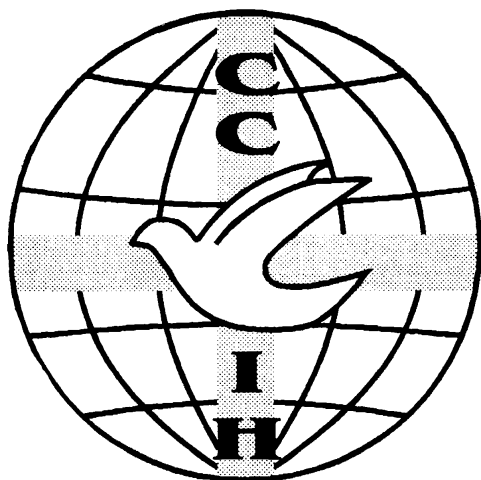


The CCIH FORUM

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*Promoting International Health and
Wholeness from a Christian Perspective*



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Table of Contents

<i>CCIH IN BRIEF</i> by Franklin Baer	1
<i>Community Links for Sustainable Health Care</i> by Shobha Arole	2
<i>Christians Pioneer International Health Concepts</i> by Raymond Martin	8
<i>AIDS Orphans in Africa: Lessons Learned and Possible Strategies</i> by Vicky Calver	13
<i>CYBER-CCIH: International Aid</i>	16
<i>NEWS IN INTERNATIONAL HEALTH</i> Massive Effort Against Diseases of Poverty	17
<i>SUITABLE FOR FRAMING: Hannah Whitall Smith</i>	19
<i>PATTERNS FOR LIFE: The Just Shall Live By Faith</i> by Tokunboh Adeyemo	20

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CCIH in Brief

by Franklin Baer

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The second “C” in Christian Connections for International Health is sometimes confusing. For example, Raymond Martin was referred to in a recent presentation as the executive director of Christian **Concoctions** for International Health.

Concoctions aside, I believe that the *connections* component of CCIH has at least three important meanings:

First, *connections* means promoting networking among Christians and Christian agencies working in International Health. This networking also includes connecting people to field-oriented resources, especially those from a Christian perspective. It also means connecting Christians and Churches with the larger professional and secular world of governments and global development agencies.

Second, *connections* means helping people, especially in underserved areas, to get connected to information and services that can improve their own physical, mental, spiritual and social well being.

Third, *connections* means being creative. William Plomer said it best, “Creativity is the power to connect the seemingly unconnected.” This power to connect can inspire new ways to improve health services.

It is said that Gutenberg invented the printing press when he made a creative connection between pressing grapes in a winepress and pressing words in a printing press.

In truth, Gutenberg borrowed and connected several technologies to create his printing press. However, as Thomas Edison once said, “Keep on the lookout for novel ideas that others have used successfully. Your idea has to be original only in its adaptation to the problem you're working on.”

Opportunities to connect are all around us. Get connected to CCIH, and let us know how we can help you get connected to others.

Community Links for Sustainable Health Care

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The impact of sustainable, community-based health care has been studied and well documented at the Comprehensive Rural Health Project (CRHP) in Jamkhed, India. This program was developed by Dr. Raj and Mabelle Arole out of their Christian faith and concern for the rural poor of India. As shown in the table below, the project has had a significant impact on health indicators.

Impact on Health Status at Jamkhed, India

Year	1971	1976	1986	1993
Infant Mortality Rate	176	52	49	19
Crude Birth Rate	40	34	28	20
<i>Children Under Five</i>				
Immunization: DPT & Polio	0.5%	81%	91%	92%
Malnutrition: Weight for age	40.0%	30%	5%	5%
<i>Maternal Services</i>				
Prenatal care	0.5%	80%	82%	96%
Deliveries by trained attendants	<0.5%	74%	83%	98%
Couples using family planning	<1.0%	38%	60%	60%
<i>Chronic Diseases</i>				
Leprosy Prevalence	--	2/1000	1/1000	0.1/1000
Tuberculosis Prevalence	--	15/1000	11/1000	6/1000

The keys to success for these impressive results are the product of an integrated development approach with the health center as a facilitator to empower community organizations and village health workers (VHW).

The Role of the Health Center

The health center itself is a facilitator to bring about these changes. There is a need for facilitators external to the community to bring people together. Staff members from the health center need to act as facilitators with real sensitivity and ability to bring people together. People consider the health center to be their own and also look to it as a place that will give them guidance and support.

