Anglican Health Network

Autumn 2009

Snapshots

A word from the Network Coordinator

The World Health Organization took a significant step forward in its engagement with faith-based organisations at a consultation that took place in Geneva on the 10 - 12 November. The agenda focused on the mapping of faith based health facilities alongside those of the public and private sectors. Given the claims that faith-based health facilities can equal if not exceed the number of state health facilities in a number of developing countries, it is essential for any national health planning exercise to include all service providers. This might sound obvious, but there is still resistance to seeing religious service providers as intrinsic components in a publicly defined health system. By incorporating our sector into national mapping regimes, a Ministry of Health is far more able to assess how Anglican and other church hospitals can contribute to their public health objectives.

I was pleased to be joined at this conference by Dr. Ernest Nwaigbo, medical director of the Diocese of Owerri in Nigeria and Emmanuel Olatunji, HIV/AIDS coordinator for the Council of Anglican Provinces of Africa (CAPA) based in Nairobi. The mapping agenda was dominated by the African context, particularly in view of some proposals for 2010 by the International Health Partnership to step up their objectives. Our contribution helped to make the mapping process appropriate to this context; whether related to the shaping of questionnaires or in the handling of data. As a group of 50 participants from different faiths and parts of the world we also found this a great opportunity to share experience and ideas. Experience in Memphis (see later article) complemented that in India and related to developments in Southern Africa. Faith-based health care is becoming truly globalised.

AHN provides a forum for collaboration and sharing within the Anglican Communion and already provides remarkable intersections of common interest. The Global Health Community is growing in its appreciation of faith-based health services. With this and other steps, it is beginning to incorporate our health activity into the overall picture. As we engage more meaningfully in this process, we will find ourselves asking what it means to collaborate with the state for the long term. What are the gains and losses? How should Anglicans shape the economic models of their services in an era of high donor interest? What does mission mean when it is carried out in partnership with the state?

I hope that through our sharing as a network, we will help each other to find answers to these challenging questions as we face these evolving opportunities. This newsletter provides just a small 'snapshot' of what is happening out there. It is time we made this more visible. It is one of our well known Anglican figures who is making this possible in WHO. Canon Ted Karpf, as partnerships officer in the Office of the Director General, is driving this forward. He deserves our support and appreciation.

Emmanuel Olatunji and Dr. Ernest Nwaigbo at the WHO consultation on mapping FBO health programmes.

For further information about the network, please look at the website: http://ahn.anglicancommunion.org/index.cfm

Faith based leadership in the fight against AIDS: Fikelela wins Cordaid Award 2009

'If you want to go fast, walk alone;
…if you want to go far, walk together'

Fikelela is the HIV organisation of the Anglican Diocese of Cape Town. The word Fikelela means 'reach out' in Xhosa and it was founded in 2001. The mission of Fikelela is *to mobilise the Anglican community to make a sustained positive contribution to the reduction of the number of new HIV infections and to drive HIV&AIDS education and care, in partnership with others*. It's work is focused in 3 areas:

Church mobilisation

Churches are encouraged to start an HIV&AIDS task team. This group ensures that 'HIV is brought into the church'. This takes place through services to commemorate World Aids Day, candlelight memorials, orphans day, and inviting people living with HIV to share their stories. The task team also makes sure that education takes place through workshops, leaflets and other forms of communication. There are also many practical projects. Some churches run support groups for HIV+ people, offering them a place at the church and practical support for the group to run. Others link with hospices or other projects to offer their assistance or are involved in counselling and fundraising

Orphan support

For those children who do not have an extended family member, the project provides short term emergency care at the Fikelela Children's centre. Children are nursed back to health and placed onto anti-retrovirals where necessary. They then recruit, screen and train foster carers as a child is placed back into the community in supported foster care. For orphans who are living with grandmothers or aunts, there is a joint project with Care for Kids. The churches provide emotional support, monthly food parcels and school stationary and uniforms.

