

Better to Light a Candle

Val D. MacMurray, Ph.D.

*Presented at the Second Annual
Meeting of
Collegium Aesculapium
Salt Lake City, Utah*

There is a saying that comes out of African missionary literature: "It is better to light a candle than to curse the darkness." The observation seems an apt one today as we contemplate the challenges of international health, the immensity of the darkness surrounding these global issues, and the opportunity of creating and fostering a spark, albeit it a small one, that will stand against that darkness.

In the past two years, in my capacity as executive director of the Thrasher Research Fund and health officer for The Church of Jesus Christ of Latter-day Saints, I have had the educational experience of visiting the developing nations of Africa, Asia, Central and South America, and the Caribbean. Last February I lay on a bed in a jungle village of West Africa on an evening where the heat and the sultriness combined to make each breath a struggle. I was exhausted and feeling ill, both physically and mentally, too tired to sleep and yet too exhausted not to. As I lay in that state somewhere between the sleeping and waking, thoughts pressed upon me of the hundred million people of Nigeria with whom I shared this black night, the starvation with which they daily lived—about to be multiplied many-

fold by the famine that would arrive within a few weeks, brought on by a year-long drought—and the sickness and the inescapable tropical diseases that precluded taking a drink of water without first treating it.

I felt that night the intense loneliness that kept me pinned on that uncomfortable bed, spinning on a globe that held, half the world away, my wife and children. For a flicker of time, I thought I was in my own home, listening to Maryann call, "It's time for breakfast" and seeing my rosy-cheeked children run past my door. It was a moment, to use Eugene England's eloquent phrase, when I lay "awake . . . my mind besieged by woe and wonder."

In speaking to the Collegium today, I wish to talk about those thoughts of "woe and wonder" that have been developing over the past few years on my visits to the continents of this shrinking spaceship earth. Let me share with you some of my acquaintance with the woeful darkness that shadows much of the globe; then let us discuss what candles we may light.

Scope of the Problem

At a recent planning meeting of the Thrasher Technical Advisory

Chloroquine has been the most useful and reliable compound to treat malaria, but *Plasmodium falciparum*, the most dangerous of the malaria parasites, became resistant to it in large areas of Southeast Asia, South America, and the western Pacific.

Committee, held at the Centers for Disease Control in Atlanta, its immediate past director, Dr. William Foege, gave an overview of the triad of "woes." The First and Second World countries, he observed, must deal with environmentally and occupationally caused illnesses, such as pollution and motor-vehicle accidents, and those stemming from drug, cigarette, and alcohol abuse that can only be termed self-induced.

In the Third World, the three-pronged spear of poverty, illiteracy, and disease creates the weapon that holds those populations at bay, with a superimposition of the Western trio and a back-up trident of still another three: population pressure, malnutrition, and infectious disease. In the Fourth World, or the shadow country within poor countries occupied by the poorest of poor, every one of these problems is exacerbated.

The Western world had the luxury, if we may say so, of working out its solutions to poverty, illiteracy, and diseases without the pressure that comes of populations spiraling in uncontrollable jumps. Now the Third and Fourth worlds are struggling to deal with their own problems and also facing the inevitable consequences of importing the Western world's current plagues. Smoking rates in developing countries now approach those of the Western world. In twenty years they will be facing epidemics of lung disease.

We stand on the shore of oppression and misery with two cen-

turies of knowledge and technology behind us. How do we learn about those problems which are new to us? How do we deliver that knowledge in a way that can be used? And does it matter that we can?

