

“He sent them out to proclaim the kingdom of God and to heal the sick.”

Luke 9:2



AHN NEWSLETTER

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ANGLICAN HOSPITALS EXPAND RAPIDLY IN SOUTH KERALA

Stepping over steel rods and bags of cement, I picked my way through to the hospital administration entrance. A mere 15 km north of Trivandrum, Kazhakottam Rural Health Training Centre is already kitted out with 100 beds. The latest building project will double that. The medical director explained how this burgeoning hospital serves a mixed community of local middle class workers as well as many nearby coastal fishing villages. The designation ‘rural health training centre’ hardly seems appropriate now with such a large facility planned. Such is the growth of population and economy in India that the local health systems can barely keep up. With the support of the Diocese of South Kerala and substantial bank loans, the expansion at Kazhakottam will relieve some of this pressure. It seems the demand for these high quality yet affordable health services will continue apace.

Bishop Gladstone and his medical director, Dr. Bennet Abraham, are boldly constructing a diocesan health system that is fit for purpose in 21st Century India. Kazhakottam is one of 3 existing mission hospitals in the diocese that have benefitted from extensive investment. In just 20 years, the small 6 bed clinic in a tumble-down colonial building in Karakonam has been transformed into a 550 bed teaching hospital, the Dr. Somervell Memorial C.S.I. Medical College and Hospital (SMCSI). From its opening, the college swiftly gained a top regional reputation, yet it

serves some of the poorest communities in Kerala State. SMCSI also works extensively in North West Tamil Nadhu, particularly amongst those fishing villages that were decimated by the tsunami in 2004. Its targeted approach to providing high quality low cost health services makes it the medical facility of choice for most people in the district.

The third hospital, Kundera, is the oldest hospital in the region and is celebrating its centenary by constructing a further two floors on top of its existing refurbished structure. In conversation with Bishop



Gladstone and with Dr. Bennet following my tour of these excellent facilities, I realised that they were not ready to settle down yet. Why should the people of this region not have the very best health services at a price they can afford? There may be more to come. Not that everyone has to trail to these hospitals to receive a consultation. With primary care clinics and eye camps week by week throughout the region, people are also receiving attention closer to home as well. This too may be an area for further development.

Following presentations at the inaugural meeting of AHN, Dr. Bennet recognised that health microinsurance could bring a more robust financial basis for this work. Like most Anglican hospitals these three hospitals have relied on the fees that patients normally pay for each treatment. In partnership with MicroEnsure, a pilot project was launched in August 2009 at Karakonam. Over the year it attracted 40,000 members. The pre-paid security of an insurance premium gave people the confidence to seek medical attention they had previously put off. Demand rose and the hospital had to work hard to expand treatment to some of the poorest whose modest premiums were subsidised further by federal government. Not surprisingly this put a great deal of pressure on the scheme. The Diocese is undeterred, however. This is a long term project to create a sustainable and appropriate health service available to Christians, Hindus and Muslims alike.

The health system of the Diocese of South Kerala is a leading example of what can be done through bold leadership and creative planning. The state health system is fraught with many problems. The private hospitals are too expensive for the majority of people. These three Anglican hospitals reach out to the many and bring life and health to those who most need it.

Paul Holley, AHN Coordinator, following a visit to the Diocese of South Kerala in July 2010.

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COMMITTED TO HEALTH CARE: THE CHURCH OF UGANDA



Employing around a quarter of the national health workforce, the Church of Uganda may well be the most committed health provider of the Anglican Communion. Its flagship facility in Kampala, Mengo Hospital, has not only a national, but also a regional reputation. People come for treatment from DR Congo, Kenya and Tanzania to benefit from some of its clinical specialties. The earliest hospital to be built in East Africa (1897), it is proud of its history and its reputation as a centre of excellence.

But this is just the most visible face of a range of health programmes and facilities that are spread throughout the country. With its 10 million members, the Church of Uganda reaches into the most remote rural communities and offers medical services to the poorest. The provincial health coordinator, David Matseketse, is working with donor and UN agencies to extend that reach even further. This is a province that takes Christ's call to heal the sick very seriously indeed.

