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Understanding disease – traditional, modern and Christian approaches

Transforming communities with Good News in all its fullness

The heartbeat of integral mission

Integral mission or holistic transformation

Preparation for short- or long-term medical mission

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Please submit all contributions to:

THE EDITORS Dr John Foley
12 John Ramsay Circuit, Hope Valley, SA 5090
Ph: 08 8395 5007
Email: djfoley@ozemail.com.au
Dr Paul Mercer
Ph: 07 3348 9940
Email: silkymedical@ozemail.com.au

Subscription and change of address details to the National Office listed below.

SUB-EDITOR Sue Furby
14/57 Moss Road, Wakerley, Qld 4154
Mobile: 0403 822 006
Email: suefurby@hotmail.com

CMDFA

CHAIRMAN
Dr Judy Fitzmaurice
38A Stevens Street, Pennant Hills NSW 2120
Ph/Fax: 02 9980 5860 Mobile: 0434 967 678
Email: judyfitz@securenym.net
Or: fitzbitz25@hotmail.com

NATIONAL OFFICE
Unit 35A / 9 Hoyle Avenue
Castle Hill NSW 2154
Ph: 02 9804 8890 Fax: 02 9804 8644
Email: office@cmdfa.org.au

BUSINESS MANAGER
David Brown
Contact through the National Office

NATIONAL SECRETARY
Dr Yvonne Lai BDSc(WA)
Email: yvonne.yl.lai@gmail.com

NATIONAL TREASURER
Dr Richard Allan (PHD Economics)
Email: office@cmdfa.org.au

ReGS (Recent Graduates & Students)
Dr Joanne Ma (recent graduates)
Email: joannejjma@gmail.com
Dr Christopher Chan (students)
Email: christopher.chanchimyuk@gmail.com

BRANCH SECRETARIES
NSW and ACT:
Richard Wong
Email: nsw@cmdfa.org.au

QUEENSLAND:
Vincent Lee
Email: qld@cmdfa.org.au

SOUTH AUSTRALIA (and NT):
Chrissy Lai
Email: Lai0051@hotmail.com

WESTERN AUSTRALIA:
Moses Lee
Email: Office@cmdfa.org.au

VICTORIA (and TAS):
David Tsang
Email: victoria@cmdfa.org.au

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editorial

Integral mission or holistic transformation

"Integral mission or holistic transformation is the proclamation and demonstration of the gospel. It is not simply that evangelism and social involvement are to be done alongside each other. Rather, in integral mission our proclamation has social consequences as we call people to love and repentance in all areas of life. And our social involvement has evangelistic consequences as we bear witness to the transforming grace of Jesus Christ." "As in the life of Jesus, being, doing and saying are at the heart of the integral task".

(The Micah Declaration on Integral Mission, www.micahnetwork.org/en/integral-mission/micah-declaration)

This edition of *Luke's Journal* looks at ways in which members of CMDFA and others are working out the "integral task" in Australia and the world. They demonstrate that "evangelism and social responsibility, while distinct from one another, are integrally related in our proclamation of and obedience to the gospel... They mutually support and strengthen one another." *(Evangelism and Social Responsibility: an Evangelical Commitment. Occasional Paper No 21. www.lausanne.org;all-documents.lop-21.html)*

James Wei's remarkable story of developing a rural health project in India comes about through a chance meeting and a long personal relationship.

Steve Bradbury in *The Heartbeat of Integral Mission* draws on experience of working with TEAR in Uganda, Cambodia and Nepal to raise to central prominence " No-strings-attached, extravagant love – Christ-like love – this is the heartbeat of integral mission."

Judy Fitzmaurice describes Community Health Evangelism approach in communities training volunteers as a wholistic and transformational development ministry based on sound primary health care and development principles, combined with a consistent Biblical framework.

Teem-Wing Yip calls us to take up the challenge of mission in central Australia. The need in our own country is as legitimate as overseas mission and is neglected.

Doug Shaw tells the story of Intermed, a course of practical preparation for health workers with a strong Christian foundation as preparation for integral mission.

Nathan John's work among people with disability in India and his personal experience of disability in his family are described. The inclusion of those with disability in our community and missions bring blessing.

The articles are like a few splashes of colour on a very big canvas depicting God's mission of redemption for the world. There is so much more of the picture that could be displayed and we will not see the completion until the last day.

Owen Lewis
Guest Editorial

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"Shining as Lights"
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The Heartbeat of Integral Mission

by Steve Bradbury

Director of the Micah 6.8 Centre at Tabor Victoria. Designer and Coordinator of Tabor Victoria's MAVP Aid and Development, and teaches both undergraduate and graduate courses in integral mission for Tabor and Whitley Baptist Theological College. Served for 25 years as the National Director of TEAR Australia (1984-2009), and several years as Chair of both the Micah Network and the international Board of Micah Challenge.

