Among All Nations

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Christian healthcare worldwide

Photo: CMS

On a journey

'They admitted that they were aliens and strangers on earth . . If they had been thinking of the country they had left, they would have had opportunity to return. Instead, they were longing for a better country . .'
(From Hebrews 11:13-16)

When, in the creation story, Adam and Eve were turned out of the Garden of Eden, they were not turned out of an enclosed garden. They were turned into an enclosed wilderness, and became confined to the limitations of time and space. They saw things in physical proportions and felt overwhelmed. Their smallness made them feel meaningless.

God can turn this meaningless existence into a journey of hope. Abraham and Sarah left home and became too old to have children, but Abraham believed God's promise that he would have children as numerous as the stars he saw in the desert sky at night. They had one son of their own but many descendants, and countless spiritual children of Abraham and his God are still being born again today.

This issue includes several stories describing journeys of faith and obedience. One reports 'I changed my whole life's plans in two months'. Others have gone on journeys lasting a professional lifetime. Andrew Potter, working in Benin, visited colleagues in Nepal and found himself 'on a bit of a high'. Returning to his own work was 'Oh! so depressing'. Asking 'why are we here?' his answer on reflection was 'I am here to serve'. We hope the following pages will help you with some ideas for journeys of service.

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.

Highs & Lows *in Nepal and Benin*

Andrew Potter, an ophthalmologist, recounts feelings prompted by a visit to Nepal

One Sunday afternoon in Nepal two colleagues and I drove about six miles to visit a twelve hectare piece of land owned by the hospital. It was open farm-land. Now, a few years on, it is thickly wooded, as thousands of young trees have been planted. Several large ponds have been dug and stocked with fish. The sky was cloudless, the sun brilliant and, with a gentle warm breeze, it was idyllic.

I was in Nepal to upgrade my surgery. Christian Blind Mission has decided to offer blind people intraocular lens implants after cataract extraction so that they will no longer have to wear those thick, heavy glasses. Working alone for over twelve years I've not benefited much from meeting others who serve in the developing world. After walking through dense clumps of tall bamboo we sat down on a wooden veranda to chat. First to speak was Dr Margaret Hogeweg. For three months of each year she works with CBM visiting hospitals and clinics in South East Asia, including China, Mongolia, Tibet, Vietnam, Thailand, and Burma.

Eye camps

For seven weeks she works for the Lions Club of Holland, holding eye camps in Nepal in remote mountain villages. She and her eye nurses and a string of porters carry all they need: food, bedding, clothes, medicines, instruments, equipment. They walk for two or three days up valleys, over mountain passes, through snow, across rope bridges, along slopes where landslides have obliterated the footpaths, and fording streams, until they reach their first village.

They set up the clinic in any available building. For four or five days they examine patients, selecting those who need surgery, then operate and, leaving a couple of eye nurses there to look after the surgical patients, trek for a further two or three days to the next isolated hamlet. Over seven weeks she operates on between 350-400 patients (the number of operations for an 'average' ophthalmologist in England in a full year). She has done this for ten years - and is now in her fifties. Her work has been recognised by the Nepali government and she is to be decorated by the King.

For six weeks she visits Nigeria on behalf of the Dutch Leprosy Association. She travels for six months each year, leaving her husband in Holland. While at home she works for part of the year in a university department of ophthalmology. It makes one breathless just listening to her.

Next Dr Albrecht Hennig described how in 1983 he was sent to set up an eye department in a small general hospital in Lahan, south east Nepal, about twelve miles from the border with northern India. The population of Nepal is around 19 million, but India's 900 million seem just a stone's throw away. Annual outpatient attendance has soared from 17,000 to 72,000. Last year they operated on over 12,000. This puts into perspective my recent boasting in Benin, when I reached just over a thousand! CBM built him a 270-bed eye hospital next door to the general hospital and they employ a staff of sixty including two Nepali eye surgeons.

Dr Hennig's two sons are now in a boarding school in India. Before that they were in Kathmandu, which takes over a day to reach by car, so for several years his wife and sons lived in the capital during term time and the family endured long separations. That takes commitment.

And the woods and fish ponds? They are to help the hospital support itself financially. The timber can be sold and new trees planted. The fish will go to market and all this will provide income to enable the fees to be kept low. Meeting Dr Hogeweg and Dr Hennig was stimulating and enriching. I salute them.