Population Pressures

First, population pressures. According to an National Public Radio report (July 21, 1984, "Chinese Population," Bill Busenberg) drawn from a World Bank Report, "It took mankind a million years to reach a population of one billion. The second billion required only 120 years. The third billion was added in just 32 years. And the fourth billion took a fleeting 15 years. Today, global population stands at 4.8 billion . . . and another five billion people will be added to the earth's population, doubling it, in the next 65 years, even under optimistic projections. Almost all of that increase will come in developing countries of Asia, Africa, and Latin America. By the year 2050, . . . population in the poorest countries will more than double from 3.5 billion today to 8.5 billion. During that same period, population in the industrialized countries—the United States, Europe, and Japan—will increase only . . . slightly from about 1.3 billion today to 1.5 billion. . . . Africa . . . will expand six-fold. Nigeria will become the third most populated country in the world then. In Latin American, tiny El Salvador will grow from 5 million people today to 17 million. In Asia,

India's population will double to 1.5 billion, making it the most populous in the world, surpassing China. . . . Kenya . . . will increase its population eight-fold."

Malnutrition

Malnutrition causes illness and makes mild illnesses into serious ones. Alex B. Morrison, chairman of the World Health Organization's Scientific Technical Advisory Committee of the Special Programme for Research and Training in Tropical Diseases, has pointed out that in many developing countries "malnutrition is the single most important public health problem. More than half the human race is either undernourished or frankly malnourished." A child who contracts measles in a developing country has a 20 percent chance of dying. At present, only about 25 percent of the people in Third World cities have "dependable access to reasonably safe and clean water and adequate sanitary facilities." In rural areas, fully 75 percent of the people lack ready access to clean potable water. They often have to walk up to ten kilometers for water and carry it back home in containers that are far from clean.

Poverty exacerbates malnutrition and disease. People are poor because they are sick and sick because they are poor. In addition to the disease of the temperate climates, inhabitants of tropical countries bear the added burdens of chronic infections like malaria, schistosomiasis, or filariasis, which may lead to early death, but which also "invariably result in debilitation and intense chronic suffering. Their most frequent victims are children but . . . they can disable an entire population.

"The average life expectancy at birth is about 72 years in the developed countries of the north; it is about 55 years in developing countries of the south, and in Africa and

southern Asia is only about 50 years. Of every 1,000 children born into poverty in the least developed countries, 200 die within a year, another 100 die before the age of five years, and only 500 survive to age 40. Infant mortality rates are 10 to 20 times higher in developing countries than in those which may be termed 'developed.' The World Health Organization has estimated that about a tenth of the life of an average person in a developing country is seriously disrupted by disease. . . . Of the estimated 80 million children born each year in the developing countries, fewer than 10 percent are immunized against the common infectious diseases of childhood. Diarrheal diseases . . . are estimated to kill over 4 million children in developing countries each year" ("Health for All: The Challenge to Do Better," delivered upon receiving the David M. Kennedy International Service Award, BYU, March 13, 1984).

Infectious Disease

Six major groups of tropical disease are probably the most important. These include: malaria, schistosomiasis, filariasis (including river blindness or onchocerciasis), trypanosomiasis (including both African sleeping sickness and the Latin American form called Chagas' disease), leishmaniasis (a group of diseases having many forms ranging from self-healing skin ulcers to fatal generalized infections), and leprosy. These six are perhaps among the best documented because they have, since 1976, been the targets of the Special Programme for Research and Training in Tropical Diseases, jointly sponsored by the United Nations Development Programme, the World Bank, and the World Health Organization. (Much of this material is drawn from its 1984 report, "Venture for Health," Geneva: World Health Organization, 1984.)

Throughout the tropics, half of

African trypanosomiasis, or African sleeping sickness, constitutes a permanent hazard for at least 50 million Africans, with 20,000 new cases being reported yearly.

all school-age children have malaria. In many parts of Africa, one child in five dies before the age of six from malaria. Young men and women may suffer such severe attacks of fever that they cannot work the land. Pregnant women are especially vulnerable. Even if the mother survives, the unborn child may die. Therapeutic drugs may not be available. Even when they are, they cannot prevent reinfection.