Imagine yourself walking with me along a narrow foot track in rural east Uganda. We wind our way through fields of cassava and little clusters of small mud-walled homes. The sun is just beginning to set, so the high temperature of a steamy tropical day is reducing to a more gentle warmth. There's a little breeze, and kids out playing in the cool of the early evening call out cheerfully to us as we meander by.

After about 30 minutes we reach our destination – a compound containing a few small homes. Sitting outside chatting and enjoying one another's company are three elderly women. They weren't expecting us, but our Ugandan companions are well known to them, so they offer us a shy but warm greeting. This quickly transforms into an enthusiastic welcome when they hear we are from TEAR Australia. "We are so happy to meet you," they say, "because of you we are able to live normal lives!"

Let me explain. The three women are all widows. Their husbands had been killed by Karamajong raiders from the north. Those same raiders had stolen their cattle. For the Iteso people, as with the Karamajong and many of the other ethnic groups in the eastern regions of Africa, cattle are like money in the bank. But more than that, for these women cattle meant the capacity to plough enough land to ensure adequate food production. Without cattle they would be condemned to abject poverty, and all the suffering such poverty brings. Added to this is the scourge of HIV/Aids, introduced into the region during a period of civil war. Many of the children of women like these had died, leaving large numbers of Aids orphans to be raised by widowed grandmothers.

What had TEAR done that caused these women to so enthusiastically welcome us into their community? In the grand scheme of things, very little. Our part in the process of enabling these women to "lead normal lives" had been a minor one. We had made a small grant to a regional community development agency that had been set up by the Pentecostal Assemblies of God in Kumi. They were the ones embedded in their local communities, and they were the ones doing the work. They used part of our grant to provide particularly vulnerable families with a couple of replacement cattle. The three widows were among the recipients. They had combined their cattle, and grown them into a small herd. Their land could now be ploughed, and they could sell their excess milk. They were far from wealthy, but this small income was enough to cover their basic needs and those of their grandchildren. They could, in their words, now "live normal lives".

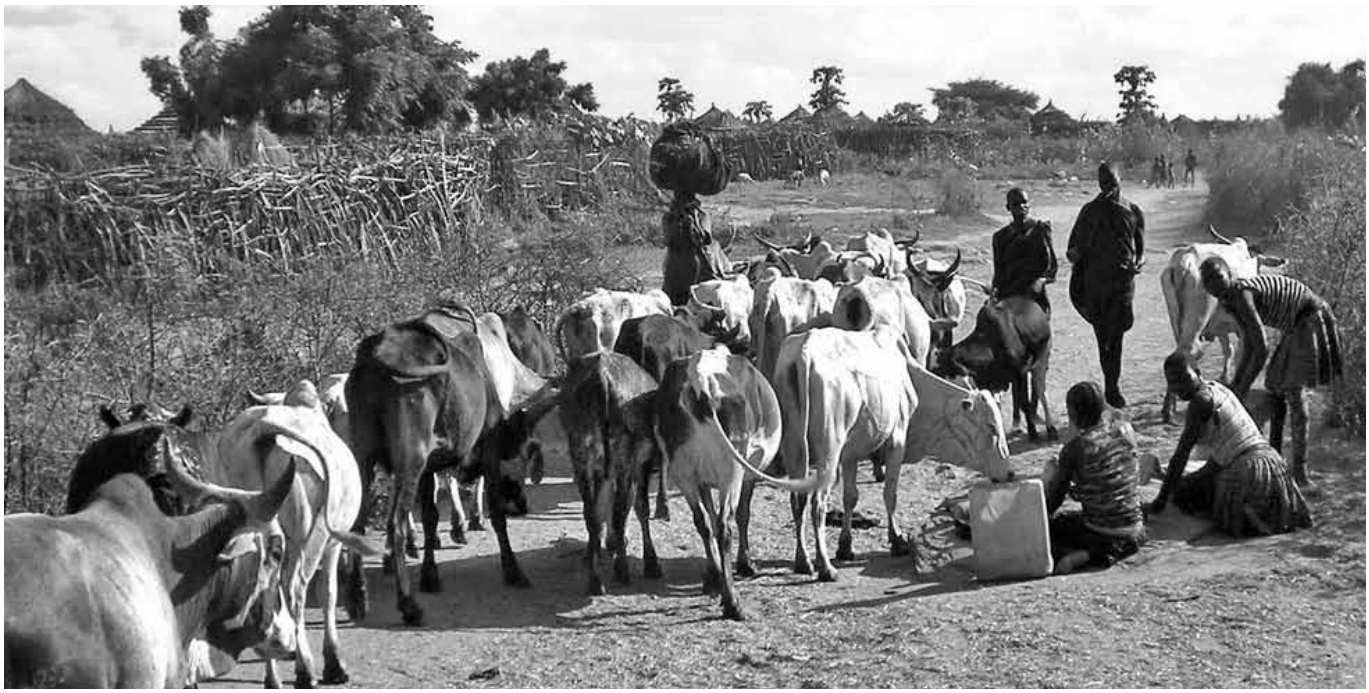
This is just one small story – but it provides us with the human face of development.

