Among All Nations

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Christian healthcare worldwide

Photo: Liz Anderson

Is health policy rational?

We kid ourselves we are rational beings, with a capacity for reason we use as and when we want. The World Bank sees health, nutrition and population as integral to its economic policy. It admits it does not have the technical competence of WHO, but it has a lot of money and intends to use it, one Bank economist saying 'Policy based lending is where the bank really has power - I mean brute force'. The Bank also sees itself as a 'knowledge bank', but if it thought brute force could win patient concordance or community participation it would possess knowledge without wisdom.

Part of Christian mission is interpreting God's view of his creation. The age of medicine as pure public service is not over. Unless there is more reason than economic policy to care for the 1.3 billion people living in absolute poverty, mankind is likely to destroy himself and commit 'globicide'. But there is a creator who has given man rationality and in Christ has given reason to use it for a higher purpose than self interest.

Why are Christians not having more effect on world health? It must be the result of the combined choices of every individual who could have been involved. Yet one individual's choice based on truth is ultimately more powerful than all the brute force of a policy that is not. That choice is to implement faith by action and not succumb to the brainwashing of the world, however weak the action based on faith may appear. The cross is inevitable in the Christian life but it is the way that leads from truth to God's kingdom.

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.

Who is the true mission doctor in Africa?

asks surgeon **Michael Cotton** as he suggests Africa's greater need is for managers and administrators

Gone are the days when European doctors went out to join fellow senior staff in a remote but well-equipped and well-organised mission hospital. Most nursing staff and many of the doctors are now locally trained, and a European may arrive to head a team of locals with little knowledge of the local set-up and no experience of it.

Sense of alienation

It may come as a surprise to find that in strictly missionary terms, there is no need for the doctor at all! African churches are more alive, more spiritually aware, and have many more faithful members than those at home. Furthermore, the institution is now in the control of a local organisation, and has its own hierarchy, often more traditional and immovable than its parent European body. That organisation may have lost its vision, and be wracked by internal division, social scandals, and, most commonly, frank embezzlement. No wonder the doctor just gets on with medical work, only too happy to get out of the long-winded committee meetings at which little is decided and less resolved.

The European may find himself or herself working alongside a local practitioner with more experience, and indeed more expertise. This colleague does not struggle with the local language. The doctor may be surprised to find his or her standing locally is not as high as expected and that recommendations and medical orders are not universally accepted. Frequently, the apparently good ideas meet with an overtly positive response but nothing changes, because the local staff are too embarrassed or too polite to argue their case openly. A sense of alienation develops.

The European remnant in a hospital may stick together socially in an enclave, often regaling each other with stories of the locals' incompetence or ignorance. The tendency for superior racist thinking to encroach is then great, and this further alienates the European doctor, who anyway often has a living standard far above those around (simply in terms of books, furniture, cooking facilities, video/TV/computer etc). An outsider who questions how much impact the medical missionary has is met with bemused silence.

Radical rethink

It may well be that the role of medical mission must be radically rethought. Where a national government fails to provide medical services, a mission can step in to fulfil this function - but this needs great sensitivity and tact, and a deep knowledge of local tensions, needs and politics. The mission should probably co-operate rather than compete with government in providing medical input. Yet whenever a mission begins to work with official national agencies, it seems that financial support from Europe flies out the window. Support is based on individuals, and one person on his or her own can generate a lot of valuable backing.

A major need in Africa is not for doctors and other health professionals but for administrators. The singularly vital role of the administrator is too frequently downplayed by mission societies; yet even in a small hospital many thousands of pounds pass through the system. What a temptation for a local, however well-meaning, who sees his lifetime earnings pass before his eyes (on paper at least) in a month! How tempting to use these funds to help out a distressed relative in genuine financial difficulties! How easy to forget this misdemeanour when it is never noticed because no audit is kept! How readily money disappears into personal projects . . .

Not only is the European manager unaffected by these peculiarly African temptations, but he or she has administrative skills gained from working in a well-ordered society unlike the chaotic African *melee,* is computer literate, has a good knowledge of accounts, etc. However, most importantly, he or she has contacts in Europe and hopefully knows how to write appropriate proposals to donor agencies for obtaining funds. These are highly developed skills that doctors neither have, nor have time to acquire.

Who is the true mission doctor?

In all this, the position of the doctor working in the government institution (usually for a pittance owing to drastic devaluation of the local currency) has been overlooked. He or she has very little control over the work situation, over colleagues, and over disposal of the resources available. Yet he or she is in the real world, battling to provide a good medical standard when many colleagues have disappeared after 10am because the demands of private practice supervene. The poorest of the poor patients is someone for whom Christ died, created in the image of God Himself, and the doctor refuses to allow them to be shunted around by officious or uncaring hospital clerks.

The doctor covers for colleagues who have vanished on their night on-call, does not get pushed around or compromised by the big-shot politician, may even have to dirty hands in the muddy waters of local politics for the benefit of those with no voice, and is willing to treat the patient with HIV who is shunned by the rest of the staff.