More than half the world's population lives in malarial-risk areas. Although more than 200 massive eradication efforts during the late '50s and early '60s all but eliminated the disease in Europe, the Middle East, South America, India, and the southern United States, by the 1970s, strains of mosquitoes had developed that were resistant to insecticides. Chloroquine has been the most useful and reliable compound to treat malaria, but *Plasmodium falciparum*, the most dangerous of the malaria parasites, became resistant to it in large areas of Southeast Asia, South America, and the western Pacific. These resistant strains have now appeared in India and Africa. This is the most disheartening news of all. Chloroquine has literally been a lifesaver in Africa because widespread eradication and mosquito control campaigns have simply not been developed.

Modern dams and networks of canals have become the symbols of agricultural progress for the food-hungry lands of Africa, Asia, and South America. But many of the farmers who work such newly reclaimed tropical lands are infected

with schistosomiasis, a disease spread by freshwater snails that follow the new irrigation systems. In the space before predators develop, the snails take a quantum leap in breeding. They transmit the disease through small larvae that penetrate the skin and, as adult worms, damage vital organs. There are an estimated 200 million cases of schistosomiasis in the Third World, and the disease is gaining ground.

"In parts of West Africa, victims of river blindness walk to work in a line, each grasping the hand of the person ahead—all being led to the fields by a young boy who, although also infected, is still able to see." There are an estimated 30 million cases of onchocerciasis, or river blindness. About 90 million cases of this lymphatic form of filariasis are estimated, and about 900 million people are thought to be exposed to it.

American trypanosomiasis, called Chagas' disease, begins with a bite of the reduviid bug, a blood-sucking insect that transmits this parasitic disease by defecating near the site of its blood meal. The fecal material contains the parasite which gains entry to the host through this small wound. The primary infection may not even be noticed and the disease may remain dormant for years while the trypanosomes multiply. Ultimately they will cause severe damage to the nervous system, the heart, or the digestive tract. A young man in his twenties may already be suffering from damage to the nerves of the heart and has an irregular, slow heartbeat that effectively pre-



vents him from doing any hard work and may cause sudden death. Twenty to 60 percent infection has been reported in some Latin American villages, representing about 10 million people. There is no satisfactory cure for Chagas' disease. While parasitologic cures are available, chronic organ damage appears irreversible.

African trypanosomiasis, or African sleeping sickness, constitutes a permanent hazard for at least 50 million Africans, with 20,000 new cases being reported yearly. This parasitic disease is spread by the tsetse fly and is characterized by irregular fever, generalized lymphadenopathy, cutaneous eruptions and areas of painful, localized edema. Central nervous system symptoms include tremors, headache, apathy, and convulsions, later progressing to coma and death.

Leishmaniasis is another disease caused by intracellular protozoan parasites of warm-blooded verte-

brates. At least 400,000 cases of leishmaniasis occur each year, with "new species" being reported faster than they can be fitted into any identification system. American leishmaniasis causes localized ulcers and if left untreated can persist for years with death resulting from secondary infection.

About 11 million people in the world suffer with leprosy. The Acworth Leprosy Hospital in Bombay sees about 250 patients a day. Long-term treatment with drugs is required, but they become generally less effective, and many people, fearing the social consequences of being "lepers," do not follow through on treatment. *Mycobacterium leprae*, the bacillus that causes leprosy or Hansen's disease, has usually been treated with dapsone; but as many as one-third of the new cases do not respond to treatment because the infective agent has become resistant to this drug. Furthermore, only one in four leprosy patients receive treat-

ment of any kind.

In short, the darkness is dense, real, and oppressive. There is indeed a temptation to curse the darkness. I have felt that temptation myself. I would not say that the energy of anger that such a curse may represent would not be a good thing, but after the anger come despair and hopelessness. What can be done? What are even major resources against such overwhelming odds?

Lighting Some Candles

Actually, the news is much more hopeful than might at first be suspected. My personal conviction is strong that no gesture of human love and compassion is wasted, even if it is to bring water to a dying person. The cynic may point out—and possibly with reason—that the cup from which he drinks is unwashed and that the water in it is not pure, but the act of offering it in love and shared sympathy for the human con-

dition that acknowledges the briefness of each life is in itself adding an ounce of good to the scales that weigh out continually the woe and wonder of the world. However, optimism is not inappropriate.

