Among All Nations

Christian healthcare worldwide

Photo: Church Mission Society

Partnership among all nations

'That thy way may be known upon earth,
Thy saving health among all nations.'
(Psalm 67: 2 AV.)

Partnership among all nations was always in God's plan for his creation. The psalmist saw this. The plan would result in joy since the nations would be ruled justly and in plenty, with the land being farmed sustainably.

The psalmist called this wholeness 'saving health'. The plan has two sets of ingredients - the human race is invited to know, understand and obey God's ways, but the plan can only work if God makes it work. The psalmist called this 'God's blessing'.

Among All Nations wants to see more Christian health professionals share in that partnership among all nations, and experience that coming blessing.

Among All Nations is produced in partnership with the **Medical Missionary Association** and **Christians in Health Care** as the international section of *Triple Helix*. They also produce the magazine *Saving Health*, which has more articles on healthcare with mission, and a more comprehensive list of multidisciplinary service opportunities. Details on p15.

Jenny Blackman, on a medical student elective in north-east Zaire, discovered surprising contrasts with work back home

When Lightning Strikes

It was late October in the rainy season, with thunderstorms occurring on most of the otherwise hot, dry days. Eric Kibondo, a 27-year-old nursing student, was at the house of his friend, Patrick. It was early afternoon. He was sitting at a table revising.

Suddenly there was a bolt of lightning, simultaneous with its thunder. Later someone described it as ‘the sort of ominous crack that sends shudders down your spine because you know that something has been hit’. That ‘something’ was Eric.

The current had been conducted through a metal bar supporting the roof above Eric. It caused a cardiac arrest. Patrick was hit too and initially appeared very confused as he went to seek help. Several nursing students tried to administer heart massage but it took another 10 minutes before proper cardiopulmonary resuscitation cycles commenced.

Ever since returning to Bristol, I have thought more about cardiac arrest management and compared the crash teams here with the events in Zaire. Medical staff in the UK also take several minutes to arrive at an arrest, but they usually expect to have an ECG, an anaesthetist to intubate, oxygen and a defibrillator to shock the heart into a regular rhythm. Instead, having asked for an Ambu bag from theatre to ventilate Eric more effectively, a non-medical friend rushed back with the bag used for newborn babies!

More important than differences in resources and frustrations with the limitations of medical management in rural Africa, however, is the power of prayer. Regrettably, this is not part of the standard protocol for doctors in UK hospitals as they hurry along corridors to a crash call. In Boga, students, hospital staff and friends immediately joined together to pray, and this earnest corporate prayer continued late into the evening and beyond.

Lonu, a close friend of Eric, set up an IV and gave 1mg of adrenaline, 20 minutes after Eric’s heart had stopped beating. The heart restarted, with a good output. Eric was carried by stretcher to the intensive care unit in the hospital. He was extubated a short while later when his voluntary respiratory effort returned. Although he did not speak, or show signs of being able to see, he was extremely agitated. There were movements of all four limbs and he had to be restrained, the danger of masking signs without monitoring equipment ruling out sedation.

Eric had a superficial burn from the top of his head down to his chest, with an exit burn on his legs, but with no equipment for further investigations to assess internal damage, the outlook was uncertain. Prayers changed from petitions for his survival to trying to place into God's hands the fear of this bright, fit, young student going into a persistent vegetative state.

Lightning injuries often cause death, mainly through cardiac arrest. However, the chance for successful resuscitation is usually greater because the majority of victims are relatively young and healthy and seldom have significant heart disease. Nevertheless, the spectrum of neurological lesions includes the entire neuroaxis from cerebral hemispheres to the peripheral nerves. Morbidity also follows burn injury to other organs lying in the pathway of the current, and from damage caused to the brain and other organs by anoxia during cardiac arrest.

Therefore, next morning, Eric’s threat in jumbled Swahili and Lingala brought both relief and great joy: ‘Na kobeta yo . . . acha mi’ - ‘I'll hit you . . . leave me alone’!

Over the following weeks his recovery continued. Short term memory loss, confusion and unsteadiness on walking were understandable. But he was determined to join us several days later on the grass bank overlooking the volleyball pitch to watch a very important match, the nurses versus the fourth year student team.

I have several further reflections about Eric’s case:

1. Lightning injuries are reported to affect about 1,000 persons worldwide each year, but this must be a great underestimate. In equatorial Zaire in the heart of Africa during the rainy season, the threat of lightning is a daily reality.