There are certain expectations from the people regarding the health center. The community expects prompt, appropriate, good and low-cost effective service. The center also functions as a referral for secondary care. The community supports the center if the facility can meet their needs and respond to emergencies such as dealing with fractures, appendicitis, surgical, medical, obstetrics and pediatric care. At this level they do not look for super specialties and are willing to go to tertiary centers for these problems. People within the community need to have a sense of ownership of the health center.

Further, the communities look at health economics. When patients go to the health center, they like to know the exact cost of care. It is important on the staff's part to be open and discuss the monetary side of health care. Keeping things sustainable at the health center level involves the staff's familiarity with health economics and providing low-cost secondary health care that is effective.

Links are also established between the community and the health center, and on returning to the village, the patients are followed up by the village health worker and mobile health team. This linkage among three levels ensures people being aware of the economic background of the people in the communities. It also provides for ongoing support and exchange of information.

An Integrated Development Approach

The role of the health center becomes one of listening to the community, facilitating its development and empowerment, training and sharing information, and support and referral. When the staff first begin to work in a community, they aim to build up relationships and to build and strengthen community organizations. The makeup of a typical village in the Jamkhed area is shown in Box 1.

Box 1: A Typical Village in Jamkhed, India

A typical village is fragmented, divided by caste, economic, religious, political factions. It is made up of the following groups of people;

- A few wealthy, high caste people who have easy access to all the necessary services, e.g. school, medical care, government officials, bank and credit facilities, clean water, transportation. They actively prevent percolation of information, knowledge and development to the lower castes.
- Poor, marginalized people (the majority) –
 - dependent on the wealthy for their livelihood
 - no decision-making power
 - no access to outside knowledge, government or other development programs
 - little or no access to modern health facilities
 - no access to safe drinking water
 - resorting to local healers (spiritualists, herbalists) and traditional remedies
 - People with leprosy, tuberculosis, HIV/AIDS are ostracized and driven out of the village, living on the outskirts.
- Women, who are marginalized and discriminated against both within the household and the community, e.g. maldistribution of available food and no access to money.

Really listening to the community takes much time and a variety of approaches. Games such as volleyball are good ways of bringing people together, relaxing with them, and hearing what they have to say. For example, Box 2 shows a list of community suggestions that typically emerge over a time of listening and discussing.

Box 2: Community Suggestions to Improve Health

- Common minor illnesses should be taken care of by the people themselves, with advice from the VHW, using scientifically sound treatments, including effective traditional remedies.
- Increase the knowledge and skills of the VHW and provide her with simple medicines for common diseases.
- Use effective measures to prevent diseases.
- Certain basic health services are the right of every citizen and should be part of a state health program. This should be provided through public health services in which the community should take more and more responsibility as the process of development progresses. The community also holds the government accountable for providing available programs to all people.
- Community organizations should set apart a fund for those few who need to pay for but can't afford secondary health services.
- Community organizations should be partners with health services to ensure that there is equity in health care – that the poor and marginalized have access to care and information and are integrated into the community.

On further discussion, the community decided that with effective community-based primary health care (PHC) the above interventions would reduce the need for a clinic in every village or community. This would include a Village Health Worker selected by and responsible to her village. The community PHC approach would also reduce the number of people that need to be referred and thus reduce the cost of health care.

CRHP has found that effective organizations of women, men and children are vital to successful community health care. Motivated organizations can help cut across caste barriers, religious and other differences; they often include a few socially minded rich people. The community becomes well integrated. When both caring health staff and effective community organizations are present, various changes occur.

Box 3: Examples of Community Actions

1. People identified malaria as a leading cause of illness in their village. They understood that malaria was spread through mosquitoes that thrive in stagnant water. As a community they cleaned up the village, made underground drainage pits, and reduced the incidence of malaria.
2. In one village, Madhu Wadekar was found to have HIV/AIDS. The village people accepted that Madhu had a serious disease and needed support and care. The community organizations took care of him, provided a job for his wife, and ensured that his children were looked after. They supported him well until his death.
3. Sri Mule is a leprosy patient, with ulcers and deformities. He was ostracized and had to live outside the village. Once the community organizations understood about leprosy, they brought him back to his home, ensured that he had proper treatment, and supervised his rehabilitation. Today he is an active member of the men's group.
4. Ashok Gavale came from a poor background. He was bitten by a poisonous snake. He could not afford the expensive anti-venom. His community contributed Rs.10,000 towards his care.
5. Three poor tuberculosis patients were looked after by the community, which met the expenses for medicines, ensured adequate food, and later arranged for credit facilities for them to start income generation activities.
6. The village people are aware of the preventive programs and ensure that all children are immunized. Growth monitoring of children up to age three is carried out by the organized groups and appropriate action taken if children are found to be malnourished. They make sure the government workers come to give immunizations on schedule.

