Beyond our comfort zones is a 4/2 divide that won't easily go away, writes **Ted Lankester.**

At the turn of the millennium most of us have been eating, drinking, spending and celebrating. Some financial traders have received multi-million pound bonuses. For two thirds of the world, about four billion out of six, most stomachs have been full and there is money in the bank or under the bed.

Global health priorities

Mike Webb/Tearfund

Community Health worker

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There is another world out there that refuses to go away: the one inhabited by two billion people - the same as the total world population in 1930. If you're on the wrong side of the 4/2 divide you will have no effective access to health care or essential medicines. There may be a hospital or health centre near you, but you will be too poor, too sick or too frightened to go there. If you do, there will probably be few drugs on the shelf, too little equipment in OPD or theatre, and too few staff with too little morale to meet your need.

You will probably be feeling hungry. Collecting a full bucket of reasonably clean water will indicate a successful day. You are likely to be languishing in the foetid squalor of an illegal slum, or working as a bonded labourer on a rich person's farm. You will snatch time to arrange family weddings, but you may have to mortgage your house or life to do it. A chronic cough may mean ruin for you and your family, unless your particular TB programme is fully funded and well managed. That would be a rare bonus.

During the first seven days of the year 2000, while we were stockpiling presents, surfing the net, making love and worshipping God, others lived and died in another world.

- 21,000 children died from malaria.
- 11,000 mothers died from pregnancy related causes: 99% of those in developing countries.
- 77,000 people died from tobacco, a deliberately crafted, addictive poison in whose manufacture or financial investment some of our friends, relatives, sponsors or pension funds are probably involved.
- 110,000 adults and children became newly infected with HIV. It will be tens of thousands more in one year's time.

While we trumpet about the wonders of global communication and e-commerce, let's remember that 25 countries in Sub Saharan Africa have less than one telephone per 200 people and fewer still have internet access. There are still villages in two continents where there is zero female literacy; forget computer literacy.

So what are the priorities? Here is a personal selection:

The elderly

Today there are 580 million people over 60, of whom more than half live in the developing world. By 2020, the number will have grown to one billion. Tackling this will require the best strategic managerial and medical minds. Because virtually all of those involved will never know what it feels like to be old, it will also require imagination and compassion.

Healthcare workers will need to develop new strategies for the priority which Dr Gro Harlem Brundtland of WHO has identified: increasing the quality of old age. One way to do this will be preventing and treating non-communicable disease, so that middle aged people can continue to work and earn. It will involve fighting the blight of ageism in a youth-dominated global culture. It will follow as much an empowerment model as a provision model.

The Mentally ill

Surveys from a wide variety of settings show that about one patient in three has a mental health component to their illness. We can argue about definitions and proportions but the ocean of unrecognised, untreated and dismissed mental suffering worldwide is a scandal. Some countries have virtually no

psychiatric services. For others, asylums resemble mediaeval prisons.

Few community health programmes have a mental health component. There needs to be an explosion of care, intelligent response, logistics, training and delivery in this area before the sheer numbers of those suffering from depression, dementia, anxiety and substance abuse paralyse us by the brutality of their size. This is an area requiring visionary and lateral thinkers, twinning with movers and implementers. It's as much a pioneer field in the developing world as surgery was 100 years ago.

Strengthening existing health facilities

In areas of greatest need a few heroic health care workers keep some essential services just functioning as resources and morale ebb away. Many hospitals are not just understaffed, but unstaffed. Many shelves are not simply lacking essential medicines, but are starkly bare. In many countries, existing hospitals and health centres are dying through a thousand cuts.

They can be resurrected by a thousand lifelines. Committed groups of health care workers, income generators and managers, can draw alongside in supportive partnerships to construct development plans, encourage, empower, monitor and pray. Compassionate, non-patronising and long term linkages can transform hospitals dying on their feet to become renewed trailblazers in the midst of despair. We are not just looking at firefighting - sending out a surgeon because the existing medical officer has collapsed after three months permanently on call. We are looking at building capacity and empowering hospitals to manage and deliver health care efficiently and effectively. We are searching for ways, old and new, of mobilising and generating income; using models, from running safari lodges and fuel stations to forging partnerships with philanthropists and private businesses.

Setting up new community health programmes

Scattered in the poorest communities - rural and urban - are motivated individuals or groups of local people isolated from the knowledge and resources to put their ideas into action. We need to identify these groups and then train, encourage, empower and support them. This will involve hundreds of small-scale partnerships, linked by a common commitment to Health for All and to best practice. At present we have vast areas of need, and scattered but disempowered groups of potential change-makers, born and bred in their own communities. We also have equivalent numbers of skilled and compassionate people distributed worldwide, willing to help but unable to find the bridge to the opportunities on their doorstep and often mesmerised when they do.

