

CHE overview

community health evangelism

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DEVELOPMENT PROVERB

Go in search of your people.

Love them.

Learn from them.

Plan with them.

Serve them.

Begin with what they have;

Build on what they know.

But with the best of leaders,

When the task is accomplished,

The people all remark

“We have done it Ourselves!”

Source unknown

COMMUNITY HEALTH EVANGELISM OVERVIEW

GOAL

The goal of Community Health Evangelism (CHE) is to establish a development ministry whose purpose is to bring together Jesus' Great Commission (Matthew 28:19-20) and the Great Commandment (Matthew 25:37-40). This is accomplished by training community members as Community Health Evangelists (CHEs) who regularly visit 5 – 10 neighboring households, sharing the gospel and promoting principles of disease prevention and healthy living. The program is designed to be transferable, multipliable, and ongoing after the training team leaves the area.

BIBLICAL BASIS

In addition to the Great Commission and the Great Commandment, Jesus made a startling statement in Matthew 25:34-40. He asserted that as we give food and drink to those in need, take in strangers, clothe the naked, look after the sick, and visit those in prisons, we are doing these things to Him. Jesus calls us to be His disciples, sharing the gospel and serving others in love, meeting them at the point of their need.

Jesus not only calls us to *be* disciples, but also to *make* disciples. He wants our ministries to multiply and His love and truth to reach the ends of the earth, touching individuals, households, and communities, now and eternally. Christian community development is rooted in obedience to the commands of Christ. It is driven by a desire to see individuals come to faith in Christ and to see lives, households, and communities transformed by obedience to the principles of God's Word.

We are told in II Timothy 2:2 to train faithful men to teach others who, in turn, will teach others. Here is multiplication as each one teaches those who will go on to teach others both spiritually and physically.

When Jesus walked this earth, He ministered to the whole person. As Christians, we too are responsible to meet both physical and spiritual needs and to train others to do so also.

When Jesus sent out His twelve disciples to minister to others, He commanded them to heal the sick, being concerned for the physical needs of others, as they preached the Good News of Jesus Christ. Today, if we are to follow Christ's example, we too must be concerned for physical and spiritual healing as were the disciples.

Traditionally, a number of missions have been committed to caring for people's physical and spiritual needs, but they use different people to present the evangelistic message from those who care for physical needs. Often in day-to-day practice, however, a missionary is faced with incredible physical needs. For many missionaries this leads to conflict of interest between urgent physical concerns and the spiritual needs of the people. Accordingly, we believe the basis for all health care should be a blend of curative and preventive care, balanced with Biblical instruction.

COMMUNITY HEALTH EVANGELISM (CHE) MEETING NEEDS

THE NEED

There are immense needs in the two-thirds world. 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 abound, due to contaminated water and food, improper waste disposal, and poor hygiene, sanitation, and nutrition. UNICEF reports 40,000 children die each day of diseases that are preventable.

Serious respiratory diseases occur frequently because of overcrowded living situations, low resistance due to poor nutrition, and lack of knowledge of how to prevent transmission to other family members. Typhoid, diphtheria, tetanus, and whooping cough are common diseases that can be prevented through the use of inoculations (vaccinations). Environmental health diseases transmitted by snails, insects, and other animals can be prevented by the use of other modern medicines.

Good health is more than just medical elements. For a person to be truly healthy many elements are involved. To this end CHE attempts to deal with the elements presented below:



In over 40 countries Medical Ambassadors International (MAI) uses the Community Health Evangelism (CHE) strategy to train, visit, consult with, and hold accountable, national Christian training teams to address the above issues. In addition, we have trained over 400 Christian organizations to use CHE. MAI is a member of the Global CHE Network.

CHE is a multifaceted, community-based, development strategy that deals with the whole man – physically, spiritually, emotionally, and socially. Our training teams equip local villagers as CHEs in the needed physical, social or emotional topics, and spiritual area. The CHEs then put into practice what they have learned in their own lives and share this with 5 - 10 neighboring families on a regular basis.

Historically, most of the available medical personnel and funds in the developing world have been committed to hospitals, which provide curative care for only five to ten percent of the population. In most of the two-thirds world countries, 80 percent of the health professionals are found in cities, while 80 percent of the people live in rural areas. The majority of the clinics and hospitals are also in the cities.

The best medical care is to prevent the disease before it occurs. Curative medicine seeks recovery from existing diseases rather than preventing diseases. It is expensive and not available to the majority of the people, especially those in rural areas and villages. Therefore, CHE places its greatest emphasis on prevention, which involves community development. However, there is still a need for resources of curative care, such as clinics and local hospitals for dealing with the more serious illnesses.

Although most diseases are preventable through health education and immunizations, we also train CHEs to recognize basic diseases and treat them in the home. As an example, in Africa worms can be treated with papaya milk. In addition, CHEs are taught how to recognize the signs and conditions severe enough to need treatment at the hospital.

CHEs also meet needs in another critical area – malnutrition. CHEs teach how to grow and properly prepare vegetables and other foods. The “Food 3x3” lesson plan is an easy way to remember what foods to eat at every meal: (1) an energy food – potatoes or bread; (2) a body-building food – beef or fish; and (3) a protective food – oranges or pineapples.

Sanitation can be a problem in houses made of mud and when access to water is limited. A crucial factor for health is to train people to build pit latrines and keep clean homes. Many villages have no running water, so people walk three to four kilometers to draw water from a dirty river. CHEs teach villagers how to find a clean source of water and how to protect it to keep it clean. They also teach ways to purify water. In addition to teaching the villagers about sanitation, the CHEs tell them how Jesus Christ can cleanse their lives of sin permanently.

THE COMMUNITY HEALTH EVANGELISM (CHE) APPROACH

Medical Ambassador’s CHE strategy is broadly aimed toward the whole community. This is done by training local villagers to share spiritual, physical, emotional, and social truths with their fellow villagers.

The CHE strategy includes the following primary characteristics:

1. Concentration on meeting priority needs keenly felt by the village through simple community projects. These projects are designed to empower the villagers to do as much as possible on their own. We attempt to begin at the ability level of the people in relation to their leadership, initiative, and self-reliance.
2. An integration of preventive medicine, health education, and sometimes curative care, into a total program. The emphasis is on prevention and education with expected results in changed lifestyles and conditions.
3. A vision and goal to reach the most people as possible.
4. A program of instruction that shows the people how they can participate in their own development. Lessons are developed that are aimed at simple health education, identification of major diseases, recognition of the need for medical care, and care of the sick (especially children).
5. Community self-help and community leadership emanating from the peoples’ commitment to the program.

