

**The Christian Community's Contribution to
the Evolution of Community-Based Primary Health Care**

based upon a presentation by Dr. Carl E. Taylor, Dr. John H. Bryant

*Two veterans of the early Christian experience and the AlmaAta conference 1978 of
WHO/UNICEF reminisce and share information about these early years.*

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Contents

- I. Introduction
- II. The Run-up to Alma Ata
 - A. Tubingen, Germany Conferences
 - i. Tubingen I
 - ii. Tubingen II
 - B. The Christian Medical Commission
- III. Alma Ata
- IV. Post-Alma Ata
- V. Into the 21st Century
 - A. Millennium Development Goals
 - B. Current Status of CBPHC
 - C. Quo Vadis
- References

Presenters' Bios

Professor John H. Bryant has had an extensive academic career in public health and global health. Over the last four decades, he has professed for a variety of schools around the world, including Mahidol University, Bangkok; Aga Khan University, Karachi; University of Vermont; Columbia University School of Public Health; and currently with Great Lakes University of Kisumu, Kenya (Tropical Institute of Community Health and Development). He also served as Deputy Assistant Secretary, International Health, DHHS, during which time he represented the US at the AlmaAta Conference. He co-founded the Christian Medical Commission and was the chair for its first term. His seminal book, *Health and the Developing World*, 1969, was instrumental in introducing much of what we consider international health to the public health world.

He is currently functioning independently, as visiting professor, and as consultant in relation to programs in multiple organizations. Of special importance is work on Problems of Orphans and Vulnerable Children (OVC) in Urban Slums of Africa, initiated in 2005, in response to request by UN Habitat, Nairobi. This work focuses on community-based primary health care in slum settings, with special attention to recent advances in the science of early childhood development.

Dr Bryant has received numerous awards from various US and international organizations.

Professor Carl E. Taylor has dedicated his life to improving the health care of people throughout the world, building on the principle of equity. He has made tremendous contributions to the field of international health. He was one of the founders and first director of the Department of International Health at JHSPH in 1961, the first department of its kind at any school of public health. Over the course of 30 years, he worked in India, first as director of Memorial Hospital, a Presbyterian Mission, and then as head of a preventive social medicine department at Christian Medical College in Ludhiana. He served as UNICEF director for China from 1984 through 1987, and as primary WHO consultant in preparing documents for Alma Ata, a World Conference in 1978 on Primary Health Care for the first time. He is currently Professor Emeritus of Johns Hopkins University Bloomberg School of Public Health.

Through his extensive field experience and professional expertise, he is promoting exploration of innovative and sustainable solutions to health care needs in the developing world. Partnerships are needed, bringing together officials, communities, and experts in a "flexible and varying balance depending on local circumstances." Expertise is needed, but the programs must be adapted to the local situation and owned by the local community. This approach is described in a Johns Hopkins Press book - *Just and Lasting Change: When Communities Own Their Futures*. He continues to teach a course at JHSPH on Primary Health Care with special emphasis on community-based approaches.

Dr. Taylor has been the recipient of numerous awards for his efforts, the most recent of which is the Inaugural Global Health Council Lifetime Achievement Award which he will receive on May 28 at the GHC's 35th Anniversary Celebration.

I. Introduction

Religious institutions and facilities have long been associated with the provision of health care to the poor and disenfranchised. In the developing world, this service provision was entwined with the colonial power nations and thus predominantly involved the Christian communions of such western countries as England, France, Belgium, the Netherlands, Spain, and the United States. These countries established Christian health facilities throughout the developing regions of the world.

Inherent in this model was the western bias toward providing health care in the form of clinical medicine in curative facilities – hospitals. Provision of services was “top-down” from highly educated medical missionaries to recipient patients who often had an incomplete knowledge of their health status and disease. This fit comfortably with the western mindset that colonial powers knew what was best for their subjects and conformed to the view of *noblesse oblige*, sometimes colloquially referred to as “the white man’s burden.” For missionary hospitals there has always been the second orientation that churches themselves are institution-oriented, focusing on those who come to the church; and so the institutional base of health care in developing nations – hospitals – was a comfortable fit for the Christian missionary providers.³

Early estimates were that church-related health facilities were reaching only 20% of the populations in developing countries, while 80% were untouched.^{i 3} While this estimate might have been overly optimistic, the point is made that, in many instances, they were the only health services available and still served only a small percentage of the populations where they were located.

