More than a Mere Social Service Agency

Mennonite Central Committee's Health Ministry from 1920 to Today

Paul Shetler Fast

The COVID-19 pandemic revealed to many people the fragility of our health systems, shook the foundations of many institutions, and called into question countless assumptions about public health. Many relatively privileged people who believed infectious diseases had been banished to history, to the poor, and to the marginalized were reminded of our shared vulnerabilities to disease and death. Many who believed they could trust their government to protect them in a crisis were disappointed by their leaders. Many who thought they saw eye-to-eye with their family members, neighbors, and fellow believers were wounded by the deep and painful fissures that divided people over questions of risk, who and what to believe, and what values should take precedence in times of |crisis. Many organizations, including faith-based nonprofits and churches, were forced to rethink what activities were worth what level of risk; what health-related responsibilities they had to the people whose lives they touched; and how to balance the potential competing priorities of mission, staff and constituency well-being, and the health of the broader communities they serve. For many Christians, navigating the pandemic brought to the surface deeper faith-related questions about how we understand health, risk, solidarity, liberty, purpose, and community, as well as what we are willing to sacrifice and take risks for. For many Anabaptist agencies engaged in health work, COVID-19 forced a reexamination of our implicit theology of health and its role in our witness.

Mennonite Central Committee (MCC) has been one of global Anabaptism's largest expressions of collective faith through global service in the past century. While not explicitly evangelistic, MCC has seen itself from the beginning as more than "a mere social service agency" doing secular humanitarianism

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and development work.[1] Instead, its founding members viewed the organization as a form of witness through action "in the name of Christ," whereby meeting basic needs (including health needs) became a way of embodying Christ's love for the world.[2] MCC describes itself as being "a ministry of Anabaptist churches" brought together to share "God's love and compassion for all in the name of Christ by responding to basic human needs."[3] While little has been written about an explicit theology of health in MCC, its Anabaptist faith perspective—which infuses all aspects of the organization's identity, purpose, vision, and way of working—has informed the ways that MCC staff and programs have conceptualized and approached questions of health and healing in their work.

As MCC's Health Coordinator through the COVID-19 pandemic, I've helped support and guide MCC's international health programming and internal response through these difficult and polarized times. This has forced me to think critically about the values and principles that underly our work at the intersection of faith, community, and health. By looking back at the past century of MCC's health programming, it is possible to articulate the foundational values that have informed MCC's health ministry as it has restlessly sought to respond to ever-evolving needs in the communities it serves. More clearly articulating these values and how they have manifested over time in MCC's work can serve to ground difficult health-related decisions, especially in times of polarization and crisis. Four faith values that have proven particularly important in guiding MCC's approach to global health programming are (1) a call to minister to those who are suffering, uprooted, and vulnerable; (2) a wholistic conception of humanity, where the spiritual, psychological, social, and physical elements of health are intertwined; (3) community as the center of lived faith; and (4) humility.

What these faith values mean in practice to MCC's health programming is best understood by observing how they have shaped and been shaped by the historical trajectory of this work over the past century. MCC's health work has spanned the globe and included distribution of medical supplies in Europe during wars and post-war reconstruction; staffing and then running North American mental health hospitals starting in World War II in the United States and Canada; direct construction, staffing, and management of clinics and hospitals around the world from the 1940s through the 1980s; community water

1 M. C. Lehman, *The History and Principles of Mennonite Relief Work: An Introduction* (Akron, PA: Mennonite Central Committee, 1945), 41.

2 John D. Unruh, *In the Name of Christ: A History of the Mennonite Central Committee and Its Service, 1920–1951* (Scottdale, PA: Herald, 1952), 363.

3 Mennonite Central Committee, "Priciples and Practices: Guiding the Mission of Mennonite Central Committee in the Name of Christ," (Akron, PA: Mennonite Central Committee, 2012).

and sanitation projects; HIV/AIDS responses in the 2000s and 2010s; and more recent work responding to trauma, sexual violence, and the neglected health legacies of violence.

While this programming history is complex, it can be simplified as falling into three broad and overlapping approaches to health work that have been dominant in MCC's health ministry in different eras: (1) medical relief, (2) the development and strengthening of health systems, and (3) community-led public health. Each of these approaches to health work has been informed and shaped by MCC's faith values, and the transition from one approach to the next was often driven by a desire to live into these same values more fully as MCC learned from its experiences and strove to adapt and respond to changing local contexts.