Prevention work

In 2004 Fikelela conducted research into the sexual activity of Anglican Youth in the Diocese. Based on this research, a peer education program was set up called Agents of Change. Peer educators are trained to run a 20 session life skills program in their church and community.

In 2008 through the work of the churches and task teams Fikelela was able to support 410 orphans, 750 young people through the peer education program, and 390 HIV+ adults. Approximately 9000 people were reached through workshops and training events.

It was a source of great pride for the many participants that Fikelela won the 2009 Cordaid award for faith based leadership in the fight against AIDS. Check out the website: www.fikelela.org.za

Hard outcomes through soft strategy: Some lessons from our Methodist colleagues

What are trust and connection worth in terms of health? How about $4,102 per patient? Early data comparing the medical experience of 228 patients who are members of Congregational Health Network (CHN) to matched control patients at Methodist LeBonheur Healthcare in Memphis shows hard gains using soft strategies. The hard news first: the patients are 80% African American, 60% female and just over 60 years old. Looking at the top reasons for admission makes clear the challenge and the opportunity: congestive heart failure, fibroids, diabetes, other cardiovascular disease and general mental health. These are the young Medicare patients who tend to be high consumers of services with many good reasons to do so: high lifespan stress and decades of accumulated health risks that simply come with growing up black and female on the Delta. This is a group of patients that is skewed toward the more challenging end of the spectrum, but otherwise look like a great many thousands of our other patients.

The Congregational Health Network is a covenantal relationship among 173 congregations designed by clergy and healthcare workers: a web of trust to help people navigate the journey from home to medical care and back. It is a human bridge connecting the professional care system (including the hospital) with the natural caring system of family, neighbors and especially congregations. It is not a fancy bridge, but it gets people across dangerous waters typical of the healthcare journey. CHN adds some sturdy railing, directions and real help: full time navigators at each adult hospital and hundreds of unpaid liaisons in participating congregations. Trust is built by acting in a trustworthy manner, by actually helping people get what they need.

Anyone looking at the top causes for admission can see huge opportunities for education and early intervention. Targeted training can amplify the caring capacity of those natural systems, but that only makes the early data more significant. Simple trustworthy connection has profound effect all by itself. How much? Looking at the CHN patients with the top 12 admits compared to their peers, the total savings is just a few dollars shy of one million. The average length of stay (a crucial factor in both safety and cost) is shorter. Mortality is almost exactly half. The number of patients that readmitted within 30 days (a key measure of effective care) is 20% less than that of the matched control group.

Dr. Lucy Gilson, of the University of Cape Town, examines how trust affects access and quality in healthcare systems. She distinguishes between the involuntary trust one is forced to have in a medical crisis in a system one can't choose. No choice means no trust. And lack of trust means fear, friction and disconnection, all of which create a cycle of bad outcomes measured in every way that matters. Voluntary trust creates collaboration, respect and alignment. At Methodist we have a front-door standard: we want every patient to show up at the right door (not the ER), at the right time (early, not late in the disease condition), ready to be treated (mainly meaning, not filled with fear) and not alone. For this first 228 patients we missed on the first two standards (90% came through the ER), but the other two are met enough to make $908,454 of difference. What if we the hospital and the natural caring system got it right all the time on every patient? If Methodist Healthcare, which serves more TennCare patients than any other system in Tennessee, was able to see the impact at full scale, it would mean tens of millions of dollars - and hundreds of people going back quickly to their families and work, and no small number of birthdays.

Faith and faith organizations play a critical part in building trust. Faith, in this model, is glue when things need to stick together and solvent when things need to be unstuck. It is the blended intelligence of what clergy know about life and what the medical leaders know about disease. It is the blending that matters. Hospitals and congregations can't do that alone or apart. And they can't do it without government policies and programs like Medicare, TennCare and private insurance companies, too. Dr. William Foege said that it is not hard to be brilliant. Simply think of the dumbest thing possible and do the opposite. Today's health non-system, so filled with fear, friction and disconnection is both dumb and cruel. The way toward brilliance and decency is across a new bridge of trust and connection.