The prototype international health organizations, the Pan-American Sanitary Bureau and the parallel Paris and Geneva offices in Europe, were focused on preventing the transmission of communicable diseases from underdeveloped, largely tropical regions, to Europe and the United States.ⁱⁱ The primary mode of prevention was exclusion and quarantine, particularly among ships’ passengers and crew.

During the period from the middle of the 19th century until World War II, there were parallel evolutions in the definition of health, the science of disease, and the technology to study and treat various organisms. In the 1850s an active debate raged between the contagionists and the non-contagionists on the “cause” of disease (malaria means “bad air”). Through such pioneering works as James Lind’s discovery in 1747 that citrus fruit remedied distemper at sea (scurvy) and John Snow’s remarkable epidemiological work in 1854 with cholera in London, the scientist community gradually became more sophisticated in understanding disease etiology and transmission.

At the conclusion of World War II, the growth of transnational – international – health coalesced in the creation of the World Health Organization.^{iii 5} At the historic 1946 meeting in New York, the evolution of science and an expanded understanding of health culminated in the statement of the classic principle that:

Health is the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

ⁱ McGilvray, 1965, p. xv

ⁱⁱ The three offices, and their locations and dates of establishment, were:

The PanAmerican Sanitary Bureau, Washington, DC, 1903

Office International d’Hygiene Publique, Paris, 1907

League of Nations Health Organization, Geneva, 1920.

ⁱⁱⁱ In 1971, the medical historian, Neville Goodman, characterized the creation of WHO: “For the first time a single world-wide inter-governmental organization had been set up, empowered to deal with all aspects of human health. In the impressive preamble international cognizance had for the first time been taken of the concept of positive health as against mere freedom from disease; of mental health; of health as a fundamental human right and of the obligation of governments to ensure it to the individual as far as possible.” Goodman, Neville M. *International Health Organizations and Their Work*. 2nd ed. Baltimore: Williams & Wilkins, 1971, p. 166.

The momentum coming out of the foundation of WHO reinvigorated interest in improving health in developing countries in the post-War era, particularly by economically advantaged “western” countries with their clinical/curative orientation to health. The Christian community in the West was very much part of this revolution and was a key player in the movement toward Community-Based Primary Health Care (CBPHC).

II. The Run-up to Alma Ata

A series of events occurred, primarily in Europe, that examined the role of western medicine in developing countries, the unique role of the Christian community in providing health care, and the need to expand beyond fixed facilities into affected geographic regions to provide meaningful health services, particularly in rural areas.

Health care in many colonies and newly independent states was heavily dependent upon Christian medical facilities. Typically, these were hospitals staffed by western health professionals; host-country nationals were employed largely as low-wage support staff. Periodically, exceptional young people (largely men) were sent to Europe and the United States for medical training on the assumption that they would one day return and provide medical services in their countries of birth.

As these countries began to peel away from their largely European colonial overseers, the question was frequently posed, “What should become of the Christian hospitals?” As we immersed ourselves in this work, we began to recognize that this was the wrong question. What needed to be addressed was, “What should we do about the health of the populations served?”

Unfortunately, this led to a polarization between existing hospitals and community work. This divergence in viewpoint was actively examined by Church leaders and eventually led to a direct impact upon WHO and its policy initiative to implement Primary Health Care around the world.³

A. Tubingen, Germany, Conferences

1. Tubingen I

In May 1964 a conference was held at the German Institute for Medical Missions in Tubingen, Germany, to examine the role of Christian hospitals in developing countries. The 18 participants acknowledged that there was a gap between the theologians who were interested in medicine and medical practitioners, who did not always reciprocate this interest.^{iv}

Further, there were many practical issues related to the operation of what were essentially missionary hospitals in very poor regions of the world, including staffing, funding and sustainable operating budgets. While started by well meaning and wealthy churches and churchmen in the West, operating costs were increasingly being transferred to host-country religious communities, who were incapable of maintaining them.