Medical Relief: Direct Ministry to Those Who Are Suffering

MCC was founded in 1920 to provide short-term humanitarian aid primarily to coreligionists in Europe.[4] During the World Wars and their aftermath, much of MCC's international programming continued to focus on a short-term relief model. For healthcare, the focus was on sending supplies and personnel to address the immediate medical needs of suffering, uprooted, and vulnerable people. This approach grew out of MCC supporting their constituency's desire for a direct and immediate response to suffering. It aligned with the faith value of ministering directly to people's basic needs.[5] This focus on short-term, highly targeted, direct medical relief was also the dominant form of global health, humanitarian action, and medical missions at the time.[6]

During MCC's opening trip to Ukraine in 1920, some of the first programmatic work organized by MCC staff Clayton Kratz and Orie O. Miller was medical relief. They purchased medical equipment and supplies for two Mennonite hospitals; selected a doctor as one of the first three field staff hired; and provided the most war- and famine-affected communities with emergency medical supplies, including medications, cloth for bandages, and soap for disinfection.[7]

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4 P. C. Hiebert and O. O. Miller, *Feeding the Hungry: Russia Famine 1919–1925: American Mennonite Relief Operations under the Auspices of Mennonite Central Committee* (Scottdale, PA: Mennonite Central Committee, 1929).

5 Mennonite Central Committee, "Twenty-Five Years: 1920–1945," in *Mennonite Central Committee Archive Collection IX-39-2*, ed. Mennonite Central Committee (Goshen, IN: Archives of the Mennonite Church, 1945).

6 Randall M. Packard, *A History of Global Health: Interventions into the Lives of Other Peoples* (Baltimore, MD: Johns Hopkins University Press, 2016), 13–15; Anne-Emanuelle Birn, "The Stages of International (Global) Health: Histories of Success or Successes of History?," *Global Public Health* 4, no. 1 (2009): 53–55.

7 Hiebert and Miller, *Feeding the Hungry*, 97.

As MCC's relief work expanded in Europe—and eventually, globally—medical relief was a key component of this programing. The work was generally defined by its focus on short-term emergency response and simple, technical, and materially based interventions (i.e., sending medical supplies and equipment) that relied on foreign technical staffing (doctors, nurses, lab technicians, etc.). The clinical focus was generally on acute medical needs directly tied to the humanitarian emergency: wound care, acute malnutrition, surgery, physical trauma rehabilitation, and so on. MCC constituency packed crates of medical supplies (including bandages, basic medications, needles, syringes, and surgical tools); sent doctors, nurses, and other medical professionals; and sponsored short-term relief missions to war- and disaster-affected communities. Medical professionals sent by MCC as volunteers to do this work tended to be on very short-term assignments—often shorter than six months—and did the clinical work directly. Local staff and volunteers often served in auxiliary and logistical support roles or shadowed foreign staff to train under them. Expatriate service workers often came with all the supplies and equipment they would need, generally raised their own support, and relied little on local resources, supply chains, or staffing.

MCC incurred relatively little expense for this work, as most supplies and equipment were donated, staff volunteered their time, and many clinical staff paid their own way or raised their own support. This approach to global health ministry was appealing both because it aligned with the faith value of direct aid to those suffering acute needs and because it involved low barriers to entry, few long-term commitments, and little need for extensive local infrastructure or staffing.

Geographically, MCC's medical relief work started in Ukraine in the 1920s, stretched across Europe during World War II, and followed Mennonite refugees to South America before spreading globally in the 1940s. Early examples of this medical relief work include the following:

- Regular material aid shipments of medical supplies, equipment, and medications to violence- and famine-affected areas of southern Russia/Ukraine and the areas Mennonites fled to starting in the 1920s. This medical material aid was part of more comprehensive emergency relief, which included food, agricultural supports, clothing, and blankets.[8]
- Financial, material, and staff support for emergency medical services in United Nations Relief and Rehabilitation Administration (UNRRA) camps serving refugees across Europe and Egypt during World War II and its aftermath.[9]

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8 Hiebert and Miller, *Feeding the Hungry*.

9 Mennonite Central Committee, "Annual Workbook: 1945," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite

- Short-term volunteer doctors, surgeons, nurses, and dentists sent with supplies to support urgent clinical work in the Mennonite colony in Primavera-Friesland, Paraguay, starting in 1942.[10]

Despite the appeal of this type of programming and its resonance with MCC's constituency to provide direct, tangible aid to ameliorate acute suffering, the limitations of relying too heavily on short-term medical relief work quickly became apparent to both MCC staff and partners. Short-term direct-aid projects can be effective at addressing immediate needs, but they too often do little to develop long-term sustainable systems of healthcare. Using mostly foreign staff on short-term assignments does little to develop local capacities or independence and creates challenges to ensuring culturally, contextually, and linguistically appropriate care.

This became particularly apparent as project participants became increasingly diverse with MCC's expansion beyond Europe and historic Anabaptist communities. Without shifting models to something more rooted in the communities they served, MCC ran the risk of being seen as "patronizing" or perceived as "motivated by racial, national or even ecclesiastical prejudice."[11] Additionally, MCC staff and partners began to worry that their hard-fought short-term health gains would quickly be undone if deeper issues driving poor health were not also addressed.