6. A commitment to delegate most of the tasks to local church leaders, community leaders, and the CHEs, who can best generate local support and commitment for the program.
7. An understanding that the content of the training must be transferable and multipliable.
8. A commitment to use readily available local resources as much as possible.
9. Provision for good working relationships with the nearest available hospital for necessary obstetrical, surgical, and medical care of severely ill patients.
10. Mass inoculation programs for childhood diseases and polio. Such programs should be community sponsored.
11. Provision for sanitation training with an emphasis on cleanliness, safe water, and proper use of pit latrines.
12. Provision for easily accessible family planning instruction materials.

An underlying foundation for a CHE Program is that the community chooses the project and sees it as its own. Too many times outside organizations do something for the people then leave, and what had been accomplished disintegrates. The emphasis from the beginning must be on the community taking ownership.

CORE ELEMENTS OF CHE

Community Health Evangelism is made up of three essential groups:

THE TRAINING TEAM

The training team initiates the program and usually comes from outside the area. Each training team consists of two to four people with a combination of vocational skills (medical, agricultural, pastoral, social work, etc.).

THE COMMITTEE

A successful Community Health Evangelism Program that will be multipliable, transferable, and ongoing must be community-based rather than outside agency-based. The program must be integrated around community committees, which are chosen from community members. The committee carries out this goal.

The committee should be community-based. The members should be mature, well-respected individuals who represent different segments of the community (educational, governmental, business, agricultural, medical, etc.).

THE COMMUNITY HEALTH EVANGELISTS (CHEs)

The Community Health Evangelism volunteer, or home visitor, is the major worker in the program and is chosen by the committee. Adequate attention to their ministry will require about six to eight hours of training per week.

As the CHE volunteers are being trained they will:

1. Put into practice what they have learned around their home and with their family; modeling what they have learned.
2. Promote good health, prevent disease, and model abundant Christian life with their neighbors.
3. Practice evangelism and discipleship with individuals and groups.
4. Do home-visiting on a regular basis, sharing the spiritual and physical truths they have learned with assigned neighbors.
5. Teach in a way that will help others to become teachers.

PROGRAM DESCRIPTION

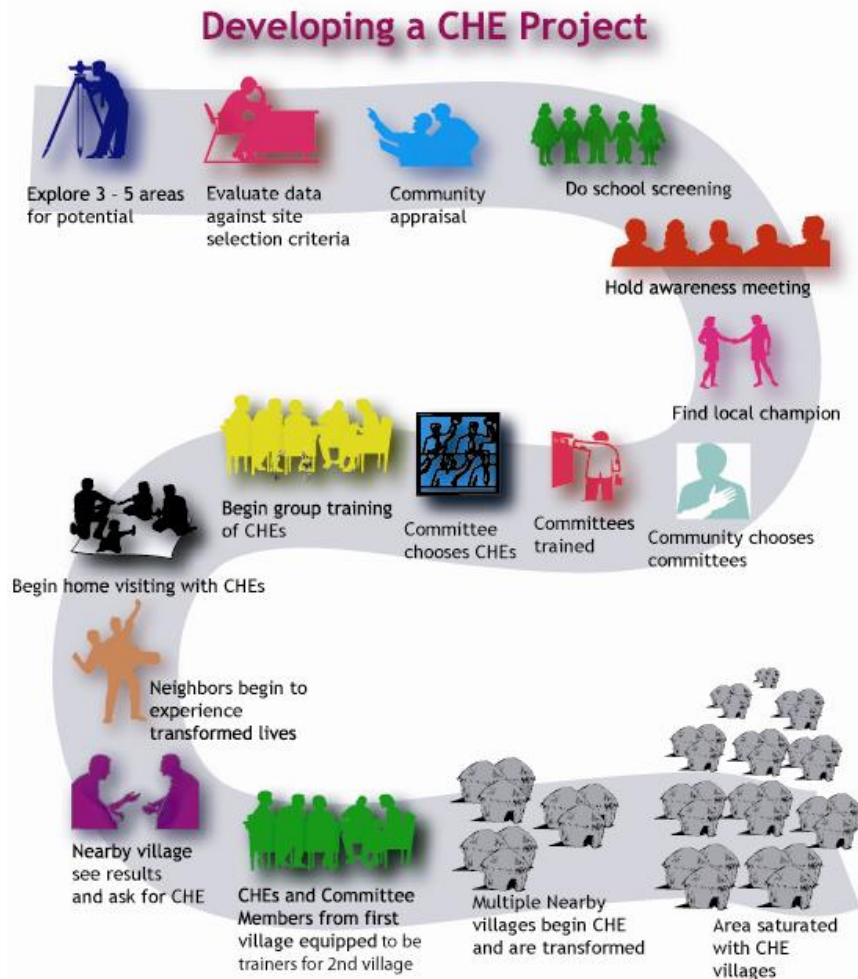
STEPS IN A COMMUNITY HEALTH EVANGELISM PROGRAM

The process and training courses below are designed by Medical Ambassadors to teach individuals and organizations how to put into action their own integrated ministry of Community Health Evangelism (CHE). Once the participants are trained, they are able to set up a CHE program and teach volunteers how to implement the work in their own village. All teaching is done in a participatory style; the learner is the center of attention, not the teacher.

1. **First Step:** A desire to make a lasting difference in the lives of people in developing countries is a prerequisite.
2. **Vision Seminar:** A 14-hour, two-day seminar is used to introduce the CHE concept in a new country or area. Organizations or key village leaders who are interested in an integrated approach to wholistic community-based development are the ones who should attend this seminar. The next step is to participate in a Training of Trainers I (TOT I).
3. **Teaching National; to be Trainers:** Training of Trainers (TOT) enables people to teach the workers in the field how to put CHE into practice. TOT I focuses on the philosophy of CHE, how to choose a location, and how to start a CHE program. Spiritually, it emphasizes evangelism. The training normally takes 4-½ days covering 32 hours of classes.
4. **After TOT I:** The newly qualified trainers are to return to their areas and form a three or four person training team.
5. **Selection of a Village:** A training team takes great care to select the most receptive village. Discovering the methods of how to select a village takes place through an evaluation process taught during TOT I.

