hospital and families in need of its services.

Archimedes, the ancient Greek mathematician and scientist, said, "Give me a lever long enough and a place to stand, and I will move the world." In this sense, we use love, care and compassion to move the world. We see great things happening out of small beginnings. We are dynamic, and we are still learning.

We believe that community involvement is the practical way to deliver palliative care services in an era when the cost of receiving care is high.

Malawi faiths unite against HIV and AIDS: the Malawi Interfaith AIDS Association

**By Patrick Nayupe, primary health care/AIDS manager,
Christian Health Association of Malawi.**

“There is no way we can ignore the fact that HIV and AIDS are eating up the very fibres of our congregations,” said Bishop Peter Misukiwa, chairperson of the Malawi Interfaith AIDS Association (MIAA), in a meeting of Muslim and Christian leaders arranged to address the HIV and AIDS pandemic. Bishop Misuka continued, “HIV and AIDS are drastically affecting all our congregations on a daily basis. That is why we have come to realise the need for a multi-faith approach to fight the diseases.”

The background

The HIV and AIDS epidemic has been a reality in Malawi since the first case was diagnosed around 1985. However, in the years up to 1994, government and faith-based organizations (FBOs) were in a state of denial to the fact that we had a national crisis on our hands. Faith communities did not respond to the epidemic adequately, and when they did respond it was with a dual approach. As always, the members of faith communities cared for the sick, and strove to take care of the increasing number of orphans. However, since the focus of concern about HIV and AIDS was their sexual mode of transmission, the faith communities considered the issue as a moral one, and were unable to recognise the health, environmental, social and development crisis that existed. This influenced the kind of response that the faith communities made. In their opinion, the approach of the government and secular non-governmental organizations, which was the wholesale distribution of condoms, especially in schools, was making matters

worse. Some communities saw the diseases as signs of the “end times” about which nothing could be done. The result was that two sources of communal authority, namely, the government and the church, gave seemingly contradictory messages.

Establishing a united commitment of churches against HIV and AIDS

In November 2002, regional church conferences took place in each of the three regions of Malawi under the theme, “Churches breaking the silence on HIV and AIDS”. During the conferences, it was felt that FBOs in the country did not have a forum or body to co-ordinate their work on HIV and AIDS. The National AIDS Commission’s strategic framework review, carried out in early 2003, also raised this concern. In response, several Christian FBOs set up a task force. Two Muslim organizations subsequently joined the group.

At the end of 2003, therefore, the task force changed its name to the Malawi Interfaith AIDS Association (MIAA). The association has seven members. These are the Episcopal [Anglican] Conference of Malawi, the Malawi Council of Churches, the Evangelical Association of Malawi, the Muslim Association of Malawi and the Qadria Muslim Association of Malawi, plus two Christian professional associations: the Christian Health Association of Malawi, and the Association of Christian Educators in Malawi.

MIAA’s mission is to facilitate a united commitment of faith communities in the struggle against HIV and AIDS. MIAA aims to bring hope, dignity and quality of life, and to break the silence and remove the stigma and discrimination related to HIV and AIDS. It facilitates and coordinates programmes that use rights-based and gender-sensitive approaches to deal with prevention, care, support and the mitigation of the impact of HIV and AIDS. The association’s belief is that, in the struggle against HIV and AIDS, FBOs enjoy the particular advantage

of the authority, courage and commitment of their religious leaders, as well as their members' volunteering spirit, which is grounded in religious principles and beliefs. With respect to prevention, an analysis of gender, sexuality, discrimination and stigma are key elements in MIAA's approach.

The coordinating secretariat and its main activities

MIAA is a secretariat body that coordinates and supports the AIDS work carried out by its member organisations. MIAA is directed by a council made up of five male and five female religious leaders, and an executive committee of 14 with, again, a gender balance. The MIAA secretariat has a staff of seven people, who work directly with a Programme Technical Committee of 14 HIV and AIDS coordinators or managers from the member organisations. It is through this committee that member institutions implement MIAA programmes.

The main task for the secretariat is to facilitate a united commitment by faith communities in the fight against HIV and AIDS. MIAA has now gained experience, and acquired the necessary skills to coordinate a robust faith-based response to the problems the community faces. Since its establishment, and despite some teething problems, the secretariat has developed the necessary structures to scale up its response to HIV and AIDS.

Through its training of religious leaders, and the provision of gender, sexuality and life-skills programmes for adults, youth and children in 72 religious congregations in six districts, MIAA is contributing to the reduced vulnerability of women and girls to infection by HIV. Religious leaders are trained to convey positive messages to their congregations about issues of gender, sexuality, cultural and religious practices, stigma and discrimination.

MIAA's training programmes attract keen adult congregation members. Children and young adults also acquire knowledge and appropriate life skills that together promote positively changed behaviour. There is a system for identifying best practices and lessons learnt, with the knowledge gained being disseminated through the MIAA secretariat, exchange visits and media coverage. Plans for scaling up the intervention to other districts are regularly developed and agreed to.

Strengths and challenges

The fruitful and effective collaboration between Christian and Muslim faith-based organizations is a shining example of bridging gaps between different faiths. Malawi's history of interfaith relations indicates that there was hardly a stable relationship when it came to working together on religious matters. There is a sad history of clashes and mutual hatred between Christians and Muslims, so that joining hands in the fight against HIV and AIDS means more than an effective collaboration; it is also a sign of reconciliation.

Six years after its inception, MIAA continues to play a pivotal role in the coordination and facilitation of HIV and AIDS programming across the country. MIAA brings together the mother bodies of the FBOs involved so that they can speak with one voice in advocating for the rights of people infected and affected by HIV and AIDS. On all levels of its work, MIAA benefits from the capacity of FBOs in terms of resource mobilisation and project management.

MIAA's effectiveness has led to an increased recognition and support by the Malawi government, and to an improved acceptance of FBOs at district level. The activities of MIAA have led to a mutual understanding between the State and FBOs on the issue of promoting antiretroviral therapy rather than simply trusting in faith healing for AIDS.

In trying to save people from HIV and AIDS, MIAA faces some challenges. There can be, for example, differences between those who wish to promote condom use as a preventative measure, and various faith groups who stress mutual faithfulness and abstinence as the way to prevent HIV and AIDS. Another challenge is that in mixed-gender groups, sometimes women and young people are not equally represented, especially within the Muslim society, where women are not allowed to be active in public. There is also a problem posed by the high expectations of FBOs in terms of incentives. The religious leaders involved see that secular organizations working in the same field receive remuneration, and expect FBOs to be treated similarly.

Yet, despite the challenges and hurdles, MIAA is grateful to God for its having made a real difference in combating HIV and AIDS in Malawi by joining together the forces of the different faiths.

HIV and AIDS are drastically affecting all our congregations on a daily basis. That is why we have come to realise the need for a multi-faith approach to fight the diseases.

Hope for the future: the Reach Out Mbuya Parish HIV and AIDS Initiative, Kampala

By Nandawula Roselyn, public relations assistant, Reach Out Mbuya Parish HIV and AIDS Initiative.

Reach out in love

The Reach Out Mbuya Parish HIV and AIDS Initiative is a community-owned faith-based organization (FBO) run by Our Lady of Africa Church in Mbuya, Kampala. The project grew out of the church's traditional activities of caring for sick and marginalized people. In Mbuya parish, volunteers wanted to relieve the pain of sick people, who could not access help from others. Members of the parish would visit these people in their homes, pray with them, comfort them and hold their hands during the last days of their lives. Towards the end of the 1990s, the vast majority of the sick and dying who were visited had AIDS. This was when Reach Out Mbuya was born.

In May 2001, a small team was established to add medical and, shortly afterwards, social support to the existing gestures of love shown towards suffering people. A Danish physician, Margrethe Juncker, joined the team, which also had the support of the parish priest who promoted its work among his Mbuya congregation.

Holistic care using low-cost interventions

The key entry point for our clients is medical care. Reach Out Mbuya addresses both body and mind issues with a range of services that include general medical care, paediatric and adolescent care, antenatal care, referral for delivery, post-partum care, antiretroviral therapy (ART), free counselling and testing, home-based counselling and test-

ing for couples, tuberculosis and other opportunistic infection prophylaxis and treatment, home visiting, and laboratory services.

Food is supplied as part of essential medication, and, eventually, when health is regained, opportunities for starting a small business are provided through microfinance and income-generating programmes. The children of sick people receive help with school fees in order to receive a basic education and thus stand a better chance of a brighter future.

From a very humble start with only 14 clients, Reach Out Mbuya has grown to serve more than 3,300 people living with HIV and AIDS. We have expanded from one to four sites, three being within Kampala and one in the Kasaala Luwero District, 74km north of the capital. At present, more than 1,680 clients are on free ART drugs.

Our vision is to provide community-based approaches using low-cost interventions. Our mission is to curb the further spread of HIV infection by educating all residents of Mbuya parish about HIV and AIDS, and to enable those already living with HIV and AIDS to have a responsible and dignified life.