After three to five years of listening and dialogue, community actions (see box 3) lead to the following common results:

- Community organizations include people from all segments of society.
- A village health worker (VHW) is chosen and supported by the village.
- VHWs and community organizations work in partnership with health service providers (health team) to ensure good services are available.
- Through proper health information and training from health teams, community organizations can assess their health situation, analyze

causes, and develop action plans with the health team. (As they gain more experience and health information with each planning/action cycle, the involvement of the people in determining and becoming responsible for maintaining their health increases.)

- In analyzing health problems, the people are able to identify the linkages with environment, harmful traditional practices, and discrimination against women that influence health; and they take appropriate action.
- Poverty being an important factor, organized communities are empowered to have income generation programs, access to bank and credit, and access to all development services.
- There is access to information, training and secondary health care.
- Persons ostracized by diseases like HIV/AIDS, leprosy and tuberculosis are well cared for in the community, supported and rehabilitated.

Sustainability

By addressing social issues, people are empowered and have equitable access to all facilities. The close linkages of health with other factors -- such as environment, sanitation, safe water -- need to be recognized. These programs may initially require a large investment, but in the long term they lead to sustainability and effectively improve health.

People need to become aware that good health comes through their own actions, both as individuals and as a community. The more information they receive, the more they can make changes for their own good. Once a certain amount of awareness is reached in the communities regarding health, social and economic issues, sustainability is possible through community participation both at the village and referral center levels.

Sustainability of health care involves working with the communities and the health center in an integrated approach for promotive, preventive, curative and rehabilitative services, and within bounds of the economics of people. Sustainability is not only in financial terms, but more importantly through knowledge, attitudes, practices, values, and the development of caring and sharing communities, where all people are included.

Editor's Note" Jamkhed International Foundation is an organizational member of CCIH. This article was published in "Footsteps," Tear Fund, UK, Fall 1998.

Christians Pioneer International Health Concepts

By Raymond Martin, Executive Director, CCIH

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Traditional and "Non-traditional" Health Sector

World Health Organization Director General Gro Harlem Brundtland, in her keynote address at a recent conference in Switzerland calling for an intensification of the fight against diseases of poverty, said that "we must go beyond the traditional health sector – working with people in their homes, their work places, their schools, their community halls and their places of worship."

Churches and Christian non-governmental organizations welcome this expanding openness to partnerships with WHO, a U.N. agency which in the past tended to limit its collaboration to member governments. If Dr. Brundtland had examined the history of the engagement of Christians and other faiths in health and healing, however, she may not have described working with places of worship as "non-traditional."

Care of the sick has been a traditional undertaking of religious institutions and people of faith. Healing was a key focus of Jesus' ministry. The word "heal," which has connotations of salvation in New Testament usage, appears 66 times in the four New Testament gospels. In commissioning the twelve disciples, Jesus "gave them power and authority to drive out all demons and to cure diseases, and he sent them out to preach the kingdom of God and to heal the sick" (Luke 9:1-2). Other religious traditions, e.g. Muslim, Jewish, Buddhist, Hindu, African, are also concerned with the sick.

Read about the history of hospitals in an encyclopedia and you will see that in a major way it is the churches and religious orders that were the pioneers of institutions for the sick. In more recent times, it was most frequently churches and Christian missions that established organized health and healing institutions in developing countries. In the long perspective of history, therefore, it is governments that are often the "non-traditional" purveyors of health services, not the houses of worship.

Although not yet ratified by the World Health Assembly, WHO has advocated changing its definition of health to add the word "spiritual." The new definition would read, "Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of

disease or infirmity.” It was largely the influences of churches that brought this change. This wording resonates well with the CCIH motto – *promoting international health and wholeness from a Christian perspective.*

20th Century Christian Role in International Health

This article focuses on the Christian contribution to health in developing countries. Establishment of hospitals was one of the first priorities of Christian missionaries a century ago. These ministries of health and healing were inspired by Jesus’ example, responding to the most immediate needs of communities. Medical missions helped to legitimize the arrival of Western Christian missionaries and their spiritual message. A progressive movement based on the belief that there are social and spiritual determinants to health and wholeness brought together faith and public health in an enterprise committed to community improvement that radically changed the world.