2. This reinforces the importance of basic life support skills. I arranged small group teaching in Boga for nurses and nursing students, in French and using an old resuscitation mannequin. The students were not only keen to learn, but very aware of the importance of CPR because of Eric.

3. The dedication to prayer of Eric’s colleagues, the power of prayer, and their response in thanksgiving made a tremendous impression on me. I still feel amazingly challenged. For many in Boga, this incident gave local people new strength and unity in prayer, and faith in God’s plan for renewal in their crumbling land. My prayers now are for peace to be restored to Zaire, Rwanda and Burundi.

Jenny Blackman did her elective in Boga, Zaire in October-November 1996, just before the outbreak of the recent civil war.

tears for **Sudan**

Hope abounds amid deprivation and suffering in war-torn southern Sudan. Raymond Givan reports

In 1996 I was asked: 'Would you consider organising a vaccination team in the southern Sudan?' Sudan is ten times the size of the British Isles, with a population of 25 million people. Five million live in the country's southern provinces. Most of the south is covered with swamps and rivers and is fairly inhospitable. Civil war has raged there since 1982, but from the beginning I felt God was drawing me to serve these people.

The first step was a pilot expedition. This helped formulate clear goals: to seek and encourage the embattled Church and to bring relief through medicines and vaccinations. A few months later we flew to the northern borders of Kenya and boarded a DC3 for a four-hour flight into Sudan. We had emergency backpacks in case it was necessary to walk back. An enthusiastic welcome awaited us. The plane stuck in the mud and had to be dug out and pushed by hundreds of tribesmen. We walked to our base camp.

We trained three teams in the art of giving injections. In the first two days 350 children were immunised. Then in the next three days the teams were sent out, immunising about 1,000 a day. I learned that in the months prior to our visit about 700 babies had died in this area in a measles epidemic, and I saw many malnourished as a result. There were also some cases of active polio. On the previous visit, the local dialect version of the *Jesus* film had been left, along with a small generator. It had been shown 26 times. While we were there it was shown twice. At one location, on a tributary to the Nile, there must have been 1,000 people in attendance.

Only the New Testament has been written in their dialect. The Old Testament stories are heard secondhand or read in Arabic or English, the language of education in the south. There is no currency. The people plant crops but the army comes down to steal, rape, and burn their crops. The barter system is based on salt, sugar and soap. There is much corruption and I was unsure I could trust anyone. The people feel betrayed by the free world.

Many Christians are paying the ultimate sacrifice for their faith. There are reports of Christians crucified upside down. Many children have been taken into slavery by raiding forces from the north.

Despite all the agony and deprivation caused by war, the churches are growing. To visit one we trekked 14 miles, sometimes up to the neck in swamps, and crossing two rivers. In all it took eight hours. We were met by hundreds of people singing praises to God. The church, made of mud in the shape of a cross, seated 1,000 people and was full. They wanted us to preach and teach immediately and listened through translators. They killed several chickens and a goat for us to eat. The next morning I tried to hold a clinic but had to give up because there was a risk of it causing a riot.