Despite the very real problems of keeping missionary hospitals going, the focus of the Tubingen I conference turned toward an attempt to delineate the appropriate and unique role of

^{iv} McGilvray, 1965, p. 11.

the Christian community in health and healing. Historically, healing was the purview of the congregation as a whole, e.g. the community. Sometimes efforts of medical practitioners obscured or inhibited the congregation from taking responsibility for the healing institutions. The seeds for participatory community-based health care had been sown.

There was a recognition that the Church could obviously never meet all of human need for health care, but it should always regard new avenues of service as demonstrations of how need should be met. To this end, it called for an integrated witness in which medical work could be correlated with social work, nutrition and agriculture, and community development and thus recognize that medical care was only one component of a diversity of disciplines, all of which were necessary to promote and maintain health.^v

2. Tubingen II

In September 1967 a second conference was convened at the same German Institute for Medical Mission, and the discussion continued on a unique brand of Christian healing and the best way to manifest this through health interventions, particularly in developing countries.

Interest had continued to grow in the wholeness of man in society on the part of both clergy and lay churchmen. Some nascent social epidemiology studies indicated that a patient's confidence in a healer shortened the time of his convalescence. But as James McGilvray, first director of the Christian Medical Commission (CMC), noted, "Unfortunately, this element of faith or trust is not always reciprocated by the physician. By the euphemism of the 'cooperative' patient the physician usually means the completely docile patient."^{vi}

While physicians and social scientists were trying to come to grips with the wholeness of man in society, the theologians were examining the act of healing within the precepts of the Christian communion. Again, McGilvray reported:

In every act of healing, Christ regarded himself as representative of the community which participated with him then and still should through the Body, the Church. So it is the Christian congregation as a whole which is *meant* to be the healing Body of Christ among men and *can* be when it has effectively become a community knit together in Him. When the Christian community serves the sick person in its midst, it becomes itself healed and whole.^{vii}

McGilvray found the contributions of Dr. Robert Lambourne, a British physician and renowned author on theology and psychiatry, to be most insightful, reporting a disturbing picture of the manner in which modern care was at odds with the quest for health and wholeness. Hospitals became factories for repair of things rather than a hospice for the care of souls. The growth of medical specialization tended to break down the patient into pathological parts so that he is treated less and less as a whole patient. Lambourne's concepts of health and wholeness had strong implications for the congregation. It is only when the Christian community serves the sick person in its midst that it becomes itself healed and whole, suggesting a moral basis for individuals and communities to be involved in any consideration of how resources are to be used to promote their health.^{viii 4}

^v McGilvray, 1965, p. 24.

^{vi} Ibid.

^{vii} McGilvray, 1965, p. 25.

^{viii} Bryant and Richmond, pp. 152-174.

B. The Christian Medical Commission (CMC)

In 1968 the World Council of Churches (WCC), an umbrella of largely Protestant communions, and the Lutheran World Federation established the Christian Medical Commission (CMC) in Geneva. “By 1910 there were 2100 hospitals and twice that many clinics operated by mission agencies of the Protestant Church alone.”^{ix} CMC was established to assist the WCC to determine the best use of these health facilities around the world. CMC was specifically charged with conducting research, including data collection and surveys to determine how best to meet the health needs of communities served by mission hospitals. Of course, this was done in the context of a general concern for the health and health care of people living in the poverty settings of developing countries. The first Director of CMC was James McGilvray, who had been active in many capacities, including the Tubingen Conferences, in examining the Church’s role in providing health care in newly emerging nations around the globe.

The offices of the very small staff in Geneva^x were very near WHO headquarters, and this facilitated dialogue between the two agencies. Both authors of this essay, Drs. Taylor and Bryant, were founding board members of CMC, and Dr. Bryant was the first Chair. While CMC sometimes engaged in purely ecclesiastical debates, such as whether the Bible deals with the issue of human rights, the primary focus was on providing health care to the largely poor populations of the world.