Medical education was an early Christian innovation at colleges such as Makerere in Uganda and Brown Memorial in Ludhiana, India. The Vellore Christian Medical College in India is now celebrating a century of service, honoring its founding missionary Ida Scudder who established a college to train women doctors. In the early 20th century, Christian missionaries also brought in nursing education, including the value system of serving.

In the past century, health has evolved as a primary responsibility of governments. Even so, a 1998 survey by the Institute for Development Training found that “Religious Health Networks are the second largest health system in the developing world, second only to government programs.”

In sub-Saharan Africa, most of the early hospitals and health programs were established by Christian churches and mission. Even today, 40% of hospital beds in much of Africa are in church and mission institutions. In Asia, this proportion is estimated at 20%.

The Christian influence on the later 20th century evolution of concepts such as “health for all” and “community-based primary health care” is a fascinating story. In the early 1960s, an international conference in Tubingen, Germany, shocked mission boards by pointing out the limited impact of hospitals in improving health levels of entire communities. A second conference in the mid-1960s on the healing role of the Christian community resulted in the eventual establishment in 1968 of the Christian

Medical Commission of the World Council of Churches, based in Geneva, Switzerland. Many countries soon set up national commissions to coordinate the health and medical programs of various Christian groups.

In the 1960s and 1970s, forward looking Christians pioneers, many of them still alive today, dared to extend the traditional mission of healing the sick to an effort to lift the health status of entire communities and nations through health outreach to the community, emphasizing prevention and health education. The successes of these Christian-based programs, integrated with the spiritual mission of the church, caught the attention of government and aid organizations.

The Christian Medical Commission (CMC), the epicenter of much of the fervor for these new approaches, was a short walk down the street from the WHO headquarters in Geneva. During the time when Halfdan Mahler, himself a former medical field worker in India, was Director General of WHO, there was constant interaction between the officials of these two neighbors, WHO and CMC. Over 50 WHO staff received CMC’s journal, *Contact*. A 1974 WHO/UNICEF study entitled *Health by the People* cited three models of community health innovation (Guatemala, Jamkhed, and Java), all inspired by Christians. Mahler told his colleagues that if they wanted to know what the cutting edge issues of international health were, they should go down the street to the CMC. Exciting new ideas infiltrated into WHO officialdom, so that by 1977 WHO had adopted a health for all objective through the primary health care approach.

The new thinking is illustrated by a question posed to early CMC leaders Jack Bryant and John Karefa-Smart about how the World Council of Churches should handle the problem of young churches in the newly independent states of Africa and Asia that had inherited hospitals from rich parent churches but were without resources to manage and sustain them. How should those hospitals be used and managed? Their response was that this was the wrong question. The question should be: what can the churches and the hospitals for which they were newly responsible do about the health of poor and vulnerable populations in the communities where they live? That question and further suggestions for action were part of the turn of the churches toward primary health care.

Commonalities in Church Health Programs

What are the common features of health programs managed by faith communities?

- **Coverage** - reaching rural villages, urban slums, refugees, i.e. most underserved.
- **Sustainability** - faith communities have local roots and management and are often linked to global religious networks.
- **History and Credibility in Health**- tradition of compassionate care of suffering, pioneering in community and institutional health programs, and reputation for quality services and management integrity.
- **Holism** - focusing on every aspect of human life (physical, mental, spiritual and social), addressing human concerns that transcend scientific medicine and public health.
- **Ethics, Justice and Advocacy** - addressing root causes and core values derived from beliefs rather than empirical inquiry.

Impact of Christian Faith on Health

How does the Christian faith impact health? Here are six points presented by Dr. Daniel Fountain, long-time missionary to Congo, at the 1998 National Council for International Health conference:

1. **Community Health** – The Bible helps shift attitudes away from fatalism toward activism and responsibility to take initiative to improve sanitation, health, water supplies, food production, etc. The church provides a community structure for health and development efforts and moral values that support trusting and cooperative relationships.
2. **Management of Health Services** - Christian models of management emphasizing accountability, responsibility, shared power, and service can lead (but not guaranteed) to improvements over hierarchical power relationships and concentration of power in the chief or director.
3. **Maintaining Integrity of Health Programs** - Religious faith can provide a spirit of unity and common purpose in social and professional relationships and a structure for managing conflict.
4. **Justice, Poverty, and Health** - The Judeo-Christian Scriptures give clear principles concerning economic and social justice and demonstrate God's concern for poor people. If followed, poverty and inequity are reduced, enhancing health.