Making a difference

We have all seen the statistics of poverty, sets of numbers which so hopelessly and inadequately try to define and measure the scale of human suffering. And our knowledge of what it means to inhabit those statistics can only be sketchy if we haven't had the privilege of getting to know by name at least some of those who rank among the world's poorest people, listen to the stories of their communities, hear their histories, be infected by some of their pain, be amazed by their resilience and persistent humanity.

But, as inadequate as our knowledge is, we nevertheless recognise that billions of people struggle for survival below the poverty line. We have seen the charity advertisements. We understand that it is possible for community development interventions to make a difference in the lives of the very poor, and because of this we have probably bought our gran a goat for Christmas from the TEAR Gift Catalogue, or one of the myriad of clones that it has spawned. Who knows, one of us may even have made the donation that provided for the purchase of the cow that was handed over to one of the women I met on that pleasant Ugandan evening.

Strategic community development interventions such as these, that provide the poor and marginalised with the means of production, or new knowledge and practice that reduce illness and thereby increase productive capacity, can and do make a critical difference.



But hard-earned experience has taught that such interventions must be managed so as to enhance human dignity rather than further erode it, to empower locals in their pursuit of a better future rather than further disempower them. The agenda for economic and social development in a community must be the product of genuine and respectful dialogue. Sadly, the battlefield of community development, if you can forgive me a singularly inapt metaphor, is strewn with the carcases of failed projects and disappointed hopes. Far too often this is because the outside "expert" has assumed he or she knows what is needed and what must be done, and has failed to adequately acknowledge the wonderful reservoir of human giftedness that God has already placed in the community. In the words of Jayakumar Christian, the CEO of World Vision India, the poor too often suffer because of the god-complexes of the rich and powerful.

But, development interventions leavened with wisdom and respect can facilitate economic and material improvements in very poor communities, and this is very significant. So significant in fact that I want to emphasise that nothing I am about to say should be interpreted as in any way dismissive of the value of economic and material improvement. If you are very poor, if life is very hard and very tenuous, then a lift in your productive capacities, and a lift in your family income and the security of that income, can be the source of much happiness.

This was beautifully illustrated in the experience of a small Cambodian rural community I visited just a year or so before I left my work at TEAR. Economically it was a very poor community, and an indigenous Christian development organisation had been working with some of the poorest families to improve their circumstances. I sat with a few of the folk under one of the homes on stilts, where we sheltered in the shade as we discussed the impact of the project. Through a translator, they spoke to the TEAR staff member responsible for liaising with TEAR's Cambodian partners, answering her questions as best they could. The translator was much more skilled in Khmer than English, so it wasn't a straightforward discussion. We wanted to know about the new micro-enterprise initiatives that had been developed, the new wells drilled, the number of pigs that had been distributed – simple data, but the translator struggled to ask the right questions. But somewhere in the mix of our discussion he must have asked the perfect question, because suddenly what we heard from a group of the women went something like this:

"Now, because of this project, we are so much happier. Our husbands have stopped beating us, and now we can now afford to send our children to school. There used to be only a couple of Christian families in this village, and now there are several Christian families and we have been able to build a small building to worship God in. We are so much happier than we used to be!"

"...the poor too often suffer because of the god-complexes of the rich and powerful."

This was no carefully rehearsed answer, but a communication from the heart.

As I listened my eyes welled with tears, and believe me I am not a weeper! What I was hearing and seeing was the evidence of transformational development. An

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outcome such as this is what the integral mission practitioner yearns, prays and works for.

We must not make light of the massive significance of material and physical well-being, as though it didn't matter. It matters to God. Christianity's sacred texts are full of exhortations that insist that the generosity of creation must be distributed justly so that no one goes without. These same texts recognise the sad realities of economic mal-distribution - whether this is the result of the misuse of power, a consequence of natural disaster, or the product of human failure and weakness – and urge *those who have* to respond with radical generosity and justice to *those who have not*. It matters to God that each person has access to the resources needed to flourish. And what matters to God should matter to us!