An issue the Commission faced head-on was the political movement of former colonies in Asia and Africa into independent states in their own right. Christian hospitals were part of the colonial legacy, and this aggravated not only political sensitivities but also the practice of leveraging medical care for proselytisation. As Dr. Taylor stated in 1969:⁷

During the early years of medical missionary work the dominant motivation was clearly evangelistic, but this is now the source of considerable criticism by governments in many developing countries. Their concern is that medical work, like other socially oriented mission activities, has often appeared to be a device for ‘proselytisation’. The modern justification, therefore, is to say that we engage in Christian medical work to show Christ’s love and because we are following Christ’s example. Such statements go back into early mission thinking, but they have taken on increasingly humanitarian overtones as a means for gaining secular respectability.^{xi}

Initially, WHO officials in Geneva were reluctant to deal with a church-affiliated organization. This reticence may have been grounded in the fact that the Roman Catholic Church had been heavy-handed in preventing WHO from actively promoting family planning activities in the 1960s.^{xii} At the insistence of some member-states, WHO was proscribed from including contraception in any of its health programs.^{xiii}

When the tuberculosis specialist and career WHO employee, Dr. Halfdan Mahler, became Director General in 1973, the dialogue between WHO and CMC stepped up. In one notable exchange, a CMC staff person, Nita Barrow, was asked to come to WHO to address

^{ix} McGilvray, 1965, p. 3.

^x Including Ms Connie Gates, then editor of *Contact*, now with Jamkhed International

^{xi} Taylor, p. 182.

^{xii} Litsios, see specifically footnote No. 45.

^{xiii} WHO Official Records. No. 42: “Fifth World Health Assembly, 1952”, pp. 241-242.

15 senior staff on primary health care. Nita's statement at the time was, "You know, I'm not sure this is a good thing to do. It reminds me of David and Goliath." To which Dr. Mahler replied, "You know, I'm a parson's son. I know what David did to Goliath!"

The relationship between CMC and WHO blossomed into a working group, with staff from both organizations as participants. CMC research came up with three prototype community programs that both illustrated and helped shape the evolving concepts of primary health care:

- *Central Java*: Dr. Gunawan Nugroho and his wife started a health program in 1963 in Indonesia. Because poverty limited patient access to the program's services, they created a "health fund" so everyone could receive treatment, as well as increase family income by expanded chicken and goat farming.
- *Jamkhed, India*: Another husband-and-wife team, Rajanikant and Mabelle Arole, developed a health program in the early 1970s based upon community decision-making. They established a viable and effective health care system that involved the community, was planned at the grass roots, used local resources to solve local health problems, and provided total health care not fragmented care.
- *Chimaltenango, Guatemala*: Dr. Carroll Behrhorst trained community health promoters and included such activities as literacy, family planning, and agricultural extension in his broad-based program.

III. Alma Ata

In 1978 a landmark conference on Primary Health Care was held in the city of Alma Ata,^{xiv} then the capital of the Central Asian Oblast of Kazakhstan within the Soviet Union. The impetus for this conference was the recognition that health care in the poorer nations of the world simply did not work very well. Up to that time, it was the largest gathering of health ministers ever assembled.

In addition to being Chair of the CMC, Jack Bryant was on the Executive Committee of WHO and Director of the Office of International Health for Health and Human Services of the US Government. Along with Dr. Julius Richmond, he represented the US at the Alma Ata conference, ensuring that these ideas received a full and robust hearing. Carl Taylor, as a consultant to the WHO, was appointed to the drafting committee that prepared the final report to the conference and incorporated both practical experience and conceptualization from CMC.⁶ The publication reflected the consensus of a wonderful international team. The committee carefully protected all drafting since this team effort was considered confidential. The result was widely distributed as the Declaration and Final Report.

In recognition of the need for better use of contemporary science in health services, the huge inequity in service availability, and the growing disparities in health status, particularly in poor nations around the globe, there emerged from this conference the iconic proclamation of universal health care:

Health for All by the year 2000.

^{xiv} "Alma Ata" was the Russification of the name of the Kazakh city of Almaty. Even though the city is now universally recognized as Almaty, the previous Russian term of Alma Ata is conventionally used in reference to this landmark international health conference.

While this meeting portrayed enormous consensus among the international health community on the need to focus on promoting better health throughout the world, not just to protect “developed” countries from communicable diseases emerging from economically challenged tropical nations, there were serious differences in perceptions about the lofty goals of the conference.

