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Community Health Evangelism Background

There once was a village in Eastern Uganda where the people were suffering because of health problems. Each year many people were sick and many died.

One day, an English doctor came to the village. He told the people he would help them with their problems. The people were very happy and willing to do anything he suggested.

The first thing the doctor did was build and equip a clinic to cure the people of their many sicknesses. The doctor's church in England provided funds to purchase drugs and supplies, and the doctor began working long hours every day.

Many were helped, but the doctor soon noticed the patients were returning with the same problems of malnourishment, worms, and diarrhea. Many of their children were dying from measles.

Whenever there was a new health problem, the people would ask the doctor for his advice and he would tell them what to do. This

seemed to work well until the doctor himself became very ill and had to return to England. There was no one to replace him.

One year later, a visitor came to the village. He saw many sick people. He talked to the people and they said that they used to have health workers and medicines, but since the doctor from England left nothing had been done.

The village situation described above is an analogy for many in sub-Saharan Africa. There must be a better, more permanent solution for the health problems of Africa's villages.

Health

Extensive research was undertaken in 1978 to learn what various secular community health programs were doing. The World Health Organization had just introduced its primary health strategy, which resulted from a meeting of 140 countries at Alma Ata, USSR.

There was a mutual recognition that curative medicine had been available for years, but the rural village people of the world were not getting healthier.

A declaration came from Alma Ata which stated that people have the right and duty to participate, individually and collectively, in the planning and implementation of their own health care.

There is a very high infant death rate in the developing world, stemming from the poor level of health care available to pregnant women and newborn children. Family planning efforts

have in turn been impeded by the high death rate because village parents want to insure against child loss by continuing to have children.

Our investigations revealed that most major village health problems were related to malnutrition. One half of those who die in the villages of developing countries are under five years of age. Most of these deaths are due to a combination of malnutrition and infection.

Diarrhea and gastrointestinal diseases, resulting from contaminated water and food, improper waste disposal, poor hygiene and sanitation, and poor nutrition, are endemic.

Serious respiratory diseases are rampant because of overcrowded living situations, low resistance due to poor nutrition, and lack of knowledge about how to prevent transmission to other family members.

Typhoid, diphtheria, tetanus, and whooping cough are common village diseases, which are preventable through the use of vaccinations.

Environmental health diseases transmitted by snails, insects, and animals can be prevented through the use of modern medicines.

Historically, most of the available medical personnel and funds in developing countries have been committed to hospitals, which provide curative care for 5% to 10% of the population. Availability of this care has been limited to the relatively few who can afford the cost it, or to those living within walking distance of such care.

In most third world countries, 80% of the health professionals are found in cities, but 80% of the people live in rural areas. The majority of the clinics and hospitals are also located in the cities.

Transportation is difficult for rural residents, and modern health care is too expensive for the masses of rural people. As a result, rural villagers are usually neglected with regard to health care and health services.

When health services are received by villagers, they are mostly curative. But 80% of village disease problems are preventable through such measures as health education and vaccinations against major diseases.

Another major problem is that of health delivery–getting the cure or prevention of disease to the people. Sometimes people are unaware that their diseases can be cured—they need education.

Often, facilities for dispensing health services are too far removed from the people. The basic problem for most rural Third World people is accessibility. To overcome this problem, medical services should be mobilized to go where the people are.

Curative medicine seeks to cure existing diseases, rather than preventing them in the first place. This approach is expensive and narrow—and ineffective in reaching the masses. It is like a fireman waiting around to put out fires, when taking measures to prevent fires in the first place would be better, less costly, and far more effective.

The Pyramid of Health

Health care can be viewed in terms of a three-tiered pyramid. At the top tier is the hospital, followed by the clinic, and lastly, the community at the bottom.

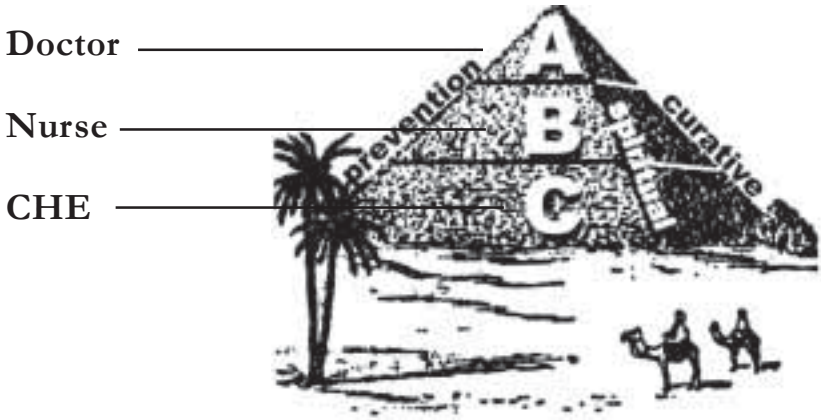
A. **The Hospital** is staffed by doctors and highly trained medical professionals, who use sophisticated equipment and techniques. The care is primarily curative, and may serve up to one hundred thousand people.