A network of care

Reach Out Mbuya depends on what we term a community network of care, which forms the backbone of our holistic care approach. Our network enrolls knowledgeable clients who become part of the programme so that, through them, the social, spiritual and emotional wellbeing of our other clients is improved. Our community network of care is made up of a number of groups: Mother to Mother Supporters, Teenager and Adolescent Supporters, Community ART and TB Treatment Supporters (CATTS), and Community Supporters. Each of the CATTS has 10 to 15 clients, whom they supervise. They monitor drug adherence, and identify those in need of critical medical care. They are also on call for clients admitted to hospital. In addition, they carry out

home visits, count pills and do basic counselling. This strengthens the workers' relationships with their clients in the community, and this, in turn, creates a sense of ownership of the Reach Out Mbuya programmes.

Community sensitisation is done under the motto, "Friends for Life". We help the community of Mbuya to appreciate the beauty of life by promoting healthier life styles through educational activities. Seminars, skits, sport, music, dance and drama, educational talks and films are the key methodologies we use to reach different groups of people in the community. Friends for Life also supports people who are frustrated when they are diagnosed as HIV positive, and helps them to overcome despair and stigma.

Using the slogan, "We have a second chance, and that chance is now", we aim to ensure that both clients and non-clients enjoy a new life filled with hope and love. In a warm atmosphere, people living with HIV and AIDS are accepted, and their contributions valued. At Reach Out Mbuya, the clients are full of life, and hope is in the air; you see it on their smiling faces.

The best part, though, is that the distinction between service provider and service receiver fades away; more than half of our 279 service providers are clients themselves, and we believe that the rest of the providers appreciate that they receive each day more than they give.

Transformation through love

We are striving to base our work on love for our fellow human beings in whatever shape or state we meet them. We cannot claim that we always succeed – far from it – but we are trying. We were honoured by the visit of Dr Peter Piot, a former UNAIDS executive director, who declared, "The world needs Reach Out." However, we at Reach Out Mbuya continue to ask, "What would Reach Out do without the

world?” We thank God that we have the chance to bring hope and healing to people living with HIV and AIDS, who are stigmatised and isolated because of a lack of love from their family, relatives and the community.

“Love is the explanation for everything, a love that opens up to the other in his unique individuality and speaks to him the decisive words, ‘I want you to exist’” (late Pope John Paul II). To us at Reach Out, love explains all of our success.

Love is the explanation for everything, a love that opens up the other in his unique individuality and speaks to him the decisive words, “I want you to exist.”

Lessons learnt

Looking at the four case studies in this section on innovative and transforming responses to HIV and AIDS, there are seven important lessons to be learnt:

- recognising marginalized and forgotten people, and addressing them in a socially and culturally appropriate manner is an effective way of HIV prevention;
- the united commitment of faith groups creates a common base in the fight against HIV and AIDS, as does common prayer and jointly expressed faith that brings people together;
- caring for people with HIV and AIDS breaks down stigma and discrimination in communities, and allows people to be involved and contribute their strengths and resources to their communities;
- people living with HIV and AIDS act as agents of change in both prevention and care, and can even play a vital role in clinical care;
- innovative financing models will strengthen access to health care for families infected and affected by HIV and AIDS;
- where churches recognise and address issues such as HIV and AIDS, they can facilitate transformation in the community;
- FBOs can apply scientific knowledge and quality standards to prevention and care, and effectively use modern standards of monitoring and evaluation.

Hospitals as centres of a holistic approach to health

Introduction

For centuries, Christians have provided hospital care. Monasteries provided nursing care, and the 18th century mission movement began in many countries with a school and a hospital. By 1910, Protestants ran 2,100 hospitals and more than 400 clinics on the “mission fields”, as they were then called.

Following 20th century independence for many countries, mission agencies began to withdraw from the classical mission fields. Mission hospitals were handed over to governments and churches. In the 1970s and 1980s, many European mission agencies and development partners stopped or reduced funding for hospitals, and many church hospitals then had to begin raising funds through hospital fees. This made it difficult in many places for the poor to access good quality health care.

Traditionally, hospital-based care is curative care, and in many countries mission hospitals provided high quality care. However, due to a lack of finance, retaining professional hospital staff is becoming increasingly difficult, and this is compromising the quality of care provided.

Even today, many churches still run hospital services, and often do so in remote areas and under adverse circumstances, based on a calling to provide care for the poor and marginalized. In recent years, many hospitals have introduced community-based services and primary health care. Despite the many challenges they face, Christian hospitals are an important aspect of the healing ministry.

One of the two case studies presented here describes a classic mission hospital founded through an American mission, and that today belongs to the African Inland Church in Kenya. It is a hospital with state-of-the-art health care but also a strong community outreach programme. The other case study is of a hospital with a similar history but in an Indian context, and which belong to the Emmanuel Hospital Association.

Health care to God's glory: holistic healing at the A.I.C. Kijabe Hospital, Kenya

By Justus M. Marete, executive director, A.I.C. Kijabe Hospital.

In 1915, the Africa Inland Church (A.I.C) began a small medical clinic in a mission station at the edge of the Rift Valley in Kenya; over the years, the clinic grew into the Kijabe Hospital. This large teaching and referral establishment provides one of the most comprehensive health care services in Kenya, and serves not only its local community but also all the provinces of Kenya and even surrounding countries. Currently, the Kijabe Hospital has more than 250 beds, over 300 out-patient visits each working day, and in excess of 600 staff.

Besides being a centre of excellence with regard to the medical care that the hospital provides, there are some other prominent features on which I will focus:

- all the hospital's services are rooted in the vision of holistic healing as the fulfilment of Jesus' command to heal, and, accordingly, chaplaincy is an essential component of the hospital's structure;
- in fulfilling Jesus' command to heal, we are committed to serving impoverished and underprivileged people, which is why we focus on community involvement and try to improve the health situation of people in rural settings;

The vision of holistic healing

Pioneering missionaries at the beginning of the 20th century realised that when people came seeking medical care because of physical pain, their pain was often a manifestation of more needs than just the physical ones. Many patients were also longing for spiritual assistance and encouragement. This is why a vision of holistic healing originated from

the beginning of Kijabe Hospital's work.

The hospital continues to believe that many physical diseases have spiritual and/or psychological aspects, and therefore a spiritual diagnosis is often called for. Our motto is "Health care to God's glory", and our workers are committed to care for the whole person in the process of carrying out their daily chores.

Our mission statement says, "With God's help and to his glory, AIC Kijabe Hospital seeks to provide excellence in compassionate health-care, education and spiritual ministry in the name of Jesus Christ".

Chaplaincy

Over the years, our team of chaplains has grown to the current number of nine full-time and two part-time chaplains. The hospital is organized into six divisions with a director at the head of each. It is a reflection of the importance that we attach to our spiritual work that chaplaincy is one of the six divisions. Each chaplain is assigned to a ward, and our school of nursing has a dedicated chaplain for its 170 students and 14 lecturers.

Many of our chaplains have had the opportunity of training at the Tenwek School of Chaplaincy, where the concept of making a spiritual diagnosis is emphasised. It is realised that whilst the physical alleviation of pain may be temporary, every person who comes to believe gains an everlasting freedom from pain and suffering in the life to come.

On a daily basis, a chaplain can visit at least 15 patients in the hospital, as well as attending to other duties, such as meeting staff. On Sundays, the hospital choir sings to patients on the wards. The adjacent Moffat Bible College assigns many of its students to our hospital for the work practice component of their training; this includes spending Friday

afternoons speaking to our patients about, among other things, the Christian gospel.

Community involvement in health care for people living with HIV and AIDS

We have more than 5,000 patients receiving antiretroviral therapy in our facilities. Our method of enrolling patients for HIV and AIDS care has a special feature. We have community health workers, who have been trained and are living within the communities, and patients must obtain a referral letter from the community health worker living near them. Getting a referral letter represents a commitment to adhere to the rigorous and life-long treatment that will be required, as well as a resolve to adopt a responsible life style that will help curb the spread of the diseases. As an encouragement to the community and a step towards reducing stigma, some of our workers in this programme are recruited from patients who are now living healthy lives as they continue with their own medical treatment.

Neonatal community health project

As in other developing countries, perinatal mortality remains high in Kenya. About 70 out of every 100,000 children die in late pregnancy, during birth, or within the first seven days of their lives. New-born children in rural areas are especially at risk. Having skilled personnel in attendance at delivery is a key to reducing perinatal mortality. Therefore, in 2008, the Kijabe Hospital launched its Neonatal Community Health Project Kijabe, which now operates in two pilot regions adjacent to the hospital.

A survey conducted in the project's preparatory phase discovered:

- more than 90% of mothers deliver their babies at home;
- only 20% of women are assisted by skilled birth attendants, 35%

to 70% of women receive help from untrained relatives or neighbours, and almost 10% of women deliver without any help at all;

- many mothers are unable to recognise the danger signs of diseases that especially threaten new-born babies (e.g. fever, convulsions and, dyspnoea).

To address this situation, the project team began training local health professionals (midwives, nurses, medical doctors, traditional birth attendants) in the quality health care of new-born children. In addition, community health workers, antenatal and postnatal mothers, and members of women groups are being trained in preparing for delivery, caring for babies and recognising signs of diseases.

The mothers involved in the project are eager to learn, and appreciate the teaching that is being given. One of the mothers, who had been taught by the project team in an antenatal group, found the teaching particularly helpful and important. Next time she came to a training session, she brought along three other expectant mothers from her village. After all the mothers in the group had delivered their babies, they asked the team to continue to visit their village so that they could learn about the continuing danger signs to look for in their babies. In this kind of way, knowledge is spreading and more people are enjoying better health.