Health ministers from the West interpreted the goal as *health* for all. Those from developing nations interpreted the goal as health for *all*. This difference in emphasis led to an awareness of the special importance of equity in Primary Health Care (PHC). Coming out of the conference, the entire global health community, developed and developing, was energized to ramp up health care around the world. The tenets of serving the poor, service to the community as a whole, disease prevention, and the pivotal role of women in health, developed following Tubingen I and II and refined by CMC, were firmly built into the evolving framework of PHC.

IV. Post-Alma Ata

As soaring as the proclamation of *Health for All by the Year 2000* was, we soon discovered that principles without a system to make them operational lose their effectiveness, while a system not founded on generally agreed principles can be without significant effect.

The principles established at Alma Ata legitimized the community-based primary health care format, which included:

- prevention as well as curative clinical care;
- service at the closest point of contact (in the community, not in a distant hospital);
- service by the lowest level provider, appropriate to the task;
- a tiered system of health care, starting with the family and community at the household level, through the community-based clinic and on to primary, secondary and tertiary referral facilities;
- equity in service provision, with special emphasis on women.

Of all of these, we are convinced of the primacy of community empowerment. Along the way there were setbacks. One of the “models” of PHC used in the run up to Alma Ata was the “barefoot doctors” of China. This very large and very poor country had instituted an equitable PHC system within the confines of their available funding and health personnel; a cadre of sub-physician health staff (Barefoot Doctors) that provided PHC in the towns and villages, particularly of western China. But as the country progressed in its economic development and modernization, the political leadership looked to western countries, such as the US, with its high-tech hospital-based system. They abruptly dismantled care provided by the “barefoot doctors,” the largest and arguably one of the most equitable and effective community-based PHC systems in the world at the time.

In the years following Alma Ata, real-world challenges making these principles a reality have continued to emerge. We found that programs around the world need to address:

- firm, long-term political support in both developed and developing countries;
- a simultaneous commitment to social equity and health systems development;
- manpower imbalances in both numbers and skill training;

- emergence of non-communicable diseases;^{xv}
- the triad of poverty, population growth and environmental degradation;
- money (the recession of the early 1980s was particularly disruptive to moving forward on Health for All in the developing world).

As progress was made across a broad spectrum of primarily underdeveloped countries, some realities emerged. These included the need to:

- strengthen district health systems
- conduct surveillance for equity
- apply new technologies to support Primary Health Care
- recognize the social determinants of health
- understand that health is an integrative process
- meld health into other aspects of development

People of good will can disagree – and did. As the health needs of developing countries met the reality of inadequate resources to provide health for all, an important dichotomy arose. Many health ministers and program administrators wanted to pursue balanced, carefully allocated, comprehensive primary health care – so-called horizontal programs. Others held out for targeting selective – vertical – programs that focused on achievable program goals. Donors, who had decided that an achievable victory was worth the investment, as well as being politically useful in obtaining additional funds and political credit, often influenced decisions to implement vertical programs.^{xvi 7} For example, a worldwide initiative was launched to eradicate smallpox from the face of the earth, and this remarkable goal was achieved in the early 1970s. During the same period, similar efforts to eradicate malaria were not successful; and today we still have a long way to go in eradicating this vector-borne disease, due to insecticide and drug resistance that emerged after these programs were initially launched.

In affected communities perceptions were often at odds with central and global planners. This dichotomy between international donors and recipient communities continues to the present day. In many countries local communities resist participating in “immunization days” conducted by WHO because they perceive their health needs much more broadly than a handful of vaccine-preventable diseases. The US government is at the moment renowned for aggressively attacking HIV/AIDS in sub-Saharan Africa, making wide use of faith-based organizations. But a few of these religious programs insist on abstinence-only interventions, even denying condoms to discordant couples; and many resent this avowed “Christian” approach to vertical health care.

In spite of many inconsistencies, we can state that a genuine success story is the increasing integration of health into broad economic and development programs at the national and international level. Most major donors, including the multilateral and bilateral agencies, support – and fund – this integrated approach to development. These broad gauged policies, in turn, put into force the principles of Community-Based Primary Health Care (CBPHC) initiated by CMC and WHO dating back to the run-up to Alma Ata and growing out of the original pilot field programs such as Java, Jamkhed and Chimaltenango.