> *"…political and economic thought, particularly as it relates to international development, is founded on an inadequate and ultimately harmful vision of what it means to flourish, a vision that is fundamentally acquisitive."*

The Report contends

> *"that we desperately need to regain a fuller, more realistic vision of human flourishing – of humans as creative, productive, responsible, generous beings – if we are ever to address the problems of poverty, inequality and environmental degradation that threaten the world."* [1]

"It matters to God that each person has access to the resources needed to flourish. And what matters to God should matter to us!"

Economic and material development matters, but it is not all that matters, not by a long shot.

> *"One does not live by bread alone, but by every word that comes from the mouth of God." (Mt.4.4)*

Transformational development embraces fully the need for economic and material development. But it goes beyond this in recognising the critical truth that human beings cannot flourish on bread alone. More than that, it also recognises that a purely economic understanding of development can be harmful and destructive.

In a 2010 report produced by Theos, Tearfund and CAFOD in the UK it is argued:

Before continuing I want to make an important aside.

A transformational understanding of community development should help us recognise that change is not something that is only needed in the communities of need, but also in the communities of excess. The "realistic vision of human flourishing", as defined in the *Wholly Living Report*, involves justice and radical generosity, the acknowledgment that the earth's bounty is a gift from the Primary Owner, given on the understanding that it is to be shared fully among its human inhabitants.

Human flourishing

Let me return to the issue of human flourishing. A core Biblical assertion is that the full flowering of human flourishing is dependent on "every word that flows from the mouth of God" being taken into account. This means that we need to take into account the whole Biblical story and the wholeness of the Biblical story. We need to understand the overarching narrative and its content, for in a unique way it is the carrier of the word of God. In its pages we see God's hopes of shalom for his creation – of peace and love, of justice and compassion – of a human society in which there are no more tears, in which all human need in all its various expressions will be satisfied, and humanity will live in harmony with itself, with creation, and with the Creator. Christians who have understood this have been in the forefront in championing human rights, social justice and greater equality, as well as in the forefront of humanitarian aid and community development. Sadly, it also has to be recognised that, whenever and wherever the institutional church has become aligned with the powerful, many in its leadership have been at the forefront of resistance to the demands for greater social justice and equality.

Absolutely central to the Biblical narrative is the core conviction that it is only in a loving and obedient relationship with God that we can experience the quality of life and living that is our Creator's intention. It is here that we must part company with the secular model of development that has dominated the understanding of development in Western society for the last 60 years.

During my last visit to Nepal, I met briefly with a small group of Christian women who had gathered together for their weekly Bible study. One of them had walked for two hours to get to the group – and it was no light stroll either, but a matter of clambering up and down mountain slopes with a baby strapped to her back. Moreover, I knew that the once reliable Monsoon rains had come very late that year,[2] and people like this woman and her husband were frantically planting out their paddy rice in the race to give it time to mature for harvest. Yet, despite the four-hour round trek and the urgency of the planting schedule, here she was at a Bible study. I asked her why she came. She couldn't even

Photo: Nancy Collins - http://www.abohemianadventure.net/nepal-photo-gallery.html

read the Bible, but had to rely on one of her friends to read it to her. With my colleague Ramesh translating, she simply told me that she and her husband had decided to become followers of Jesus only a year or so ago, and if I knew what a difference that had made to their lives, then I would understand why there was no way she would miss her weekly Bible study and fellowship.

I believe this woman and her husband, along with several other Nepali Christians I encountered on that same visit, are vibrant illustrations of the truthfulness of Jesus' claim that it is in relationship with him that we can experience "life in all its fullness".[3]

In language highly unusual in the academic discourse on development, Michael A. Edwards, an influential development practitioner and author of numerous papers on the work of Non-Government Development Organisations, argued in a conference address in 2003 that "the future of the world depends on how successful we are in developing a new science of love".[4] He explained that more than twenty years of "evaluating individuals and organisations that work for peace and social justice", had convinced him there is "a missing link in many of these efforts that holds back their effectiveness and achievement, and this missing link is love, or more precisely the failure to use love as the basis for the functioning of the organisation and its work." Edwards pointed to Martin Luther King Jr as his inspiration for this thinking, who in turn, of course, found his inspiration and motivation in his relationship with Jesus.

"Jesus uniquely taught and demonstrated the content of love, and he reinterpreted the Biblical command to love our neighbours as an imperative to respond to the needs of those who are poor, marginalised, exploited, or persistently neglected."