The Neonatal Community Health Project Kijabe demonstrates that it is possible to achieve huge changes with comparatively small budgets. We are confident that this project will significantly improve the health of mothers and children in the two areas where it is operating, and we hope to establish the project in other regions in the near future.

When people came seeking medical care because of physical pain, their pain was often a manifestation of more needs than just the physical ones.

Existing for the poor: community health services at the Duncan Hospital, Raxaul, Bihar, India

By Iris Williams, German Institute for Medical Mission, Tübingen, Germany.

A time bomb

The Duncan Hospital is located in the border town of Raxaul in the state of Bihar, one of the poorest and most backward states of India. The hospital is managed by the Emmanuel Hospital Association (EHA), the largest Christian non-government provider of healthcare in India, with 20 hospitals and 30 community-based projects in 14 states. During the 1980s, when many European missionaries had to leave India, the idea of EHA, which is a federation of mission hospitals, was born. Over the years, the federation has grown to become a medical missionary movement and a fellowship of Christian health professionals committed to bringing wholeness of life to the marginalized members of the varied communities the association's members serve.

Today, Duncan Hospital is the EHA's biggest hospital (200 beds); it provides secondary medical care, and offers several specialities, e.g. maternity, eye care, dentistry and neo-natal care. Additional to medical care, the hospital has a well-organized and effective Community Health Department (CHD), plus an AIDS Control and Treatment Project (ACT).

To provide Christian holistic care to everyone is a challenge in Raxaul, which is a time bomb of a place with severe social and economic problems as result of the presence of truckers, commercial sex workers, daily labourers, and intravenous drug users.

Raxaul is situated on the border with Nepal, and is very poorly developed. There is a high-density population of 250,000, and the crowded place is unhygienic. The only paved road in the area is the highway that connects Calcutta (now officially called Kolkata) with Kathmandu in Nepal, along which an enormous number of trucks pass every day.

The population is very poor; 60% of the people live below the poverty line (the criterion for the line in these circumstances being that one has less than one proper meal a day). Most of the people are landless, and earn what little they get as daily labourers. The main religions are Hinduism and Islam; Christians are in a minority. Due to many years of corrupt systems and State neglect, the Biharis have a reputation for being rather rough and aggressive, and of regarding life as having little value.

Staff shortage is another challenge for the hospital management because few people are prepared to come and work in such a remote place, where there is not even a restaurant.

Nevertheless, those who do come to work and stay are very committed and devoted, and strong in their faith, which is the basis of all the hospital does. The hospital take its motto, "In step with the master", seriously and the majority of staff are Christians. The hospital's highest goal is to serve the poor and the marginalized, which means that it never turns anyone away, nor leaves anyone untreated, even if he or she cannot afford the cost of treatment.

Community health services

Besides its regular hospital services, Duncan Hospital has a Community Health Department (CHD), which offers health services to the community. The aim is to train people, raise awareness of different health issues, and educate people to embrace behavioural change so that they become empowered to live better lives. This community

health work is well organized, and has a multi-sectoral and holistic health approach.

According to Dr Joshua Gokavi, who is a Duncan hospital doctor, a strong bond has developed between the hospital and the community it serves because hospital staff are willing to step beyond the building's boundaries to answer people's needs. In 2007, for example, when heavy monsoon rains and then floods hit the region, the hospital staff felt it was their duty to care for the people. After going out on the first day with medical equipment, they returned in the evening frustrated because they had discovered that what people needed was not medical supplies but food. So, the CHD team coordinated a team of volunteers and, for three months, 16 to 18 people supplied 11,000 families with food packages, and attended to their medical needs as they arose. This engagement raised the level of goodwill towards the CHD team and the hospital, and now offers a good basis for other programmes that the hospital runs.

The CHD has 22 staff and 60 village health workers in around 172 villages in four blocks within the East Champaran District, where 300,000 people live.

Since the beginning of their work 10 years ago, when people first went out to raise awareness about social, economic and health issues, the village health workers have made an incredible impact on the community, and have seen many changes, especially in the lives of girls and women.

In the beginning, the health workers faced scepticism from the villagers because the workers were Christians and the local people belonged to various non-Christian religious backgrounds, and therefore thought that the visiting workers had come to convert them to Christianity. However, through determination, frequent visits, good quality work and effective results, a good and trusting relationship has been built. Today, the village health workers enjoy an excellent reputation in the area, where the community accepts and trusts them. As a result, the

health workers now adopt a more direct approach compared to what went on at the beginning of the project.

The village health workers mainly teach psycho-social life skills and behavioural change, and the CHD aims to make communities sustainable by empowering the local youth in various aspects of living. Those who receive training will then empower others in the community by influencing them.

Challenges and achievements

The work of the Duncan Hospital with communities has been a joint learning experience and, despite many challenges, has achieved much. The interaction with girls and married women was difficult at the start, especially for male volunteers. Now, the community has confidence in the hospital's Community Health Department; this shows in that parents now send their daughters to meetings, and newly married couples also come to listen and talk.

A female village health worker recounts how, in the beginning, her husband stopped her from doing the work because he disliked the fact that it meant she spoke to other men. The woman explained to her husband that she wanted to be free to do the work, and that he could trust her but he would not believe her. Nevertheless, the woman joined a CHD team out of sheer determination, and after a while her husband realised that she was not doing anything wrong but that her work was good and helpful. Today, the husband is proud of his wife.

Another result of the CHD's work is that the number of early or child marriages has been reduced because girls learn to be more assertive and to speak openly. The decision-making process regarding marriage has changed, and girls and young women are now more self-dependent. Today, girls are also allowed to stay at school for longer; beforehand, boys only usually enjoyed this privilege.

Jarina, a Muslim woman, is another example of what the Community Health Department of the Duncan Hospital has achieved. Jarina joined the women's group and learned there. Today, she is a peer educator herself. Had she not joined the group, she would have got married two years ago. From the honorarium she earns with the CHD, she has bought a bicycle, which she uses to go to the villages, where she teaches, and to the high school for further study. The community sees that Jarina has changed since she joined the CHD programme and, as others are also encouraged to join, she is acting as a role model. People here observe first before they act. Therefore, in the beginning only a few people joined the programme; now, more and more women are doing so.

Women and girls still make up the group with the highest illiteracy rate in the area due to a lack of education for them. In the CHD's adult literacy programme, women and girls are taught to read and write, and do maths. Today, some women have started their own businesses, keep their records themselves, and can fill out their bank forms by themselves. Through achieving literacy, these women have become more independent, have their own income, and cannot be cheated easily anymore.

During group meetings, the women receive health education (vaccinations, how to deal with HIV and AIDS and which precautions should be taken, how to use pills and condoms, etc.). Another important issue concerns how the women can deal with their husbands, when the men return home after having gone away to work, and persuade them to take an HIV test.

As a result of peer educators going from door to door to talk about issues related to HIV, AIDS, gender and sex, people now have information about the spread of HIV, and how to use a condom. They also know that they can come to the hospital for testing, counselling and treatment. In youth groups, topics such as marriage, sexuality, masculinity, HIV and AIDS and health practices are also discussed.

Hygiene habits have improved greatly through the introduction of low cost toilets, as well as garbage and soak pits.

People living with HIV and AIDS were and still are facing stigma and discrimination from the community. When they began their work, the CHD staff quickly realised that they were making matters worse by visiting HIV-affected people because it drew the attention of neighbours and other villagers to them. This effect is slowly decreasing as the lives of people living with HIV and AIDS are improving as a result of the visits. Patients receiving antiretroviral treatment attend support group meetings at the hospital every other month to talk about their experiences with the medications they are taking, and how they generally feel. During these meetings, sessions on safer sex and other HIV-related issues take place. The information people receive is then taken back into their communities. Talking openly about HIV and AIDS remains difficult, so it happens that people will ask those who know about HIV prevention and AIDS treatment to come for a walk, “so that I can show you the fields”. In this way, the matter can be discussed in private.

Having had the honour and pleasure of visiting the hospital and field workers myself, I must say that their commitment and determination impressed me deeply. I am sure building up all the different features of the community health programme was not easy, especially at the beginning. However, it is encouraging to see how the community now accepts and trusts the hospital and its workers, and appreciates all that is being done. All of this gives me hope.

To provide Christian holistic care to everyone is a challenge in Raxaul, which is a time bomb of a place with severe social and economic problems as a result of the presence of truckers, commercial sex workers, daily labourers and intravenous drug users.

Lessons learnt

The two case studies that we have included in this section to illustrate how Christian hospitals can be centres of a holistic approach to health, suggest the following:

- a Christian hospital recognises the role of the community it serves and its special needs, especially among marginalized groups, women, children or people living with HIV and AIDS;
- Christian hospitals can provide care in remote and sometimes socially unstable areas;
- Christian hospitals can recognise the spiritual needs of patients and communities, and serve those needs through a system that involves chaplains and other religious leaders as necessary;
- Christian hospitals can provide medical care to the best possible standards.

Healing through spiritual care offered by communities and hospitals

Introduction

Today, it is widely recognised that health is not only a medical issue; it is also a process to which various factors simultaneously contribute. Most people regard psychology and psychotherapy as healing disciplines but also know that the healing of relationships through social sciences can have a huge impact on a person's physical and mental condition. Moreover, a person's spirituality and the spiritual care that churches provide are increasingly recognised as factors that impact on someone's physical and mental health. Many people appreciate the spiritual care that congregations and churches offer as a unique contribution to health and healing, and as something that no other healing discipline can offer. The spiritual elements that churches contribute to the healing process are specific to the churches, and different from the medical, psychological and social approaches to health. The former can add value to the latter.