Back in Benin

I was on a bit of a high in Nepal and not just because I was in the Himalayas. It is good for us to ask occasionally 'Why are we here?' Today in church, during the incomprehensible translation from French into Fon, my attention was drawn to verse 12 from Ephesians chapter 4: '. . to prepare God's people for works of service . .' Aha! 'Service' is not a word one hears very often these days. We hear of 'fulfilment', 'reaching one's potential', 'doing what feels comfortable'. Even among the so-called caring professions few talk of vocation.

Returning to Benin was oh! so depressing. I felt close to writing a letter of resignation. Somehow I didn't. A dreadful nurse left. Better ones took his place. Patients began to arrive in larger numbers. After six months without rain the heavens opened. But above and beyond all the difficulties is the sense from which I am unable to free myself. It is that I am here to serve. Should I leave, resign, or be fired, nothing will remove that vocation.

Dr Andrew Potter works in Benin and this article has been extracted with permission from his newsletters.

modern medicine modern mission

David Clegg looks back to Jesus to set a standard for contemporary Christian health-care with mission.

Jesus healed those he met who needed to be healed, and at the same time he spoke to them about the Kingdom of God[1]. Their healing was part of the evidence for his authority, but apart from that he had no hidden agenda.

No disgrace in the diagnosis

Whether the illness or disability was the result of their lifestyle, or that of their parents', or had no connection with either, their healing did not depend on repentance. On just one occasion[2] he did delay healing, as first he debated with the crowd about whether it was easier to heal the body or to forgive sin. In this case the paralysed man had been lowered through the roof by his friends in order to jump the queue. There was no danger of his being embarrassed further by this little bedside tutorial.

The only pre-condition for healing seems to have been faith in Jesus[3,4,5]. People asked him to heal them. No failure to heal nor complication of the cure is recorded. His disciples failed to cure an epileptic boy[6] but Jesus took over and healed him.

Once when a woman with menorrhagia secretly touched Jesus in a crowd[7] and was healed, he did ask her to say what had happened in order to teach that it was her faith in him that had healed her. Sometimes [8,9] he told the patient to tell no-one else because he wanted to avoid being delayed in his preaching ministry by his healing ministry. Moreover, he did not at this stage want his divine identity to cause open conflict with the authorities.[10]

Jesus healed people out of compassion.[11] They did not owe him anything. When he had cured ten men with leprosy[12], only one bothered to come back and thank him. Those he healed were under no obligation to follow him as a result of their healing.

If a physical cure of disease or disability is all that happens through healthcare, there is only a temporary benefit. Jesus' gospel teaches that whether we are sick or healthy, there is always sin to be forgiven, self to be abandoned and eternal life to be received. Following him means confessing his name and living a life of service. So, the healing practice of Jesus challenges a secular health service that may heal the body, but ignores the healing of the soul.

John the Baptist spent his life telling his nation, Israel, then under Roman occupation, that God would send the promised Messiah to deliver them. John, imprisoned by Herod, and seeing no sign of Israel's release, wondered whether he had made a mistake in pointing to Jesus as the one who would fulfil this prophecy. Jesus sent John's followers[13] back to him with the message: 'The blind receive sight, the lame walk, those who have leprosy are cured, the deaf hear, the dead are raised, and the good news is preached to the poor. Blessed is the man who does not fall away on account of me.'

Jesus' healing was evidence of the coming of the Kingdom of God, but his authority does cause some to fall away. Since his life on earth, a healing ministry to the poor has developed wherever that gospel has been preached. Jesus had taught his followers that they would do greater things than him. Scientific medicine could have controlled and eliminated diseases of poverty and affluence world-wide, but instead, lifestyles have seldom changed for the better. Technology has failed to control many potentially controllable diseases. And new ones have replaced those that have gone. Meanwhile curative medicine has priced itself beyond the reach of the world's poor.

In many churches in the developing world there has been a resurgence of faith healing. It may not always be honest but when it is honest, something greater than the cures is happening - 'the poor are hearing the good news preached'.