5. **Caring for the Whole Person** - A medico-pastoral approach to healing is justified by recent developments in psychoneuroimmunology that reinforce the belief that body, mind, and spirit are intimately interrelated as a functional whole.

6. **Epidemic Diseases** - Commitment to Christ and to serving others motivates health care workers to care conscientiously for the sick. Church hospitals and health programs provide a surveillance network for disease outbreaks.

Challenges for the Future for Faith-Based Institutions

Christians played a towering role in 20th century developments in international health. What are cutting edge issues where Christians can play a pioneering role at the beginning of the 21st century? Here are a few suggestions:

- Strengthen advocacy for the poor, oppressed and marginalized, promoting equity and total coverage for all, leaving no one behind.
- Integrate health programs and congregational life to promote healthy behaviors and lifestyles, for example to reduce HIV transmission.
- Expand partnerships with other faith groups, governments, international institutions, and secular health agencies.
- Participate boldly with national and global powers in decision-making regarding policy and resource allocation.
- Speak out on medical ethics and moral implications of health policies.
- Lead in research and practice of spiritual dimensions of health and healing.

Editor's Note: This article was first presented at the 1999 APHA conference.

AIDS Orphans in Africa: Lessons Learned and Possible Strategies

by Vicky Calver
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Tragically, the worst is yet to come. During the next decade, more than 40 million children will become orphaned by AIDS and this 'slow burn disaster' is not expected to peak until at least 2030. Without a doubt, AIDS has placed an entire generation of Africa's children in jeopardy. (Presidential Report "Findings --the problem").

In the view of many experts, churches and other faith-based organizations have a particular advantage in the care of AIDS orphans. According to Sandra Anderson of UNAIDS, "Churches Already Have Networks of People and Networks with Other Churches." To build on this comparative advantage, World Relief has examined the needs and perceptions of affected people to ascertain appropriate, long-term approaches to helping orphans reach their life potential. This includes addressing spiritual as well as physical, emotional and mental needs. Below is a summary of what was found in terms of approaches being used, lessons learned, recommendations and possible strategies.

Three Approaches to Care of Orphans:

1. Providing a new home environment

This approach emphasizes the importance of a child growing up in a home with a father and/or mother as central figures in the family. There may be problems, however, because children may lose any inheritance due to them from their biological families. There is also a risk that the larger community and local church may avoid responsibility for these children.

2. Encouraging a community response

The needs of the orphans can be met by improving community capacity to provide food, emotional support, guidance in food production, the lending of household items, medical care, and ensuring their security and safety. Different people in a church could seek to support the different needs of such a household with their varied gifts. Churches can establish schools for their education and vocational training as well as provide spiritual support.

3. Strengthening extended family capacity

Another approach is to encourage the extended family's ability to respond so that they can continue in their historical role of responding to the needs of orphans. The sheer number of AIDS orphans in Africa, however, limits the capacity of the family in some places. This approach may be more feasible when combined with approach No. 2, where the church or the community also contributes, for example, through school fees or loans to enhance the family's income generating capacity. The family can be strengthened to provide psycho-social support to the dying parent and the orphaned child.

Lessons Learned:

1. Projects that appear to have passed the test of time and effectiveness include ones which have a positive family or family surrogate relationship, and a strong community or church involvement.
2. Most responses to orphan's needs surround the physical needs of food, clothing, and shelter.
3. Vital needs of education, sibling support, trauma counseling, future planning, and spiritual needs where neglected are detrimental to the success of the child's future.
4. Simple interventions may be very effective and inexpensive. They include mentoring, regular oversight, the development of simple church-based schools, appropriate training in food production.
5. Children must be part of the grieving process with their parents before death.

Recommendations:

- The church will be our primary channel for intervention.
- Children will be maintained in families and with siblings when possible.
- Community education, resourcing, and networking will be integral parts of any program, necessary for cultural acceptance, the reduction of stigma, and the long-term survival of programs.