Of course, it is vital that churches and congregations providing spiritual care do not oppose other approaches to health, and do not prevent people from using them. Churches must recognise the limitations of the spiritual approach, and promote a complementary approach to health and healing rather than an exclusively spiritual approach.

Many people today long for spiritual care to be offered to them along with other ways of healing. The examples of the Pentecostal churches in Ghana, of Holy Rood House in the U.K., and of Jacob's Well in France show clearly that many people are in need of spiritual care on an individual level as well as part of a group or community of some sort. The case study of Holy Rood House is a good example of an integrated approach to health that includes a variety of healing professions.

Spiritual care is especially important for terminally ill patients, as the article on Christian health services in Indonesia shows.

Healing and reconciliation from an African Pentecostal perspective

By Apostle Dr Opoku Onyinah.

An African Pentecostal perspective

The term African Pentecostal here includes African Pentecostal churches that trace their origins directly or remotely from a revival that began at Azusa Street in Los Angeles, U.S.A. in 1906. African Pentecostal also describes those who for various reasons came out of the older Pentecostal movement churches or mainline mission churches to form their own churches with Pentecostal traditions. African Pentecostal indicates that these churches in Africa have ‘indigenised’ their worship to suit local situations. These churches have not formalised their traditions in written forms; they exist in oral form and are presented in narrative ways. In fact, the reading of liturgy or prayers is not considered as spiritual. Nevertheless, the practices of African Pentecostal churches are similar not only to older Pentecostal churches in Africa but also to those in other parts of the world.

Corporate worship as a form of healing and reconciliation

For Pentecostals, healing and reconciliation is part of their tradition and a necessary part of every service. Pentecostal church services are participatory, and involve body and mind. The liturgy normally follows the instruction of Ps. 100:4: “Enter into his gates with thanksgiving, and his courts with praise.” Pentecostal services begin with a time of confession, then a gathering of blessings, the acknowledging of God’s sovereignty, supplication, praise, the giving of testimony, and preaching. Everybody is encouraged to take part either in prayer, testimony, dancing or singing a chorus or hymn. During prayer time,

people are encouraged to tell God about their problems and anxieties, confess their sins and ask God for healing. It is believed that this time of corporate worship brings the blessing of healing, and a freedom in one's spirit, and forms the basis of peace and reconciliation within oneself, as well as unity among Christians.

The opportunity to speak out loudly or quietly, individually or collectively, and to do so with the hope that God will answer people as individuals, is of itself therapeutic. It enriches people's spiritual lives, and they are then able to face everyday life with fortitude and hope. This type of corporate worship is often based on Bible passages, such as 1 Cor. 14:26 and Eph. 5:19. Texts including 1 John 1:9, Heb. 10:22 and Ps. 51 are used as the biblical basis for encouraging people to confess.

During the time of testimonies, people share their life experiences, problems, dreams, hurts, and successes. Sometimes, people confess their sins openly to the other members of the congregation. The pastor or presiding officer may stop people from making a public confession if he finds the issues too sensitive. Through insights from testimonies, the leaders become aware of the basic concerns of individual members, which can include healing, family problems and unemployment.

Preaching during the service is tailored to suit the needs of the people. It affirms the fact that there are problems in life that need the salvation of God. Sermons in Pentecostal churches are often centred on the power of Christ to save, to liberate people from the traumas of life, and to deliver people from the power of Satan.

At the end of such services, people who need healing of any sort or have problems in life are invited to come to the front for prayers to be said for them.

Understanding the need

After the close of the service, the pastor may listen to those who want to see him on a personal basis. Telling their story enables people to listen to their own stories, hear them for themselves, and explain and offer reasons for their actions. Sometimes, a person's anxieties, fears, guilt, hurts, bitterness, loneliness and mistakes all pour out. Having someone who is willing to listen and understand all of this is a great relief. The whole process helps to release tensions and pressure for the one telling his or her story.

The pastor then begins to interpret what has been said, and suggests what actions might be taken. He may refer those with physical and psychological symptoms to appropriate professionals among the church's members, if there are any. The professionals can include physicians, educationalists, marriage counsellors, teachers and solicitors, who give their services freely.

For those whose cases are considered spiritual or psychological, the pastor may probe further by questioning the clients with a view to praying for healing for them. Sometimes, the pastor will do this by himself; at other times, a special group of people who are thought to be gifted in this field will join him.

If a case is considered spiritual and, for example, the client thinks there is a demonic element involved, the pastor would initially accept the individual's view and then probe it. If, after a reasonable interaction with the person in question, the pastor finds the situation to be of a different kind, for example, a psychological one, he should be able to counsel the client until there is a shared understanding of what will lead to the healing of the client.

On the other hand, if the pastor finds the situation to be complex and beyond his understanding, exorcism may be performed after the person has passed through a further counselling session. This is often

done by a group of people led by a pastor or an elder. Some Pentecostal churches have also established prayer centres or camps that carry out such exorcisms.

However, arriving at a conclusion that a person's case is demonic needs extra care. An analysis of the encounters between Jesus and the demons in the gospels brings out some characteristics that may indicate a demonic presence in a person. These include extraordinary strength, indifference to pain, vocalisation of distress when confronted by Jesus, and a change in the sufferer's voice. However, psychiatrists have shown that these symptoms almost always have a natural cause. While this may not rule out the possibility of a demonic presence in some cases, it shows that many cases, which people consider demonic, have a scientific explanation. Therefore, arriving at a decision of demonic activity or witchcraft possession should not be done lightly; the pastor or leader must have explored all possible natural explanations.

The presbytery as a healing agent

In some Pentecostal circles, the pastor may refer to the presbytery (the church's leadership team) people who are hurting others or whose cases may involve marital breakdown or personality conflict. Often, the presbytery is best placed to handle cases that involve conflicts between church members, family members, or husbands and wives. The presbytery may refer the case to a smaller group, for it to bring back a recommendation to the presbytery. The small group will invite relevant parties to come and tell their stories and discuss matters. The group will then recommend to the presbytery what therapeutic actions are needed. These may include an apology to be offered, or a confession to be made. Some of the church leadership team may need to visit a family that is hurt and explain things to them. Others may need to help reconcile people in the community who have quarrelled with one another. Such efforts often bring reconciliation to disheartened married couples, and offended church members. The attempts to bring

people together become a support mechanism for Christians; people are encouraged by the attention given to them, and having had the opportunity to share their hurts with the leaders of the church. For people to be aware that they are known and cared for as individuals becomes a valuable healing mechanism. Here, the church patterns its counselling along that of the traditional African system of providing community therapy and bringing about reconciliation.

The eucharist at the heart of the healing community

Among Pentecostals, the church itself is seen as a healing community. This comes through most clearly in the celebration of the eucharist. In some African Pentecostal traditions, a week's preparation, which includes fasting and prayer and seeking to be at peace with one's neighbours and all believers, is required before attending the eucharist. The week provides the time to carry out a self-examination and to maintain a holy life. It culminates on the Sunday morning when the celebration takes place; often this is the first Sunday of every month. On this occasion, the minister reminds the congregation to examine themselves and confess all known sins before coming to the table; not to do so would be considered as partaking unworthily, and has serious consequences.

A Pentecostal concept of salvation

The practice of healing and reconciliation among Pentecostal churches shows clearly that the African concept of salvation intersects with that of the Pentecostals. The concept of salvation among many of the African peoples includes having good health, prosperity, abundant life, protection from the spirit of evil entities, safety and security. In Christianity, "salvation" has become a technical term to describe God's action in setting people free from their sins and the consequences of sin, and bringing people into a situation where they can experience God's blessing. The Pentecostal concept pushes this understanding

further by engaging with the African worldview, and thus maintains that salvation includes the dealing of Christ with the supernatural and human agencies that militate against the health, peace, success, prosperity or total well-being of people. It is assumed that it is the responsibility of the Christian to appropriate these things through prayer.

For many Pentecostals, it is the prayer the pastor offers that makes the work of doctors successful, the medicine effective, or businesses successful. Again, it is thought that it is the prayer of believers that will break the power of evil in order that people within a community will live at peace or be reconciled with one other.

For many Pentecostals, it is the prayer the pastor offers that makes the work of doctors successful, the medicine effective, or businesses successful. Again, it is thought that it is the prayer of believers that will break the power of evil to enable people within a community to live at peace or be reconciled with one another.

A place for wounded people: Holy Rood House, England

By the Revs Elizabeth and Stanley Baxter, executive directors of the Centre for Health and Pastoral Care with the Centre for the Study of Theology and Health in Thirsk, England

A place of rest and peace

Holy Rood House in Thirsk, Yorkshire, U.K., is a base for the Centre for Health and Pastoral Care along with the Centre for the Study of Theology and Health. Begun in 1983 by Morris Maddocks, then bishop of Selby, the ministry of a first house was to offer a place of rest and peace to people in need of healing and pastoral counselling.