By the early 1940s, as MCC put down roots in more diverse contexts and sought to live more fully into its faith values, its approach to health work began to shift. As MCC worker Robert W. Geigley explained in a 1943 evaluation of the struggling health programs in Paraguay:

> Here you cannot assume that [short- term] material aid will bring any lasting result. You save a man from syphilis, and he dies of tuberculosis. You cure him of TB, and he goes back to the same home with the same poor food and diet, and in six months he has TB again. . . . The approach to problems here must be very different than in the case of European areas. . . . We therefore [propose] a long, slow developing [health] program, with the idea of starting at the bottom with broad projects . . . looking for results only over a period of ten to twenty years.[12]

Central Committee, 1945).

10 "Report to Mennonite Central Executive Committee Meeting, March 13, 1942," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/12, Meeting #89* (Akron, PA: Mennonite Central Committee, 1942).

11 Lehman, *Mennonite Relief Work*, 41.

12 Robert W. Geigley, "Report: Paraguayan 'Thank You' Project," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/15, Meeting #106* (Akron, PA: Mennonite Central Committee, 1943), 2.

This push toward longer, more durable impact that was more responsive to and owned by the communities being served can be seen across MCC programs in the 1940s to the 1960s. While support for developing durable healthcare systems and public health approaches became dominant models of health work for MCC after the 1940s, medical relief has remained a part of MCC's work around the world, particularly in emergency and disaster relief contexts. Medical relief work retains its appeal, despite its shortcomings, because of its resonance with MCC's faith value of working directly to alleviate acute suffering. Today, MCC continues to support medical-relief-style projects in several humanitarian crisis hotspots. However, unlike earlier medical relief work, these projects are primarily led by local partners, with local staff and local supply chains.

Development of Healthcare Systems: Wholistic, Durable, Community-Based Care

MCC's shift toward more sustained development of local healthcare systems, starting in the 1940s, grew out of several intertwined issues: (1) the recognition noted above that medical relief's impact, however well targeted at those most in need, was always going to be short-lived; (2) a renewed focus on a faith-based wholistic conception of humanity and health that is poorly served with short-term acute medical care alone; and (3) a faith-based desire to situate health and healing within community and the outreach activities of the church. The two dominant ways in which this new approach manifested in MCC health programming starting in the 1940s were (1) the placement of Civilian Public Service (CPS) staff at American hospitals and clinics (specifically mental health hospitals) during World War II and (2) hospital and clinic construction, staffing, and management as strategic entry points to new communities during MCC's global expansion. In both cases, these types of health programs often started as short-term medical-relief-style initiatives that quickly morphed into longer-term support for and development of local healthcare systems.

Starting in 1941, MCC became both a primary administrator for CPS placements of conscientious objectors to military participation and an overseer of medical care for CPS camps.[13] In 1942, 103 CPS volunteers were placed in mental health hospitals in Virginia, Delaware, New Jersey, Pennsylvania, and Ohio. This number grew to 748 volunteers across 21 hospitals in 11 states by 1943, with 130 CPS volunteers waitlisted for placement and an additional 200

13 Unruh, *In the Name of Christ*; Mennonite Central Committee, "Our Responsibility for Medical Care in Civilian Public Service Camps: Definition of Its Scope and Limitations," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/11, Meeting #86* (Akron, PA: Mennonite Central Committee, 1941).

wives of male CPS volunteers serving alongside them in mental health hospitals.[14]

In 1944, this engagement with US mental health hospitals expanded beyond CPS through the Hospital Summer Service program for women at mental health hospitals in Ypsilanti, Michigan, and Howard, Rhode Island.[15] This program quickly grew to include 58 volunteers by 1946.[16] The majority of MCC staff serving in mental hospitals through these programs were classified as ward attendants, who provided for the personal care of patients and served in administrative and logistics roles (rather than as medically trained staff providing clinical care). During World War II, over 1,400 men and 400 women served with MCC in mental health facilities across the United States.[17]

This exposure to the mental health system was transformative and connected deeply with MCC staff and constituency's belief—rooted in their faith—that health and healing was more wholistic than the narrow physical biomedical construct dominant in Western medicine at the time, including in the domain of mental health.[18] As MCC-CPS director Albert M. Gaeddert wrote, "This program has opened to us a whole new area of human need of which we had not been altogether sensitive."[19]

MCC staff were increasingly driven to be pioneers in improving the quality of mental health services and, because of their faith, advocating for the humanity and dignity of people with mental health conditions. Gaeddert described MCC's particular calling to transform the "callousness" of mental healthcare as a "service of love . . . for our fellowman . . . under the guidance of God . . . in

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14 J. N. Byler, "Annual Report of CPS Men Serving in Mental Hospitals," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/16, Meeting #110* (Akron, PA: Mennonite Central Committee, 1943).

15 Mennonite Central Committee, "Annual Workbook: 1944," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite Central Committee, 1944).

16 "Evaluation of Hospital Summer Service Program," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/26, Meeting #141* (Akron, PA: Mennonite Central Committee, 1946).

