THE CONTRIBUTION OF THE
CHRISTIAN MEDICAL COMMISSION
TO HEALTH CARE IN AFRICA IN THE
POST COLONIAL ERA

Dan Kaseje, MD, PhD
Professor of Public Health,
Vice Chancellor, Great Lakes University of Kisumu

WHO's initiative on Global Health Histories Meeting in
Nairobi,
February 6-8, 2006
PRESENTATION OUTLINE

• The worrying African trends
• The History of CMC
• Contributions:
  • Influencing the global policy
  • Networking within and beyond countries
  • Advocating for justice and fairness
  • Capacity building
  • De-stigmatizing AIDS
  • Documentation and dissemination
• FBO potentials for accelerating improvement towards the MDGs
Worrying Trends

- Africa ranks last in most MDG indicators
- Problems are greatest where resources are least
- 70% of households trapped in poverty and ill health
- Delayed care seeking for the poor leads to higher costs
- Traditional systems of care and indigenous efforts continue to be ignored
- People appreciate the availability, affordability and acceptability of traditional systems
- Difficult to develop strategic partnerships at frontlines of care (due to artificial dichotomies)
- The optimism of the Sixties has given way to disabling pessimism in the Nineties (millennium)
THE VICIOUS CYCLE

1. Differential social stratification
2. Differential vulnerability
3. Differential exposure
4. Asset owned, location, gender and age determine access to information and services (Coverage/exclusion)
5. Poverty/social status leading to ill health, proximity to causative factors (risk of exposure) lack of access to preventive means
6. Struggle with the pull and push factors of social inclusion
7. Double exclusion at micro & macro levels (Survival linked to exposure)
8. (Experiences - micro level exclusion)
9. Ill health further compromised
10. Access to EEDL, given our labour intensive economy
11. Chronic humiliation
12. Eroded resilience and resistance
13. Differential consequences
Total Expenditure on Health as Percent of GDP 1998-2004
Problem Statement cont....
DISABLING PSEUDO-AFRICAN MENTAL MODEL:

- **People viewed as vulnerable**, powerless, sick, at risk rather than as partners with capacity and commitment to maintain good health
- **Problem Conceived as** Disease, malnutrition, sanitation rather than poverty, inequity & marginalization
- **Professional trained to provide** prescribe, inject, educate, help, save, rather than to facilitate, dialogue, partner, etc. Not able to handle people going through unusually hard times, with multi-dimensional brokenness, needing livelihoods, empowerment, healing in addition to drugs, vaccination, latrines, health talks
- **Capacity seen as skills and knowledge not balanced** Authority and Responsibility
CMC HISTORY

- Motivated by the notion of a unique Christian understanding of health and healing
- 1963: Tubingen 1 - Address the complexities of health that go beyond the medical, what is the role of Medical Missions post-colonial era?
- 1967: Tubingen 2 - led to the birth of CMC in 1968

mandated to:

- Enhance the quest for Christian understanding of health
- Promote innovative approaches to health care (CB-PHC)
- Facilitate networking within and between countries
- Confront unjust structures with evil marketing strategies
- Promote integration in service delivery beyond medical
- Look for, document innovations across the world & share
- Conduct studies to find solutions & influence strategies
- Re-orientation of personnel for the complex context
A STUDY BY CMC REVEALED:

• Churches were making more than 40% contribution of medical facilities in many African countries.
• Yet Governments tended to ignore the contribution of the churches in their planning, budgeting and deployment of staff.
• Most of the churches' medical activities were focused round curative services in hospitals, run on Western models. Little focus on health promotion.
• The cost of operating these institutions was increasing annually. As a result, higher fees had to be charged & the services became inaccessible to the poorest people for whom they were intended.
• The location of the units tended to be determined not by health needs but by proximity to church structures.
1. INFLUENCED HEALTH POLICY

Examples (thro’ regular dialogue: WHO-CMC)

• Made unique contribution to PHC, many papers at Alma Atta from CMC Network
• Essential drugs initiative (CMC’s PAG)
• Growth of the New Public Health, a professional approach that is more ethical, just, rights based, and community oriented;
• The critical role of Social Determinants of Health, insisting that health is not only medical.
BY PROMOTING HOLISTIC CARE FOR ALL

CMC strengthened Churches in taking over Mission facilities that were Western, designed to serve the privileged few and transformed them into people controlled systems of care for all.