In June of 1984, I attended the annual Joint Coordinating Board meeting of the Special Programme for Research and Training in Tropical Diseases held in Bangkok, Thailand. In those meetings hopeful news on these six infectious diseases was reported. For example, vaccines against malaria are being developed, and several should be ready for trial within the next few years. Research is progressing on developing a vaccine that could prevent infection by attacking the *Plasmodium* sporozoite as it enters the human host. A merozoite vaccine would be particularly helpful in saving the lives of children and pregnant women. A gamete vaccine could reduce or interrupt the transmission of the disease. Several types of vaccines or vaccines combining several antigens may eventually be needed.

Another encouraging development is that a fish that feeds on mosquito larvae has been introduced into sections of Somalia. Field studies in 26 villages show that these fish virtually wiped out the mosquito larvae and, as an added bonus, grew large enough to eat. In New York City, a team of scientists have been able to transfer a gene from malaria parasites to a bacterium that produces a protein identical to that created by the parasite. Therefore engineered genetics make wide-scale experimentation on vaccines possible. A new drug Mefloquine, developed in the United States and Switzerland, is effective against the malaria parasites resistant to chloroquine. It is being tested now in Brazil, Thailand, and Zambia. In China a substance derived from a traditional medicinal plant, *Artemisia annual*, has been found effective against cerebral malaria, a potentially lethal form, and is now being developed.

In the Church of Christ there should be no person hungry, no person poorly clad, inadequately clothed, and no person who doesn't have the hope . . . some day of living under . . . [a] . . . roof. This is an ideal not beyond accomplishment, not beyond realization." —David O. McKay

Educational programs in the Philippines have identified many myths about filariasis among the local people and, by replacing the myths with correct information, have made it possible for the villages to participate in disease control. In West Africa, *Bacillus thuringiensis* Serotype b.t. H-14 is being used to control the blackfly, which had developed a resistance to DDT and other insecticides. Furthermore, genetic engineering is an active area of research to examine new methods of controlling bacillary larvicides.

A quick-test kit has recently been developed to identify those infected with trypanosomiasis. Since about 150 species of wild and domestic animals can harbor this parasite, international protocols to aid neighboring countries in surveying the incidence of infection have been developed. In Brazil, scientists from nine countries in the Western Hemisphere are working on ways to standardize and assess diagnostic tests.

In the treatment of leprosy, different combinations of drugs have been assessed. Although they are more expensive to administer, they are also more cost effective since they do not require lifelong administration. Several new compounds are now being laboratory tested. One of the most exciting developments came in 1971, when researchers in the United States discovered that the nine-banded armadillo has a massive reaction to *M. leprae*. A single gram of armadillo liver tissue can yield as many as 10 billion bacilli, which may be enough to produce from 100 to 1,000 doses of vaccine. A vaccina-

tion against this ancient and terrifying disease may be the most helpful sign on the horizon. Sixty-five scientists in 23 countries are now actively collaborating in this research according to a design drawn up in 1974. Killed-leprosy bacilli vaccines are being tested in Norway at the present time with encouraging results.

These direct attacks on killer diseases are also being reinforced by massive national and international attempts to build a health infrastructure. Just as bridges and roads are not directly part of the nation's economy but must be in place for the economy to function, so acceptable levels of health require certain underlying structures. Halldan Mahler, director general of the World Health Organization, speaking to the International Congress for Infectious Diseases in Vienna in August 1983, noted that "the technology exists, but it must somehow be made cheap and sufficiently simple to be used by people with little or no training in the health sciences." He identified six components:

1. General education on health matters. "Entire communities need to understand the environmental and socioeconomic conditions that foster infectious diseases."
2. Proper nutrition, safe water, and basic sanitation.
3. "Multisectorial action" and cooperation. For instance, malaria is not just a health problem; it also involves rural development, agriculture, and water resources.
4. Appropriate use of tech-

**A fish that feeds on mosquito
larvae has been introduced
into sections of Somalia.
These fish virtually wiped out
the mosquito larvae and,
as an added bonus,
grew large enough to eat.**

nology. He cited the eradication of smallpox, not by worldwide immunization but by a simple yet sophisticated system of "surveillance, containment, and selective immunization" made technologically possible by the development of a freeze-dried thermostable vaccine and a simple bifurcated needle that a nonprofessional could use.