A diagnosis that disgraces us

As healthcare professionals, we and the societies who have raised us face a diagnosis that disgraces us. The gospel has not been preached and a healing ministry has not been taken to all the world. We may also face a therapy that is threatening to the economy on which our professions have been built, for when the poor are empowered the rich are disempowered. This was what Jesus wanted. It made him unpopular and led to his death.

In some places the emergent churches are using scientific medicine according to the values of the Kingdom of God. They are combining it in a holistic ministry that includes Kingdom preaching and teaching. In spite of opposition, partnership in these projects is the way medical mission should be going.

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

References

1. Luke 9:11
2. Luke 5:17-26
3. Luke 7:9
4. Luke 8:50
5. Luke 18:42
6. Luke 9:37-43
7. Luke 8:43-48
8. Luke 4:43
9. Luke 5:14
10. Mark 3:12
11. Luke 7:13
12. Luke 17:11-19
13. Luke 7:18-23

Healing in the Killing Fields

A few hundred yards from the Church of Uganda mission hospital in Kiwoko stands a simple memorial. It marks the mass grave of 372 people killed by government soldiers in 1985. That atrocity was one of many perpetrated during the bush war in the Luwero Triangle in the 1980s.

These people were summarily shot, accused of sheltering members of Yoweri Museveni's National Resistance Army. In a poignant moment our Ugandan guides open the cover and we peer down into the darkness at a pile of skulls. 'Were any of these people your relatives?' we ask. All four of them nod silently.

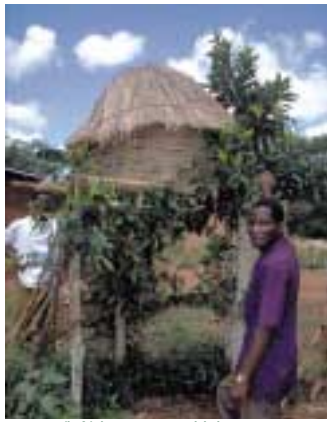

Photo:John Crone/CMS

Moses (left) inspects a chicken coop

Luwero, Uganda's 'Killing Fields', was a byword for violence and inhumanity. In the wake of the bush war it was almost depopulated. Now the people are returning and Kiwoko Hospital, founded at the end of the war, is one of the signs of hope in the area. It began as a simple local clinic. Under the energetic leadership of Dr Ian Clarke of Church Mission Society, Ireland, it grew into a major hospital, offering a full range of services including a commitment to community based healthcare.

Dr Nick Wooding of CMS UK has been at Kiwoko for just a few months. Nick and his wife Kate are 'old hands' as far as Uganda is concerned. Between them they did five short term placements in Uganda before becoming CMS mission partners. One of Nick's tasks is to supervise community health care. 'I could stay at the hospital all the time, treat people and make them better. But that would do nothing to prevent disease', he says.

Community health workers

What is important, however, is the way he is going about it. There was already a team of local community health workers before Nick came to Kiwoko. His task is to help them set clear goals and to give the support they need to do the job. 'I try to stay in the background and can offer advice if asked. It is important that they know they can count on the support of senior staff at the hospital.'

That means working alongside the community health care team, in particular its leader Moses Ssekidde. Moses heads a team of six trainers and 30 community health workers. The community health workers are voluntary people selected by the community to mobilise and educate the community in health matters.

Moses says that the community's long term aim is to have a qualified community healthcare facilitator for every square kilometre in Kiwoko's catchment area. His team walk their beat or travel on bicycles provided by Friends of Kwiwoko.

Preventing disease is more than half the battle. The team has identified a number of key areas that will make a difference in the fight: nutrition, water and sanitation, AIDS prevention, economic development, mother and child health, prevention of communicable diseases, self help for the disabled, and evangelism. The problem of AIDS is growing. In 1986, according to Moses, there was just a single case in the Kiwoko district. Currently there are 35 sufferers.

Food and water

Proper nutrition is top of the list. The Ugandan government says that 19 per cent of the population is too poor to buy adequate food. 'Another problem is that even where families can grow enough food for their needs, they don't always know how to plan a balanced diet for their children', says Moses.

Next most urgent is provision of clean water and proper sanitation. Government surveys a decade ago in Luwero found that five out of 10 waterholes for domestic use were contaminated and only half the households had a properly constructed pit latrine.