There is no need for this to be a lost cause. Just a fraction of the entrepreneurial energy that goes into starting a new airline or mobile phone company could come up with a menu of options to empower locally born shakers and movers. They in turn could transform thousands of communities within a generation. The ASHA urban health programme working with nearly 200,000 slum residents in New Delhi is just one programme showing that empowerment of local enthusiasts is a winning formula. So is the inspirational rural health programme at Jamkhed in the state of Maharashtra.

Fighting tobacco

...And coming up with alternative employment schemes so that those innocently making their living growing and processing tobacco are not themselves plunged into poverty.

'THE PARADIGM FOR THE NEW MILLENNIUM WAS INVENTED BY GOD AND DEMONSTRATED IN JESUS CHRIST. IT IS BASED ON KNOWING, FEELING AND UNDERSTANDING THE WAY OTHERS STRIVE, SWEAT AND WEEP, BY DRAWING ON OUR OWN EXPERIENCE OF HUMANNESS AND FRAILTY...

David Livingstone A Heart for Africa

David Livingstone (1813-1873), the well-known explorer, was a medical missionary to the African continent. His famous appeal at Cambridge University (1857) prompted hundreds of students to volunteer to serve in Africa. He was an active campaigner against the inland slave trade. Through his influence many hospitals were built, African nurses and midwives were trained and the practices of good hygiene and nutrition were taught widely. He died in what today is Tanzania having left instructions that his heart should be buried in Africa.

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Ida Scudder Woman with a Mission

Ida Scudder (1870-1959) came from a long line of missionary doctors. While visiting her parents in India she was struck by the need for female doctors there. Thousands of women were choosing to die rather than to accept medical treatment from a man.
After completing her training in America, she went to Vellore in India. After overcoming the initial mistrust, she founded a one-bed women's hospital. Ida Scudder visited many villages to treat those who could not come to the hospital. By 1918, she had succeeded in opening a Medical College at the hospital, aimed at training Indian women to become doctors. She was its first principal. The Vellore Medical College remains one of the finest institutions of its kind, with an international reputation.

The opium trade of the last century was deeply shameful. It is a fraction of the scandal that lies behind the manufacture and promotion of another ancient poison.

Tobacco robs families, communities and countries of wealth and health for one purpose alone - the generation of money for directors and shareholders. We need to fight this as health care professionals, via aggressive lobbying, tactful diplomacy, unyielding persistence and innovative local initiatives.

Anyone - you - can start by writing to an investment company or pension fund you are linked to, enquiring about their policy on tobacco investment and withdrawing your funds if they continue to support the industry. We should give maximum and informed support to WHO's Tobacco Free Initiative.

Accelerating the fight against HIV, TB and malaria.

We can opt for one or both of two streams. We can become involved at the frontline; helping to develop effective local programmes and training others to do the same. Being thoughtful, cultural and intelligent in our response and advice. Not opting out when problems appear to be insoluble. Thinking of new ways, with our African colleagues for example, for the social marketing of bed nets: giving effective management support to struggling TB programmes: sharing ideas about how to make DOTS* strategies work more effectively in politically destabilised areas, or in regions with the devastating emergence of MDR TB.

Or we can become involved at a global and strategic level. Designing programmes, researching new drugs, lobbying in the corridors of power and influencing philanthropists. We need an endless stream of new ideas, new money, new drugs and new techniques which field workers can adopt, adapt and use.

So what is the answer to this catalogue of need?

A newly packaged dose of kindness, compassion and aid from the swimmingly wealthy to the drowning poor? Not exactly. We can keep the compassion and kindness but throwing rescue ropes down pits or chucking aid at those we pity is yesterday's paradigm, except at times of crisis or disaster.

The paradigm for the new millennium will not be exactly new. It was invented by God and demonstrated in the incarnation of God in Jesus Christ. It is based on knowing, feeling and understanding the way others strive, sweat and weep, by drawing on our own experience of humanness and frailty. It is founded on an intelligent and accurate assessment, not just of needs but also of underlying causes which tyrannise the lives of the poor. It is grounded by working in partnership with those born on the wrong side of the 4/2 line: on helping to empower them by sharing experience, training and competencies until they can do it themselves.

It is having the impetus to apply the most appropriate ideas, medicine and technology already invented to those who without it will die.

Christian health care workers have a commitment together with humanitarians of all faiths or none to do this effectively. Commissioned by a mandate from Christ, inspired by a living experience of God's love, and empowered with God-given intelligence, we can work together with the disinherited, to empower and transform them from the blight of poverty to lives enriched economically and spiritually.

This will require a global traffic of health and development workers going from any country to any country, guided by emerging best-practice principles in the area of international health care. It will be a worldwide movement and not just a western/northern dominated response. We can all play a role by bidding into some point of this global process. We can give our best in terms of time, skills and resources, in whatever way God through our personal circumstances inspires us.

God is incarnate in the year 2000. What are we waiting for?

Ted Lankester is director of InterHealth, and is on the Board of Tearfund.

* DOTS stands for Directly Observed Treatment Short course and is the preferred way of maximising TB compliance through personal observation