In this way CMC brought hope that health for all was possible against the odds of corruption, poor infrastructure and poverty shaped by the unjust world order and the hostile forces of globalization.
2. FORMED HEALTH ASSOCIATIONS TO:

- Conduct joint advocacy with governments for enabling environment and direct support (financial, personnel)
- Form joint procurement of drugs to reduce costs
- Avoid wasteful duplication and competition
- Work together on training and other issues
- Provide a mechanism for sharing and scaling up innovations:
  - Integration of services with other sectors
  - Shaping services around the life patterns of the population;
  - Active partnership with local population for ownership and to reduce dichotomy
PARTNERSHIP MODEL THAT:

- Recognizes, affirms and builds on the strengths of every stakeholder involved, valuing every contribution (ideas, skills)
- Focuses on promoting synergistic relationships in which each partner equitably benefits from the relationship based on mutual trust and confidence
- Encourages each partner to focus on areas of own influence in Joint actions to achieve agreed health objectives
- Provides opportunities for learning from one another to scale up locally developed models for continuous improvement in complex contexts.
Trends in Under-5 Mortality Compared to MDG Target, Ghana

Source: Binka et al. (2005).
3. CONFRONTED MULTINATIONAL MALPRACTICE IN AFRICA BY

- Advocating against breast milk substitutes
- Advocating against “donations” of expired, useless and even dangerous medicines
- Developing standard guidelines for donors and recipients
- Establishing efficient, sustainable joint procurement programmes to enhance access to essential drugs at reasonable costs, to replace unhealthy donations
4. PROMOTED HOLISTIC CARE FOR PLHA

Tackled the issues of stigma in Churches and promoted the development of models of compassionate care more consistent with the life and teaching of Christ.

Advocated increased access to ARVs and took the lead in Countries (Kenya)

There are aspects of care that FBOs have unique capacity to address effectively, embracing the social roots and consequences rather than being limited to clinicals.
THE PRECASO MODEL

- PREVENTION
- POVERTY
- SOCIAL SUPPORT
- CARE PROVISION
- ILL HEALTH

TRAPPED
H/HOLD
5. CAPACITY BUILDING FOR HEALTH THRO’

- Formal education that enhanced abilities at all levels (from the household) for better management of situations for health.
- Re-orientation of health personnel for the partnership approach to service delivery, recognizing the capacity of consumers as partners, able to Listen and Dialogue (where traditional healing systems excel).
6. DISSEMINATION TO SCALE UP INNOVATION

• By producing a regular periodical, the Contact
• Assessing and documenting innovative actions for health & disseminating internationally towards global policy change
FBO POTENTIAL TO PROMOTE HEALTH IN AFRICA

• They build and sustain more social and development interventions than any other type of institution in Africa.
• They provide a vibrant institutional base for good works and a training ground for social entrepreneurs needed to promote health in Africa.
• About half of health work in Africa could be religious, religiously affiliated or motivated, whether measured by memberships, or volunteers.
• They mobilize and spend billions of dollars each year on social services, such as food housing for the poor, through regular giving, not dependent on outsiders.
• They are an influential advocate for social justice, human rights, social norms, attitudes and behaviours. They have undisputed role and responsibility of building and maintaining healing communities amidst brokenness in the society.
FBO POTENTIAL TO PROMOTE HEALTH IN AFRICA

• They teach values relevant to health and healing, including compassion, forgiveness, fairness and respect for others beyond self.

• They are engaged in public issues of the day, and can play a role helping communities overcome distrust, animosity, and sometimes violence to contribute to health and healing.

• Millions of people in Africa (No choice but God to rely on)

• Regular religious services attenders meet many more people weekly than non-worshipers, making religious institutions a prime forum for building health healing communities.

• Faith provides a moral foundation for health and healing, may forge spiritual connections between individual impulses and public health issues.

• Faith helps people internalize an orientation to public goods, with profits measured differently. Because faith has such power to transform lives, faith-based programs can enjoy success where secular programs have failed.
FBO PROMOTE HEALTH BEYOND BOUNDARIES

• They build bridges by spiritually grounded rituals to bring communities together in celebration and healing.
• They command community respect, and therefore can communicate with moral authority.
• They draw inspiration from scriptures that almost universally emphasize peace, fellowship, healing broken communities, bodies in addition to broken souls.
• They have stood up through history as an agent of social change. Men/women have committed themselves to serve the afflicted, the sick, the lonely, and the poor.
• They contribute moral values that inspire action, and organizational structures able to convene, sanctuary, nurture new ideas for health improvement.
THANK YOU