The Azur Christian Health Centre in Hoima is typical of many small hospitals governed by diocesan authorities. Its 30 staff members manage 5 wards in 3 single storey blocks. They deal with a range of conditions but focus especially on maternity services. The hospital's doctor is

employed by a project backed by a donor to ensure that women receive the best attention when pregnant. The operating theatre is equipped to provide consistently successful interventions such as C-sections. Given a local fertility rate of 7.2, this is a major contribution to the health of local people. Not that Azur neglects to support family planning. The presence of an NGO partner ensures that families get advice and access to appropriate contraceptive interventions.

To add further clinical support Azur works with the local public hospital. An agreement allows for part time consultancy from doctors there. Bishop Nathan Kyamanywa has worked hard to marshal the resources of supporters from around the world to invest in upgrading buildings and improving outreach services. HIV services are emerging with the aid of international donor programmes. Complacency is, however, never an option. Relying predominantly on the payment of affordable fees by patients, Azur can only barely get by. Despite the best efforts of its manager, Albert Joloba, and with committed support from diocesan authorities, revenue is insufficient at a time when donations are depressed by the financial crisis. Public funding averages around 5% of budget and is limited to certain primary care functions.

In the background, the Uganda Protestant Medical Bureau offers technical support and national coordination, particularly when it comes to international donor programmes. The director, Dr. Lorna Muhirwe, is well aware of the limitations imposed on Anglican health care in the face of low local revenues and limited donor support. Not least among the challenges is the availability of staff. Nursing staff in Anglican hospitals are paid below the public sector rate. A number of doctors are paid by the Ugandan government, but they are in short

supply, particularly outside the main urban centres. New options need to emerge.

Uganda has already had experience of health microinsurance. A scheme was introduced by Microcare in 2004. Unfortunately the business model failed and a number of Anglican hospitals are still owed significant sums of money from past claims. This is a sobering lesson for the Anglican Health Network as it seeks to make its pilot programmes effective. But, far from being negative about the principle, each of my conversations in this visit looked hopefully at what we are doing. The microinsurance principle is a good one, and may bring a more sustainable economic model for Anglican health care. But it needs to work effectively for members and providers. This is the key to our pilot in Tanzania. All eyes are fixed on its progress.

Paul Holley visited Uganda in August 2010.



A MINISTERIAL CONSULTATION IN STELLENBOSCH

Dr. Aaron Motsoaledi, Minister of Health for South Africa, met recently with members of the National Religious Association for Social Development (NRASD). The two-day conference was hosted by Archbishop Thabo in the picturesque setting of Stellenbosch, the base for this longstanding interfaith association. As a recently appointed principle recipient for the Global Fund in South Africa, NRASD is about to become more prominent in supporting faith-based health-related initiatives in a nation that bears the heaviest burden of HIV and TB.

Representatives from a wide range of religious groups made presentations about their projects and shared their enthusiasm and commitment to work in a more coordinated manner. Dr. Motsoaledi recognised the interwoven relationship between Church/Mosque/Temple and State and encouraged the participants to continue to offer their contribution to improve awareness of health education messages, tackle stigma and support those needing care and treatment.

South Africa's troubled past led to a significant diminution of the health care interests of its churches. The apartheid government took over the schools and hospitals of the Anglican

Church and removed the pattern of community service common in other parts of Sub-Saharan Africa. But once the country found its freedom in 1994, Anglicans engaged energetically and effectively with the immense challenge of the spread of HIV. With grants from the US and UK governments it formed Anglican Aids in 2003 and extended programmes throughout the country.

However, there are major challenges ahead. Public health facilities do not extend effectively into the poorest communities. Private hospitals are internationally respected but only serve those who can afford expensive insurance. To meet the challenge, Dr. Motsoaledi described a fresh initiative in primary care. He also presented his case for a National Health Insurance plan to release new investment to expand services.

Archbishop Thabo welcomed the opportunity to think through with his fellow faith leaders what role they can play in this challenging context. Following the provincial synod the week before, health had been placed high on the agenda of the province and will feature as one of its major priorities.



Canon Desmond Lambrechts, formerly of Anglican Aids and now director for the NRASD public health programme, becomes responsible for taking forward the momentum created by the consultation.