Evangelism may be carried out in a hospital. Since many people are close to death, they may be quite open to spiritual issues. There is little opportunity for follow-up and discipleship because the patients are frequently far from home and they stay at the hospital for only a short period of time.

B. **The Clinic** is staffed by a medical assistant or nurses, who spend the majority of their time diagnosing and treating the patient.

Most clinics also provide antenatal care for expectant mothers and care for the newborn, as well. They give inoculations and weigh the baby to check its growth against norms. They may also do some health teaching.

Patients may walk some 3-5 kilometers to the clinic, which typically must serve up to ten thousand people. The Gospel can be shared with the patients and some follow-up can be accomplished, if the clinic personnel walk to the patients' villages.



C. **The Community-Based Program** is staffed by local villagers trained in prevention of disease, promotion of good health, and the "how-tos" of living and sharing the abundant Christian life.

The emphasis is placed on prevention and not cure. Here, the community worker visits people in their homes, instead of the people coming to the worker. Health training, evangelism, follow-up, and discipleship are carried on in homes by fellow villagers with whom the people can identify.

In community health, we aspire to take health services to the community rather than asking the people to come to a central institution.

As can be seen in the pyramid, more sophistication is necessary, more resources are required and used, the care is more expensive, and the number of people reached is fewer (though the population served is larger). The basis for all national health care should be a blend of curative and preventive health care, balanced with Biblical instruction.

Primary Health Care

At the Alma Ata conference, "Health for All by the Year 2000" (through Primary Health Care) became the focal point for world health. Primary Health Care is defined as essential care that is accessible, acceptable, affordable, all-inclusive, all-together (participatory) at the center (the nucleus), and is amendable to self-reliant initiatives.

There once was a village on the top of a mountain. It was a beautiful mountain and many visitors would come to see the people who lived there.

Unfortunately, there was a cliff near the path that led to the village. Often, as visitors or villagers moved along the path, they would slip and fall over the cliff. Some were injured, and some even died.

The people of the village gathered together and decided they should build a dispensary where they could bring injured people. However, even after the dispensary was built, people kept falling off the cliff and some died.

The village again met and decided they should have someone stationed below the cliff to rush the injured people to the dispensary. Perhaps, if they arrived quickly, they would not die. Even after they did this some of the injured continued to die.

Finally, one of the elders suggested that the village people erect a fence along the path to prevent people from falling over the cliff. They did this and found that no one fell over the cliff any more. Visitors continued to come and the village remained a happy place.

Prevention is better than cure!

Most health care problems are approached with the idea of building a dispensary to take care of those who are sick instead of developing a program, like the fence, which will prevent the problem in the first place.

Health care has two major halves and both must be operating. There is an African proverb which says, "It takes two fingers to kill a louse."

The two fingers of the traditional half of health care are generally planned and directed from the top and are curative-centered. There should be a second half planned and directed by the people in the local community that starts where the people are—"beyond the dispensary." Community-based health care is the "outer" half of primary health care.

Characteristically, Primary Health Care (PHC) has consisted of those interventions which have trained health professionals to perform, to protect and to promote the health of the people. The emphasis has been on what the professionals do for people through mass control programs in public sanitation, improvement of water supplies, and vaccination, which have resulted in great advances in health. But little progress has been made in health care related to change of behaviors.

Community-Based Health Care (CBHC) takes PHC in a different direction, motivating people to take responsibility for their own health care. In it, the people take the initiative to improve nutrition, sanitation and living conditions.

Behavior is directed by a person's underlying values, beliefs and basic assumptions. If changes are to occur in habits and life-style

behaviors, the motivation must come from within. Changing belief systems and habits must begin with new knowledge, which is best gained through active participatory learning.

A strong CBHC program needs to be developed. We want to take people beyond PHC to the place where the people themselves take the initiative and ownership for their own health. We try to demonstrate how CHE is able to better meet their needs today.