This doctor is the true mission doctor of 1999 . . . yet how many mission societies recognise or support such a person?

Michael Cotton is a consultant surgeon in Bulawayo

Handing on the baton

Peter Taylor, another missionary surgeon in Africa, argues there's still work for expatriates and Kisiizi needs several!

In a mission hospital today the doctor needs a broad based clinical competency, and in addition often needs skills in personnel management, financial accountability, stock control, building maintenance, continuing medical education and liaising with central government about district health policies. One minute he or she will be devising staff rotas, the next approaching donors abroad, then assessing the future clinical development of TB work, then helping out in outpatients. Running a mission hospital can appear like juggling balls in the air, but there seem to be many more balls than at home and often there is a strong wind blowing in your face at the same time.

Here at Kisiizi Hospital the staff comprises five doctors (of whom two are expatriate), five clinical officers, 40 trained nurses and 40 student nurses and untrained assistants. There are many areas of recent development. The surgical theatre is busy every day, and the range of cases was recently expanded with the appointment of a surgeon.

Kisiizi has just been approved by the Ugandan government to train enrolled nurses. The hospital is trying to make its services accessible to the disadvantaged and has pioneered a community-based health insurance scheme and a community programme for the physically disabled. A rehabilitation centre is being built offering physiotherapy and occupational therapy and a mental health programme encourages the community to bring people to the hospital for treatment. Kisiizi is becoming more integrated within the government's health policy by being given responsibility for the local sub-district.

Kisiizi has always had the spiritual witness of the hospital at its heart, with the holistic vision of its founder to 'bring life in all its fullness'. It has had a strong impact in the local church and many of its staff have moved on to appointments in the government service far and wide.

However, there are two key vacancies coming up. First, the medical superintendent is returning to the UK in a year's time. At present there isn't a national doctor ready to take his place. Secondly, the surgeon will also be returning, in two years. A national doctor is going for specialist surgical training but there will be a two year gap before his return. Why do we need to replace these people with expatriate staff?

One key reason is money. Kisiizi was deliberately set up in a rural area to meet the needs of the poorest. Today, only half the budget comes from patient fees. The rest comes from individual supporters overseas, NGOs, and the government, which provides less than a quarter of the budget deficit.

Expatriate staff come free of charge and with a wide network of contacts they can use to promote the development of the hospital. An equivalent national doctor would cost more than the hospital could afford. It is also a difficult reality of life that when expatriates leave, the readiness of NGOs to support projects also declines. National doctors are under huge pressure to employ their relatives and friends and provide financially for the school fees of their dependants. In their own comments to us here at Kisiizi, they are fearful that if development slows down or salaries are not paid under their leadership, then they will be accused of 'eating the money'. They are glad to be free of these pressures.

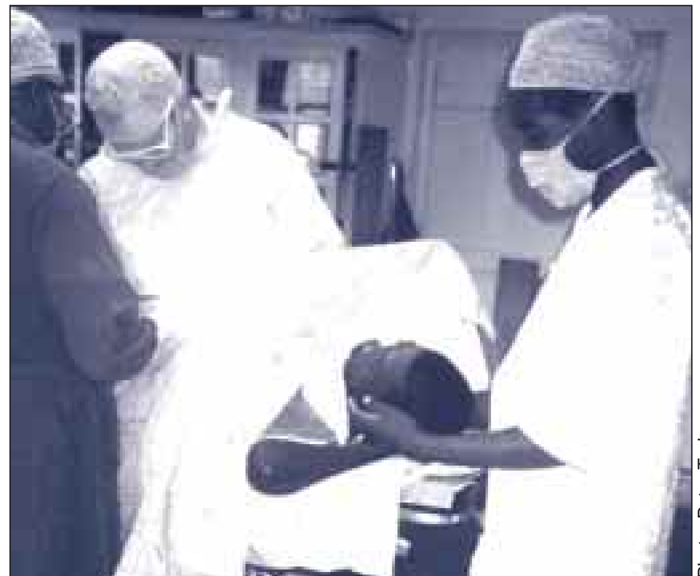

Photo: Peter Taylor

A second reason for wanting to use expatriate staff is less obvious. Although the development of Kisiizi has been marked by a steady improvement and expansion of services, it lives permanently on the edge of sustainability. When crises come, adaptability and lateral thinking are needed to get round the problem. Equipment tends to lie broken. Staff do not have the background of Meccano sets. It is sometimes easier for the expatriate to mend a broken suction machine or design a new computer database. In the NHS, doctors become exposed to many different styles of management which can be used for mission hospital problems.

The work represents a deep and testing challenge with a unique level of satisfaction. A previous medical superintendent said 'Working here is like a marathon relay race and each runner does his best until handing on the baton to someone else'. Are you up to the challenge?