Paul Holley presented a paper at the NRASD consultation to bring a global overview of faith based health initiatives.



CHA NEWSLETTER

The most recent edition of the Africa Christian Health Association Platform was published in September. Articles include the following:

- ACHAP's partnership with CCIH to the U.S Congress
- Retention strategies at Koyom Hospital in Chad
- Distribution of pharmaceuticals in Sub-Saharan Africa
- A job opportunity in Southern Sudan.
- Profile of Christian Health Association of Nigeria

This is freely available to download on the following link:

<http://www.africachap.org/x5/images/stories/13th%20edition%20bulletin.pdf>

TB CONSULTATION

It is estimated that around 2 billion people are infected with the TB bacillus. Most do not succumb to the disease, but when they do it is a chronic condition that afflicts 9 million new sufferers every year. Out of these, almost 2 million die annually. TB is particularly associated with those communities extensively affected by HIV. However, compared with HIV and malaria the TB pandemic is considered under-resourced and under-recognised by donors and campaigners. The Geneva-based Global Fund is mandated to tackle each of these 3 diseases, but is not yet fully funded to match the demand.

Unlike malaria and HIV, TB is not referred to directly in the headline Millennium Development Goals. It is rather considered under 'other diseases'. In fact, by virtue of certain interventions and statistical manoeuvres, the TB MDG indicators can be considered already achieved. However, the disease is still growing and killing increasing numbers. Much

needs to be done to begin to bring this chronic scourge under control. Of particular concern is the growth in multidrug-resistant forms of the disease, and indeed most seriously, the emergence of extensively drug-resistant forms among HIV sufferers that make treatment very difficult.

In September 2010, the Stop TB Partnership invited a range of civil society organizations to the headquarters of the World Health Organization for a consultation. A range of advocacy groups, development agencies and representatives from church organizations gathered to consider how to expand attention and increase impact on the spread of TB. Paul Holley, AHN coordinator was there to represent the Anglican Church.

Anglican hospitals are already active in some of the National TB Programmes (NTPs) that are providing treatment for sufferers. For example, Mengo Hospital in Kampala has a unit that treats the twin diseases of TB and HIV, funded by grants flowing

through the Ministry of Health. Other hospitals around the communion will also be similarly engaged. With its distribution of clinics and dispensaries in rural areas, Anglicans are well placed to do more. The consultation focused on the availability of funding available to faith-based organizations through the Global Fund and through TB Reach.

In addition to the challenge of implementing universal treatment and prevention strategies, there remains a stigma in many societies against those who have TB. This is also an issue the church can do something about. Whilst many faith-based groups have produced materials to tackle stigma against those who are HIV+, there are few resources related to stigma against TB sufferers. This gap needs to be addressed.

If AHN members would like to work more closely with others to develop robust responses to the challenge of TB in their communities, then please contact Paul Holley.

It was in 2006 that WHO launched the Stop TB Strategy. The core of this strategy is DOTS, the TB control approach launched by WHO in 1995. The six components of the Stop TB Strategy are:

- 1 PURSUE HIGH-QUALITY DOTS EXPANSION AND ENHANCEMENT** Making high-quality services widely available and accessible to all those who need them, including the poorest and most vulnerable, requires DOTS expansion to even the remotest areas.
- 2 ADDRESSING TB/HIV, MDR-TB AND THE NEEDS OF POOR AND VULNERABLE POPULATIONS** Addressing TB/HIV, MDR-TB and the needs of poor and vulnerable populations requires much greater action and input than DOTS implementation and is essential to achieving the targets set for 2015, including the United Nations Millennium Development Goal relating to TB (Goal 6; Target 8).
- 3 CONTRIBUTE TO HEALTH SYSTEM STRENGTHENING BASED ON PRIMARY HEALTH CARE** National TB control programmes must contribute to overall strategies to advance financing, planning, management, information and supply systems and innovative service delivery scale-up.
- 4 ENGAGE ALL CARE PROVIDERS. TB PATIENTS SEEK CARE FROM A WIDE ARRAY OF PUBLIC, PRIVATE, CORPORATE AND VOLUNTARY HEALTH-CARE PROVIDERS** To be able to reach all patients and ensure that they receive high-quality care, all types of health-care providers need to be engaged.
- 5 EMPOWER PEOPLE WITH TB, AND COMMUNITIES THROUGH PARTNERSHIP** Community TB care projects have shown how people and communities can undertake some essential TB control tasks. These networks can mobilize civil societies and also ensure political support and long-term sustainability for TB control programmes.
- 6 ENABLE AND PROMOTE RESEARCH** While current tools can control TB, improved practices and elimination will depend on new diagnostics, drugs and vaccines.