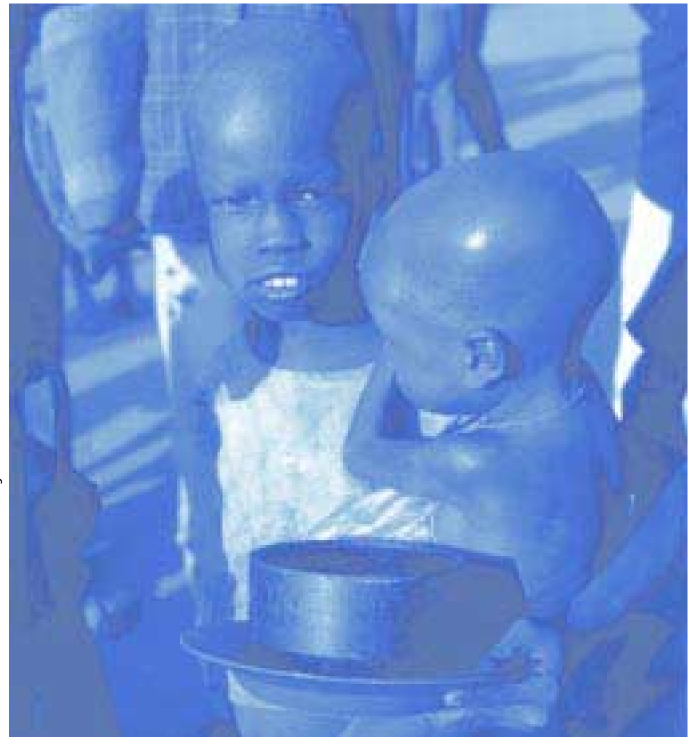

Photo: Church Mission Society

Since then I have paid two more visits to southern Sudan. It was lovely to meet old friends and they were overjoyed to see us. I organised the immunisation of 2,500 children and saw many sick people. There were many surgical and medical conditions including river blindness, guinea worm, bilharzia and tuberculosis, but malaria was the most common. The afternoons were too hot to work or even to sleep. The International Red Cross is hoping to establish centres for primary health care and have already begun a vaccination programme.

During all my visits I saw despair, but also hope. The church of Jesus Christ is being built in a way I have never experienced before. In one area I visited it has grown from 11 to 17 churches of over 1,000 people. 'The wind blows wherever it pleases' (John 3:8).

Dr Raymond Givan works for the Africa Inland Mission

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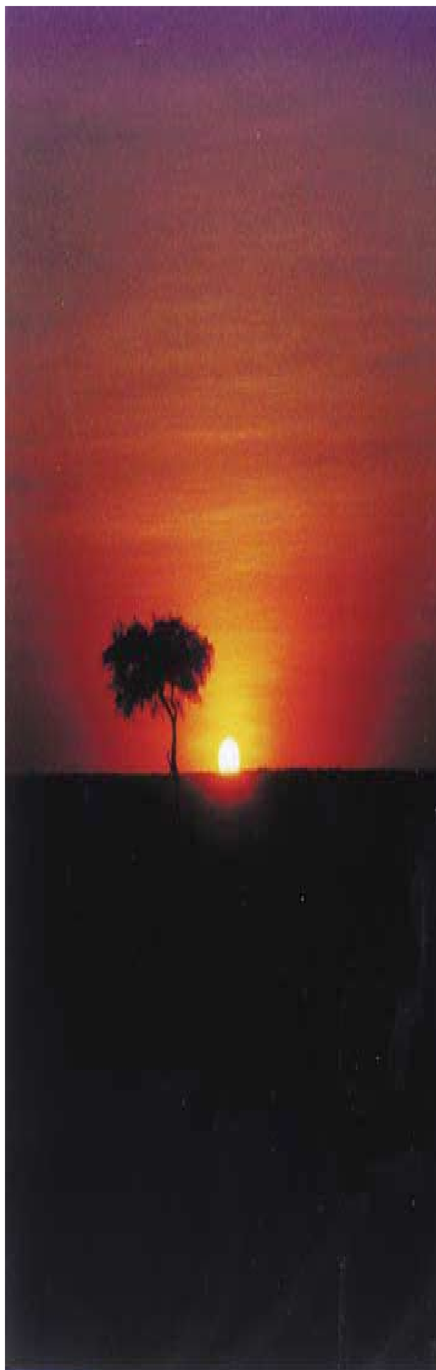

David Clegg believes the opportunities for healthcare with mission have never been greater, and reflects on three key components of Christian care

As we enter the next millennium, is medical mission over? Is the sun setting on a golden era?

Many with experience in developing countries believe the scope for Christian healthcare with mission has never been greater. There are more sick, poor and hurting people in the world today than ever before. God loves the world and still desires that his 'saving health'should go 'among all nations'.

Perhaps then it is just the language for which the sun is setting? The word 'missionary' conjures up an old-fashioned image of colonialism and paternalism, and words such as ''partner'' may become more appropriate.

Jesus clearly left his church with the command to mission, and while the way we relate to others has changed, our way of life should still demonstrate Christlikeness in three areas.

1. Intensity of care: For those we go to

The word 'love' may also have some new interpretations, but the commands to love God and to love one's neighbour are not old fashioned. We can be kept aware of the health situation among the nations by listening to the BBC World Service, by reading professional journals, and by taking mission magazines.

If we are called to go ourselves, we will take our professional help into a world where some health indicators are getting better and some are getting worse, but scientific answers alone are not enough to combat the AIDS pandemic, broken marriages, and child abuse. Teaching the Christian truths of Jesus' death and resurrection in the power of his Spirit can halt these disasters and meet many needs of those who suffer their consequences.