17 "Annual Workbook: 1945."

18 Michael Kennedy, *A Brief History of Disease, Science, and Medicine: From the Ice Age to the Genome Project* (Mission Viejo, CA: Asklepiad, 2004), 396–99; Allan V. Horwitz, *PTSD: A Short History* (Baltimore, MD: Johns Hopkin University Press, 2018), 51–79.

19 Albert M. Gaeddert, "Exhibit X: The Report of the Civilian Public Service Program to the Mennonite Central Committee," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/19, Meeting #123* (Akron, PA: Mennonite Central Committee, 1944), 6.

following the uniqueness of the Anabaptist vision."[20] MCC's faith values called the organization beyond simple short-term medical relief, to see the individuals they served as fully human, with spiritual, psychological, and social needs that could not be disentangled from their physical circumstances and health.

As early as 1944, MCC staff and constituency were pushing for deeper engagement in mental healthcare system transformation rather than the short-term staff placements the work had begun with.[21] This shift toward systemic change of the mental healthcare system was exemplified by the writing and publication in 1946 of "The Attendant," a practical training guide written by MCC CPS volunteers for new mental health staff to provide higher quality care.[22] This pamphlet later became the *Handbook for Psychiatric Aides: A Textbook of Patient Care*, the go-to reference guide for decades for frontline inpatient mental healthcare.[23] Additionally, by 1945 MCC's Mental Hygiene program was being recognized as a leader in the United States and Canada for its depth of frontline expertise and commitment to quality patient care and advocacy in mental health.[24]

In 1946 MCC began the process of establishing its own mental health facilities to model alternative approaches to mental health treatment that would live up to the "highest Christian standards of care" in a "home like atmosphere" that used only "scientific therapies of demonstrated value."[25] As Elmer Ediger, MCC's Director of Mental Health Services and Executive Secretary of Voluntary Services, wrote in 1946, "We recognize that the Christian has a responsibility to the mentally ill and the mentally deficient. . . . As followers of our Master, we are constrained to bring to our fellowmen the ministry of healing [and] our responsibility extends not only to those who suffer physical illness but to those

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20 Gaeddert, 6–7.

21 Mennonite Central Committee, "Evaluation of Hospital Summer Service Program."

22 Gaeddert, "Exhibit X: The Report of the Civilian Public Service Program to the Mennonite Central Committee."

23 National Mental Health Foundation, *Handbook for Psychiatric Aides: A Textbook of Patient Care* (Philadelphia, PA: National Mental Health Foundation, 1946). This reference guide remained in publication for three editions over twenty-five years. For broader historical perspective, see Alex Sareyan, *The Turning Point: How Men of Conscience Brought About Major Change in the Care of America's Mentally Ill* (Washington, DC: American Psychiatric, 1994), 159.

24 Mennonite Central Committee, "Annual Workbook: 1945," 2–3.

25 Elmer M. Ediger, "Exhibit III: Considerations and Recommendations on Possibility of Utilizing Leitersburg, Maryland Farm as Mental Rest Home," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/27, Meeting #142-143* (Akron, PA: Mennonite Central Committee, 1946), 5.

who are ill in mind and soul."[26] MCC's faith calling here was to effective clinical care that did not disregard the wholistic humanity of the patients or the need for them to remain embedded in community. By 1967, MCC had supported the development of seven mental health hospitals in the United States and one in Canada. Soon after, an additional three Mennonite mental health facilities became associated with the growing Mennonite Mental Health Services program in the United States and MCC Canada's Mental Health Program.[27] Eventually, all of MCC's US and Canadian direct service mental health programs were spun off to local ownership. Decades later, many continue to be leaders in mental health within their regions.

Paralleling this deeper engagement with mental health systems in the United States and Canada, MCC's work abroad became increasingly connected with healthcare systems, starting in the 1940s. As MCC expanded its global footprint and began programming in new communities, healthcare was often seen as a natural starting point at the intersection of locally identified community needs, MCC's historic competence and constituency interest in medical relief, and the faith calling to minister to the acute needs of suffering people. This work was often done in coordination with mission hospitals and missionary medicine, which was growing in prominence globally during this era alongside colonial health structures. In many colonized countries, government-run colonial medicine was tasked with protecting the health of colonial and local elites and organizing disease-control public health campaigns while health services for the poor majority were left to missionary and philanthropic groups or what locals could afford or provide on their own.[28]

In 1942, MCC began building and staffing a hospital in Primavera-Friesland, Paraguay. This new work included paying for the medical education of locals to eventually take over from expatriate volunteer doctors.[29] This was the first documented instance of MCC's health program intentionally shifting from a medical relief model—with imported staff and supplies—to a strategy of building health system capacity to provide local health services for the long run. In 1943, MCC began staffing and developing medical, dental, and nutrition clinics and hospitals around La Plata, Puerto Rico, with a mix of foreign and local

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26 Ediger, 1.