MICRORISK EXAMINES ANGLICAN HMI LAUNCH

The microinsurance industry newsletter, *Micro-risk*, recently published this article to demonstrate the potential of new distribution channels. As financial services evolve to offer a wider range of services to those on low incomes, the Church may thus find itself a growing focus of attention. Following on from its commitment to promote microfinance systems through the successful programmes of Five Talents, the Anglican Communion may find through AHN's pilots the opportunity to expand that commitment into microinsurance. Further information about *Microrisk* publications can be found on: www.micro-risk.com



ANGLICAN CHURCH OFFERS NEW DISTRIBUTION OUTLET IN EAST AFRICA

MicroEnsure will begin a six-month trial in October of a health insurance product offered through Anglican churches in Dar es Salaam, Tanzania. It will offer a new approach to distribution that takes microinsurance beyond the limitations of microfinance institutions.

Microinsurance intermediary Micro-Ensure's policy will cost \$35 to \$40 per family and covers hospitalisation for malaria, maternity and diarrhoea and respiratory diseases (HIV and TB are covered by government programmes).

Customers pay 50 percent of the premium at the start and can decide whether to renew and pay the additional 50 percent after six months. 25,000 to 30,000 people will be involved in the pilot. Micro-Ensure believes that if the pilot is a

success there is compelling potential for expansion, with more than 40mn Anglicans in Africa.

The Anglican Health Network's co-chairman, Lee Hogan, spotted the microinsurance opportunity that the church offered after he was invited to distribute mosquito netting to poor communities in Malawi.

Hogan explained: "It became clear that a church structure that had been originally set up to distribute the gospel was a very efficient

network for distributing things like mosquito netting."

Hogan thinks faith-based distribution of health insurance could work for other Christian denominations and other faiths such as Islam. "It's a lot easier to distribute something like this through people who already have a reputation and are credible," says Hogan.

And the biggest challenge to the scheme is achieving volume. The aim is to have more than 1.5mn





lives covered by the fifth year. The classic microinsurance distribution model is of an insurer working with a microfinance institution, but alternative channels are increasingly being seen as the way to reach larger populations.

While microfinance institutions can reach 150mn families, microinsurance has a potential client base of 3bn, according to a Lloyd's 360 Risk Insight report. Other distributors may be able to offer types of policies that aren't as attractive as life and credit life for microfinance institutions.

The difficulty with alternative distribution channels is finding the right brand and setting up an infrastructure without incurring large overheads. Richard Leftley, president and CEO at MicroEnsure, commented: "Anyone who tells you they've got the solution probably isn't telling you the truth. We're reaching 3 percent of the available market, so there's got to be a better way of doing it."

Mobile phone users in Africa typically carry multiple SIM cards to keep down the cost of their calls. And Namibia-based financial services conglomerate Trustco Group has devised a way to encourage its customers to use more airtime by employing funeral insurance as an incentive - with more cover accrued the more they use their phones.

One solution is to take a bigger slice of the pie. Broker Aon Risk Solutions is working in Bolivia with

the microfinance institution to distribute life and health products to marginal urban dwellers. It does include most of the front and back office processing, and takes a 25-35 percent margin for the work.

After starting with a client base of 95,000 a year ago, the numbers have grown to 250,000 in 2010.

HMI TANZANIA LAUNCHES IN THE PARISHES OF DAR ES SALAAM

During the months of October and November the AHN sales team have been out in the parishes of the Diocese of Dar es Salaam promoting the health microinsurance programme (HMI). Japhet Makau, AHN country manager, has recruited and trained the team in conjunction with our partner MicroEnsure. The policy has been named 'Imani', which in Swahili means faith. It is offered to local residents of any faith, but the sales will take place at parish churches after the services on Sundays.