Jesus uniquely taught and demonstrated the content of love, and he reinterpreted the Biblical command to love our neighbours as an imperative to respond to the needs of those who are poor, marginalised, exploited, or persistently neglected. He fed the hungry and healed the sick. He searched for those pushed to the edges of society, and he spoke words of life and hope, of love, renewal and redemption to all who wanted to hear. In a fascinating encounter with one who suffered multiple marginalisation because of gender,

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ethnicity, religion and lifestyle, he stated that "those who drink of the water that I will give them will never be thirsty. The water that I will give will become in them a spring of water gushing up to eternal life."[5]

If my neighbours have no safe, drinkable water, then my love for them will urge me to do all I can to change this. That same love is what inspires me to share with them what I know of the one who is the "water of life".

However, it is imperative to recognise that the humanitarian aid context creates conditions that will require the Christian faith-based development workers to be especially vigilant that legitimate evangelistic intent does not stray across a critical boundary into illegitimate coercive practice.

All development and humanitarian programmes necessarily involve transactions between people of greater or lesser dependence on the one side, and those who are the conduit for essential resources or services on the other. Within the context of these transactional relationships there is an inevitable imbalance of power, regardless of how much care is exercised, and regardless of the humility or otherwise of the development of aid workers. Given this, the potential for misunderstanding and manipulation, even unintentional, is considerable. Therefore, great sensitivity is required to ensure that no person needing our material support can reasonably think that the adoption or imitation of our religious practices may be a means of ensuring it continues or even increases.

"If my neighbours have no safe, drinkable water, then my love for them will urge me to do all I can to change this."

Our vigilance and integrity in this regard may help ease the suspicion that continues to be felt within the development establishment regarding the motivation and agenda of some Christians working in community development. According to Rick James, "Most governments… want to engage with the institutional forms of faith (the religious institution), but remain suspicious about the spiritual dimensions of faith (belief in God). Not surprisingly secular donors still would like a sanitised separation between the institutional and spiritual elements."[6] This is very true of the Australian government, as can be seen from even a cursory look at the relevant policy guidelines.

Sadly, the practices of some Christian development organisations and workers give good reason for governments to be suspicious of our motivations and agendas, and I would argue that there is a real need for evangelical Christian faith-based development organisations to work together to develop a code of ethical conduct that addresses the complex tensions and issues that abound along the evangelism/development interface.

Conclusion

St Paul urged the small community of Christians in the city of Ephesus to practise the love of Christ:

> *"Watch what God does, and then you do it, like children who learn proper behaviour from their parents. Mostly what God does is love you. Keep company with him and learn a life of love. Observe how Christ loved us. His love was not cautious but extravagant. He didn't love in order to get something from us but to give everything of himself to us. Love like that."*[7]

No-strings-attached, extravagant love – Christ-like love – this is the heartbeat of integral mission. It is the inspiration and it is the fuel. It is what shapes the agenda and what sustains the practitioners. "Observe how Christ loved us… and love like that." ●

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Understanding Disease

traditional, modern and Christian approaches

by Dr Michael Burke

MBBS FRACGP PhD.
Correspondence –
mnjburke@bigpond.net.au

According to evidence-based medicine, a medical practitioner needs to take into consideration the values and expectations of the patient. This consideration has a different appearance when examining patient discourses of disease in a community such as in Tanzania East Africa.

It has been my privilege to have an ongoing association with Tanzania and its people over many years. This paper presents a review of the ways in which disease is understood in Tanzania. This allows both comparison and contrast with our own local Australian understanding. This understanding is examined through the lens of the diseases related to HIV and AIDS. The article will concentrate more on traditional approaches, as it is assumed this readership will be well-schooled in modern interpretations of disease. In conclusion, a reflection on a Christian approach to disease is shared.

Tanzania is a country in transition both economically and socially and in terms of its understanding of and responses to disease, Tanzania is looking both internally and externally for strategies to negotiate new challenges such as HIV and AIDS. Within this context, Tanzanian people use a range of ways of thinking about disease, some traditional, or from a western perspective from the "periphery", and others from a western perspective that are modern, externally sourced discourses from the "metropole" (Connell, 2007a).

While infectious diseases have been relatively recently recognised as caused by viruses, bacteria and other micro-organisms, communities in rural Tanzania, and in sub-Saharan Africa, have for generations sought to construct an understanding of the presence and consequence of disease in their daily lives using other explanations. These explanations have helped communities to understand and respond to both diseases, such as malaria, and health interventions such as family planning. Others have argued that some traditional explanations can worsen the spread and exacerbate

"Tanzania is looking both internally and externally for strategies to negotiate new challenges such as HIV and AIDS."

the consequences of disease such as HIV. From the viewpoint of international health experts, many of these traditional explanations are "irrational", yet within the everyday life of communities these explanations have great power, influence and consequence. International health workers work within different discourses, i.e., modern discourses, such as modern public health and human rights. This writing looks at the traditional and modern understandings of disease such as HIV and their impact on interventions to address HIV.