^{xv} As they progressed through the epidemiological transition many developing countries suffered from the double-whammy of “old world” diseases: infant diarrhea, vaccine-preventable diseases, and pneumonia; and “mature country” health problems: diabetes, cardio-vascular diseases, and cancer.

^{xvi} Smith, p. 911.

V. Into the 21st Century

The pursuit of health for all is something that is now generally accepted as an appropriate, if idealistic, goal among health professionals throughout the world. International development organizations, institutions and relevant actors are now looking in a fresh way at what are the desirable characteristics of health and social development. The fact that these characteristics include cost-effectiveness, community participation, intersectoral action, and the whole issue of sustainability, and are recognized as an appropriate and legitimate way to proceed, is a validation of the CBPHC concept launched by CMC and WHO 40 years ago.

A. Millennium Development Goals

The Millennium Development Goals (MDGs) were the product, in the year 2000, of 189 countries signing the UN Millennium Declaration. This historic call to action – at the dawn of the new century – set forth an ambitious agenda for improving the lives of the world’s poorest citizens by 2015, through a joint effort of both developed and developing countries. In 2005 the 60th annual meeting of the UN General Assembly in New York focused on improving the status of health and well-being, particularly among the poorer nations of the world. A product of this meeting was the codification of eight MDGs, ^{xvii} targeted for implementation by 2015. Three of these are directly related to health, and others, such as empowerment of women, directly impact the status of health, particularly among the disenfranchised of the world.

B. Current Status of CBPHC

The quest to make Community-Based Primary Health Care relevant in today’s world continues. Under the auspices of the American Public Health Association’s International Health Section, a task force has been formed to study the effectiveness of CBPHC. The task force has reviewed a number of programs and feels confident in concluding that the major precepts of PHC have been verified, that particularly the lives of children and mothers are preserved through the community approach to primarily prevention programs, backed by higher order health facilities. The group has also identified areas that need further investigation, such as urban slums. But they believe that the biggest challenge is applying the lessons of small, pilot programs to broad populations and health systems.

Just as scaling up vertical interventions was the overarching priority in the 1980s and 1990s, the challenge for the next two decades is going to be scaling up packages of integrated interventions (with a strong component of CBPHC) which can be effective in lowering mortality AND which can serve as the building blocks of a system of primary health care. Having sufficient planning, financial, professional, and technical support will be critical in order for this effort not to fail in the same way that the primary health

^{xvii} The eight Millennium Development Goals include:

- No. 1: End hunger and extreme poverty.
- No. 2: Achieve universal primary education.
- No. 3: Promote gender equity.
- No. 4: Reduce child mortality.
- No. 5: Improve maternal health.
- No. 6: Combat HIV/AIDS, malaria, and other diseases.
- No. 7: Ensure environmental sustainability.
- No. 8: Develop a global partnership for development.

care efforts of the early 1980s failed. But even more importantly, ongoing strong and rigorous evaluations of integrated packages of interventions at scale under varying conditions will make it possible to learn as we go along and thereby ensure success toward the goal that all agree is a global priority – Health for All as defined by the International Conference on Primary Health Care in 1978.⁸

C. Quo Vadis?

Where should the Christian community be going as we move forward in the 21st Century?

One suggestion has been a second Child Survival revolution. This sparked a Child Survival series in the *Lancet* that recently called for a renewed focus on health system strengthening, nutrition and “continuous monitoring and tracking of health programmes.”¹¹ There is no question that the initial thrust of Child Survival: EPI, ORT, and ARI,^{xviii} and later, micro-nutrients, including vitamin A, and overall improvement in nutrition, have had a dramatic impact on lowering infant and child mortality in developing countries around the world. But as we perceive the proposed second revolution, we believe it subscribes to the same top-down donor-driven approach of previous health development programs. It is not sufficient for program monitoring to simply be “country-led;” rather, the future suggests optimal accountability and quality improvement when the community drives the evaluation.²

As members of the faith community, which by definition is community based, we argue that the Christian community should help resist repeating the mistakes of the past and insist upon community involvement and empowerment in future initiatives. People should be proactively and intimately involved in protecting and maintaining their own health. We see this as the only way to ensure sustainability, cultural relevancy and true democratization of the process. Health, we believe, is something that should be done *by* people, not just *for* people; and an important component of this is the social environment in which people live.