The insurance policy has been shaped according to local requirements through a series of focus groups. Four conditions will be covered: Malaria, maternity, respiratory disease and diarrheal diseases. The premium equivalent to \$40 will be paid in two equal instalments at 6 monthly intervals. This will cover a family of up to 5 members for comprehensive treatments relating to any of these 4 conditions.

12 local hospitals and clinics will provide the services. There will be no further payments or cash involved at the point of access. Each member of the programme will have a family identity card that will be presented to the participating health facility as and when treatment is required.

The policy is fully insured through a local insurer, Golden Crescent, backed by a large and well respected Johannesburg insurer, Hollard. Japhet and his team have an initial deadline to complete all registrations by the end of November. A delay of 6 months will then elapse before further registrations can take place. This is to try to limit the adverse effects of people signing up only when they become sick or pregnant. Insurance is designed to benefit from a wide risk pool so that the whole community can share the burden of health expenditure on behalf of those whose expenses escalate.

By motivating the communities of faith to share this insured project, AHN hopes that a ground-breaking model will be established. Health insurance is generally limited to the wealthy in Africa. Public capacity is limited and cannot cope with the overwhelming demand. Releasing the resources of local communities in an equitable way, with the backing of experienced insurers may well create a new wave of opportunity to improve the health of the many.

A full report on the success of this first launch will be available in the next newsletter.

ANGLICAN HEALTH CARE IN YEMEN

Christ Church was built in 1863 as the garrison church for British Forces in Aden, with Queen Victoria as one of its first benefactors. It remained active until 1970 when, following the British withdrawal in 1967, the communist government of South Yemen requisitioned the building. It was then used as a storage facility, and later a gymnasium, until the reunification of North and South Yemen in 1990.

From 1987 until 1993 the then Bishop of Cyprus and the Gulf, John Brown, was in negotiation with the government of South Yemen, and subsequently the united Republic of Yemen, for the restoration of the church to the diocese. The combination of an agreement that the church would build, fund and run a medical clinic for mothers and babies, and a fatwa issued by the Grand Mufti of the Yemen ordering that Christians should be permitted to worship freely (just as 'Muslims are permitted in Britain') clinched the matter, and the church was restored, finally being rededicated in 1997.

Both the church and the clinics have come on greatly, through the leadership of successive chaplains/directors, and under the guidance of Bishop John's successors.

The following news over past months gives a flavour of the work that goes on in the clinic:

We are delighted to announce that two Korean doctors, Jihong and Sunghye, have arrived at Christ Church and are working at Ras Morbat Clinic on a permanent basis. Dr Jihong is an experienced ophthalmologist and has already proved to be a great asset in the Eye Department. We have been without a permanent eye surgeon since January and have been dependent on visiting surgeons to perform operations.



Jihong's arrival means that regular operations have resumed which is wonderful news for the many people in Yemen who are visually impaired. Jihong is also training the two junior ophthalmologists, Dr Tahani and Dr Randa, who have recently joined the Diploma in Ophthalmology course at the University of Aden. Jihong's wife, Dr Sunghye, is a gynaecologist/obstetrician and is serving the local female population in the General Department. The clinic has not had a gynaecologist for a number of years and word is now spreading that she is here. Both doctors have been received warmly by the clinic staff.

Another exciting development in the past few months is a new partnership with the United Nations' refugee agency, UNHCR. There are two large refugee camps on the outskirts of Aden and UNHCR has engaged our clinic to provide eye care to the refugees in Kharaz camp. A team from the eye department has been visiting the camp to perform basic eye examinations

and to refer patients for operations at the clinic. So far the project has been running on a pilot basis and we hope that the partnership will lead to a more significant commitment in due course.

For further information and contact details for the chaplain, Revd Nigel Dawkins and his wife, Revd Catherine Dawkins, see the website: <http://www.christchurchaden.org/index.html>

FROM DISASTER TO HOPE: A NEW ANGLICAN CLINIC IN MYANMAR

During the aftermath of the Nargis cyclone that hit Myanmar in May 2008, the Anglican Church became very active in the relief effort. Teams were organized to meet the health needs of some of the devastated communities. The number of deaths was estimated at 138,000 - the worst disaster to hit Myanmar in recorded memory. But amidst the carnage were families trying to survive; needing food, water and care. The Church responded energetically and effectively.