Gary Gunderson is Senior Vice President of Methodist LeBonheur Healthcare and Director of the Center of Excellence in Faith and Health. This article was adapted for the Washington Post on 16th September 2009.

2009 Council of Anglican Provinces of Africa Primates Meeting

The Archbishops of the African continent gathered in Nairobi early in September to consider a range of issues facing them. Their secretariat is based in Nairobi and has a particular commitment to improving Anglican responses to HIV/AIDS. This programme is overseen by Canon Grace kaiso of Uganda, and operated by Emmanuel Olatunji of Nigeria. The primates gathered with a number of other senior figures from the continent to offer a statement as reproduced on the following page.

In the context of this bold and purposeful health-related statement, Lee Hogan, programme coordinator of AHN and Richard Leftley, CEO of MicroEnsure, made a presentation about the potential of micro health insurance. In a continent where there is such poor access to quality health services, the micro health insurance concept proved to be of great interest to the primates. Not only would it allow their members to even out the financial burdens of disease, it would also allow Anglican health facilities to become service providers in the scheme; allowing them to develop more robust business models.

The primates encouraged AHN and MicroEnsure to pursue their partnership within the CAPA provinces, and to establish a pilot project that could further demonstrate the applicability of micro health insurance.

Micro health insurance Africa pilot launched

Following the CAPA meeting, Lee and Richard made visits within the Anglican Church of Tanzania. Revd Canon Dr. Mwita Akiri, general secretary of the province, accompanied them from Nairobi and introduced them to a range of clergy and lay people. They were able to visit clinics and test out their thinking in stakeholder meetings.

With the enthusiastic support of Archbishop Valentine Mokiwa, the decision was made to site the pilot programme in the Diocese of Dar es Salaam. The location proved very attractive for various reasons. MicroEnsure already offers other forms of micro insurance in Tanzania and therefore has an existing track record and familiarity with the regulatory framework. Dar es Salaam has a range of service providers, including an Anglican clinic, which can offer a good deal of initial flexibility in setting up the scheme.

At the end of October, AHN announced the pilot in a press release issued through the official Anglican Communion News Service. The Archbishop of Canterbury graciously added substance to the release with a supportive quote. The announcement went out to over 8000 recipients, some of whom responded with interest in joining the network.

MicroEnsure is now engaged in initial discussions on the design of the pilot. It is expected that a scheme will be ready for its first members within the next 6 months.

Micro health insurance India update

Dr. Bennet Abraham, medical director in the Church of South India, moved swiftly after the AHN inaugural meeting in June to develop a micro health insurance project for his hospital in Karakonam. This will offer an additional opportunity to test the potential of micro health insurance. Already the scheme has signed up 18000 people. India has a more developed insurance market in which MicroEnsure has a swiftly growing presence. AHN will ensure that progress is reported and lessons learned so that other dioceses and provinces can asses the value of this concept.

African Leadership Consultation on HIV/AIDS and Related MDGs

A Joint Communiqué from the CAPA Primates Meeting

ACNS 23rd September 2009: We, former African Heads of State, religious leaders and non-governmental organisations engaged in combating HIV and AIDS, convening in Nairobi, Kenya, under the auspices of the Council of Anglican Provinces of Africa (CAPA), have engaged in a consultative dialogue on HIV and AIDS in Africa in the context of the Millennium Development Goals (MDGs).

The purpose of this dialogue is to develop a Network of African Leaders Against HIV and AIDS, committed to providing necessary leadership to develop a dedicated long-term advocacy drive to mobilise an effective response to HIV and AIDS and to encourage active citizens as agents of change in Africa.

We are committed to collective responsibility to address HIV and AIDS as the greatest development challenge in Africa, a continent carrying 25 percent of the global disease burden of HIV and AIDS, yet forming only 10 percent of the world's population. We declare this to be a historic moment, in which political and religious leaders will work together with renewed commitment to overcome the HIV pandemic and reverse the current situation.