6. **Entering a Village:** There are a variety of ways to introduce a CHE team to a village and these methods also are taught during TOT I. There is an entire series of activities available during this phase.

7. **Awareness Meetings:** These meetings create an understanding of the community assets and needs, revealing which ones are of greatest importance. It is important to provide a structured time where people have opportunities to express and explore what they know about their community. Also, the community begins to learn about CHE.



8. **Community and Worker Selection:** Once the villagers express interest in adopting the CHE strategy, the villagers then elect their own committee which will oversee the program development. The villagers also choose their own Community Health Evangelists (CHEs) who will teach the principles to their neighbors, possibly through picture booklets. Both the Committee and the CHEs are

trained over the next six months by the training team. During this time many who are not believers in Christ come to a saving knowledge of him, and those who do not know Christ often lose their motivation and quit the program. Thus, the program is both community-owned and spiritually strong.

9. **Committee Training:** A six-day, 18-hour training curriculum teaches the village committee their responsibilities. By teaching the Committee first, the individuals begin to take responsibility in their leadership roles in their village.
10. **CHE Training:** The prime training targets are the CHEs, the home visitors. CHE lessons are taught by the training team. There are over 1,000 lesson plans from which the community can choose what they want to learn. This training team normally trains 15 – 25 CHEs in one geographical area, typically two days per week, until 40 – 50 sessions have been completed. Each session includes a spiritual/moral value lesson and a physical or health lesson.
11. **Problem-Solving:** Once trained, the villagers go to work to solve what *they* consider their most pressing community need. This need is voted by all committee members.

12. **One-on-One:** CHE home visitors put into practice in their own homes what they have learned. They then visit their neighbors and teach them what they have learned. A part-time CHE home visitor can work with 5 to 10 households.
13. **Multiplication to Nearby Villages:** These changed communities become models and individuals from these communities multiply their efforts to nearby towns and villages. Three to six local CHEs will be chosen from those trained by the initial outside training team to become trainers themselves. These local training teams will expand the program into adjacent communities within their area.
14. **Funding:** As much as possible, funding for the individual program needs to come from the local communities. Where local resources are insufficient, funds may be solicited from in-country agencies that are interested or working in community health, agriculture, etc.

WORKING IN CREATIVE ACCESS COUNTRIES

CHE is adaptable to meet needs of differing religious, cultural, governmental structures, and geopolitical situations. We are now working in creative access nations, known as the 10/40 Window. This area stretches from 10 to 40 degrees North latitude. It reaches from Japan on the east through North Africa and Southern Spain on the west. Europe and northern Russia are not in this window, but Russian's old Muslim republics are included. It is in the 10/40 Window that 60 percent of the world's population lives, with 82 percent of the poorest of the poor living there.

Changes have been made to CHE so it will be better accepted by the medical professionals and religious forces in these closed countries. In these countries this strategy is known by other names.

SPIRITUAL MINISTRY THROUGH MORAL VALUE TOPICS

God's Word is introduced through storytelling and role plays. Moral value teaching is related to physical health as much as possible. If possible, the training team should be mature believers who will pray for the community they are working in and follow-up those who are seeking a relationship with God. Relationship development with religious leaders and health professional is key to successful introduction and sustainability of a program.