(See job descriptions under 'vacancies overseas')

Peter Taylor works at Kisiizi Hospital in Uganda

Does Romania

Joy Moore is convinced the answer is 'yes'

Ten years ago we watched our television screens in amazement as Laszlo Tokes, a priest of the Hungarian Reformed Church in Romania, preached to his congregation in Timisoara. His faithfulness to the gospel and determination not to succumb to the directions of his bishop, who was a communist lackey, resulted in the 1989 revolution and the downfall of the Ceaucescu regime. Before long our screens were full of dreadful pictures of Romanian orphanages and of the impoverished population who had spawned them.

Many charities moved in to help. Amongst them was The Hawkesly Christian Romanian Trust (or to use the Romanian abbreviation, ATCH-S) established by an English couple, Steve and Mandy Hughes. Seeing that aid was not enough they settled in Sibiu, a university town in Transylvania graced by beautiful Saxon architecture.

Medico-social and spiritual needs

Steve was an Anglican clergyman and Mandy was a health visitor. Two needs were apparent to them; one medico-social and one spiritual. On the medical side the hospitals were ill-equipped, the status of nurses was very low, and community care was pretty well non-existent. Those with the greatest need received least. Those who were the most able received most. No one received much.

On the spiritual side the population had a number of ethnic groups, each with its own predominant denomination, worshipping in its own language and ministering to the cultural as well as the spiritual needs of its people. There was a need to meet together across the divides of history, race, language, politics and denomination and to be reconciled through Christ with each other.

Two interdependent centres were started, a health initiative in Sibiu and a reconciliation centre with residential facilities and conference rooms in a village 12 km outside Sibiu.

Photo: Joy Moore

Romanians love being photographed

Fact finding visit

In 1997 I was coming up to retirement as a consultant community paediatrician. One of the clergy at my church suggested I help the Hughes. I went on a fact-finding visit. My work had been mainly advisory to the Local Education Authority and to Social Services on children with special needs. I had also been much involved with child protection work. I did not know whether this type of experience could be translated to the Romanian situation.

By the time I arrived in Sibiu in April 1999 Steve had been appointed to the post of Chaplain to the British Embassy in Bucharest. Mandy remained a director of the Trust, keeping a watching brief from a 6 hour train journey across the Carpathian Mountains.

The work of both centres had been left in the hands of a young enthusiastic team of Romanians who had just welcomed an

Photo: Joy Moore

28th April 1999 - the church is derelict

still need us?

English health promotion officer working with VSO.

In the ATCH-S offices I found this Chinese proverb framed on the wall:

- If you are thinking one year ahead sow seed
- If you are thinking 10 years ahead plant a tree
- If you are thinking 100 years ahead educate the people

It was clear this sentiment has been at the heart of the work.

Nursing links

Mandy had established a link with Lancaster University and a number of Romanian nurses are on British nursing courses. A School of Nursing is currently being established in Sibiu by an English nurse tutor from Lancaster University. There are regular visits to the ATCH-S centre from a British health visitor and a group of British family planning nurses have run courses for the staff. Good relationships have been developed with the Sibiu hospital medical staff and the ATCH-S centre is used for parentcraft classes. It is also used by the newly established Romanian Down's syndrome group for whom ATCH-S is running literacy classes with a group of Down's children.

The hospitals in Sibiu are staffed by able doctors and much equipment has been given by Belgian, German and Dutch hospitals. Nevertheless the levels of staffing, equipment and patient care cannot be compared with those prevailing in UK hospitals. There was for instance no adequate equipment for testing the hearing of handicapped children.

Many of the conditions treated are rarely seen in England - for example rickets, congenital syphilis, and ascaris infections, to name but a few. There is ample scope for accident prevention. Parents work in the fields and children are often left unattended. There is no child protection system in Romania. One nurse told me when showing me a one year old with syphilitic anal condylomata that child sexual abuse does not exist in Romania! Other nurses asked for teaching on child protection.

Photo: Joy Moore

Ada, the ATCH-S nurse, dispenses antibiotics in the open ... the family hut is rat-infested

Can anybody help?

One day I was asked to do the clinic at a village some 75 km from Sibiu. Whatever was said about a health service for everyone, the reality was far removed from the theory! We drove in the ATCH-S jeep over the hills on a mud track. The village street was a deeply rutted mud quagmire. The clinic room was primitive; there was only a stethoscope and a very unreliable sphygmomanometer. It felt as though the whole village had turned out to see us! We had few drugs; what we had were German and most people could not afford to buy them. Hypertension was a major problem.

I met many very well educated young people but the village schools I visited were extremely impoverished. None of the children in the literacy classes was wearing spectacles. At least two of the pupils had very marked squints and one of these took no part in the lesson at all. Do these children really get hearing and vision tested as in the UK? I doubt it.

Back in the office of ATCH-S in Sibiu I watched the literacy class for the Down's children. Nuti who takes the class is a village girl who is gentle and kind and who needs some input from someone skilled in teaching children with special needs.

So is there anyone reading this who feels they may be able to help?

(See 'vacancies' overleaf)

Dr Joy Moore is a retired paediatrician who lives in Surrey