27 Mennonite Central Committee, "Executive Secretary's Report to the Mennonite Central Committee Canada Board," in *MCC Canada Archives, Executive Committee Minutes 1956–2012, Folder 1967 June MCCC Board Meeting Attachments, Meeting #020* (Winnipeg, Canada: Mennonite Central Committee Canada, 1967), 2.

28 Packard, *A History of Global Health*, 22.

29 Mennonite Central Committee, "Primavera Hospital Report to the Executive Committee," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/15, Meeting #106* (Akron, PA: Mennonite Central Committee, 1943).

staff.[30] In 1946, MCC was building on the "foundation of a medical program" in China that had begun as a missionary effort to create a mission hospital that would eventually serve as a base for building relationships and expanding a full spectrum of MCC programming.[31] This same year brought new hospital and clinic construction as well as volunteer staffing in the Philippines, Ethiopia, and Mexico, with India following close behind.[32]

In each of these cases, MCC's involvement started with shorter-term volunteers and medical supplies, in line with the established model of medical relief that MCC was accustomed to. These projects, however, quickly morphed into the development and support of durable healthcare systems as it became obvious that making long-term investments, building local capacities, and providing more wholistic care were needed to make durable impacts in line with the organization's driving values.

This shift toward directly owning and operating healthcare systems rather than supporting short-term placements with partners and mission agencies also allowed MCC more control over operations, values, and approach. This higher level of control allowed MCC programs to take on what one MCC leader described as "a consistently MCC pattern of service," where fewer compromises on values had to be made to accommodate partner agencies, whether secular, governmental, or church-affiliated.[33] For example, when MCC began its medical work in Cuauhtémoc, Mexico, in 1951 through short-term staff seconded to a governmental hospital, staff were quickly frustrated by the low standards of care and their inability to effect system changes. This prompted the launch of MCC-run clinics instead.[34]

In Haiti, MCC began its work in 1958 by seconding medical staff to the Hôpital Albert Schweitzer (HAS), which was run and funded privately by the

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30 Orie O. Miller, "Exhibit Ix: Report of Visit to Puerto Rico to the Executive Committee," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/23, Meeting #137* (Akron, PA: Mennonite Central Committee, 1946).

31 C. L. Graber, "Exhibit Xi: China Report to the Executive Committee," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/25, Meeting #140* (Akron, PA: Mennonite Central Committee, 1946), 2.

32 Mennonite Central Committee, "Annual Workbook: 1946," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite Central Committee, 1946).

33 "Memo of Understanding: Vietnam Unit 8/16/54," in *Mennonite Central Committee Archive Collection IX-5-1*, ed. Mennonite Central Committee (Archives of the Mennonite Church, Goshen, IN, 1954).

34 Harry Martens, "Exhibit 2: Commisioner Report to Mexico: Cuauhtémoc," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #03/06, Meeting #213* (Akron, PA: Mennonite Central Committee, 1953).

American philanthropists Larry and Gwen Mellon. While the clinical quality of work at HAS was excellent for its time, MCC staff were dissatisfied with a lack of autonomy to shape their approach to the work; the colonial-style and distance between HAS staff and the community it served; the lack of local ownership and staffing; and the inability to integrate faith and a wholistic faith-based vision of health into their work they felt called to.[35] As one MCC staff in 1959 reflected, "HAS was like an American colony in the heart of Haiti, and we as MCC did not always fit well within that."[36]

In response, MCC began work to start its own standalone clinic and hospital in partnership with the Haitian Ministry of Health in Grande Rivière du Nord, Haiti, in 1959. While MCC continued its support for HAS and the MCC-run clinic in Grande Rivière du Nord for several decades, by the early 1960s the health programming approach had clearly shifted from short-term relief-style staff placements to long-term development of durable health systems. This shift allowed MCC staff to fully live into their faith values of community ownership, wholistic health, and humility in walking alongside locals in less colonial patterns.[37]

This model of health programming through health system development and strengthening, with increasing shifting of responsibility to local control, became the dominant form of MCC health programming from the 1940s through the 1980s. While MCC no longer directly runs clinics and hospitals, modern versions of this approach can still be seen in MCC projects that support partner-run healthcare systems around the world.

Current projects that invest in the development of durable healthcare systems include Lebanon, where MCC has partnered for many years with the Middle Eastern Council of Churches in developing and sustaining Our Lady Dispensary clinic in Beirut; Nigeria, where MCC has partnered with Faith Alive Foundation to establish, develop, and expand clinics that provide wholistic maternal and child healthcare and HIV-specific care; and Democratic Republic of Congo, where MCC supports local primary and emergency care clinics for displaced people in Kikwit and Mubimbi.