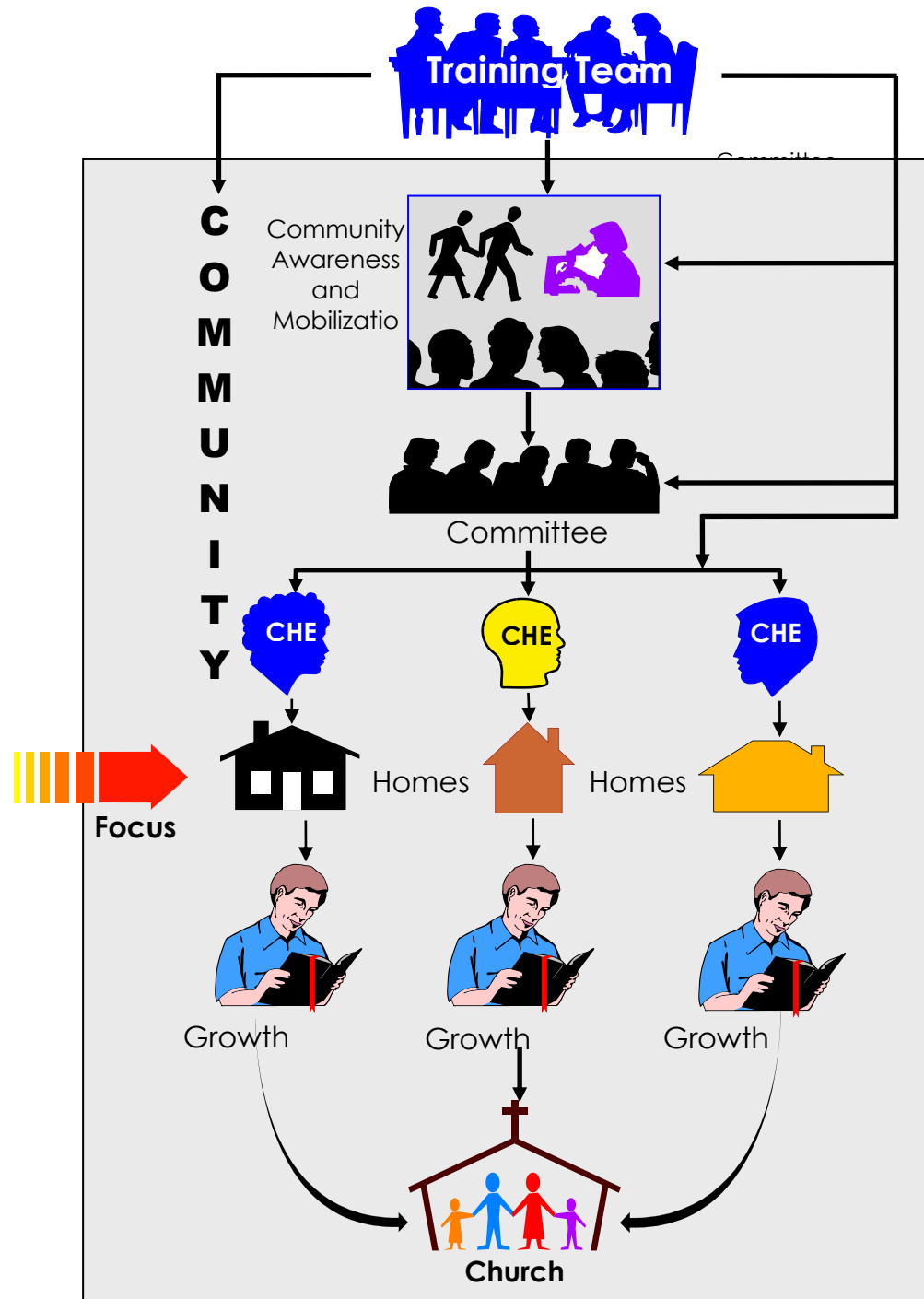
DIFFERENT APPROACHES TO CHE

Different approaches for starting a CHE Program are available for different situations. The community-based CHE program, which is described below, is the most commonly used.

The **most desirable model** is a community-based model, which enhances the probability of success. There are also family-based, church-based/initiated, and government-initiated approaches to CHE, which are used based on the nature of the target area.

COMMUNITY-BASED CHE MODEL

The community-based model is the most desirable model because of the probability of success. Once a project is truly owned by the community, the villagers take responsibility for their own lives and those of their neighbors. Mortality rates and sicknesses decrease, children are no longer malnourished, neighbors live in harmony with one another, family and spouse relationships are strengthened, the gospel is shared, churches grow, and communities become wholistically healthy. Community-based models are used in many of our open access countries.



FAMILY-BASED CHE APPROACH

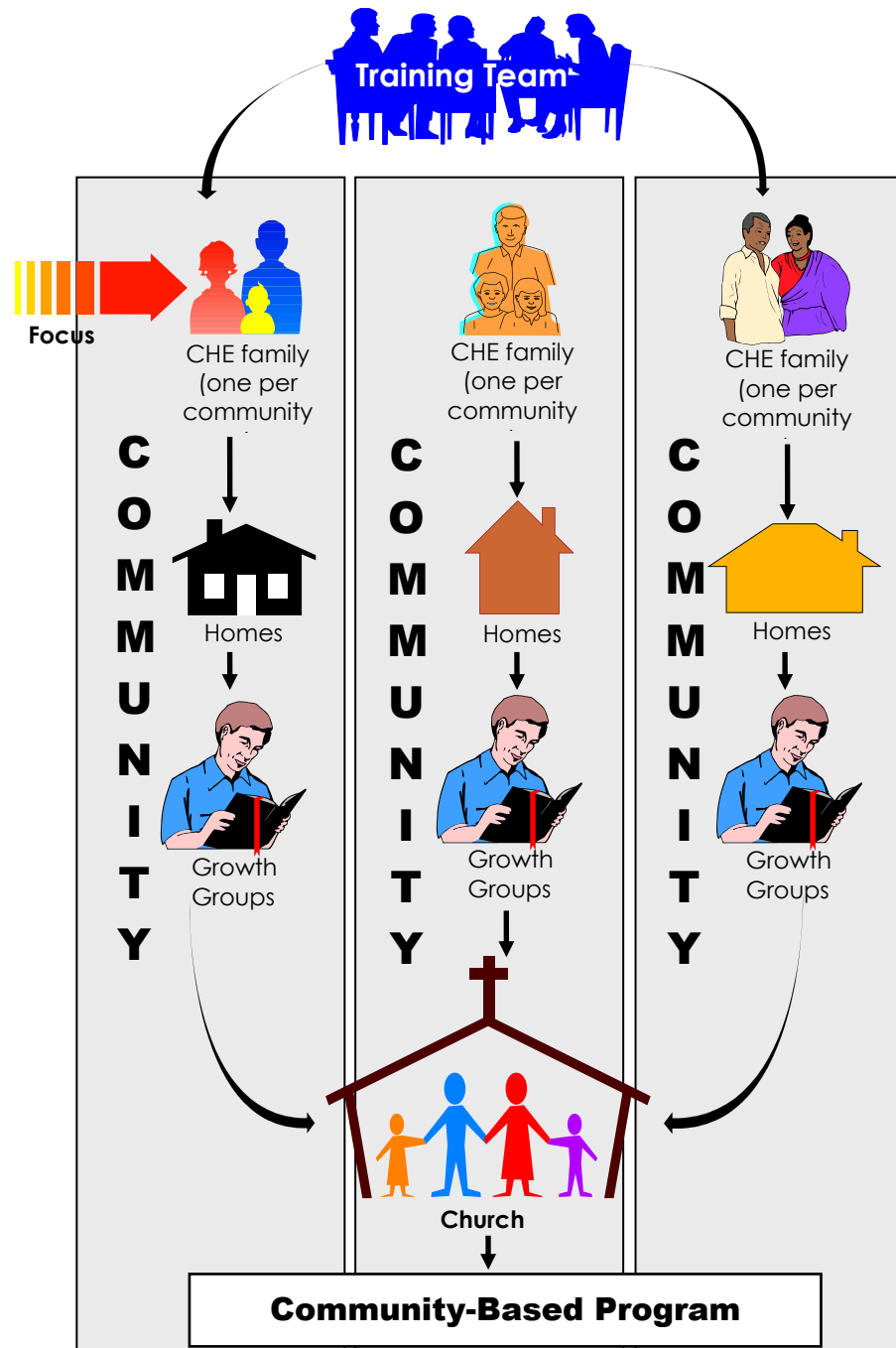
In an antagonistic, non-Christian area devoid of any Christian churches, CHE may be initiated by finding or planting a Christian family who are willing to be salt and light in a non-Christian community. The family members are trained as CHEs, and when a neighbor has a problem, they take the initiative to help them. In addition to being a good model, they are encouraged to share what they are learning with their neighbors. As people come to Christ, experience God's love, and see the benefits of an integrated ministry, a normal Community-Based CHE Program is begun.

The family's training is a combination of training designed for a CHE and a trainer, but their main role is as a CHE. This Christian family becomes a nucleus for the future development of a community-based CHE program. They function under area leadership without a local committee directing them. Once their work bears fruit and they make disciples, the couple may take on the role of trainers and begin a church-based CHE program whose nucleus is people who have come to Christ.