It is our desire to assist countries to go beyond their existing Primary Health Care Programs to implement Community-Based Health Care. Trained local volunteers can be vital catalysts for a Community Health Care Program. They can help alleviate the health problems by teaching their neighbors principles which have direct impact on their physical health. Yet, all work is done in conjunction and cooperation with the existing health care system.

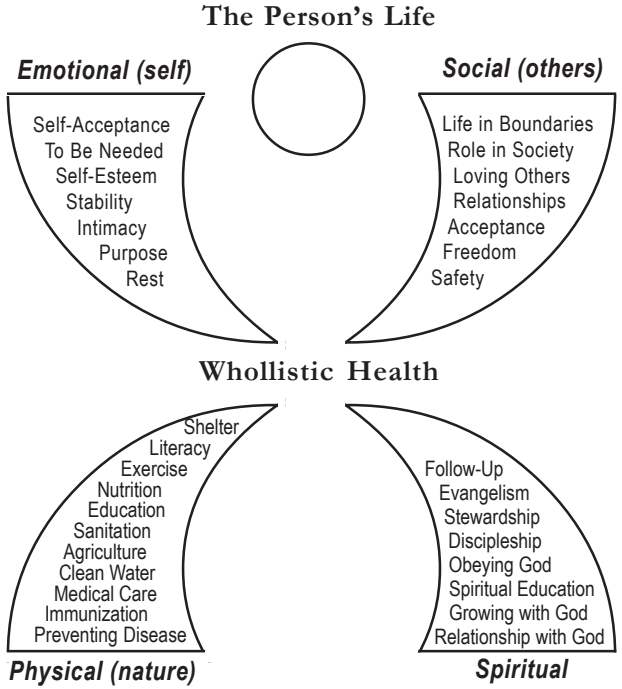
Traditional Health Education

When we examine traditional community health programs modeled after public health principles, we see many differences from the approach we have been discussing. Some of the differences are important to educators; therefore, we need to compare them. Dr. Mahler, Director General of the World Health Organization, says, "Health educators should see to it that they put an abrupt end to that type of health education, which was concerned with telling people how to act." Moses Stambler, in *Health Education in Less Developed Countries*, looks at "Traditional" health education and compares it to "Modern" health promotion.

	Traditional	Modern
Primary Concern:	Medicine and disease prevention.	A wholistic approach, incorporating cultural and psycho-social factors.
Objective of Health Care:	Individual is acted upon by the professional.	To participate jointly with others from the community.
Method of Instruction:	Downward transmission of knowledge and current information.	Incorporates participation and community involvement upward from the people.
Role of Health Official:	'Provider of service'.	'Facilitator' - A learner who will dialogue with the people about culturally appropriate health responses.
Role of Education:	To teach people the 'right' way with formal instruction.	To encourage people to participate in their own health care through informal learning.
Role of the Individual:	To teach people what to do.	To increase individual and community capability for self-reliance.

Good Health

For a person to be truly healthy, many diverse elements are involved. Having good health involves more than what is defined by Primary Health Care (PHC). Good health is much more than just medical elements, and involves all facets of development. Because of this, CHE attempts to deal with the components presented below.



Good health can also be defined in another way. It is living in harmony with God, others, one's self, and nature around us. If there is a break in harmony in any one of these relationships, then there is sickness. Restoration of the disharmonious relationships is called healing.

This may seem to be rather simplistic, but if a person really thinks how this applies practically in their life, they will see the truth in this definition. This definition also shows the relationship between all aspects of a person's life. If there is a breakdown in any one of these relationships, a person can not be considered healthy; therefore, good health depends upon experiencing harmony in all relationships. Health care then covers and addresses the following elements, as detailed in the chart above.

As we have seen, modern health care emphasizes promotion of good health by attacking the causes of health problems through health education and preventive medicine. Preventive medicine and health education can be effective in reaching the multitudes and in demonstrably eliminating the sources of disease.

But to be truly effective, in addition to providing medical services any successful program must educate the people to care for themselves. At the same time, and with the same strategy and teachers, the village people can be taught how to know God and how to draw upon His power for their daily needs.

A Wholistic Approach

When Jesus walked this earth, He was concerned about the whole person. He obviously cared about the physical side of man as well as the spiritual, because He devoted much of His time to healing the sick. Following His example, as Christians we must also be concerned for the well-being of the whole man.

Christ's last command was recorded in Matthew 28:19-20: "Go, therefore, and make disciples of all nations, baptizing them in the

name of the Father, the Son, and the Holy Spirit, teaching them to observe all that I commanded you."