Each of these health systems is administered and staffed by local health professionals, governed by local boards, staffed and resourced for long-term sustainability, and takes a wholistic view of health and healing. They embody

35 Elaine Stoltzfus, *Tending the Vision, Planting the Seed: A History of the Mennonite Central Committee in Haiti 1958 to 1984* (Akron, PA: Mennonite Central Committee, 1985), 17–30.

36 John M. Bender, Interview by Paul Shetler Fast, May 21, 2021.

37 Elaine Stoltzfus, *Tending the Vision, Planting the Seed*, 34–75; John M. Bender, *Mennonite Central Committee in Grande Rivière Du Nord, Haiti: The First Year 1959–1960* (Dolores, CO: Self-published, 1999).

the logical end point of the approach MCC staff began working toward in the 1940s as they pivoted away from a short-term, medical relief model with expatriate staffing and an urgent-care physical medicine approach to health and healing.

Community-Led Public Health: Humility in Giving Up Control

Despite the successes of MCC's healthcare system programming, staff and partners wondered—even in the early years of these projects—if a more localized, wholistic, preventative, and community-owned approach might be both more successful in the long run and a better fit with MCC's values. In Haiti, Dr. John Bender, who was tasked with starting the MCC-run clinic in Grande Rivière du Nord in 1959, very quickly realized that deeper change was required. "There were overwhelming healthcare needs," said Bender. "We did what we could, but it was never enough. Only treating problems after they developed medically was never going to be enough."[38]

Within a year of its launch as a medical clinic, MCC's work in Grand Rivière had begun to take on a more wholistic and public health approach. Agriculture programs were started in an attempt to prevent malnutrition before people needed to be treated clinically. Radio programming was developed to provide proactive public health education on disease prevention, water treatment, and sanitation. And preventive health outreach activities were launched to improve water quality, encourage latrine construction, prevent malaria transmission, and improve maternal and child health.

By the time MCC ended its support of clinical health work at Grande Rivière in 1980, and soon afterward at HAS, MCC's work in Haiti had almost completely transitioned toward supporting community-led preventive public health efforts.[39] The shift away from direct provision of medical care either as short-term relief medicine or longer-term healthcare system development was paralleled across the MCC system as community-led public health became the dominant approach to improving the health of the communities served. This work has been characterized by a focus on community-defined needs; seeking upstream preventive and durable solutions to health problems and using local staffing; adapting programming to the cultural context; and being community led.

MCC's earliest public-health-type work dates to water, sanitation, and hygiene (WASH) programming with CPS volunteers during World War II. In 1942, MCC CPS volunteers launched a hookworm eradication program—including basic latrine construction and WASH promotion—alongside local and

38 Bender, Interview.

39 Elaine Stoltzfus, *Tending the Vision*.

national government agencies in Crestview, Florida. While the program was initiated by governmental public health authorities, it only began seeing success when the community became involved in setting priorities and strategies.[40]

By 1944, similar basic WASH work with strong community participation was underway in Mississippi and Puerto Rico and soon became a central part of MCC's health work in the United States and abroad.[41] This specific public health focus on WASH and water systems, paired with community ownership of those systems, has remained a pillar of MCC's work and was a top funding priority under MCC's 2005–2015 strategic plans.[42] WASH remains a strategic priority for MCC health programming, accounting for more than one-third of all health funding in fiscal year 2022.

Community-led WASH programming supported by MCC is currently active in sixteen countries around the world. Recent examples of this type of community-led preventive public health WASH projects include

- Mozambique, where MCC has partnered with the Christian Counsel of Mozambique and the Anglican Church for two decades to provide wells, water storage tanks, school and home latrines, water treatment, and WASH education;
- Haiti, where MCC has partnered with Konbit Peyizan and local governments to help vulnerable families construct latrines and access water filters, install handwashing stations and water filters at primary schools and churches, and provide WASH education to tens of thousands of people, leading to the elimination of cholera from all participating communities;
- Chad, were MCC has partnered with Catholic-affiliated SECADEV to provide clean water, latrines, well construction, waste management systems, and WASH education to over a hundred thousand vulnerable and displaced people;
- Ethiopia, where MCC has partnered with a wide range of secular and church-based local partners to provide clean water access through borehole wells, water management systems, and latrines to schools and families across vulnerable regions of Ethiopia.

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40 MCC CPS BSC Camp #27, "Crestviews: Speical Conference Edition," in *MCC Archives, Civilian Public Service, IX-13-01, Box #24, Folder #17/43* (Crestview, FL: CPS Camp #26, 1942).

41 Mennonite Central Committee, "Exhibit X: The Report of Civilian Public Service Program to the Mennonite Central Committee," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #01/19, Meeting #123* (Akron, PA: Mennonite Central Committee, 1944).

42 "MCC Shared Strategic Plan, 2015–2020," (Akron, PA: Mennonite Central Committee, 2015), 2.

Another significant example of MCC's community-led public health approach since the 1990s has been the organization's work with HIV/AIDS. This work has focused on prevention education, destigmatization, wholistic supports, training of local frontline health workers, home-based care, acceptance in faith communities, and facilitating the integration of HIV/AIDS into existing primary care systems.