The Christians may invite their neighbors in for a weekly class on health and spiritual topics on moral values. Those who are spiritually open are invited to a chronological Bible storying approach to Bible study. They begin with commonly held concepts as a bridge to Christianity.

We are using this model in over 120 villages in eastern Nepal and northern India, with all Buddhists and Hindu communities in the foothills of the Himalayan Mountains, where over 105 fellowships/churches have been started.

The Family-Based CHE Approach is usually a precursor to a Church-Based CHE Approach which should lead to a Community-Based CHE Approach.

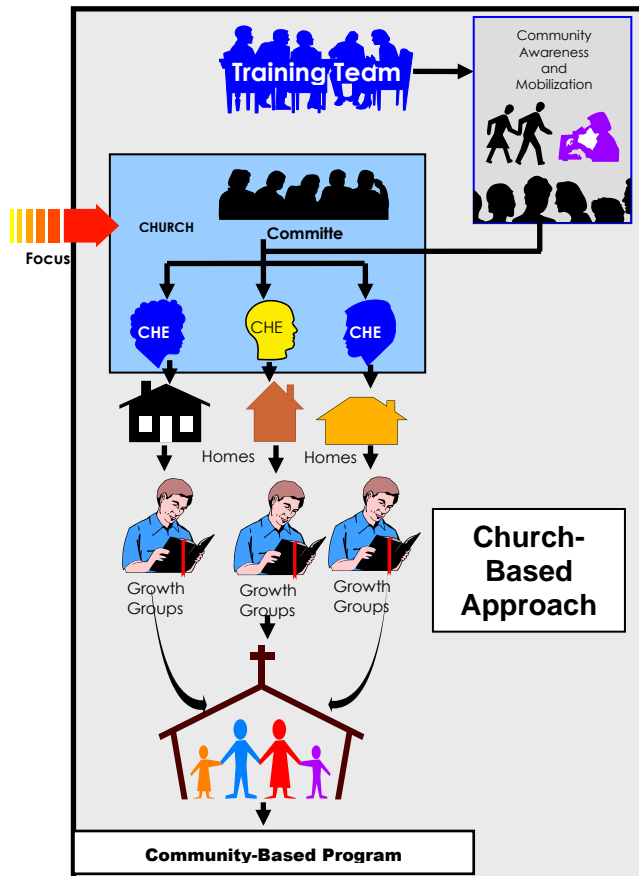
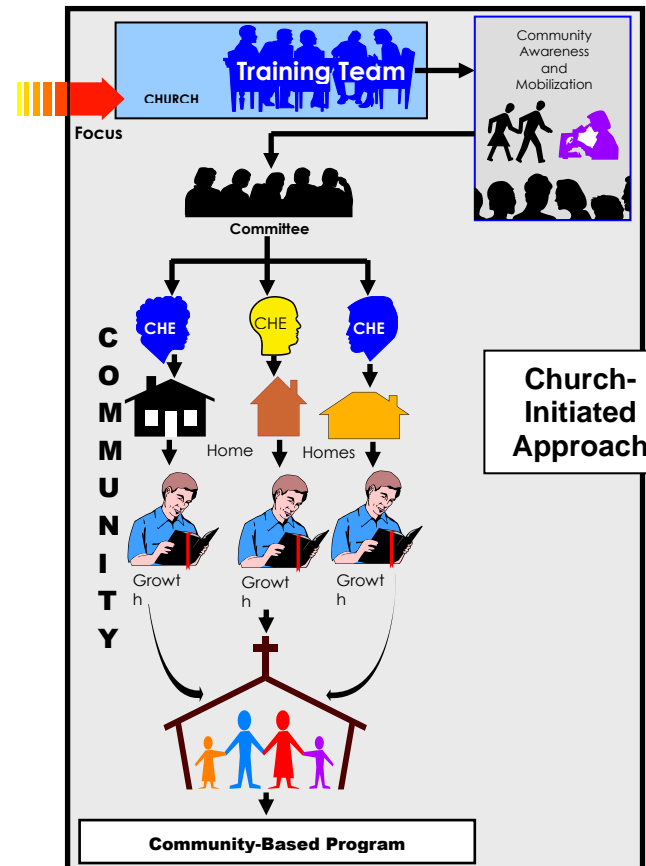


CHURCH-INITIATED AND CHURCH-BASED CHE APPROACHES

The CHE strategy may begin through the church when the target area is too large or there is little unity among the community (i.e. urban settings). If there is only one church in the community that is open to CHE, then the committee members and the CHEs will probably be made up of only church members. If this is so, the church will probably be seen as the initiator and doing something for the community. Therefore, there may be little or no community ownership. This is a church-based approach. But if the church is open, it is best to have non-church members on the committee and as CHEs which will build community ownership. This is called a church-initiated, community-based approach.

One major difference in a church approach is that there is the opportunity for the trainers to be volunteers if they are from the church and they see their service as a ministry of the church. If that is the case, then there needs to be more (8 – 12) trainers equipped since they will not have the time to work as does a full-time trainer.

If there is more than one evangelical church in the community, equal representation from all of these churches



should be on the committee and chosen as CHEs. One small (50 member) evangelical church may not have the resources to establish and maintain a CHE program unless this is their main outreach into the community.

The churches must view this strategy as a means to reach out to their non-Christian neighbors in a wholistic way rather than exclusively using it for their own church members. The more churches involved the better, since an individual church may not have enough members or resources to enable the development of a broad-based community program.

GOVERNMENT-INITIATED CHE APPROACH

Some centralized health care systems necessitate that we attempt to work through the existing health care structure due to the pervasive authoritarian mindset. To try to work directly with the communities themselves as in a community-based CHE program will usually prove unrealistic.