In 1992, the North of England Christian Healing Trust moved to Holy Rood House. We, the present executive directors at Holy Rood, are both Anglican priests, and have worked in tough 'urban priority areas' for most of our ministry. Early at Holy Rood House, we realised that there was a need to look at theology and its relationship to health and healing. Therefore, in 2000, the Centre for the Study of Theology and Health emerged naturally from the therapeutic work of Holy Rood House, and as an addition to it.

We realised that we could neither talk about healing without talking about health, nor talk about health without realising it was also a justice issue. So, we have widened our interest in healing to areas of conflict resolution and mediation.

Holy Rood House is a centre, a home and a community. An inner core of residential members lives near, or on the premises. Each of our resident community members has a particular skill to offer, e.g. gardening,

house maintenance, cooking, administration, pastoral, clowning, musical, artistic, etc.

At the moment, our residential community consists of members from Tanzania, South Africa, South India and Scotland. Such a group of people working together as a team also shows something about the healing power of unity. We are an ecumenical community. Therefore, we are able to write our own liturgies, and often centre them on the particular needs of our guests.

Our residential and wider membership comes from all the churches. Everyone takes part in the weekly community eucharist. This is itself a sign of healing and health amidst the disunity within the church.

A multidisciplinary, holistic approach to health and healing

Before commencing our ministry at Holy Rood House, we visited all the homes of healing in the U.K., and learnt a great deal about how to do things and how not to do things. Because of this experience, we decided that we would go down the 'secular' route regarding the accreditation of our therapists, whether they were counsellors/psychotherapists or body therapists. We did not wish to confuse evangelism with professional therapeutic care, and we felt that so-called biblical or 'Christian' counselling confused these boundaries. It became clear, also, that the church had abused many people who came to us, if not always sexually, then often theologically.

It also became clear that much of the church still had a dualistic approach to healing (much of the current discussion on the question of sexuality is an example of this). There was still a split made between the body and the spirit, even among many committed to the ministry of healing.

As our ministry developed, we discovered that most of the people who were drawn to stay with us were suffering some form of loss (of a partner, job, health, dignity, status, etc). Some of the problems presented were very complex, and many of those presenting them were very vulnerable. This made us more determined than ever that whatever help we offered our guests, it should be professional. In the area of counselling and psychotherapy, we abide by the code and practice of the British Association of Counselling and Psychotherapy, which is the largest counselling organization in the U.K. The association is engaged, with others, in negotiations with the U.K. government about the introduction of a statutory register. We are also a member of the Association of Therapeutic Communities, which is another professional organization.

At Holy Rood House, we use what may be described as body therapies, physiotherapy, massage and aromatherapy. This has proved difficult for those who seem to think that healing can only be effective through the ministry of Christians, and that to use therapies whose founders may have had other belief systems is to allow in the 'demonic'. Those who think this way are often those who themselves have problems about how they understand the body, which many people disassociate from the 'spiritual'. This is often true of those who have been sexually abused, who then begin to despise their bodies. Often, after sensitive professional counselling, a guest is willing to receive a massage or some other body therapy. This enables the person to begin to have a more holistic understanding of their humanity.

However, we do not neglect the sacramental side of the healing ministry, and at the regular community eucharist we offer anointing and the laying on of hands. There is a regular pattern of prayer in the house, and we meet three times a day in the chapel for community prayers.

Many of the people who stay with us have been wounded and, in some cases, almost destroyed by church institutions. Our chapel services have been a means of drawing these people gently back to a worshipping community. We are often confronted by what can only

be described as abusive theology that produces overwhelming guilt in those who are already ill, either in mind, body or spirit. Some of this comes about because of the dualistic approach to healing that has often existed in parts of the healing ministry of the church.

The need for cooperation in the healing ministry of the churches

We are aware that we are only one centre among many in the United Kingdom that have very different approaches to the ministry of healing. Until recently, most of these centres came together under the Churches' Council of Health and Healing (CCHH). The CCHH's purpose and function were:

- to provide a common basis for the healing movements that stand on Christian foundations;
- to draw into closer fellowship and co-operation the movements that share this common basis;
- to co-operate with guilds and other Christian agencies in the promotion of united prayer and witness appropriate to their common aim and basis;
- to afford a recognised basis for the co-operation of doctors and clergy in the study and performance of their respective functions in the work of healing, and to promote this co-operation in thought and action throughout the country;
- to explore the possibilities of establishing common centres of healing under adequate medical and clerical supervision;
- to act as a centre for co-ordination and distributing experience and research, and to publish the findings of this exchange of thought;
- to bring the work of healing into closer relation with the regular work of the churches.

One of us was a member of the executive committee of the CCHH until it closed some years ago. Churches Together in England has attempted to fill the gap thus created, by having an associated group called Churches Together in Healing. This, however, is in its early

days. Others have tried to carry out some of the tasks that the CCHH previously undertook but there is no one organization that has the ecumenical and theological breadth needed to hold the various groups together.

Challenges for the future

There is a real need for the church to engage in its ministry of healing outside of what could be called the 'churchiness' of the church. Whilst it is true that healing services in our parishes and congregations are important, it is also true that to recognise healing and health as part of God's purpose and Jesus' 'Great Commission' means that we must go into the whole world to spread this message. It also means that we may have to look afresh at our missiology and relationship to other world religions. It means that we have to face up to controversial issues in the church, such as the patriarchal power base of the church, and its continued attitude to women and children, and, above all, human sexuality. What is clear is that healing is not just a sacramental sideline of the church but is central to its mission to establish the kingdom of God on earth. We have a healing God and a reconciling Christ.

There is a real need for the church to engage in its ministry of healing outside of what could be called the 'churchiness' of the church.

Jacob's Well: a welcoming prayer service offered by Communion de l'Olivier (the Olive Tree Community) of Toulouse, France

By Bernard Ugeux, founder and former director of the Catholic Institute of Science and the Theology of Religions, in Toulouse, France.

A promise from Jesus

Communion de L'Olivier (the Olive Tree Community) is made up of prayer groups involved in the Catholic Charismatic Renewal Movement in the Roman Catholic Diocese of Toulouse, France.

Jacob's Well is a prayer service that the Olive Tree Community has used since November 1986. It is a welcoming service in which the Lord gives living water to those who cry out to him, as Jesus promised would happen when he spoke to a Samaritan woman (John 4:5-11).

Most often, people come to Jacob's Well following a call of some sort that reflects this word from the gospel: "Come unto me, all of you, you that are wearied and bearers of burdens, and I will give you rest" (Matt. 11:28). God's call often comes through those close to us or by way of words heard during prayer assemblies and celebrations. People who have a spiritual director discern together if there is a need for such a measure.

People come to Jacob's Well to unburden themselves, and to ask for freedom from bonds, or the healing of wounds that prevent them from living a holistic life. In this situation, people find it difficult to recognise the merciful love of the Father for them.

Saturday programme

Jacob's Well services take place on Saturday mornings throughout the year, except for July and August. People must make an appointment to attend, and this marks an important first step in itself.

The welcoming service lasts about 45 minutes. Every Saturday, three people are received. There are three teams of eight people who lead the services on a rota basis. Three team members act as listeners; they welcome people and listen to what they have to say. The remaining five team members are the 'pray-ers', who pray before the exposed Blessed Sacrament.

The teams are formed at the beginning of the year, and stay together all year. The team on duty each Saturday meets from 9 a.m. to noon. For the first half hour, the whole team prays after having exposed the Blessed Sacrament. In this prayer, we place ourselves before the Lord to wait for him to send the Holy Spirit upon us.

After prayers, the three listeners go to another room in order to welcome the first person. After having prayed with that individual, we ask the person to express his or her request.

In these prayers, we let the Holy Spirit guide ourselves as much as possible so that he will enlighten us and the individuals we are welcoming. This is necessary in order for our visitors to discover what events or experiences have troubled their lives, and prevented them from welcoming the merciful love of the Father. The factors involved can be unhealed wounds that sometimes go back to early childhood and even to conception, or may relate to forgiveness that people find difficult to offer, or memories that still hurt.

Separately, the 'pray-ers', who know nothing of the individuals being welcomed, also pray. They spend time in silent adoration, and also have times of shared prayers of praise and intercession, and receive

charismas (spiritual gifts) from the Lord. They then do a first discernment, and write down what they have received. This may be a word from God, images, prophecies, or words of knowledge (sometimes sung). Then, they pass what they have written to the listeners.

These words and texts may confirm what a welcomed individual has told the listeners. They may also enlighten the person, or they may enable the person to recall a past event, and take a first step. The listeners discern what word they will give the welcomed person, and at what time.

Welcoming

Sometimes, the requests of individuals can be very vague. However, little by little, and surrounded by kindness and prayer, our visitors discover that God is interested in them, and loves them as individuals. In the prayers offered, the Lord gives people the insight that they are not just victims, that their vision is often distorted, and that they have to put themselves back into a relationship with the Lord. People are invited to open their past to the Lord, to pardon and to seek pardon, to want to change their lives, and to drop their defences before the Good Shepherd, who is seeking them. By doing so, people begin to live in a way that is open to conversion and to a spiritual healing that may go as far as including a freedom from the obsessive guilt that can remain, even after having received the Lord's pardon in the Sacrament of Reconciliation. People are called to abandon false gods and idolatries (e.g. magic or occult practices, and esoteric groups) and return confidently to the Lord. This step can only be taken in a climate of love and compassion that engenders confidence. The individuals involved do not feel judged or questioned because the listeners seek to put them in contact with the tenderness of God.