Traditional Discourses of Disease

These discourses are described as traditional, as they have long-standing use in community life. They include witchcraft, fatalism and ethical discourses of exclusion and inclusion. People perceive disease as a disruption to the flow of everyday life. Disease raises moral and existential questions such as "Why am I sick?" and "Am I being punished?" Whereas witchcraft and fatalism address these concerns of causation, the ethical discourses of exclusion and inclusion address and frame responses to disease.

These understandings are deeply interwoven into the complexities of everyday life, and are used as narratives of understanding by many Tanzanians today. These discourses often are intertwined.

Reflecting on non-western systems of disease aetiology, Foster (1976, p. 776) speaks of the supernatural – natural dichotomy of causation of disease under the terms of personalistic and naturalistic. A personalistic system sees disease explained as "due to the active purposeful intervention of an agent – human (witch or sorcerer), nonhuman (ghost, an ancestor, or evil spirit), or supernatural (a deity or other very powerful being". In a naturalistic system, disease is due to natural forces or conditions and by

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an imbalance in the equilibrium of basic body elements. Green (1999) writes of four possible naturalistic interrelated types of causation: (1) naturalistic infection, or folk germ theory; (2) "mystical contagion", more often called pollution theory; (3) environmental dangers; and (4) taboo violation. These writers acknowledge the overlap or permeability within their categories and also the likelihood that various categories could be understood as concurrent.

In a more focused description, Green (1999, p. 13) has described the category of pollution as denoting "a belief that people will become ill as a result of contact with, or contamination by, a substance or essence considered dangerous because it is unclean or impure". He argues that those promoting public health in Africa need to understand traditional discourses of disease.

Research findings from Tanzania indicate a move from a predominantly personalistic to a more naturalistic understanding of disease. This indicates that discourses of disease are in flux and yet there is a concurrence of personalistic and naturalistic explanations. Also the influence of modern discourses of disease, and their explanatory modes of transmission, are becoming apparent.

Witchcraft

Ashforth (2001) claims that cases of premature death or untimely illness in Africa are commonly attributed to the action of invisible forces. Witchcraft is distinguished from other invisible powers (such as divine retribution), in that the initiator of misfortune is considered another person who causes the harm.

While witchcraft provides a framework that can make sense of seemingly random events, it is a mistake to assume a logical and systematic coherence in ideas about witchcraft. Witchcraft is utilised to explain and account for various personal anxieties, insecurities and misfortunes. Witchcraft constructs an answer to the questions "why me" and "why now" for the individual who has HIV/AIDS. Witchcraft attributes agency to an individual. Witchcraft locates both the agent, the person with power to act to bring about these changes in circumstance, and the individual whose circumstances have changed, within the same community (Rodlach, 2006). To respond to the manifestation of witchcraft is to struggle with the witch by mystical or social means, or both (Ashforth, 2001). In illness due to witchcraft, Green (1999) claimed, supplication to God or to other spirits or use of medicines or rituals can lead to prevention, reprieve or cure of a disease.

Witchcraft continues to be an important part of everyday life in Tanzania and is referenced in regard to national sport and weather. The Tanzanian President Kikwete in his 2008 New Year address condemned the growing number of murders and rapes of albinos and older women linked to witchcraft beliefs (Agence France-Presse, 2008).

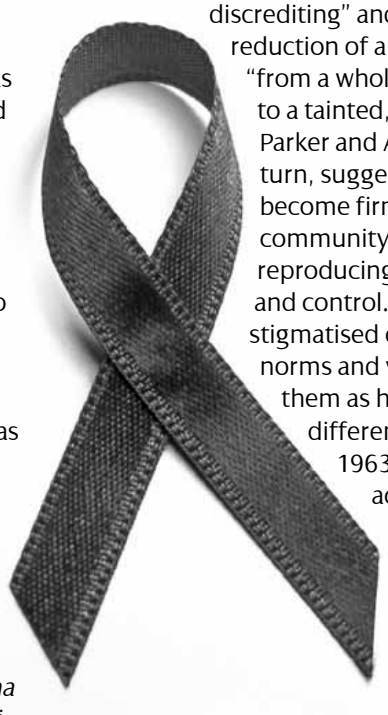
Dilger (2002) reported that while HIV/AIDS in rural Tanzania has become a massive problem in most communities, conversations on concrete cases of illness seldom centre on medical explanations of "AIDS". Instead, rumours and silences as well as explanations of witchcraft have become integral to living with and affected by HIV/AIDS.