Recalling the 2001 Abuja Declaration on Health, through the stewardship of religious institutions and political leaders, we commit to overcoming all forms of inequality and taking decisive leadership in advocating for the achievement of HIV and AIDS related MDGs by 2015, through the following actions:

1. We shall intensify our focus on mobilising our communities to overcome the consequences of stigma, lack of awareness and knowledge, and shall increase care and support for people infected and affected by HIV and AIDS, including vulnerable children.
2. We shall mobilise health professionals and community health workers to develop long-term strategies for community-based initiatives against HIV and AIDS.
3. As a Pan African initiative of religious and political leaders, eminent persons and civil society, we shall mobilise partnerships with local and international stakeholders so as to engage in effective and sustainable interventions.
4. We shall provide space for dialogue between leaders and vulnerable people, including youth and people living with HIV and AIDS, so as to learn from each other and devise new solutions to address the challenges of HIV and AIDS on the continent.
5. Given the fact that all causes of conflicts in Africa cannot equal the tragedy of HIV and AIDS, we request that our governments declare a war on the HIV pandemic and proactively mobilise a powerful response.
6. We demand that as a matter of urgency, our governments translate policies into action by allocating at least 15 percent of their national budgets to health, including programmes to ensure universal access to prevention and treatment for HIV and AIDS by 2010.
7. We call upon our governments and civil society to be resilient, to develop strong capacity to overcome the challenges of the HIV pandemic, and to identify opportunities for achieving HIV and AIDS related MDG targets.
8. Given that HIV and AIDS is not only a health and moral problem, we hereby resolve to address the vulnerability of African men and women using all available cultural resources.
9. We shall facilitate the strengthening of families and social structures to withstand the impact of the HIV pandemic, by working with governments, the international community, other stakeholders and civil society.
10. We affirm the role of religious, political and cultural institutions in encouraging young and vulnerable people to take charge of their sexual and reproductive health.
11. We shall listen and dialogue with our communities, particularly those vulnerable to HIV and AIDS, and commit ourselves to speaking openly about the pandemic.
12. We resolve not to lose this opportunity to bridge the gap between medical and spiritual approaches to the pandemic.

We hereby conclude that we shall hold each other accountable to these commitments. We shall do everything within our means and power to end stigma, denial and discrimination related to HIV and AIDS, to ensure our people live in safety and health, and to assist in achieving the MDGs through an inter-faith approach. We are committed to enabling the people of Africa to live lives of dignity.

Hands on Health: A new initiative led by USPG

USPG: Anglicans in World Mission has been involved in providing, developing and supporting healthcare for most of its 308 year history. Our missionary forebears worked with huge diligence, and often at great personal cost, to establish hospitals and clinics as part of the basic infrastructure of Christian mission and outreach around the world.

While parts of the missionary endeavour have been criticised for "buying" converts through the provision of medical facilities, this view would overall do a great injustice to a wide and forward looking view of mission, especially in the nineteenth and early twentieth century missions. Mission, in the SPG (Society for the Propagation of the Gospel) and UMCA (Universities Mission to Central Africa) view, was always seen as holistic, in which a ministry to the soul of a community could only meaningfully be addressed in the context of the upliftment of lives through both education and health.

So it is today that, although USPG (the United Society for the Propagation of the Gospel) is far smaller than it used to be, sends far fewer missionaries, and supports a smaller overseas budget, this "Venerable Society" still invests a third of a million pounds each year in supporting the medical work of the churches of the Anglican Communion in over 50 countries.

Our health portfolio focuses mainly on Africa, with a large part of our support going to strengthen the work of key, and often historic, mission hospitals. Muheza in Tanzania, St Francis Katete in Zambia (see photo), St James' Mantsonyane in Lesotho, or Malosa and Nkothakhota in Malawi would be to name just a few of the institutions that have contributed hugely to the development of medicine in Africa, and still today offer what is often a very niche part of the market, as they find their way as mission hospitals in contexts increasingly led by state provision.