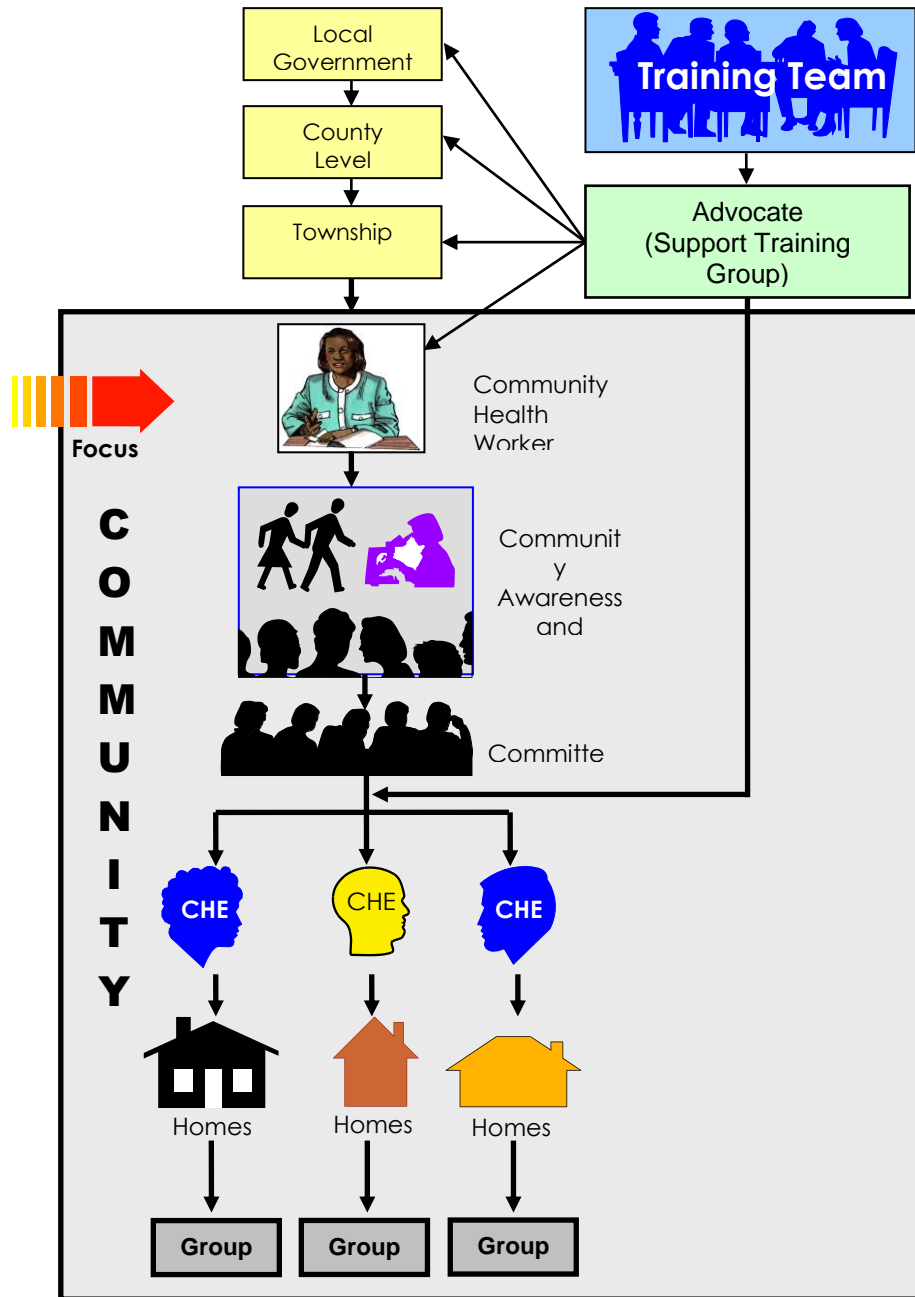
This means that we establish a contract with the Ministry of Health of that country at the district level to help them improve the health care at the Medical Aid Post. The Medical Aid Post is the lowest level medical care facility, generally with one Medical Aid Post serving two to four communities. We attempt to impact health care in multiple communities in one chosen district.

There may be 30 – 40 Medical Aid Posts in a district. The key person at this level is the government Community Health Worker who provides curative, antenatal, and well-baby care.

These workers feel they have a very good prevention system because they have had very high vaccination rates, women delivering babies at the hospital, and health teachings done by the Community Health Workers. In

reality, the people are totally dependent on the medical professional to provide health care and take NO responsibility for their own health. Medical Ambassadors' approach is to show them that the people need to take more responsibility. A CHE program is the way to do this.

Our primary thrust is to introduce the Community Health Worker from each Medical Aid Post to CHE. We do this by bringing the Community Health Workers together for a one-week training which introduces CHE concepts and how the CHE program works. Included in the training are updated key health topics along with an introduction to Moral Value teachings which is needed if there is to be lasting change.



These Community Health Workers then return to their areas to try to mobilize their community to get involved in CHE through personal explanation and a ten-session Awareness Meeting. The idea is to use a local committee to oversee volunteer home visitors.

The Community Health Workers who are successful receive assistance in training the committee members and people chosen by the committee as CHEs. (Those CHEs open to spiritual things are brought into a Bible study.) These volunteer CHEs assist the Community Health Worker in bringing good health to their community.

TRAINING PROGRAMS

Training is critical for the success of any CHE Program. All of our training is highly participatory, no matter which group is undergoing training. There is a considerable use of problem-posing situations through role plays or pictures to start the discussion. Small group discussion is widely used as well as songs, stories, and demonstrations.

THREE PHASE TRAINING OF TRAINERS (TOT)

The training process is broken into three, one-week phases with several months between each phase to allow trainees to practice what they have learned.

Phase I Focuses on development philosophy and how to start a CHE Program. Spiritually, the emphasis is on evangelism.

Phase II Focuses on developing teaching materials, methods, and curriculum. Spiritually, the emphasis is on follow-up of new believers.

Phase III Focuses on evaluation, project expansion, multiplication, and management. Spiritually, the emphasis is on discipleship.

COMMITTEE TRAINING

The committee is trained in six sessions of three hours each. They learn to take responsibility for what happens in their program. The training gives the committee members a clear understanding of how to establish a personal relationship with Christ. By training the committee first, the members begin to take more responsibility and leadership, and chose better people to be trained as CHEs.

TRAINING OF CHE HOME VISITORS

Group involvement is a key factor. The methods used are highly participatory. Volunteer home visitors go through 40-50 sessions, each including a physical/health and spiritual/moral value lesson. The training is spread over three to six months. Each day they receive one physical and one spiritual subject. They then put into practice what they have learned as they visit in neighbors' homes. After the initial training is completed, they receive two to three days each month of additional training for the next twelve months.