With discretion, liberty, and simplicity, we ask people questions so that they can deepen their requests, and to give precision to the points on

which we will pray. We do not ask that people try to recall events or experiences that could have happened but have been forgotten if they did. We leave people free to answer us. We bear witness that the Lord comes himself to enlighten them on the things for which they would like healing. We may then plead, implore, or ask the Lord to come and cut the bonds that have tied an individual, and we pray for the healing of memories. People may then give over to the Lord what is bothering them. The role of the listeners is to help people, and to intercede for people that they may turn over to God whatever needs turning over.

A follow-up to this welcoming is done in several ways, including spiritual guidance, regular participation in a prayer group, and, of course, participating in church celebrations.

The welcoming at Jacob's Well has nothing about it of a magical rite that will solve all of a person's problems. Rather, the welcoming bears spiritual fruits, and leads to an intense prayerful and sacramental life.

The listeners and 'pray-ers' attend regular training sessions on issues that include spiritual discernment and guidance, listening and inner healing, and the relationship between healing and salvation.

Work for the poor

From the outset, the Olive Tree Community has had a great concern for materially, psychologically and spiritually poor people. Prayer groups offer a free welcome to Jacob's Well, and, from this welcome, people are often able to progress spiritually, and live in greater peace through the pain of their lives.

The Jacob's Well service is free, and supported by contributions from members of a house that belongs to the community.

Prayer and reconciliation

Prayer is the principal component of the Jacob's Well service. Twice a semester, the Olive Tree Community celebrates the merciful love of God through the sacrament of reconciliation, and the welcoming of small intercession groups. During these celebrations, charismas of prophecy and enlightenment are practised, and witnesses have reported that visitors have been touched by what has been said. Visitors are encouraged to welcome these words and to persevere in the faith. Often, during the celebrations, members of the intercession groups also ask to attend a Jacob's Well service.

The Christian foundation

The Jacob's Well service comes from a Christian community whose anthropological and ethical references are Christian. The Olive Tree Community believes:

- God is the source of all life; we are created in his image, and each person is a son or a daughter of the Father;
- sin came into the world through human disobedience, and Jesus came to save all people by his death and resurrection; this salvation is definitive; we are all forgiven sinners;
- man is a finite being, fated to die but who will be resurrected to gain eternal life: “[God] will wipe away every tear from their eyes; and there will no longer be any death; there will no longer be any mourning, or crying, or pain” (Rev. 21:4);
- human love has its source in the love of the three persons of the Trinity.

In these prayers, we let the Holy Spirit guide us as much as possible so that he will enlighten us and the individuals we are welcoming, so that they may discover what events or experiences have troubled their lives and prevented them from welcoming the merciful love of the Father.

The example of terminally ill patients: holistic healing in the Christian health services of Indonesia

By F. Nefos Daeli, executive director of Pelkesi (The Indonesian Christian Association for Health Services).

I have deliberately chosen the example of terminally ill patients to reflect on the implementation of holistic healing by Christian health services in Indonesia. In terminally ill patients, the method of holistic healing is more visible than in other diseases that have to be treated at low cost, and within a short period of time. In addition, the care and treatment of other diseases usually requires the use of standard procedures, and patients can be scrutinised in ways that may not be possible for those who are terminally ill.

Dealing with terminally ill patients

People who are terminally ill may also suffer from an acute disease, such as cancer, a stroke, HIV and AIDS, thalassaemia, etc. In these patients, the healing and treatment of their actual disease usually takes a long time in hospital. Many inpatients belong to this category, and the budget for these patients is relatively high.

People who are terminally ill have a great need for a comprehensive, holistic approach to healing. It is important that health professionals, families and carers make these patients feel that their lives still have value. In addition to the provision of quality medical care to terminally ill people, all those coming into contact with them must have an attitude of compassion and empathy. Families and communities should be supportive as well, because solidarity and concern for a person's soul are essential aspects of the healing process.

The visiting and strengthening of terminally ill people by family members, friends and neighbours is highly appreciated by those who are sick, and helps them remain part of their community in spite of their illnesses. Fundraising in order to reduce a patient's and a family's economic burden is another way of giving care and support. At the same time, and within the Christian health services of Indonesia, pastoral workers and a patient's family should offer praise, prayer and worship to God to show that the disease has not spiritually beaten them. Sometimes, a miracle of healing occurs and the patient and his or her family embrace it with joy and happiness. However, in the absence of miracles, a surrendering to God's will by patients supports treatment in a holistic way.

For some patients, past behaviour and attitudes can be a burden that obsesses them, even if the past is not related to a present illness. These patients are in dire need of spiritual strengthening. Sharing the story of one's life, lamenting past hurts, prayer, repentance, forgiving others, and surrendering all one's problems to God helps patients to be released from guilty feelings and to find peace with themselves, with others and with God.

Church-related health services

Since the beginnings of Christian mission activities in Indonesia, health services and education have always been essential parts of that mission. Today, churches still take these ministries seriously. In order to fulfil their healing ministry, the churches of Indonesia created several foundations or organizations to manage church health services, and ensure their effectiveness.

Within our Christian hospitals, we have health services divisions in which the medical and nursing departments implement physical services, and the social department reviews patients, families and their communities. Pastoral counsellors provide spiritual assistance, and a

hospital's community development section is responsible for the external services, which are community-oriented and community-based in order to provide empowerment, prevention, health promotion and advocacy. In order to serve patients best, all hospital departments must cooperate with one another, especially in the case of terminally ill patients.

Nevertheless, hospitals and clinics owned by or affiliated to churches have performed differently in various regions or areas. Weak management, a shortage of health workers, and inappropriate infrastructure have affected some institutions. As a result, places that once were pioneers in health provision have had to close. Efficiency, effectiveness and sustainability are important, and have to be achieved; this holds true as much for church-related health services as it does for government-run ones.

The foundation of our ministry

Despite the many difficulties our church health services face, the church cannot withdraw from the health sector in Indonesia. The church's healing ministry, including its diaconal activities, has its foundation in the Bible (see, Exodus 15:26, Mark 10:45, Matthew 4:23; 9:35, Acts 3; 4). Proclaiming the Good News and demonstrating Christ's love through acts of healing are essential parts of the church's mission⁹.

We implement our healing ministry through a wide variety of approaches, including health services both in the hospitals and outside of them ('hospitals without walls'). What we offer can seem very

⁹Dr Bert Adriaan Supit, *Penyembuhan Holistik, (Holistic Healing)*, Bethesda Tomohon General Hospital and Pancaran Kasih Manado General Hospital, 2004.

simple but it has a deep meaning and impact. Such activity includes visiting the sick, praying for patients and their families, and serving as volunteers by doing the laundry, cleaning the floor and yard, etc.

Church health services implemented through hospitals or community-based activities reflect a holistic/comprehensive approach that takes into account all dimensions of human life, viz. the physical, social, economic, and mental-spiritual dimensions. This can be seen clearly in the case of terminally ill patients. Holistic healing corresponds with Indonesian culture, and matches Indonesia's social reality. Empathy and solidarity are signs of a deep sense of community.

Challenges

The same holistic approach characterises the health-related activities of churches and congregations. The congregations' diaconal work is part of this. Nevertheless, congregations need to increase their engagement with the healing ministry. In fact, they could become agents of health both in church and secular communities by promoting healthy behaviour and attitudes, such as bathing and cleaning, washing hands before eating, putting rubbish into bins, not smoking, maintaining high standards of domestic sanitation and cleanliness, and consuming inexpensive nutritious food.

However, only a limited number of studies have been done on the healing mission of the church and the churches' awareness of their healing ministry. For churches, it is often difficult to actualise and contextualize their involvement in holistic services and healing. Sometimes, pastoral visits and assistance are felt to be 'dry' and uninspiring.

Another challenge for us is that there are still many Christian health services that do not follow a holistic approach. They tend to concentrate on curing specific diseases instead of healing the whole person and improving a patient's quality of life.

The other thing that sometimes impedes a holistic approach is a structural one, and this is due to the above-mentioned division of services in our hospitals. Sometimes, the departments work independently of each other, and do not cooperate with or even recognise each other.

This situation is aggravated by the fact that a number of our health services see themselves as for-profit industries, and apply modern management systems to all they do. Sometimes, even their commitment to holistic healing is not inspired by the Christian spirit of serving but by a management strategy of measuring what tends to be seen as “customer satisfaction and retention”. In this situation, it is our Christian duty to make clear that our health services and holistic healing must be directed towards worshipping God, and should provide settings where the patients and all those who give of their best to patients can experience holistic healing. Holistic healing should not be restricted to terminally ill patients but should be used in all cases of disease, whether serious or not. If we implement holistic healing we will see today what was experienced by the lame man whom the apostle Peter healed through God’s power: “He jumped up, stood, and began to walk, and he went with them into the temple, walking and jumping and praising God” (Acts 3:8).

Proclaiming the Good News as well as demonstrating Christ’s love through acts of healing are essential parts of the church’s mission.

Lessons learnt

These are the lessons learnt from the case studies of spiritual care offered by Christian communities and hospitals:

- listening individually and corporately with love and compassion is part of a healing process;
- prayer, worship and other healing rituals are good resources for healing all kinds of wounds;
- churches must match theology with the social and cultural context in order to meet people's needs for healing and reconciliation;
- the church as a community can offer space for reconciliation, conflict resolution and fellowship as part of a healing process;
- the church through its biblical mandate must care especially for vulnerable or marginalized groups, and offer refuge and fellowship;
- churches must recognise their limits, and the need for professional healing and cooperation with the formal health sector;
- churches must respond to death and bereavement before they happen by offering counselling and support to the terminally ill and their families.