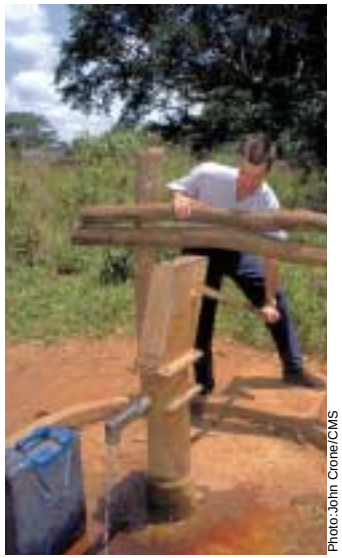

Photo:John Crone/CMS

Dr Nick Wooding works the pump

Moses and his team have been systematically trying to put the situation right. Each member of the team has set clear goals of how many new water safety projects and pit latrines they expect to see in place over the coming months. Driving amid banana and coffee groves, along muddy tracks impassable by other than four-wheel drive vehicles, we are taken to see some of the latest projects.

We stop at a recently installed bore hole with a simple hand pump. The water is drinkable without the need to boil and serves around 300 people. We are taken to a house where the family has constructed a pit latrine, a wooden rack to store cooking utensils off the ground, a chicken coop to keep animals out of the family living area, and a walled-off oven. Falling into open fires is a source of horrendous injuries, and it happens far too often here.

It all sounds very basic. People in Britain would take these facilities (or better) for granted. Here in Luwero the fight to get them in place has a long way to go. Moses suggests that a network of 200 voluntary community health workers is needed to complete the job.

A new breed of educators

Recently Kiwoko sponsored Moses on a teacher training course. It has equipped him for one of the most important parts of his work, visiting the 22 schools in the district to teach health and hygiene.

He is one of a new breed of educators. Traditionally Ugandan schools emphasise rote learning, not suprisingly when classes can be as big as 60 and teaching resources are scarce. He breaks moulds, using mime, role play and music to get across his message.

We visit two schools. Our visit coincides with a local polio immunisation campaign. Moses is keen to promote it. In Uganda 69 per cent of disability is due to polio and could have been prevented.

He has devised a mime to show how immunised people can ward off disease. The message is simple. Immunisation protects you. A child stands out at the front. A group are given masks proclaiming they are antibodies. Another group play the role of germs, putting on suitably lurid masks made by Moses.

Photo:John Crone/CMS

Health messages under a mask

With no antibodies to protect him the lone child is easy prey for the germs who descend and wrestle him to the ground. But when he is surrounded by antibodies, the germs can get nowhere near him and they are wrestled to the ground. Everyone laughs, but few will forget the lesson.

We go to another school, a simple mud hut set among a grove of trees. There are 160 children on the roll and just four teachers. Recently a dentist on a short term elective in the Kiwoko district looked at the teeth of 2,000 children and found 500 needing dental work. We sit out in the open while Moses demonstrates the fundamentals of dental hygiene, improvising with the skull of a wild pig. He demonstrates use of sticks and charcoal for those without access to toothbrushes and paste.

Where evangelism comes in

Afterwards I asked Moses about an issue that intrigued me throughout our visit: where does evangelism come into all this?

'We do it by running community Bible classes', he tells me. 'Here we believe that health is a state of complete well-being, physical and spiritual. So that is why evangelism is included.'

'If someone is suffering from headache, that person has to be treated physically. But if someone has a negative attitude to other people, that is a spiritual illness and it has to be "getatable". We have found that since evangelism helps change attitudes it has played an important role in bringing better health.'

John Martin is a journalist and broadcaster, and is also Associate Editor of *Triple Helix*. He spent three weeks in Uganda in August 1997.

a world of *opportunity*

Two students in different disciplines were changed by their electives

Deborah Roberts was a final year nursing student in Liverpool when she did her elective in Uganda in February 1997

I have long wanted to nurse and travel. Here was my opportunity to combine the two. I applied to a number of organisations who have links with hospitals in India, South America, Africa and Israel. Africa Inland Mission International (AIM) offered me the chance to nurse in Uganda with only six weeks to go.