But the emphasis in global health is shifting more and more to the provision of excellence in primary health care, and USPG supports Partners in their commitment to working especially with the rural poor, through clinics and "outstation" intervention. Particular initiatives are being taken by Partners to address the HIV pandemic, many of them involving community health education, community gardening, and land utilisation. Thus the boundaries between good mission, good healthcare and good development become more and more blurred.

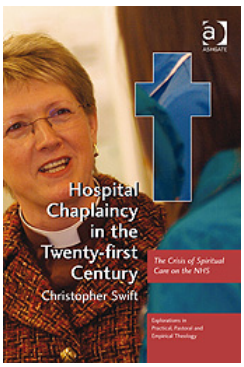
USPG is currently exploring a new initiative with partners. "Hands on Health!" is a programme about to be piloted in three areas of the world, pushing forward a particular process of community health empowerment. It is hoped that through this process, communities will be better enabled to "own" their own health destiny, and to work more creatively with those who until now have been seen as "experts" or "providers". As the process of empowerment takes root in the community, changes take place in the way professionals interact with local people, and new ways of delivering health become apparent. This, USPG believes, will in the longer term reduce dependency on external agencies, and grow the local church's capacity to stand alongside their communities with more power and effectiveness in the drive to improve the quality of life of all concerned.

For further information, contact:
The Revd Canon Edgar Ruddock, Deputy General Secretary and
International Relations Director, USPG: Anglicans in World Mission
200 Gt Dover St, London, SE1 4YB

Tel: +44 (0)20 7378 5675
email: edgarr@uspg.org.uk
web: www.uspg.org.uk

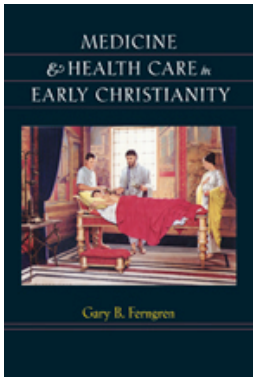
Events and Resources

Recent Publications



Issues of faith and spirituality have been resurgent in the UK since the opening of the twenty-first century. This book charts the impact of shifting attitudes towards spirituality through the experiences of health care chaplains. Rooted in a new and challenging interpretation of the chaplain's work in the past, the book moves on to describe a current crisis in the nature of spiritual care. Using the tools of practical theology to analyze these experiences, fundamental problems are identified for chaplains as they work within the culture of 'evidence based practice'. As the National Health Service struggles to balance its books in the face of national economic uncertainty, chaplains will continue to come under increasing levels of scrutiny. Some chaplains have faced the prospect of redundancy or cuts to their budgets, while a growing number of NHS Trusts no longer offer chaplaincy to patients out of hours. In this context the nature of chaplaincy itself has come into question, and rival models of the profession have emerged. Is chaplaincy a new and distinct profession within health care, based on evidence and available to all? Or is it State-funded religious activity, theoretically open to all but in practice utilized chiefly by the faithful few? In responding to these questions the book concludes with a vision of how chaplaincy can both maintain its integrity - and be a valued part of twenty-first century health care.

http://www.ashgate.com/default.aspx?page=637&calcTitle=1&title_id=9651&edition_id=11121



Drawing on New Testament studies and recent scholarship on the expansion of the Christian church, Gary B. Ferngren presents a comprehensive historical account of medicine and medical philanthropy in the first five centuries of the Christian era. Ferngren first describes how early Christians understood disease. He examines the relationship of early Christian medicine to the natural and supernatural modes of healing found in the Bible. Despite biblical accounts of demonic possession and miraculous healing, Ferngren argues that early Christians generally accepted naturalistic assumptions about disease and cared for the sick with medical knowledge gleaned from the Greeks and Romans. Ferngren next explores the origins of medical philanthropy in the early Christian church. Rather than viewing illness as punishment for sins, early Christians believed that the sick deserved both medical assistance and compassion. Even as they were being persecuted, Christians cared for the sick both within and outside of their community. Their long experience in medical charity led to the creation of the first hospitals, a singular Christian contribution to health care.