Health, justice, and access to essential drugs

Introduction

The world belongs to God, and everyone is created in the image of God. How, then, can we accept the fact that some people are born and live in comfort, while others starve?

There is global evidence of injustice in the provision of health care services, and we recognise that the world is broken and needs healing. True healing cannot take place if we continue to do business as usual. The lack of justice leads to inadequate access to health care, and we must look at the root causes of this situation in order to find solutions to the problems.

Poverty and inadequate access to essential drugs are responsible for unnecessary suffering and death. The examples given in the two case studies that follow indicate that Christian communities and institutions are taking practical steps to deal with destitution, injustice and a lack of access to essential drugs. The studies remind us that it is not enough to deal with problems superficially, and that our faith obliges us to act to address all injustice in a consistent and persistent manner.

A church community assisting marginalized people: the example of Bethel Baptist Church in Jamaica

By Sarah Newland-Martin, general secretary of the YMCA, Jamaica.

Homelessness

Homelessness is a common feature in our world, and especially in Jamaica. Homeless people can be defined as individuals who are not connected to their family or local community. The streets are their home, cardboard becomes their bed, and garbage containers provide their only means of survival. The homeless roam the streets, are often ridiculed by passers-by, and even raped and murdered. Homeless people are seen as outcasts, experience loneliness and are abandoned even by family members.

Some of the reasons why people no longer belong within a social network can include:

- loss of job, and inability to provide for one's family;
- mental illnesses, such as depression;
- rejection and discrimination of various kinds;
- drug or alcohol addiction;
- breakdown in the family;
- loss of self-esteem.

In Jamaica, it is mostly men who are homeless and on the streets. However, homeless women also exist. For some years, the community of Bethel Baptist Church in Kingston, Jamaica's capital city, has been responding to the growing number of people living on the streets. The church's hospitality committee provides breakfast on Sunday mornings for the homeless who gather in the area where the church is situated.

Recently, this work expanded with the setting up of a drop-in centre during the week. Here, the homeless can get breakfast, as on Sundays, then take a shower, and have access to a doctor and nurse, who make referrals as necessary to other medical services, including the hospital. In addition, from Mondays to Fridays, individuals can walk in and receive either soup or a cooked meal for lunch; it may be the only decent food they have all day. Representatives from a housing agency for the homeless are also on hand to help people find somewhere to live. In all we do, our aim is to try and enable homeless people to return to as near-to-normal living as possible.

Legal aid

The church also has lawyers among its congregation, who are willing to respond to the needs of the wider church community. The Bethel Baptist Church Legal Aid Clinic exists to provide legal services for its members and others at minimal cost. The project was founded to answer the needs of people who could not afford the high costs charged by individual lawyers and big legal firms.

The legal aid clinic is open on Saturdays from 10 a.m. to 2 p.m., and has four lawyers who work on a voluntary basis. The services they provide include preparing wills, and helping individuals to deal with the execution of a will after a death in the family. The centre also offers legal advice for registering new companies, preparing and signing documents, and for settling disputes. In addition, the church often holds forums to discuss legal matters so that its members can keep up to date with legal issues, and ask the lawyers any questions they may have about the law.

Other assistance

The church helps individuals find jobs, also teaches life skills, such as gardening and floral arranging. There is also an active HIV and AIDS support group. People, who may not necessarily be members of the church but are identified as HIV positive or living with AIDS, when they visit the church's health clinic or are referred to us by other churches or agencies, attend monthly support group meetings. Here, people share experiences, and are encouraged to take their medications regularly and, where possible, to offer some payment for their medications, though we never turn away anyone who cannot pay.

Homelessness is a common feature in our world, and especially in Jamaica.

Christian health associations fighting for access to essential drugs

By Patrick Nayupe, primary health care/AIDS manager, Christian Health Association of Malawi (CHAM).

Many things compromise the right to access quality health care. One obstacle can be that there are not enough of the right kinds of drugs available because of a lack of government funding. High drug prices, counterfeit drugs and unscrupulous middlemen can also prevent someone from accessing quality health care. For a long time, fighting for people to have access to essential drugs has been a priority for Christian health organizations at both national and international levels.

The Ecumenical Pharmaceutical Network

The Ecumenical Pharmaceutical Network (EPN) is a Christian, not-for-profit, independent organization committed to the provision of quality pharmaceutical services. EPN is a worldwide network of associations, institutions and individuals from more than 30 mainly African countries. The network's office is based in the Kenyan capital of Nairobi.

The roots of EPN lie in the World Council of Churches. In 1981, the WCC's Christian Medical Commission decided to provide technical support in the area of pharmaceuticals to church health programmes, particularly in Africa.

EPN is strengthening pharmaceutical service delivery in church health systems by:

- working with faith-based drug supply organizations to increase access to essential medicines;
- equipping pharmaceutical personnel with skills and knowledge to improve the quality of services in their institutions;
- promoting quality assurance and quality control activities at all levels within the church supply systems.

Among EPN's priority areas are access to and the rational use of medicines, HIV and AIDS treatment, the professionalisation of pharmaceutical services, and pharmaceutical information sharing.

National Christian health organizations

There are some good examples of Christian health organizations that have improved access to drugs in resource-limited settings. For example, the Kenya Episcopal [Catholic] Conference, and the Christian Health Association of Kenya joined together to enable people to have access to essential drugs by forming the Mission for Essential Drugs and Supplies (MEDS). MEDS is an established and leading faith-based drugs-supply company in Kenya; its work supplements government efforts to provide essential drugs. MEDS serves southern Sudan, Ethiopia, Somalia, Uganda, Burundi, the DRC, Tanzania, Zambia, Malawi, Zimbabwe, Cameroon and Chad. It has shown that church health facilities can and do contribute to efforts to improve people's access to essential drugs.

In Malawi, and as the second largest provider of health in the country after the government, the Christian Health Association of Malawi (CHAM) has struggled to make essential drugs available to the country's citizens. CHAM is in the process of transforming its pharmacy section into a full drug-supply organization, whose mandate will go beyond the current making of essential drugs available to its members'

health facilities, and expand to provide pharmaceutical support, guidance and training for the staff of these facilities.

The Christian health associations of Kenya and Malawi are just two of the faith-based organizations that fully affirm the role of church-based health institutions in the provision of quality health care services. In particular, faith-based organizations have a crucial role to play in increasing access to essential drugs for rural and remote populations.

Faith-based organizations have a crucial role in increasing access to essential drugs for rural and remote populations.

Lessons learnt

The following lessons have been learnt from the two case studies related to health, justice and access to essential drugs:

- church communities can effectively respond to the needs of people who are marginalized in our societies, and who are in financial trouble;
- volunteer expert services can provide services to people who would otherwise have no access to them;
- faith-based health institutions and organizations can play a vital role in making essential drugs available to their citizens.

Gender justice and health

Introduction

God created both men and women in his image, and this must be the measuring line for all Christian health services and healing ministries.

All over the world, and particularly in resource-limited settings, we are far from seeing gender justice as a reality. Girls are more likely to suffer from hunger and disease than are boys; girls have less access to education than do boys. Compared to men, women face discrimination in access to education, decent employment and access to health care. Often, women have no role in decision making, and many still suffer from violence in various circumstances. Accordingly, global poverty affects women disproportionately.

Christians individually and the churches corporately have an obligation to fight for the rights of women in society, and to restore their dignity. When we speak of gender mainstreaming, we mean the making of the roles of women and men in churches and society such that they have equal rights and dignity. Particularly, churches have to advocate for girls and women to have the same access to health care as do boys and men.

The following two case studies tell stories of women. The first is about relief for the suffering of women in eastern Congo. The second is the autobiography of a courageous woman who, as a young girl and under threat from her family, ran for her life through the Kenyan bush, and yet later experienced healing and reconciliation with her family and culture.

Holistic healing for traumatised women: the example of Panzi Hospital in eastern Congo

By Dr Gisela Schneider of the German Institute for Medical Mission, Tübingen, Germany.

Wealth and war in eastern Congo

The Democratic Republic of Congo in central Africa had a tragic history of exploitation and oppression under colonial rule. Then, after independence in 1960, President Mobutu ruled and exploited the country. Civil war followed Mobutu's rule, and caused millions of deaths and the destruction of families and communities.

In particular, eastern Congo has been at the centre of political and social unrest. This region of the country is extremely rich in natural resources. Among other treasures, diamonds, gold and coltan abound in the forests of eastern Congo, as do militia groups fighting for these resources (coltan is a dull black metallic ore, which when refined becomes a heat resistant powder that can hold a high electric charge; it is used in the manufacture of an array of small electronic devices, especially mobile phones, laptop computers and pagers).

After the genocide in Rwanda in 1994, thousands of Hutus fled into eastern Congo. They organized themselves into militia groups and established themselves in the forests, where they mined coltan and other resources that they sold across Lake Kivu in Rwanda, or further north in Uganda from where the minerals reach the world market. This wealth has perpetuated a 'silent war' in eastern Congo; it is a war against women and children.