MCC's work with HIV began in 1985 with small projects in the United States and Canada. While these projects—like the clinic in Belle Glade, Florida—began small and not solely focused on HIV/AIDS, they quickly developed into comprehensive HIV/AIDS programs that included medical care, food supports, economic empowerment, destigmatization campaigns, and housing.[43] In 1987, MCC was shaken when two staff members were diagnosed with HIV. This led to the creation of an MCC "AIDS Policy" and more-focused HIV/AIDS programming.[44]

By 1990, MCC Canada had placed volunteers in HIV programs in Clearbrook, British Columbia, and Toronto, Ontario.[45] By 1991, MCC staff and partners in Africa were calling HIV "the scourge of the African continent" and asking MCC to direct more resources toward community-led education and prevention efforts.[46] By 1993, large wholistic community-led public-health HIV programs had been established in Zambia and Zimbabwe, followed by programs in South Africa, Tanzania, India, Brazil, and Ethiopia within the next five years.

In 2001, MCC officially launched its HIV/AIDS-focused "Generations at Risk" (later, just "Generations") program after conducting "listening sessions" with partners, community members, and staff in highly impacted communities. This campaign included targeted fundraising in the United States and Canada, and a more defined public-health approach to programming focused primarily on community-led prevention education, homecare, and support for HIV-impacted children.[47]

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43 "Exhibit 26: HIV/AIDS Program & Resources," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #10/28, Meeting #546* (Akron, PA: Mennonite Central Committee, 2002).

44 "September 1987 Executive Committee Meeting Minutes," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #08/24, Meeting #456* (Akron, PA: Mennonite Central Committee, 1987).

45 "Annual Workbook: 1990," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite Central Committee, 1990), 7.

46 "Annual Workbook: 1991," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite Central Committee, 1991).

47 "Spring 2001 Executive Committee Meeting Minutes," in *MCC Archives, Binational Minutes & Meeting Packets 1920–2012, IX-05-01, Folder #10/21, Meeting #538*

Under the original "medical relief" model, MCC would have directed the majority of its resources to sending North American clinical staff and supplies to care for the acute suffering of people with AIDS. Under the "healthcare systems" model, MCC would have invested the bulk of its resources in building out, staffing, and suppling HIV/AIDS treatment clinics and hospital wards. Under this new model of community-led public health, with the impacted communities and local partners setting priorities, less than 10 percent of all MCC HIV/AIDS funding in the Generations program went toward direct clinical services and medical supplies, and few medical specialists served in clinical roles outside their home communities in MCC projects.[48] By its peak, around 2010, MCC was supporting community-led HIV/AIDS public health programs with sixty-seven partners in twenty-nine countries, representing the single largest category of international program funding for the organization.[49]

Since then, HIV programming has slowly been winding down, after more than two decades as the primary focus of MCC's health work. This has primarily been because of other health issues becoming higher priorities for many communities served by MCC for two main reasons: (1) HIV became better funded globally compared to other health concerns (through mechanisms like the US government's PEPFAR program; UNAIDS; and the Global Fund to Fight AIDS, Tuberculosis, and Malaria), and (2) medical interventions and pharmaceutical prophylaxis increased in effectiveness. MCC's rapid ramp-up in HIV programing in the 1990s and 2000s, the type of programming it prioritized, and its wind-down of this priority area in the 2010s to fund other emerging health priorities were all driven by the same logic of community-led public health, rooted in MCC's faith values—prioritizing the needs of people who are suffering and underserved by existing institutions; wholistically responding to health needs; centering community-led interventions; and having the humility to shift course, learn from experience, and remain responsive to changing realities.

New public-health-style programming in this vein in MCC is increasingly focused on the areas of maternal and child health, sexual and gender-based violence (SGBV), and mental health. In all of these areas, MCC supports partners that work to empower individuals and communities to prevent harms from taking place, destigmatize care seeking, and develop community-led approaches

(Akron, PA: Mennonite Central Committee, 2001).

48 GAR Advisory Group, "Generations at Risk Fund Program Assessment Report," in *MCC Archives, US Departmental Files, IX-59-IP-01, Generations at Risk 2007–2012, Box #3* (Akron, PA: Mennonite Central Committee, 2007).

49 Mennonite Central Committee, "Annual Workbook: 2010," in *MCC Archives, MCC Executive Office and Annual Meeting Minutes, IX-05-02.1* (Akron, PA: Mennonite Central Committee, 2010).

that can mitigate harm and respond to people's health needs effectively, wholistically, and with dignity. Examples of these newer types of programs include the following:

- Kenya, Burkina Faso, Nigeria, Burundi, Somalia, and Uganda, where MCC works with local partners to provide community-based maternal and child health programming using the community-led Care Group model. This model empowers parents, grandparents, traditional birth attendants, community health workers, and local leaders to be agents of change in improving maternal and child health rather than waiting on external clinical interventions.
- Lebanon, where MCC partners with MECC, House of Light and Hope, and LOST to provide psychological first aid, psychosocial support, and effective triage and referral to survivors of trauma and sexual and gender-based violence, particularly to people displaced by violence.
- Haiti, where MCC partners with SOFA and Zanmi Lasante to provide wholistic psychological, medical, social, and legal support to people with unmet mental health needs and survivors of sexual and gender-based violence.