http://jhupbooks.press.jhu.edu:80/ecom/MasterServlet/GetItemDetailsHandler?iN=9780801891427&qty=1&source=2&viewMode=3&loggedIN=false&JavaScript=y

WCC Health and Healing

Under the direction of Dr. Manoj Kurian, the World Council of Churches has a programme on health and healing. This programme supports the churches' work in the field of health and healing with particular emphasis on HIV/AIDS, mental health, and the promotion of reconciliation and the "healing of memories". They publish a regular newsletter **Contact**. The most recent edition looks at medicines in primary health care. Click on the following link to download:

http://www.oikoumene.org/fileadmin/files/wcc-main/documents/p4/contact/con-187.pdf

Christian Health Association Platform

Many Anglican hospitals and clinics in Africa are members of national Christian Health Associations. These provide a support network for supply chains, human resources and advocacy. Some have managed to access funding from governments and global donors. These are key structures within which Anglicans can further develop their health programmes. The associations have a common platform that issues a regular newsletter. To receive this newsletter, contact Mike Mugweru: Email

PWM World Mission Conference

The 2009 World Mission Conference is to be held at The Hayes Conference Centre, Swanwick, Derbyshire, UK from Nov. 18th to Nov 20th 2009. Gathered there will be Church of England diocesan link officers and UK based mission agencies. This year the conference will provide a forum to help develop a new policy and strategy for world mission in the Church of England and the wider Anglican Communion.

Ruth Wooldridge will attend on behalf of AHN, having previously assisted with the original presentation made at the Lambeth Conference on the idea of a health network. Based at present in London, Ruth is a nurse who has worked and travelled widely in the developing world. Her specialism is in establishing systems of palliative care in resourced limited settings.

partnership for world mission

Anglican Health Network

Website: http://ahn.anglicancommunion.org/index.cfm

Revd Paul Holley
Network Coordinator
Email
chemin du Couchant 7
1260 Nyon
Switzerland
Tel: +41 22 364 0030

Lee Hogan
Programme coordinator
Email

Emmanuel Olatunji
CAPA HIV/AIDS Coordinator
Email
Kilimani, Komo Lane,
Off Wood Avenue
P.O Box 10329-00100 GPO
Nairobi, Kenya
Tel:+254-203873700
Fax:+254-203870876

Claudine Haenni Dale
Organisational and legal support
Email

Global Health Conferences 2010

Global Health Council Conference, June 14-18, Washington DC

The world's premier global health conference will assess the state of the union of global health, looking at where we are and where we are going. With the theme *"Dateline 2010: Global Health Goals & Metrics,"* the conference will examine metrics, progress and challenges on global health goals (such as the Millennium Development Goals). As usual, the annual conference will address the full spectrum of global health issues, including emerging issues, and will be tailored to a wide array of stakeholders, including students, academics, policymakers, implementers, advocates, and media. www.globalhealth.org/conference_2010

Global Health Council

Geneva Health Forum, April 19 - 21, Geneva

The 2010 Geneva Health Forum aims to identify sustainable responses to crises in global health, placing emphasis on lessons learned from local and regional initiatives. These crises, by revealing existing weaknesses and disparities, offer the GHF participants the opportunity to formulate potential reforms and innovation. Creating a dynamic confrontation of perspectives, including all stakeholders active in the health sector, new forms of governance and partnering can be explored. In addition, the GHF will also investigate how innovative research and technologies can influence practice to facilitate access to health and care. Special emphasis will be given to e-health technologies, which create unique opportunities to disseminate information to improve practices.
www.genevahealthforum.org