5. Diagnoses simple enough so that nonprofessional health-care workers in developing countries can use them.

6. Continued research on treatments. He cited as an example the dramatic breakthrough in treating dehydrated babies by a simple oral rehydration therapy that can be applied by anyone and can reduce the death rate by 50 percent.

Dr. Mahler concluded his remarks: "As we approach the end of the 20th century, it is sobering to note that... we have been clever enough to generate many dramatic scientific and technological developments without being wise enough to disseminate this information to all who need it." ("Infectious Diseases in Developing Countries," H. Mahler, Excerpted by Paul D. Hoepflich, *Infectious Diseases Newsletter* 3[July 1984]:44)

As I contemplate facts such as these, I am reassured by the steady stream of light thrown by each committed health worker, each laboratory worker, and each paraprofessional patiently testing leprosy victims for nerve damage. And we come to the question that has, to some extent, brought us together today. What can be our contribution

as Latter-day Saints in lighting candles of our own against the darkness of international health problems? How can we render Christian service in developing nations?

Latter-day Saints and International Health

Dr. Alex B. Morrison, receiving the David M. Kennedy International Award at Brigham Young University on March 13 this year, spoke directly to that point in accepting the award. He, like those of us in this room today, I believe, accepted without question the flat fact that bearing the name of Christ obligates us to be responsible and caring toward those whose health is threatened by forces over which they have little control. We simply do not have the option of turning our heads, of closing our eyes, or walking away. But what can we do?

Alex suggests three guiding principles:

"1. Despite the great cultural, linguistic, geographic, and political barriers that separate the peoples of the world, we are fundamentally very much the same, regardless of our nations, kindred, or tongues. 'God hath made of one blood all nations of men for to dwell on all the face of the earth.' I am as much among family in a village of West Africa as in the classrooms of this university. We are, whether we like it or not, all sons and daughters of eternal parents; and, because we are, we bear the responsibilities of family members toward each other. We really are our brothers' keepers, with

all that implies in stewardship, responsibility, caring, sharing, and mutual interdependence.

"2. It is impossible to separate temporal from spiritual solutions. President Brigham Young knew that when he instructed the Saints to care for and 'nurse up' the tattered, suffering half-frozen survivors of the Martin Handcart Company. 'Prayer is good,' he said, 'but when baked potatoes and milk are needed, prayer will not suffice.' In many parts of the world the success of our efforts to preach the redeeming love of Christ will be conditioned upon our willingness to reach out temporarily to those in want. And was it not He himself who gently reminded us, over and over again, of our responsibilities for the poor, the hungry, the sick, the naked?

"3. 'The earth is full and to spare.' There is plenty here for all of us... To keep children from dying of malaria or measles is *not* to doom them to a slower death from starvation later on. That need not be. We *can* look after each other, with resources to spare. What is lacking is the collective will to do so."

Alex went on to elaborate what he meant by that "collective will," as "reestablishment of the concept of a caring community. Perhaps above all else it requires conquering selfishness, narrow self-interest, and complacency" (Alex B. Morrison, address on receiving the David M. Kennedy International Service Award, March 13, 1984, Brigham Young University, Provo, Utah; typescript in possession of author).

I'd like to focus our attention on directing that collective will. What does—should—can—that mean to us to read a simple scriptural injunction like 1 John 3:17-18?

"But whoso hath this world's goods, and seeth his brother have need, and shutteth up his bowels of compassion from him, how dwelleth the love of God in him? My little children, let us not love in word, neither in tongue; but in deed and in

truth.”