As national and personal incomes, however inconsistently, continue to rise, we also believe that greater emphasis should be given to the social determinants of health. Recent research indicates that the higher the differential in *relative* household income, the greater disparity in health between the highest and lowest income cohorts.¹³ A recent example is data from southwestern Virginia where the lowest income residents have a declining life expectancy due to smoking, obesity and lifestyle changes.¹⁴ This is in a community where even the poorest residents have an income that is several multiples higher than a Punjab villager, but nonetheless is well below the poverty line for the US.

In response to the growing evidence that a community’s health is highly correlated with social circumstances – the ‘causes of causes’ – the World Health Organization in 2005 created the Commission on Social Determinants of Health. This expert panel made a series of recom-

^{xviii} EPI: Expanded program in immunization, attacking vaccine-preventable diseases, particularly among children under 5.

ORT: Oral rehydration therapy composed of simple replacement fluids and nutrients, which has saved thousands of lives, particularly in children under 5.

ARI: Acute respiratory infection, treated with antibiotics has also significantly reduced infant and child mortality.

mendations on health equity and social justice.^{xix} This underlines the imperative that as faith-based practitioners, we must exert renewed vigilance toward equity in health, income and social participation across economic, ethnic, gender and regional boundaries. And this is true in both developing and developed countries.

Finally, the faith-based community goes well beyond members of the Christian communion. If we truly believe in the spiritual health of our fellow man, then we must also seek out ways to interact with, motivate and capture the faith, the commitment and the resources of other faith-based communities -- Muslims, Jews, Buddhists, Taoists, etc. If we are truly all God's children, then we must identify our similarities and coalesce our vision and faith to improve the health and well being, physical and spiritual, for all humanity.

References

1. Bryant JH. Health & the Developing World. Ithaca [N.Y.]: Cornell University Press; 1969.
2. Bryant JH and Richmond J: "Alma-Ata and Primary Health Care: An Evolving Story," in Quah S and Heggenhougen K eds: International Encyclopedia of Public Health. Philadelphia, Elsevier, 2008; pp. 152-174.
3. McGilvray JC. Quest for Health and Wholeness. German Institute for Medical Missions, Tubingen: 1965.
4. McGilvray, JC. The Quest for Health and Wholeness. German Institute for Medical Missions, Tubingen: 1981 (Revised and updated).
5. Goodman NM. International Health Organizations and Their Work. 2nd ed. Baltimore: Williams & Wilkins; 1971.
6. Litsios S. "The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach." Am J Public Health 2004;94(11):1884-93.
7. Taylor CE. "A Christian Medical Commission's Role in Health Planning." International Review of Mission, 1969, LVIII (58) (230):10.
8. Taylor-Ide DC, Taylor CE. Just and Lasting Change: When Communities Own Their Futures. Baltimore: Johns Hopkins University Press, in association with Future Generations; 2002.
9. Smith DL, Bryant JH. "Building the Infrastructure for Primary Health Care: An Overview of Vertical and Integrated Approaches." Soc Sci Med 1988;26(9):909-17.
10. Task Force on the Effectiveness of Community-Based Primary Health Care of the International Health Section of the American Public Health Association. How Effective is Community-Based Primary Health Care in Improving the Health of Children? A Review of the Evidence; March 19, 2008.
11. "The Second Child Survival Revolution." Lancet 2005;365(9478):2152.
12. Savage F, Renfrew MJ, Bland RM. "Countdown to 2015 for Maternal, Newborn, and Child Survival." Lancet 2008;372(9636):369.
13. Berkman LF, Kawachi Io. Social Epidemiology. New York: Oxford University Press; 2000.
14. Ezzati M, Friedman AB, Kulkarni SC, Murray CJL. "The Reversal of Fortunes: Trends in County Mortality and Cross-County Mortality Disparities in the United States." PLoS Medicine 2008; 5(4):e66.
15. World Health Organization. Closing the Gap in a Generation: Health Equity through Action on Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva, WHO, 2008.
16. World Health Organization. WHO Official Records, No. 42: "Fifth World Health Assembly, 1952." Geneva, WHO, 1952.

^{xix} World Health Organization. Closing the Gap in a Generation: Health Equity through Action on Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva, WHO, 2008.