- Children will be prepared for the dying and death of a parent or sibling.
- The extended church family will be prepared biblically and encouraged to participate in the care of orphans through foster care or in the oversight of child-headed households.
- We will nurture the whole child's development -- educational, physical, spiritual, social, and emotional domains.

Strategies for Consideration:

1. Develop strategies with local churches to train church leaders in developing policy guidelines, in pastoral care specific to families with AIDS, and in preparing church members to become involved.
2. Develop appropriate written resources for church leaders, caretakers, and orphans surrounding issues of care, dying, and grief.
3. Develop different key models of orphan and family support, depending upon the need, resources, environment, and opportunity. We expect these models to include: extended family parenting, foster family parenting, older sibling parenting, and close neighbor oversight of children remaining in their homes and attending their schools.
4. Explore better ways to develop and sustain income generation for families affected by AIDS. We will review and possibly adapt good practice from microenterprise development and community banking.
5. Support caretakers of orphans through strengthening church leadership in pastoral care and through the development of simple materials.

Editor's Note: World Relief is an organizational member of CCIH. A more detailed copy of this report may be downloaded at www.ccih.org.



CYBER-CCIH: International Aid

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International Aid links caring people and organizations with Christian partners worldwide, changing lives through the power of compassion.

As a distinctly Christian organization, International Aid (IA) effectively mobilizes caring people, churches, organizations and businesses to extend Christ's love and mercy to those who suffer. For more than 20 years, International Aid has provided assistance and medical support to missionaries worldwide, and partnered with churches throughout the United States to reach some of the most desperate countries devastated by war, famine and drought.

As a Christian organization, International Aid effectively mobilizes caring volunteers, churches, organizations and businesses to extend Christ's love and mercy to those who suffer due to war and displacement, natural disasters, poverty or lack of access to health care. This year, IA celebrated its twentieth year of providing assistance and medical support to missionaries and health institutions worldwide.

IA embraces hospital-based clinical care as well as primary health care and disease prevention as necessary and complementary approaches to health problems worldwide. Reflecting that philosophy, IA has developed the following health programs in its International Programs portfolio:

- Emergency Relief;
- Hospital Management and Support Services;
- Medical Equipment Services (includes the Lab-in-a-Suitcase);
- Christian Eye Ministry/Global Eye Care; and
- Child SWEEP (Survival, Welfare, Early Education and Protection).

In addition, IA runs a Mission Resource Center, and KIDS'HOPE USA, a church-based mentoring program for at-risk children in the United States.

Further information is available at www.internationalaid.org. IA is a supporting organizational member of CCIH.

CCIH NEWS: Massive Effort Against Diseases of Poverty

Can the global community continue with “business as usual” when millions of poor people are dying every year from diseases like malaria and TB that have simple, inexpensive solutions? Can the world stand by and watch as entire countries are ravaged by AIDS striking down millions of lives in their prime, reducing life expectancies from the 60s to the 40s?

Such questions were discussed by the leaders of the G8, the world’s richest, most powerful nations, when they met in Okinawa last July. Although these summit meetings do not typically focus on health, there was a collective sense that something was not right. Health for All by the Year 2000 obviously had not been achieved. So they pledged to support initiatives to reduce malaria and TB deaths by 50% and AIDS infections by 25% by the year 2010. A separate meeting of the G77, leaders of developing countries, endorsed this commitment. WHO, UNAIDS and other organizations were called on to mount a global effort to reach these targets.

WHO and UNAIDS organized an advocacy forum in October in Switzerland with 200 participants to discuss approaches to what they called a “massive effort against diseases of poverty.” What must be done to make cheap malaria drugs and insecticide-treated bednets costing only \$3 accessible to everyone at risk of malaria? How can the \$10 course of drugs, administered through DOTS (Directly Observed Treatment, Short-course) be extended to more than the one in six TB-infected persons who now benefit? What is needed to promote safe behaviors for AIDS prevention and prevent and cure sexually transmitted diseases?

Nobody is looking for a gigantic, WHO-led project to undertake the massive effort needed to reach the G8/G77 disease reduction targets. Rather, there is a call for all countries and institutions, including faith-based organizations, to study how they could intensify their efforts and mobilize the required human and financial resources.

In her keynote address, WHO Director General Gro Harlem Brundtland said that “we must go beyond the traditional health sector – working with people in their homes, their work places, their schools, their community halls and their places of worship.”