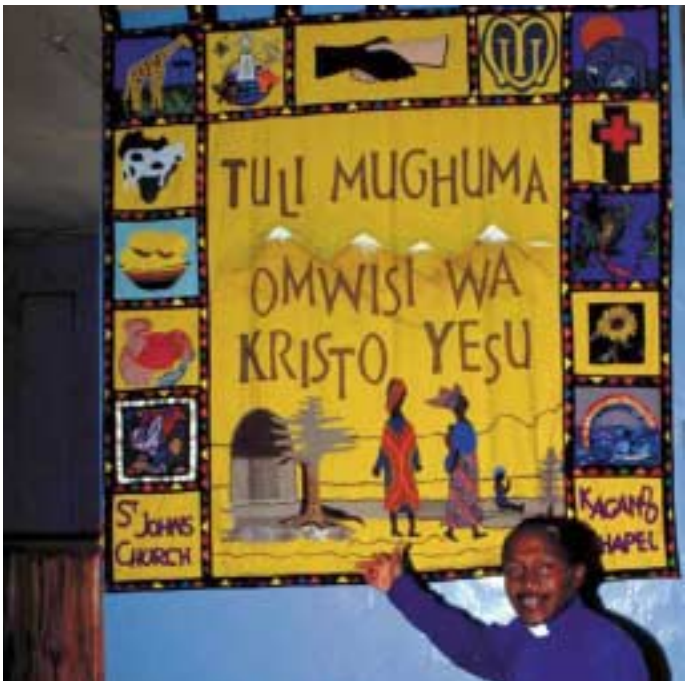

Photo:John Crone/CMS

Inside the chapel at Kagando

Kagando is located in the foothills of the Ruwenzori Mountains, bordering Zaire, in the south west of the country. It is a very remote but beautiful place with which I instantly fell in love. Kasese is the nearest town, about 45 km to the north, and the equator is just five km away. The hospital was established about 30 years ago by AIM and serves a district of some 250,000 people, despite only having 280 beds. It has a reputation for providing good and comprehensive services to the local community. Patients have to pay for their treatment here, but are free from the rumoured bribery of government hospitals. People will travel considerable distances for treatment at Kagando. During my four weeks I assisted in theatre, helped deliver babies, and expanded my (limited) paediatric knowledge. Most of my colleagues were Ugandan. Westerners are in the process of handing the running of the hospital over to a Ugandan leadership team. The staff were extremely welcoming and supportive, and I gained significant insight into nursing in Uganda, where the relatives take a very active role in caring (so different from Britain).

I am glad I took the plunge and went to Africa for my elective. It was a time of consolidation and reflection on my training so far and a chance to consider future options. Once I have qualified I hope to return to Africa to work, to Uganda if possible.

Scott Farmery was a medical student in Aberdeen when a two month elective changed his life plans

I arrived in Bangladesh the day the rains finished. Waterlogged fields made the final approach to the airport look like we were touching down on a swamp. The temperature was warm, the air humid but bearable. Airports are thankfully the same the world over.

Day two found me on a domestic flight north to the mission hospital at Parbatipur. The hospital is recent compared with the public health scheme founded by the same mission nearly thirty years ago, but its main emphasis is still prevention and community health. The staff are a mixture of nationals and expatriates. Recently the directorship and the medical team leadership positions were allocated to Bangladeshis. All made me feel very welcome.

Before I came I had tried to define what I wanted to achieve:
1. To make a contribution to the hospital, whether by helping in clinics, analysing statistics or building latrines.
2. To undertake a project acceptable for my degree.
3. To understand what it meant to be a medical missionary.
4. To get an insight into the Bangladeshi culture.

I deliberately decided against using my time to gain clinical experience or to learn about medical problems peculiar to Bangladesh. I managed all my ambitions, and also assisted a little on ward rounds.

My project involved assessing the mortality figures for the hospital. The importance of primary prevention was nowhere more clear than in those pathetic figures and tragic case notes. Infants dying from infections almost unheard of in the UK, mothers presenting with advanced pre-eclampsia, widespread TB, and malnutrition. At the root of 101 diseases is poverty in all its cruel aspects.

I changed my whole life's plans in two months. Surgery, my original ambition, would have saved just four of the 214 lives lost in two years. Based on my research I discovered that public health was the most needed specialty in situations like this. It was a lesson I wasn't expecting. I would rate my elective as one of the most incredible and constructive periods of my life. It was certainly stressful at times, but the value of experience in the developing world cannot be over-emphasised.