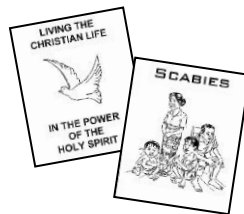
TRAINING MATERIALS

LESSON PLANS

Over 6,000 lesson plans are available. Each lesson plan has been designed to present the physical and spiritual truths using a high degree of learner participation. Each lesson begins with a problem-posing role play or picture, which helps the learner to discover the problem and its importance. The participants are involved in discovering the causes and solutions to the identified problem. Everything they learn, they then put into action by sharing it with their neighbors. All teaching must be under the guidance of the Holy Spirit.

PICTURE BOOKLETS

One major job of the CHE home visitors is to be a model of good Christian health practices in their homes. They are also to visit their neighbors, sharing what they have learned. They can use physical and spiritual picture booklets on various topics when they share with their neighbors.



The booklets are used as a review of the teaching on a given topic. The CHE home visitors practice using the booklet with each other and are observed by the Training Team in a simulated exercise. They are then given an assignment to share the booklet with at least three of their neighbors.

BIBLE STUDY GROUP MATERIALS

Bible study materials have been developed to be used by the CHE home visitors as they lead their own Bible study groups. The materials address ministry successes and failures, praying for one another, and studying various books of the Bible.

Bible stories with appropriate interpretation and application questions are a powerful way to present God's truth to both children and adults in all cultures. This is especially true in oral cultures. Thus, MAI has developed sample questions for over 500 Bible stories, helpfully indexed and organized in many folders.

HOW TO INTEGRATE THE PHYSICAL AND SPIRITUAL

The integration of spiritual truth into a physical outreach is a way of thinking, which must be constantly reinforced. Without full integrations both physical and spiritual results are reduced. Too much focus on spiritual development narrows the group of people interested, and too much focus on the physical can lead to selfishness which can make to trained less likely to care deeply about their neighbors

It is, therefore, important to spend as much time on evangelism, discipleship and worldview as on physical subjects. One-half of our class time is spent on physical teaching and the other half on spiritual teaching. Integrating both together is ideal. In addition trainers must be good models of what they teach.

CHE AND CHURCH PLANTING

In a CHE program, as people come to Christ, they begin their walk to Christian maturity led by those who won them to Christ. These new believers form a small group where they are nurtured in their faith, given ministry skills, and encouraged to help reach a target area for Christ. These members then begin to do evangelism in a target area and follow-up those they have won to Christ.

A new group of believers is formed into their own new small group. From these small groups a church is formed where there has been none previously. If there are already churches in the area, the new believers are incorporated into them, causing the churches to grow.

EXAMPLES OF HOW CHE PLANTS CHURCHES

An example of CHE planting churches in an open country is seen with a *community-based model* in our project in the Democratic Republic of Congo done in conjunction with the Presbyterian Church. After four years the project saw the number of churches grow from two to 36 as CHE and the gospel were spread from home to home.

In 90 villages in northern India and eastern Nepal, people's lives have been changed spiritually and physically using the *family-based approach*. One by one people come to Christ as they see and experience God's love. They then form home fellowship groups. In four years over 80 home fellowships were started with the largest one having 250 members.

The pastors have now formed their own denomination which the bulk of these new churches have joined. When one Christian family has a vision to see their community changed, mighty things can happen for God.

We are finding a keen interest in churches using the cell-group strategy in Central Asia to use the *family-based approach* because it gives their cell group leaders a means to help people at their point of need and not just preach to them. Cell-group churches have primarily been in urban centers but CHE gives them a means to successfully implement cell group strategy in rural areas. It builds credibility for Christians in the sight of non-Christians and shows God's love in action.

The question may be asked, "Is CHE always a successful church planting strategy?" It is only as successful as the people who implement CHE. If they have a vision for church planting, then churches are planted.

EXAMPLE OF HOW CHE HELPS CHURCHES GROW

Gavia is a village of 600 families about two hours outside of Guatemala City. The CHE program was initiated with the local Gavia church of 40 members. The committee and CHEs all are from the church. This is the only Protestant church in an area that is dominantly Catholic. The people in the village felt evangelicals were only interested in saving souls rather than physically helping others and the pastor was not respected.

After one year the people began to trust the CHE program. Because of the home visits, the villagers saw the CHE workers were interested in helping them spiritually and physically. The church grew four times its size to 160 members. The pastor is now a respected and sought-after leader in the community, and there is good cooperation with the Catholic Church.

GOALS FOR AN EFFECTIVE CHE PROGRAM

1. Spirit-filled CHE volunteers are capable of reproducing themselves in others.
2. CHE is integrated into the community infrastructure.
3. CHE is expanding to adjacent areas through local training teams after the initial training team leaves.
4. Locally self-funded.
5. Community members see the program as their own.
6. Communities with poor baseline conditions can see more than 50 percent improvement of infant mortality, malnutrition, and in the rates of targeted diseases.
7. A ratio of CHE volunteers to the population is one CHE volunteer for 5-10 households (30 – 60 people).
8. Community members are taking responsibility for their own health.
9. Other organizations are establishing their own integrated CHE program using our training and materials.
10. People are coming to know Jesus Christ and churches are being planted.

RESULTS OF A CHE PROGRAM

CHANGED INDIVIDUAL LIVES

In one project during a home-visit, we met an elderly man named Samwell. The gospel was shared with Samwell using a picture booklet. By the end of the conversation, he had tears running down his cheeks.

When asked if he would like to invite Christ into his life, he did so with excitement. After the prayer he held up the booklet, turned to us and said in English, “My passport to heaven . . . my visa to heaven.”

More than a year later Samwell remains strong in his walk with the Lord. He has other people read to him daily from the Bible and even has many Scripture passages memorized. Because of the tremendous changes that have taken place in Samwell's life, he has been a strong witness to others in the community. Samwell exemplifies the reason spiritual values must be integrated with any village health program. The need for transformed lives is just as necessary as the need for improved health care.

CHANGED INDIVIDUAL LIVES MULTIPLIED THROUGHOUT THE COMMUNITY

Our project in the Democratic Republic of Congo, done in conjunction with the Presbyterian Church, has grown rapidly throughout the community. After four years the project saw the number of churches grow from two to 36 as CHE and the gospel were spread from home to home. In one year, they watched God change their communities in many physical and spiritual ways.

Spiritually, over 1,500 decisions for Jesus Christ were made with over 500 people baptized. The CHEs led 42 Bible studies with almost 3,000 people involved.