How should churches respond to this global call to fight the major diseases of poverty? The CCIH Executive Director, who participated in the Switzerland meeting, helped organize an informal consultation among a group of Christians to discuss this question, especially with respect to

AIDS. Some of the points mentioned were:

1. **Enormous Potential** - Churches could do a lot, given their vast networks and their reach into communities.
2. **Churches' Engagement Is Too Modest** - Although many good programs exist and in some countries churches are major players in health, their collective effort is too modest and uncoordinated.
3. **Religious Leaders Are Often Ignorant of the Best Strategies** – With regard to AIDS, for example, church leaders are increasingly willing to do something, but they typically do not know what to do.
4. **Priests and Pastors Need Help on How to Address AIDS in a Christian Context** - Religious leaders are often reluctant to speak out about AIDS because they are not adequately equipped with a theology and sufficient knowledge and training to address AIDS with confidence in a religious setting. With help, they could also speak to the justice dimensions of AIDS and other diseases of poverty.
5. **Christian and Church-Based Programs Are Too Scattered, Uncoordinated and Inadequately Documented** – What is needed is a greater sharing of best practices, cross-fertilization of ideas, and more networking and partnering, both with other Christian groups as well as with governments, donors, NGOs and other civil society organizations.
6. **Likely Increase in Resources Available to Faith-Based Efforts** - With the growing attention to AIDS, it is likely that resources available to churches and faith-based NGOs will increase rapidly if they develop good proposals.

The Christian group put forward several ideas, although it is not clear by whom or how they could be implemented. They included:

- **Identify, Document, and Disseminate Best Practices** – to survey experience to date by religious institutions, assess best practices, document these programs, and share this information widely.
- **Promote Global Networks of Christian Organizations** – to share information, facilitate partnerships, and enhance a collective response.
- **E-mail Listserv and Website** – to use the power of the Internet to facilitate communication and collaboration.

(Contact CCIH if you have questions or suggestions. Email ccih@ccih.org, or write to CCIH, 1817 Rupert St., McLean, VA 22101)

SUITABLE FOR FRAMING:

Words of Wisdom from . . .

Hannah Whitall Smith

(1832-1911)

US evangelist, and suffragist.

She championed feminist causes and the right of young women to attend college

**Faith, like sight, is nothing apart from God.
You might as well shut your eyes and look inside
and see whether you have sight as to look inside
to discover whether you have faith.**

**The mother eagle teaches her little ones to fly
by making their nest so uncomfortable that
they are forced to leave it and commit themselves
to the unknown world of air outside.**

And just so does our God to us.

**God stirs up our comfortable nests,
and pushes us over the edge of them,
and we are forced to use our wings
to save ourselves from fatal falling.**

**Read your trials in this light,
and see if your wings are being developed.**

**The true secret of giving advice is,
after you have honestly given it, to be perfectly
indifferent whether it is taken or not, and never
persist in trying to set people right.**

PATTERNS FOR LIFE:

The Just Shall Live By Faith

by Tokunboh Adeyemo,

General Secretary, AEA, Kenya

But my righteous one will live by faith. Hebrews 10:38

Living by faith may sound nebulous, yet it is God's ordained way for living. Many of us, even believers, would prefer to live by something else. One day, as I bowed my head to pray in my office, the Lord brought the above text to my mind again. And He went on to say that acceptable Christian living is **not by sense**.

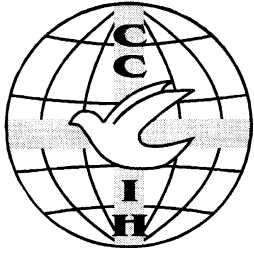
The mystery of faith is equally illogical. If we can figure it out, it is no longer faith. If we wait to understand, it is no longer faith. After we receive our salvation, we want to re-establish our independence from God. Faith negates such a move. This is the foolishness of the Galatian believers. Having started by faith, they now want to live by sense, or law (Gal. 3:3). The temptation is real: society, our peers, or our human inclinations force us to be sure of something before we step out.

A young lady was convinced that God was calling her to a new ministry. But somehow, she wanted all the details of her terms and conditions, especially her salary and benefits, before making a move. When this was not forthcoming right away, she refused to move. Her action or decision was rational. That's what all of us would do. But her decision was not based on faith. I believe she missed God's call.

Abraham never received terms and conditions, but simply an order with a promise: "Go, I will be with you and bless you."





Are you willing to go when God says go, or will you want Him to give you first the terms of service?

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