Living into the Faith Values Behind MCC's Health Work

Throughout more than a century of health programming, MCC has sought to be faithful to its calling, responsive to the communities and individuals it serves, and help bring healing to a suffering world. MCC staff and partners closest to the work have often been the primary agents of change as MCC's approach to health work has shifted in approach over time.

It was MCC staff in Paraguay who saw in the 1940s that short-term medical relief projects were not going to create lasting impact if they did not (1) address the deeper systemic and institutional problems leading to ill health and (2) empower communities to lead that change. It was clinical field staff, in places like Haiti in the 1950s, who realized that clinical medicine alone was never going to be enough to staunch the bleeding, and that more wholistic and preventive supports with local staffing would also be required. It was partners, participants, and staff in the field who signaled first that it was time for MCC to respond to the growing unmet suffering of HIV in the 1980s and 1990s, to prioritize community-led prevention efforts through local partners, and then to pivot once again away from HIV and toward other emerging priorities starting in the 2010s as community needs shifted.

MCC's health work has not remained static, and its history should not be interpreted as an evolution from good to bad, or vice versa. Each of the organization's three major approaches to health programming—medical relief, healthcare systems, and community-led public health—was dominant during

its period for reasons particular to that time and place as MCC struggled to live out its faith values:

1. **Medical relief work.** This approach served to engage a new MCC constituency and address urgent issues in places with little capacity at the time to sustain more complex work. It prioritized the faith value of responding to human suffering as quickly and directly as possible. As MCC staff member and Kenya Mennonite Church Bishop Maurice Anyanga said in a 2022 interview, "When the Church sees people dying it must respond; it must not be silent or wait for others to fix the problems. . . . The church has no option to look the other way."[50]
2. **Healthcare systems.** Building on MCC's experience of directly ministering to acute health needs, staff and partners began to call for the development of more durable community health services, to improve the quality and dignity of care in recognition of a shared wholistic humanity, and to develop local staff and capacities to sustain this work over the long term. This health-system-strengthening work leaned into MCC's faith values of a wholistic shared humanity as well as a centering of community as the locus of durable change.
3. **Community-led public health**. Despite the great successes of healthcare systems work, communities, staff, and partners realized that treatment-oriented medicine through institutions was neither sufficient to meet the overwhelming health needs nor responsive enough for rapidly evolving community priorities and the faith value of humility in giving up control. Out of these values, community-led public health, which had been a part of MCC programming since the 1940s, emerged as the predominant approach to health work globally and remained so through the COVID-19 pandemic.

Tellingly, all three major approaches remain a part of MCC's work today, as each is responsive to important faith values and each has the potential to be a good fit for particular contexts at particular times. Other parts of MCC's health work span these categories and defy easy categorization. Some projects include elements of all three approaches. Over the past century of health programming, the relative emphasis of MCC's health work has shifted over time, representing a slow, uneven, and largely decentralized evolution of approach to health that has attempted to be responsive to the diverse contexts where MCC works, the push and pull of various stakeholders, the steady accumulation of experience and wisdom, and the complicated discernment process of how faith values should guide this work. This history of health work is not best understood as an incremental refinement of a technical model of intervention but as a pragmatic,

50 Maurice Anyanga, Interview by Paul Shetler Fast, March 17, 2022, video call and notes.

earnest, and restless wrestling with a calling to minister to suffering, live out our faith values, and engage the messy collective process of discerning how best to do this in different contexts.

As Anyanga reflected on the history of MCC health work in his country of Kenya and the importance of responding to this call, he said:

> The Church has a Gospel mandate to help people in living abundant life. . . . Our responsibility to our brothers and sisters goes beyond spiritual boundaries to consider the person in their entirety. We cannot separate the spiritual from the physical, the individual from the community. . . . The body of Christ cannot turn away from suffering. People need healing, and we as the Church are called to be the hands that bring this healing. . . . Our healing of the physical body cannot be separated from healing the mind, the spirit, and even the community. When we as the Church have come together to respond to the health needs we see in front of us, whether it relates to HIV, clean water, or a sick child, we are ministering in the name of Christ, just as much as if we were preaching.[51]

MCC's health work, whether a century ago in Ukraine or present-day in the midst of COVID-19, has been shaped by this call to act—to minister to those who are suffering, without sacrificing their dignity or wholistic humanity; to remain rooted in community; and to serve with humility.

51 Anyanga, Interview.