Intensity of care: For those we send

Perhaps we know health professionals working overseas and support them in prayer and in practical ways. We can make them our representatives. To do this properly will make many demands on us but will add a valuable new dimension to our lives.

2. Purity of motive

Hope in a kingdom that does not belong to this world should not be seen as a colonialist threat by those who are concerned with the kingdoms of this world, but unfortunately, meeting the needs of the poor may be seen thus and conflict may sometimes be unavoidable.

What are the needs of the poor? I do not think Jesus sees needs as divided into 'physical, mental and spiritual'. Nor do I believe that he sees healing as a tool for preaching the gospel. His motives were pure. To him, suffering - whatever its cause and whatever its nature - was suffering.

True healing leads to wholeness. Healthcare in the affluent world has lost

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its way because it has lost that vision, but the Christian mission hospital still has the opportunity to share it. The Christian health professional does not need to be an evangelist, the mission hospital does not need to favour Christians nor those who might become Christians, and it does not need to promote any denomination or culture. It will probably have been founded by a foreign culture, and may well work within the context of a denomination, but the only requirement is that the mission staff should be servants of Christ.

The hospital's mission is Christian service. Where Christians with a heart for mission live and work together, there will be worship and study of the Word, which others can join in. The healing ministry should become a holistic ministry to the community, leading not to dependence but to freedom.

3. Humility of method

Serving Christ is an act of faith, dependent on his grace and not our ability. It cannot be paternalistic. Grace does not, however, invalidate skills acquired by training and hard work, but enhances them.

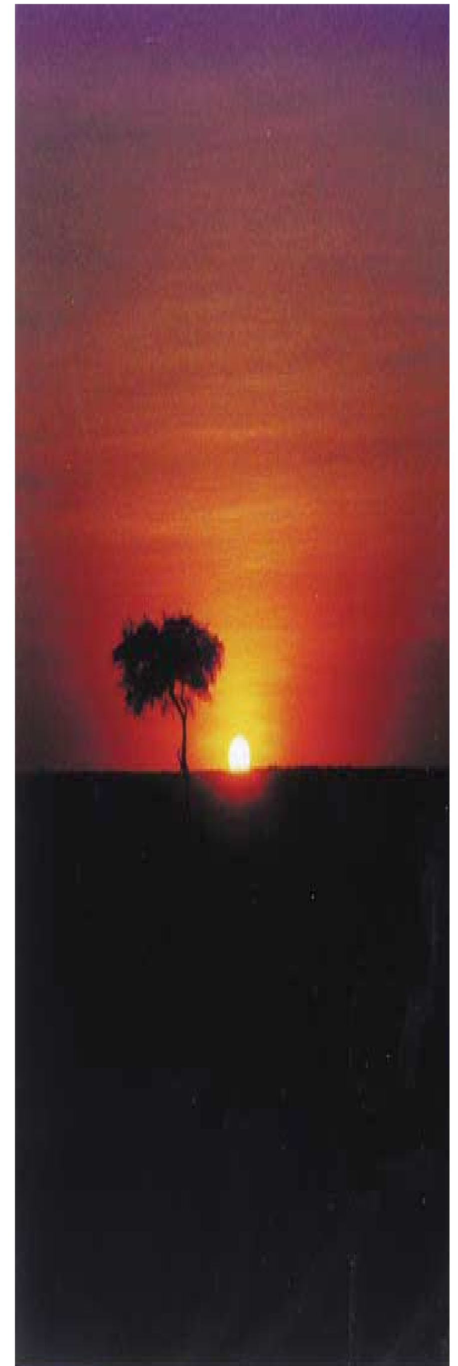
The clinical tools potentially available to healthcare today are very powerful compared with those of a hundred years ago, let alone two millennia. Sadly, widespread poverty often means they are not available. Whether the tools are available or not, we remain dependent on God. Healthcare would never usher in his Kingdom even if it were to find the secret of biological immortality. We may have no more than our shirt to bind a Samaritan's wounds, or we may have a district hospital with reaonable supplies. We may have the technology to eradicate yaws, smallpox, polio, guinea worm, Chaga's disease and leprosy, but other diseases will take their place. Human behaviour and the power of evil will still produce problems like AIDS, resurgent tuberculosis, famine and violence.

