# Global Connections Healthcare Forum – 12 July 2016

The meeting was focussed around the changes in the global healthcare that are coming about because of the Sustainable Development Goals, and in particular the changing environment and attitudes towards faith based healthcare.

## Ted Lankester of Community Health Global Network opened the meeting.

*Several key points were made:*

- Major, undocumented health needs, especially in NCDs, mental health, maternal & child health
- Unequal societies have worse health outcomes.
- Unequal access to healthcare significant. 83% of poor in rural areas have no or little access to essential care.
- World is short of 10.3 million trained health workers - reduces access for poor and isolated communities
- Need to work 'upstream' to deal with health problems, before they occur - e.g education, political activism, infrastructure development

The 17 SDGs agreed last year run from 2016-2030.
Six SDGs in particular have a key health impact - namely 1,2,3, 4, 6, 10 & 17
SDG 3 is the main health focussed goal, with an emphasis on wholeness, health and wellbeing, not just disease specific health strategies.

We need to get into theological colleges, churches and other institutions to get message that health & wholeness are integral parts of the Gospel. Pastors and theologians nned to be trained, equiped & empowered to engage with health issues.

The Tearfund initiative, Umoja was highlighted. This involves getting the church out into the community to identify the needs that exist and the resources they already have to deal with them. Similar approach to SALT developed by AFFIRM Associates and the CHGN cluster model. They key point is that it is the church, as part of the local community, that identifies its own priorities and capacities to deal with them rather than outside agencies coming in and telling them and tying it to aid funding.

We also need to look at new ways of supporting, mental and physical health of church leaders to ensure they stay healthy to lead their churches to bring health to communities.

Archbishop's Anglican Communion Fund seeking to facilitate this.

Advocacy is vital - FBOs (Faith Based Organisations) and churches need to be engaging with governments and International Agencies on behalf of the communities and groups among whom they minister.

We also need to learn how to work with other faith groups on areas of common concern and response.

## Andrew Tomkins talked about the work he had been doing with the Lancet to critically examine the role of faith groups in global health.

Secular pressure groups are trying to exclude faith & faith communities from global health. Yet ironically there is more openness to working with faith groups than ever before. We need to get the evidence together to challenge the opposition. Also we need to challenge policy driven by other ideologies that can be damaging - but we don't have enough evidence as yet to do this well.

E.g. What poverty centile are faith hospitals reaching with their care? Or what added value do faith based healthcare initiatives bring to the populations in which they work?

End Of life care has opened the door to spiritual care. It is one area in which the churches & Christian FBOs have led the way

We need to engage faith leaders with health and health leaders with faith. In particular we need to work with government.

Empowerment of local churches & communities to transform their own health and wellbeing has to be a core strategy, not just relying on faith based hospitals and specialist units.

*[More details on these talks and the presentations by EMMS and CHGN can be found in their Power Point presentations available online]*

## Discussion Groups Feedback

Two groups looked at how Christian health ministries can better engage with church leaders:

***1: 'Upstream'***

- getting in to contribute to pastor training at theological colleges – teaching on Biblical models of health, the missiological basis for healthcare ministry in scripture, etc.
- Practical training on how to engage spiritually and theologically with folk beliefs about health, and prosperity and other teaching on healing ministry that can be damaging to health.
- Exposure trips – get church leaders into communities where the church is already grappling with health needs to see how it could work on the ground for their own congregation and community. This can be South-to-south or North-to-South (or vice versa!)

***2: 'Downstream'***

- How do we better develop secondary and tertiary care to engage with church and local community primary care?
- How do we train health professionals to talk church and church leaders to talk health?
- Long-term, non-resident mission links need to be fostered between churches, and between churches and FBOs
- Develop new mechanisms to fund and enable South-to-South partnerships and links between churches (e.g. the CHGN Cluster model)

***A third group looked at what innovative models were being used and how we could share them more widely.***

- SALT Methodology (see http://www.affirmfacilitators.org/docs/SALT_Protocol.pdf) –
    - Support & Stimulate
    - Appreciate & Analyse
    - Listen, Learn, Link
    - Transfer
    - Addresses the divide between church and community, community and the health system and community and government
- Sharing and inspiring through stories
    - E.g. https://youtu.be/pCbXEyoSFgY documentary outlining SALT
    - other videos and social media to share stories and models
- ASHA invites government ministers to attend community celebrations at slums in New Delhi – build positive relationships with government, increases credibility.
- Good documentation and hard data on the work we are doing
    - Look at gross national happiness
    - Narrative
    - Get data written up well and published – e.g. on Christian Journal of Global Health - http://www.cjgh.org/
    - We need to develop training in research methodology and writing up for journal publication – getting data and stories out from the coalface to the wider world.