Physically, over 20,000 women and children were seen at antenatal and well-baby clinics with almost 6,500 children being vaccinated.

CHEs made almost 10,000 home-visits to their neighbors. There were over 1,700 new pit latrines, 1,200 rubbish pits built, and over 1,400 families received a "Healthy Home Award" for having completed five major health interventions with their family in that year.

THE PROGRAM CONTINUES ON

In another project the pastor caught the vision of CHE. Initially, an outside training team spent 16 months with him establishing one CHE project in his village. Since the team left, he mobilized the people in 40 surrounding villages to become involved in CHE and trained over 150 CHEs. He also mobilized the people to build, equip, and staff their own clinic, and then build a 20-bed ward. Both these projects were self-funded. In addition, they protected over 100 water sources and had five wells drilled by the government.

At the beginning of the project, 70 percent of the people had a problem with alcohol because they made their living brewing alcohol. After five years with the CHEs doing active evangelism, discipleship, and teaching people how to earn a living by vegetable gardening, growing tree seedlings, fruit trees, coffee, wheat, sunflowers, bee-keeping, and fish farming, less than 30 percent still had a problem with alcohol.

MULTIPLICATION THROUGHOUT A COUNTRY

In Papua New Guinea the Department of Health and Church Health Services adopted the CHE strategy as a wholistic way to approach public health. The Government Health Workers are trained as CHEs and are beginning to work in their villages. As the government is continuing to train more individuals, the CHE strategy, including the physical and the spiritual elements, is beginning to reach more villages ... more provinces ... and eventually, perhaps the entire country.

BRIEF DESCRIPTION OF TRAININGS

A SCHEDULE FOR TRAINING SEMINARS AROUND THE WORLD CAN BE FOUND AT:

WWW.MEDICALAMBASSADORS.ORG

OR

WWW.CHENETWORK.ORG

Vision Seminar

A vision seminar is a one to three-day seminar that introduces the CHE concepts. The participants are usually leaders of organizations who are interested in an integrated approach to community development and health. As a result of the seminar, the leaders then choose trainers to be trained in a TOT 1, and then implement CHE in a target location.

Training of Trainers I (TOT I)

A week-long course, consisting of 28-35 hours of training, designed to equip Christian leaders and organizations to implement their own integrated ministry of community health evangelism. Those who attend a TOT I will be equipped to set up a CHE program and to train CHE volunteers for work in their communities.

Training of Trainers II (TOT II)

A week-long course, consisting of 35 hours of training. After a community has been mobilized, TOT II focuses on developing trainee facilitation skills. This prepares the trainers to train committee members and CHE home visitors.

Training of Trainers III (TOT III)

A week-long course, consisting of 28-35 hours of training. After a CHE program is successfully adopted by a community, TOT III focuses on the evaluation of the project as well as how to multiply the project into other areas.

Urban TOT

A week-long course, consisting of 28-35 hours of training, that focuses on the preparation needed to begin a CHE program in an urban slum. The training uses the Asset-Based Community Development (ABCD) approach. The course incorporates fifty-percent of a “standard” Training of Trainers (TOT), along with lessons that focus on approaches that are effective in urban settings.

Urban Neighborhood Transformation

This is a reformatted form of urban TOT. Often focusing on a church-based outreach, it starts with a 12 hour one weekend introduction. This introduction is followed by a series of four-hour elective modules chosen, by the group to be trained, from a broad selection of topics. It was originally designed for use in United States urban slums where there are a wide variety of social service agencies. Despite the differences between urban slums internationally and those in the USA, there are many cross-over applications to be found. Training schedules for this topic can be found at neighborhoodtransformation.org.

Women’s Cycle of Life

A week-long course, consisting of 35 hours of training, that focuses on the complete cycle of a woman’s life – puberty, pregnancy, and menopause. The training covers a variety of topics including physical health, emotional support, family relationships, and spiritual truths. Women find it immensely affirming to know that God sees them as having great value.

Microenterprise

A week-long course designed to educate those who will train individuals and groups in personal and small business finance. Two general styles of microenterprise are taught. Micro-credit based on a revolving loan fund with outside funding works best for participants with successful business experience and access to rotating loan funding source. Savings and internal lending groups (also called savings and credit associations) are better for the very poor and are easier to multiply, since no outside funding is required. Increased family income improves the diet, health, self-confidence, and overall well-being of families involved.

CHE Family-Based TOT

A specialized training primarily for nationals who live in a creative access country and who will be the only CHE workers in a village or slum. The training incorporated 12 hours of TOT I to give the participants an overview of how a CHE program works. Health and development teaching is included in how they can help their neighbors physically.

HIV TOT

A week-long course consisting of 28-35 hours of training that focuses on the development philosophy of what CHE is, and how to use the CHE strategy to address HIV issues in a community. The training teaches how to create community awareness and reduction of stigma, how to advocate lifestyle and behavior changes, how to prevent infection, and how to offer compassionate care to those already infected. The training incorporated fifty-percent of a "standard" Training of Trainers (TOT).

Disability CHE

A week-long course consisting of 28-35 hours of training that focuses on the issues faced by persons with disabilities and their care-givers. The training addresses the stigma that such people face, and the spiritual lessons deal with such topics as the value God places on all persons, and his control of the events in our lives. The physical lessons cover many practical issues, from transportation to physical care and prevention of complications, to aids for activities of daily living that are based on appropriate technology for their area.

Children's CHE

A set of specialized CHE lessons geared for children. Often used for children's clubs in places in which the adult population is not interested in CHE. The physical lessons include personal health issues like cleanliness or tooth care, social issues like dealing with bullies, and spiritual lessons. Moral value lessons are used in creative access areas.

SALT

Salt and Light Training (SALT) is a practical education program for local churches. The training will help to equip and encourage the church to serve its community. SALT has been developed by Medical Ambassadors and applied in many churches in the developing world. Pastors, local churches, and organizations are taught wholistic ministry from a biblical perspective.

A ministry to the whole person is having results in a variety of religious settings and throughout the world. The results of Community Health Evangelism are very impressive based on the total transformation we often see in lives of individuals, families and communities. The Lord calls each of us who are ministering in his name to deal with people as whole persons, physically, spiritually, emotionally, and socially. The starting point and center of good health is our Lord Jesus Christ. Community Health Evangelism is one strategy that is doing just this.



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