Mutembei, Emmelin, Lugalla and Dahlgren (2002) looked at metaphors about HIV/AIDS used in western Tanzania. Initial local belief was that AIDS was a result of a curse, sorcery

or bewitchment. Metaphors like *Ihembe* (vampire), *Milamo* (curses), *Bakamulama* (has been cursed) and *Endwala enkulu* (old sickness) were associated with witchcraft.

Fatalism

Sangiwa, van der Straten, Grinstead and The VCT Study Group (2000) reported that in Dar es salaam, Tanzania, fatalism was a common response to HIV where HIV was seen as both widespread and understood as God's will. Mutembei et al. (2002) found that in western Tanzania feelings of resignation were revealed in metaphoric expressions of AIDS like *Byona busha* ("all is in vain"), *Yabinteza* ("he has sent me bad news"), and *Ajali kazini* ("accidents occur during work"). One reinterpretation of the acronym AIDS into *Adhabu Imetolewa Duniani Sikatai* ("I can do nothing, a punishment is on earth") indicated an external explanation where AIDS is regarded as caused by powers that cannot be influenced. Due to despair and feelings of being defeated, people also reinterpreted the acronym AIDS into expressions such as *Acha Iniuwe Dogodogo Siachi* ("let it kill me I can't change my sexual behaviour").



Traditional Africans are often characterised as being fatalistic; it is thought that they believe illness cannot be prevented (Green, 1999). Religious beliefs about HIV can also contribute to fatalistic attitudes and passive resignation, which hinders participation in treatment. Yet Green (1999) argues that much fatalism is related to natural causation, including theories of pollution, which in turn are related to general principles of behaviour. In this understanding, there is opportunity for agency.

Whereas witchcraft and fatalism address the locality of causation, the ethical discourses of exclusion and inclusion address and frame responses to disease. Exclusion and inclusion are at polarised ends of a spectrum of responses by individuals and communities to challenges to disruptions in everyday life.

Exclusion

Stigma and discrimination are endorsed as acceptable responses to those who have transgressed community norms of sexual practice. Goffman (1963) describes stigma as "an attribute that is deeply discrediting" and results in the reduction of a person or group "from a whole and usual person to a tainted, discounted one". Parker and Aggleton (2003), in turn, suggest that stigma can become firmly entrenched in a community by producing and reproducing relations of power and control. Furthermore, the stigmatised often accept the norms and values that label them as having negative differences (Goffman, 1963). This internalised acceptance by those stigmatised is manifested in many ways including self-hatred, self-isolation and shame. Discrimination is described as the negative acts that result from stigma and that serves to devalue and reduce the life chances of the stigmatised. HIV and AIDS have all of the characteristics associated with heavily stigmatised medical conditions in that AIDS is incurable, degenerative, often disfiguring and associated with an "undesirable death".

Green (1999) offers insight that pollution and other indigenous contagion beliefs are an area of interface between African traditional medicine and Western medicine. Jewkes and Wood (1999) describe pollution as traditionally defined as "a state of ritual impurity which is defiling or dangerous to self or others and which inheres in certain life events or conditions, in certain categories of people, or in people who undertake types of labour involving contact with pollution" (p. 164). Jewkes and Woods (1999) further develop this notion of pollution: "in addition to pollution being a state or etiological category, there are categories of dis-eases related to pollution which themselves have multiple etiologies, and that in parts of the Southern Africa region, there is a notion of non-ritual pollution which is an ethno-pathological process, a general idiom through which dis-ease is expressed" (p. 164). These complexities are acknowledged where the word "dirty" is linked strongly with "pollution".

While Western approaches emphasise fear and ignorance as key components of stigma, pollution theories present an understanding of stigma embedded in traditional discourses of disease. Pollution-related illnesses that are believed contagious, are often considered preventable, because they relate to contexts or behaviours that may be avoidable or modifiable. This argument is further developed in that there are claimed to be many similarities between traditional beliefs in pollution and modern theories of communicable disease yet expressed in different terms and symbols. Polluted persons are considered socially marginal in part because they present a risk of contagion to others.