What should be the relationship between the spontaneous gesture of compassion that leaps forward to pick up a child crying over a bleeding knee and the disciplined gesture of compassion that staffs the infirmary where the lines of patients do not dwindle from 6:00 a.m. until after 10:00 p.m. that night? How can we as Latter-day Saints create and/or contribute to world-health delivery systems that honor the spontaneous gesture but use it effectively? It is also a truism that so-called amateur do-gooders get overwhelmed, exhausted, cynical, and bitter when it becomes apparent that spontaneous charity is not enough. It is also a truism that organized methods of health-care delivery almost inevitably move more in the direction of bureaucracies and red tape so that the machine ends up cold hearted and indifferent to the very human being it was originally designed to serve.

John F. Robinson, executive director of a Christian missionary group headquartered in Michigan, has approached some of these issues in terms of Christian theology, an extremely helpful perspective for us as well. I particularly like the point he makes about a methodology for development assistance:

“The point that I focus on most in thinking about methodology for development assistance is not so much the issue of human worth but rather that of human freedom. My understanding is that God created all normal people with the capacity to make significant choices and that this is a sacred privilege that must always be respected in human relationships, even though man is always accountable for his choices. I believe that my relationship to people should enhance their ability to choose, to choose both freely and wisely, not to restrict that ability to make choices. If my development assistance results in people having greater control over themselves,

**I felt that night the intense
loneliness that kept me pinned
on that uncomfortable
bed, spinning on a globe
that held, half the world
away, my wife and children.**

their environment, and their future, I have increased their freedom. If my assistance makes them more dependent upon me or someone else, I have reduced their freedom. In short, assistance that does not compromise the freedom of those I am trying to assist nor the freedom of others who might be affected by their development implies a method that is consistent with my view of man as God intends him to be. In fact, this is the way that I perceive God to deal with people” (“Theologizing about Development,” 4-5; typescript in possession of the author).

In the jargon of my own profession, Robinson is talking about a social-change mode of development versus the professional control model. (These ideas have been drawn from notes made by Mary Ellen Edmunds in a presentation by Dr. Guy Stewart, professor and chairman of the Department of Health Education. The presentation was part of a three-week program entitled “International Practice for Integrating Community Development and Health,” June 1984.) In the professional control model as regards health care, the emphasis is on delivering goods and services by western professionals. Health education is designed to get the people to cooperate. Outcomes are evaluated according to the health status of the individuals being treated, not on the process. Change is something to be imposed on the community. It is essentially an external view. This model has been very effective in deliv-

ering raw health care. It has immunized thousands of children, filled millions of rotting teeth, treated billions of yaws, infected wounds, and sores. It has dug thousands of wells, built thousands of latrines, and staffed dozens of clinics. What this has not done has been to teach mothers and fathers how to dig their own wells, implement principles of sanitation in their own homes, or cure some of their own health needs, either by better diet or by simple medical procedures. Sooner or later, the personnel manning such outposts of health becomes exhausted and cannot be replaced, or the funds to finance such efforts run out. When the outpost is no longer staffed, the light goes out. In effect, it was the only candle in that area of darkness. It had illuminated those who had come within its circle, but it had not ignited other candles.

In contrast, the social-change model focuses on finding out what people are currently doing to cope with their challenges and trying to identify ways of improving what they’re already doing. The primary focus is not health needs, crucial though those are, but the whole web of community life—because everything is health related. It is a cardinal rule never to do anything that a local person could do with your help. Changing programs using this model have found that paraprofessionals are much more successful than professionals because the highly trained technician needs predictability and an orderly presentation of problems with specific solu-

tions. The complexity of real human beings becomes frustrating to these individuals. In contrast, there is nothing like a shortage of professionals to encourage creativity and ingenuity once the outcome is clearly identified and the myths have been separated from the facts. This model frustrates some because it is slow, and requires endless patience, listening, and small steps. Yes, it is faster to see a candle than to light one. It is hoped there will be ways to create long-term change that does not sacrifice immediate health-care needs.