Following this traumatic experience, the Church of the Province of Myanmar found a renewed vocation to make health services more readily available to the communities it serves. Archbishop Stephen Than Myint Oo selected a derelict former religious training centre to establish a health facility. Despite its very poor state, the project team managed to construct a clinic with a range of services including general primary care, health education and dental services. The CPM Compassion clinic opened in January 2009.

In the process of the project, the province strengthened its medical team under the leadership of Dr. Saw Htoo Htoo Ray Mya. The next stage of development is to expand to a 25 bed hospital with associated clinical specialities. With the support of other Anglican partners, the Church of the Province of Myanmar is becoming the latest amongst so many Anglican Churches to see the significance of its healing vocation. For further information, check out their website: <http://www.cpmclinic.webs.com/index.html>



THE RESURRECTION OF ST MARGARET'S HOSPITAL ORO BAY, PAPUA NEW GUINEA

'The Only Anglican Hospital in the South Pacific'

Oro bay is located some 50 km from Popondetta; the only town in Oro Province. The road between Popondetta and Oro Bay is one of the best roads in PNG as it is the conduit for the largest employer in the province, West New Britain Oil Palm. Palm oil is transported to Oro Bay as it is the only deep water port in the province.

There is a 10 year plan to relocate the Capital from Popondetta to Oro Bay. Mt Lamington, which towers above Popondetta, is an active volcano and in 1951 eruptions killed more than 3000 people in Popondetta. The relocation of the capital adds a renewed challenge to the work of St Margaret's Anglican Hospital as the demand for its services rises. St Margaret's Hospital was dedicated in 1963 to honor the Scottish Saint and is the only Anglican Hospital in PNG. Unfortunately, decay set in over the years due to lack of funding, lack of maintenance and loss of interest.

The hospital, now considered a Health Centre, is currently unfit for patients. It has no running water, power for only 5 hours per day, no patient access to toilets and the list goes on. The catchment area served is 160,000 people.

With the support of the Anglican Board of Missions in Australia, the province of PNG initiated a major refurbishment programme. By July good progress was reported in all areas of the 24 bed main building as

it was converted from a dilapidated health centre into a Level 5 Rural Hospital. Completion of construction is planned for November 2010. Every service area is being modified to meet current PNG National Department of Health standards.

Wards will include labour and delivery, newborn nursery, children, women, men and an isolation ward. Each ward has a toilet, shower and hand basin plus a healthcare workers' hand basin. Also included are a general triage room, recovery and A&E, X-ray, and three patient exam rooms, two of which have a full shower, flush toilet and hand basin. Integrated into the general exam room is an HIV/AIDS and STI clinic which assures patient anonymity and safety at all times.

Our colleague, Ulch Tapia, Anglican National Secretary of Health, is overseeing the project on behalf of Archbishop Joe Kopapa. With support from a range of partners including Russ Thompson of Health Equipment PNG and ABM Australia, the resurrection of St. Margaret's will provide a significant improvement to the health of its large surrounding population and provide further leadership by the Anglican Church of PNG in health services.

Any support should be directed through the following:

Russ Thompson
Health Equipment PNG (HELPNG)
9 Hawkhurst Court
Eltham Vic 3095, Australia
russt@tni-australia.com

Anglican Board of Missions ABM
St Margaret's Equipment
Fund Level 6,
51 Druitt Street Sydney,
NSW 2000, Australia
www.abmission.org

AHN BLOG

Want to keep up with AHN news more regularly? Visit the AHN website and set your RSS feed to receive the coordinator's blog. Every 2 to 3 weeks a new posting will offer news and reflections from around the Anglican Communion.

Those who are new to RSS feeds should note that this is a system that is established through a web browser. It sends an email whenever a blog is posted. The user is always in control and can switch it off at any time. The RSS button is located at the bottom of the home page. Instructions will guide you through the process of setting up a mail-based subscription to the service.



Paul Holley addressing executive committee, Diocese of South Kerala. (see full article on page 1)

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