Like all believers, Christian medical personnel must be involved in helping to fulfill this Great Commission. Spiritual multiplication should be part of any Christian health care strategy.

There will never be enough fully trained medical personnel to meet the needs of the estimated 3 billion people in Third World countries. But Christian doctors and nurses can multiply themselves by training thousands of local people to handle simple medical problems and also to share the Gospel of Jesus Christ.

Trained local Christians, working through the church, can be a vital catalyst for a Community-Based Health Care Program.

Traditionally, medical missions have been committed to caring for people's physical and spiritual needs. Often in day-to-day practice, however, a medical missionary is faced with an incredible case load. For many medical missionaries this inevitably leads to a conflict of interest between urgent physical concerns and the spiritual needs of the patients.

In contrast to this, the evangelical church has historically concentrated on the spiritual aspect of man, often to the exclusion of the other areas. The liberal church has traditionally concentrated of the physical/social aspects of man, to the exclusion of the spiritual. Both dichotomize man into segments, which Jesus never did or intended.

Some churches, in seeking to eliminate this dichotomy, have actually developed two parallel ministries. One side ministers to the spiritual

needs of an individual and the other to the physical/social aspect. They call this a balanced ministry. This is a step towards eliminating the dichotomy, but it is not enough.

An integrated ministry is needed in which the same person ministers to all aspects of another person in need. This approach views man as a whole being and deals with the need the person expresses, whether it is physical, social, or spiritual. One part may be addressed sometimes. At other times, another is dealt with. And all aspects may also be considered simultaneously.

We investigated what churches and denominations were doing in the area of primary health care and what role evangelism and discipleship played in those programs. From this investigation we concluded that any medical service or community health program should have the following objectives, if we want to eliminate this conflict of interest:

- The medical services should be viewed as a servant of the spiritual ministry.
- Success of any Christian medical endeavor should be measured more by the discipleship results than patient case load. However, the two are integral.
- Evangelism and discipleship need to be integrally interwoven into the practice of medicine and should emanate from the personal ministries of the physician and nurses, rather than through an appointed or hired chaplain.
- An adequate health care staff should be supplied so that the members can operate as a team in both the spiritual and medical aspects of the ministry.

- All the Christian medical staff and workers should receive refresher training in the spiritual skills of evangelism and discipleship. This is especially important for doctors. They must be seen as pacesetters and not as "too busy for spiritual ministry."
- The overall success of a village health strategy should be measured in terms of multiplication, i.e., everything that is taught to the Community Health Evangelists should be transferable to villagers who can, in turn, teach it to other villagers.

In community health, we seek to take health services to the community rather than asking the people to come to a central institution.

Discipleship training in a Community-Based Program provides fellowship, motivation, and a basis for team relationships. Discipleship, therefore, becomes the nucleus of the strategy. This allows both spiritual and vocational multiplication to take place, through people who are trained to be involved in both areas.

We called these trained local people Community Health Evangelists (CHEs). In God's Word, the Bible, an amazing secret is revealed: God has chosen to change the world through the lowly and unassuming–a conspiracy of the insignificant.

He once chose a ragged bunch of Hebrew slaves to become instruments of His new order. He once put a vast army to flight with 300 men carrying lamps and blowing horns. He once chose a young shepherd boy with a sling to give leadership to His people. He once invited an unlikely group of fishermen to be His channel for blessing. He has supernaturally worked through a baby in a manger to turn this world right side up.

God chose the foolish things of the world to shame the strong. He chose the lowly and despised things to nullify things that were admired by men...so that no one may boast of his own works.

Just as Jesus invited that first unlikely bunch of fishermen, so He invites us to abandon our "boats and nets" and join Him in the adventure of changing the world.

The work of discipleship and evangelism is not restricted to some spiritual "compartment" of our life. Jesus said that we are all obliged to teach others how to go the second mile, turn the other cheek, work for peace and justice, and be servants of all people.

God is working quietly through many lives to change the world. That change begins with the people who are called by His name—the Christians.

Our Approach

Our Community Health Evangelism Program is aimed at the broad-based first tier of the community. We accomplish this by training local villagers how to share spiritual and physical truths with their fellow villagers.

We desire to reach the greatest possible number of people with physical and spiritual help, and we have learned that we can do so by training Community Health Evangelists.

Early on, we could see that a model project needed to be established in a compact, identifiable target area. We utilized an approach to physical development which seeks to serve the people where they are and to help prevent disease before it starts.