I find this social-change approach to be deeply harmonious with the gospel. I'll admit that I share the American tendency to bury a problem in money, hoping that somehow the money will wash the problem away. We are not, however, free as Christians to use our comparatively greater resources as a shield between us and the human misery that afflicts so many of our brothers and sisters. I find that the social-change model treats not only the problem with respect but also treats with respect the people with the problem. It acknowledges our responsibility to learn from them before we teach and to have the teaching be a transmittal of caring as well as information. It ultimately involves the blending of both Western and traditional medicine in the David Werner tradition emphasizing self-reliance (See *Helping Health Workers Learn*, David Werner).

I also find this approach to be harmonious with the major principles of welfare service as they are currently understood. Let me enumerate them. When the system is working as it should, those who are involved are increasing in their own sense of self-reliance; they are building stronger family units that are more capable of providing assistance when needed to family members; there is a clear component that focuses on preventing temporal problems before they arrive; and there is

respectful, compassionate care for those in legitimate want—the orphaned, the disabled, the ill, and the handicapped—in ways that do not deprive them of their human dignity.

We speak often of our ideal of Christian service. I want to make it clear that when I use that phrase I am not excluding those who are not Christian. Instead, I use it to mean those who serve others in the same way that Christ served, regardless of religious belief: (1) He went among them. He breathed the same air, drank the same water, sat on the same dusty patches of earth, and gave thanks for the same food. (2) He involved them in their own change through provocative questions, through simple illustrative stories and through turning their minds in directions formerly closed to them by their traditions. (3) He provided unique services. We may be able to perform virtual miracles because of our advanced technology. He performed real miracles because he was the Son of God. His grace, his will, and his skill bridged the gap between what the people needed and what they could supply for themselves; and our own can do the same thing. (4) With every act of service came not only the service itself but the transforming gift of his love. Many of those he healed received not only health but personhood at his hands.

That is a high standard for all of us to follow. I would like to close by a moving story that President McKay told in 1941 at the launching of the Church Welfare Services program.

"In 1897 when I was on my first mission, I found myself, one morning, distributing tracts in a little undesirable district in Sterling, Scotland. I approached one door and in answer to the knock a haggard woman stood before me, poorly dressed, sunken cheeks, unkempt hair. As she received the tract I offered, she said, in a rather harsh voice, 'Will this buy me any bread?' and as I started to tell her that it would buy her not

only bread but something far more precious, a man equally haggard and underfed came up and said, 'What is it?' She handed the tract to the man and said, 'Gospel vendor! Shut the door!' From that moment I had a deeper realization that the Church of Christ should be and is interested in the temporal salvation of man. I walked away from that door feeling that that couple, with the bitterness in their hearts toward man and God, were in no position to receive the message of the gospel. They were in need of temporal help and there was no organization, so far as I could learn, in Sterling that could give it to them. In the Church of Christ there should be no person hungry, no person poorly clad, inadequately clothed, and no person who doesn't have the hope . . . some day of living under . . . [a] . . . roof. This is an ideal not beyond accomplishment, not beyond realization." (David O. McKay, "Church Progress to Continue," Special Welfare Meeting, April 5, 1941.)

As we have already observed, it is impossible to separate temporal from spiritual. We are literally in this together. Africa is not very far away. In the words of Dr. Juan Flavio, director of the International Institute for Rural Development in Philippine Villages, "Don't kid yourself. Your backyard does not end with the fence anymore. A blizzard in Brazil can change your breakfast."

The same is true spiritually. We are challenged to visit daily, in the words of the Master, the handicapped and orphans in their affliction, to relieve the oppressed, feed the hungry, and clothe the naked. Inexorably but gently he puts before us the human needs of our brothers and sisters. Gently but inexorably he asks us to meet those needs. The joy that we feel in such service is but a faint reflection of his joy only when we obey that divine injunction to care for others, seeing in them the image of his countenance. ❧