Conclusion

Intense care, pure motives, and humble methods - or, in the words of 1 Corinthians 13, love, hope and faith? Like the words 'medical mission', these words may be perceived by changing cultures with different meanings, and may produce different emotional responses, but they define Christ's way of living and working.

They are not utilitarian tools to be used with political skill and a hidden agenda, but concepts to inspire service which openly represents the master who, according to Albert Schweitzer, 'sets us to the tasks he would perform in our time'.

David Clegg is an obstetrician and gynaecologist who has worked in southern Africa for 25 years. He is now the Overseas Support Secretary of the Christian Medical Fellowship and the General Secretary of the Medical Missionary Association.



a world of *opportunity*

Obstetrician and gynaecologist Gordon Mackay shares his experience of short-term service overseas.

My wife and I planned early retirement with the hope that we would spend time abroad helping or teaching in a mission hospital. Because of elderly relatives we decided we could not leave for longer than six weeks at a time, but even so, discovered many openings. Here are four of them:

Uganda - Kisiizi Hospital

I spent six weeks at Kisiizi. Having sent my CV to the Ugandan Protestant Medical Bureau, three hospitals contacted me and I soon found myself sitting in the bus in Kampala, waiting to start the 7-8 hour journey to Kisiizi. It was wonderful to be able to stay with a Ugandan family. At least once I even managed to eat the *matoke*! There were several areas where I found I could help:

Practical gynaecology

There had never been a gynaecologist there before. We were swamped with infertility problems. A number of unusual operations were necessary. Several vesico-vaginal fistulae (VVF) presented, and I was able to teach a method of tackling these. Sadly, there were some difficult VVFs beyond even my experience. Additionally I found myself helping in the arduous on-call rota. The work involved meeting patients with eclampsia and neglected labour, rare in the UK. I could have done other clinical work, but felt it was not right to start doing things like orthopaedics at my age.

Teaching obstetrics and gynaecology

This was relevant so that a Ugandan doctor who had recently joined the unit could work independently, particularly for emergencies. I also demonstrated the use of obstetric ultrasound to general duty doctors, midwives and nurses.

Ministry

This included speaking in chapel: in morning prayers, the Sunday service and small groups. One should not impose oneself but simply be willing if asked.

India

I reviewed a project in Bombay of which I am a trustee in the UK (the Thana Trust). It involved a four-week visit to evaluate a self-sustaining clinical service for the underprivileged. A second visit to India is in prospect.

Nigeria - St Luke's Hospital, Anua, Uyo

I was invited by the consultants in Anua and partly sponsored by the British Council. I had spent a few weeks there two years before improving my surgical expertise in the repair of VVF. This time it was a three-week teaching visit. The work had four aspects:

- Regular theoretical and practical instruction in the use of obstetric ultrasound.
- Systematic teaching of obstetrics and gynaecology through talks, seminars, instruction in exam technique and mock exams.
- Inspection for the Royal College of Obstetrics and Gynaecology to report on the hospital's suitability for training for Membership.
- Christian contact with Nigerian doctors whom I had known previously, and with the local Graduates' Fellowship.

Gibraltar

I did a locum in Gibraltar for a gynaecologist who with his wife also ministers to people working with mission organisations. As he is the only gynaecologist on the island he needs a pool of those willing to do locums. This is a paid post and can help to subsidise the other work done on a voluntary basis.

Making contact

My contacts in Uganda and Gibraltar were made through the CMF. It is necessary to finance travel, insurance and a contribution towards the cost of hospitality.

What can you take?

Ask the hospital contact if there is anything you can take with you. You may go with a full case and return with an empty one, or even leave the case! Suture material is nearly always welcome and is light to carry, but there are unlimited possibilities.

Your spouse

We decided that unless my wife also has a role to play or knows the people involved, it is better for me to go alone for short visits. It is unfair for her to leave home and our local community where she is heavily involved, to go where she will have nothing to do while I'm busy from morning till night. We decided she would not go to Uganda or Nigeria, but she did come to India where she knew some people. There she was able to speak to groups of women, including church leaders' wives.

No hidden agendas

It is important not to have any hidden agendas. This is not an ego trip. The visitor must adapt to the local situation and be a servant for Jesus' sake. The end result should be encouragement both to the expatriate workers and to the local staff.

More than likely you will come away strengthened in the faith and motivated to go again.

Gordon Mackay is retired and lives in Sunderland