Relief for traumatised women at Panzi Hospital

Dr Denis Mukwege is a gynaecologist, who trained in France and then for many years worked in a mission hospital in South Kivu, a province of eastern Congo. Because of the latest war, he and his family had to flee to Bakavu, the regional capital, where he founded Panzi Hospital more than ten years ago. Mukwege wanted to establish a maternity unit but, before delivering babies, he first had to treat women who had survived rape and other sexual violence but only at the cost of serious injury.

A new pathology has emerged as a result of the war: genito-urinary fistula caused by sexual violence. The violence is committed not by people who belong to the community but by the outsiders who make up the militia groups. Their aim is the destruction of the community within which a woman lives. As a consequence of a woman's rape, her husband, children and extended family also become traumatised and humiliated. Relationships are ruined, and the community as a whole is violated and traumatised. As a result of these atrocities, the Christian values that normally exist strongly within Congolese communities have been lost.

Panzi Hospital built a special unit for women suffering the consequences of rape and violation. Initially, the unit mainly offered medical care. As well as having genital injuries, some women had also been infected with HIV, and needed specialist treatment.

Over time, the special unit has grown; today, it offers holistic care to traumatised women. Panzi Hospital has become a safe refuge for many physically, emotionally and socially injured women. A psychologist offers psychosocial support to the traumatised women, and also to their husbands and relatives. The hospital chaplain offers spiritual assistance to help the women achieve reconciliation. Husbands are counselled not to blame their wives, and couples are helped to take steps towards forgiving their aggressors in order to overcome hate and

regain peace within themselves. As a way of empowering the women to create income-generating activities for themselves, social workers provide education and training that includes literacy lessons, plus sewing and soap-making classes. The provision of legal support is also part of the programme.

In addition to his hospital work, Dr Mukwege began to advocate for peace and justice in eastern Congo. In 2008, he was named African of the Year, which is a truly appropriate award for a Christian who stayed in eastern Congo under extremely difficult circumstances, and is still fighting for the rights of women in the war-torn country.

Eastern Congo is not the only country where women suffer from abuse and sexual violence. In other countries it may be more subtle but still there are women who have no right to decide whom they will marry and when, nor do they have equal access to education or jobs. Female genital mutilation and the increased risk of HIV infection are other determinants of ill health for women, and further evidence that women's God-given right to dignity and a holistically healthy life has been and is being ignored or violated.

Panzi Hospital has become a safe refuge for many physically, emotionally and socially injured women.

Break-up and reconciliation with my family and culture: the story of a Massai woman in Kenya

My name is Siamanta¹⁰. I am from a polygamous family of four wives and 22 children that is part of a traditional Massai community. In 1979, I was eleven years old and attended class four in primary school. I had just begun to enjoy school life after having learnt how to read and write. In fact, I was very excited and could read all the road signs, and what was written on buildings and vehicles. I took every opportunity to practise my newly acquired skills on any surface and with any available medium. I used pieces of charcoal, chalk or vegetable dye squeezed out of wild herbs, and I wrote on trees, rocks, walls and doors. However, this innocent existence was not to last.

In that same year, Leshan, who was 40 years old, came to see my parents to ask them to allow him to become engaged to me. Since Leshan came from a famous family and had enough cows to pay the dowry, my parents agreed to his request. While I was busy concentrating on my education, my parents were busy organizing my marriage. Immediately, I was forced to become engaged to Leshan, and a beaded bangle (enkerena) was put on my wrist. Then, I was expected to undergo several stages of preparation for marriage. One of these was female genital mutilation.

I was very worried because I knew that my education was going to end once the preparation process began. Normally, female genital mutilation is a community activity that involves several girls of a similar age in the community. It is usually a big ceremony, and almost everyone in the community takes part. During the 'circumcision' ceremony, bulls are slaughtered, locally brewed beer is offered, and people sing and dance.

¹⁰The names in this article have been changed.

Women in traditional Massai culture

What happened to me was consistent with the status of girls and women in my traditional Massai culture. There are many expectations as to what a Massai has to do: The woman builds a shelter for her family, and provides food for the entire family, while the man moves from place to place with the family's cows. The woman has to milk the cows, as well as make sure that things are in order at home, and she also goes to the market to sell the milk and her beadwork.

A Massai woman usually has few rights and little say about marriage. Women are not involved in any decision making, especially when girls are being married off or the cows are being sold. Usually, girls have no opportunity to get a proper education. Women do not have the right to choose the number of children they want to have, and they are not able to prevent their husbands from practising polygamy. To put it bluntly, Massai women are there to be seen and not heard. A woman is considered as a child or a piece of property. When a husband has many wives, cows, goats and children he is considered rich, and he is therefore respected in the community.

When I was young, I saw many Massai women experiencing violence. The Massai women are beaten by their husbands over small issues to such an extent that they can sometimes be unable to walk. An example: normally the cows are back from grazing at around 5 p.m., and the woman must be at home. If the woman is somewhere else and returns home after the cows are back then life for her gets rough. After beating his wife, a husband will slaughter a goat and eat some of it so that he can regain his strength.

Three girls escape forced marriage and break with their culture

At the same time as I was being prepared for marriage, my older sister Resiato and my cousin Nadupoi were also forced to become engaged.

They also were made to undergo female genital mutilation, and they were well on the way to being married off as their dowry had already been paid and a day for their traditional wedding had already been set.

Fortunately, Resiatio and Nadupoi hated the idea of getting married, and they had the idea of escaping from home. They had some information about a Catholic priest who was rescuing Massai girls from early marriage. The two girls organised their escape, and luckily I heard about their plan. I asked my sister and cousin to let me join them. At first they hesitated because they thought I might leak the information to others. Also, as the priest lived quite some distance away, they thought I would not make the journey on foot.

Well, I was totally determined and when the day of escape arrived I joined Resiatio and Nadupoi. It was very hard because we had to walk over 40 kilometres to reach our rescue centre. We also had to walk in the bushes for fear of being caught by our parents and the community, especially the morans (young Massai men). The journey was very tough, especially for me since I was the youngest and did not have any food or water to drink with me. After some time, I had a severe headache and I was extremely hungry and tired; I began to cry. My sister and cousin were ready to give up on me, and asked me to return home. As going back was not a solution for me, I promised them that I was going to persevere and would not cry again. On our way forward, I did not complain again, not even when my feet and legs became sore and painful because I was walking without shoes. Today, several scars remain on my legs, and sometimes I feel very troubled when I see them because they remind me of my childhood suffering.

After a long and tiring journey, we finally reached our destination. At the Catholic rescue centre, we found Father Michael, a priest from Scotland, who listened to our story. He was very kind and offered us food and shelter. He also took me to a clinic in the centre. After a few days, we were taken to a Catholic boarding school for girls. During the school holidays, we stayed at the convent with Catholic nuns. One of

the sisters was called Sister Mildred, and she became a dear mother to us. We were taught how to pray, and live in a Christian way.

After I escaped from home my mother suffered many humiliations. She was beaten and even chased away from her home. She was denied her rights to have cows or own anything in the home. To make matters worse, my mother had given birth to five girls and no boy. Therefore, my father had to marry other wives. My mother's co-wives mocked her, and everybody in the family neglected her. This was because my father blamed my mother for not having done anything to prevent our escape. He also suspected her of having arranged our escape. She was accused of not bringing up her girls according to the Massai culture. So, my mother was no longer allowed to attend marriage ceremonies in the community because she had not been able to manage her girls. Resiatio, Nadupoi and I were considered to be undisciplined because we had disobeyed our parents.

By the grace of God, I went through primary education and high school. During my last year of high school, Father Michael, who had become a dear father to me, returned to his own country. The priest who took over from him could not continue to support my education but there were other well-wishers who paid the school fees for my last two terms.

A process of reconciliation

After 15 years, I went back home to try to be reconciled with my parents. It was not easy for me but I had to do it. My mother was very happy but my father was not. I had bought gifts for all of them, and especially for my grandmother who had sworn that I should never go back home. I regularly visited my parents, and slowly they accepted me back.

In 2004, I organized a big thanksgiving party when I visited my parents with 50 of my friends. I also bought several gifts for my parents and close relatives. During the party, I asked my dear parents to forgive me for my disobedience, and they asked me to forgive them. We were all in tears but I thank God all went well and now I am the best friend of my father. I am grateful to God because I know that had it not been for his sufficient grace, I would not have been able to forgive my parents.

I am very glad that forced marriage is now disappearing, and most Massai families send their girls to school; it is illegal not to do so. Female genital mutilation is also disappearing, and there are many other changes taking place within the Massai community.

My dream for the future is to have a rescue centre for girls who might undergo the same problem as me. I want to create awareness among other communities, such as the Samburus and the Borans, who still practice mutilation on young girls and support forced marriage

I am grateful to God because I know that had it not been for his sufficient grace, I would not have been able to forgive my parents.

Lessons learnt

The gender justice and health case studies have shown us that:

- God created men and women in his image, and gave them dignity and equal rights that churches must respect;
- because of their gender, women are more vulnerable than men to HIV infection and sexual violence, and are also more likely to suffer because of war, and therefore they must be able to protect themselves;
- churches have a responsibility to offer refuge and help to those who suffer from sexual violence or are discriminated against as a result of socio-cultural reasons;
- Christians have an important role to play in advocating for peace, reconciliation and gender equality.

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