This approach includes:

1. Concentration on meeting high-priority needs in simple community projects close to the people, to teach the people to do as much as possible on their own. We attempted to begin where the people were in relation to their leadership, initiative, and self-reliance.

2. An aggressive initiative of going to the people.

3. An integration of preventive medicine and health education into a total program. The emphasis was on prevention and education with anticipated results of changed life-styles and conditions.

4. A vision and goal to reach the most people possible.

5. A program of instruction which showed the people how they could participate in their own development. Lessons were developed which were aimed at simple health education, identification of major diseases, recognition of the need for medical care, and care of the sick (especially children).

6. Community self-help and community leadership arising from the people's commitment to the program.

7. A commitment to delegate most of the task to local church leaders, community leaders, and the Community Health Evangelists (CHEs), who will generate local support and commitment for the program.

8. An understanding that the content of the training must be transferable and multipliable.

9. A commitment to using readily available local resources wherever possible.

10. Provision for good working relationships with nearest available backup primary care institutions for hospitalization and necessary obstetrical and surgical care of severely ill patients. In the first prototype, this was through our own medical facilities, but later we decided that it would be best not to operate curative institutions.

11. Mass immunization programs for measles, BCG (to prevent tuberculosis), DPT (Diphtheria, Polio and Tetanus) and polio, should be community-sponsored.

12. Providing training in sanitation measures, with an emphasis on safe water and proper use of pit latrines.

13. Providing easily accessible family-planning instruction materials.

14. Aggressive evangelism, follow-up, and discipleship to saturate the target area for Christ. To see the Christians in these areas living holy lives and reaching out to others.

Results

We have learned a great deal from other secular and Christian projects, as well as from our own experience since 1981. Our desire is to see 100,000 rural people trained as Community Health Evangelists in countries throughout the world.

Through 1999, we have had the privilege of training more than 2,000 people from 450 churches and missions in the principles of Community Health Evangelism.

This has positioned them to either establish their own Community Health Evangelism Program or to integrate evangelism and discipleship into their existing projects.

We have been greatly encouraged and helped by the recorded results from some of our early CHE projects. In one of our early projects at Buhugu, Uganda, out of twelve people chosen by the community to undergo training, only three had a personal commitment to Jesus Christ. But by the completion of the four-month training cycle, all twelve could testify to a personal relationship with the Lord.

In addition, over a two-year period, the Buhugu CHEs have personally introduced more than 1,000 people to Christ. At one time in 1985, the Buhugu CHEs were conducting 32 Bible studies involving 285 people. Of those 285 people, 20 started their own evangelistic Bible studies, which involved an additional 100 people.

In terms of physical and social results, local trainees and workers from ten villages involved in the Buhugu project have protected 40 springs and built a 13-kilometer gravity-fed water system that serves more than 10,000 people. They have also reduced the incidence of measles by 40% and deaths due to diarrhea by 30%.

The people started a number of individual projects, such as bee keeping (65 families participating), seedling tree nurseries, ponds for fish raising, and improvements in many home garden plots, from which is derived most of their staple food.

During a period of political unrest in Uganda in 1985, it became necessary to withdraw the expatriate CHE training teams, just as several new projects were either training village committees or training the first groups of CHEs. Three of these projects were less than one year from inception. When the expatriate training team

returned eight months later, they found the communities were ready to start where they had left off and some had continued in a limited way on their own. This was especially encouraging because, at that time, all progress in Uganda (whether national or expatriate) was at a standstill due to the turmoil in the country.

It usually requires up to five years for a project to become self-reliant and indigenous; yet the Buhugu clinic continued to function on its own throughout that time.

In 1981, a project was begun in Western Kenya in conjunction with the Africa Inland Church. After a group of 15 CHEs was trained, we realized the people were not taking any initiative, but were expecting the training team to carry the entire burden. A decision was made to withdraw from the project and wait for the community to take action. Thirty months later some church leaders from that area requested that we provide more training. We then discovered that 30% of the original people trained were still doing home visiting and sharing the CHE concepts with their neighbors, without any encouragement from the training team.

In another area, a woman trained as a CHE moved with her husband to a village some distance from their original home. At the new location she found a community in need of health care, so on her own initiative she organized a CHE Training Program. This dedicated woman trained 30 CHEs and has since trained 5 of them to be trainers, in order that the Community Health Evangelism concept could be carried into adjacent areas.

These examples demonstrate what can happen when people catch a vision and, under God's direction, begin to take responsibility for their own health care and protection.