Discourses of exclusion continue with great influence in Tanzania. Discourses of exclusion may be based within or outside of religious frameworks (Mbilinyi & Kaihula, 2000) including discourses of fatalism and witchcraft. Mutembei et al. (2002) reported that many religious institutions in rural Tanzania had their own way of explaining the

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disease. To them it was – and to a great extent still is – simply a curse from God *Omulamo* (a curse, and hence related to witchcraft). Other expressions about a sick/infected person such as *nosingwa* ("you are guilty"), *wafakara* ("you have done wrong") and *Bamuchwa* ("outcast from family") indicate a blaming attitude leading to exclusion. The metaphor of *zawadi ya uasherati* ("gift of promiscuity") uses irony when accusing the sick/infected of his or her behaviour in a more direct way. AIDS was also called *jaji* (judge), and *redi kadi* (red card). These are metaphors describing the disease as leading to accusation, judgement and exclusion.

Discourses of exclusion, manifested in stigma and discrimination, or pollution clearly impede programmatic efforts for HIV prevention, testing and treatment, as well as disclosure, care and support.

"A Christian approach to health is strongly influential in our world, both historically and currently."

Inclusion

In contrast, a discourse of compassion, or inclusion, calls for the HIV-infected person to continue to be accepted and valued in community life. Discourses of inclusion may also be based inside or outside of religious frameworks (Mbilinyi & Kaihula, 2000). Dilger (2002) states that while it is true that moral discourses in rural Tanzania may build the foundation for blame and stigmatisation, they may also open the paths for the moral restoration of the sufferer and his/her family who have to cope with the strong stigma attached to HIV/AIDS, and may thus become a vehicle in "pulling together" local worlds that are increasingly in danger of falling apart. In Tanzania, families, religious organisations and communities provide care, empathy and support for people with HIV and AIDS (Burke, Corrigan, & Msuya, 2004; ICRW, 2003).

While it is important to understand traditional understandings of disease, it is equally important to understand modern understandings of disease. While the communities who are the recipients of HIV intervention programs are more familiar with traditional discourses, the designers of HIV interventions are more familiar with modern discourses of disease.

Modern Discourses of Disease

The modern discourses of disease are found in new public health, as characterised by the Ottawa charter (WHO, 1986), and human rights. These discourses have been foundational in the development of programmatic responses in HIV prevention and treatment. Human rights approaches, while addressing a much broader range of issues than HIV or health issues alone, have been of great importance in framing responses to HIV that address the dignity of the individual and safeguard an individual from stigma and discrimination.

New Public Health

De Cock, Mbori-Ngacha and Marum (2002) see a public health approach implying "that society has control over its own health and, in turn, determines which diseases are the highest priority to address. It also implies that what we fail to do determines the conditions for people to be unhealthy" (p. 67). While traditional approaches to public health dealt with collective challenges and responses, the new public health approach focuses on health as located at the level of the individual. The Ottawa Charter (WHO, 1986) is seen as the foundation of the new public health (Leeder, 2005) and is described as having five key elements: development of healthy public policy, creation of supportive environments, strengthening of community action, development of personal skills and re-orientation of health services to a community-based focus on health. The Charter is based on the belief that health requires peace, shelter, education, food, income, a stable ecosystem, social justice and equity as prerequisites. The emphasis within new public health has moved from a communal to an increasingly individualistic perspective, even though the communal concerns of social justice and equity are acknowledged within the Charter. The individual is characterised as a neo-liberal, rational, agentic individual. This is a characterisation of individuality that may well be located within the metropole; however, it is far more problematic in the periphery.

Human Rights Approach to Health

A human rights approach to health is based on the rights of individuals, founded in their inalienable dignity as humans. Human rights apply to all people in all countries, and they principally involve the relationship between the state and the people. Health policies, programs and practices both influence and are influenced by practices concerning human rights (Mann, Gostin, Gruskin, Brennan, Lazzarini, & Fineberg, 1999).

The Ottawa Charter for Health Promotion (WHO, 1986) positions social justice and equity as a prerequisite for health. While some argue that new public health and human rights approaches are complementary, others see their relationship as contested or conflicted. Currently in the domain of HIV, this is a relationship of contest and conflict. These modern discourses are examined further in relation to HIV testing. This examination highlights the similarities and the differences of the two designated modern discourses of disease. While identifying the different emphases, it is seen that distinct consequences are produced by each discourse.

Angolan community members at HIV AIDS outreach event. *Photo: http://en.wikipedia.org/wiki/HIV/AIDS_in_Africa*

Relationships between Traditional and Modern Discourses of Disease

While ministries of health and international agencies address and frame the challenges of HIV within contested modern discourses of public health and human rights approaches to health, men and woman in rural communities in East Africa and beyond will characterise and struggle with HIV within their traditional discourses of disease.

A Christian approach

A Christian approach to health is strongly influential in our world, both historically and currently. This Christian approach to health care is in ways influenced by and influences both traditional and modern approaches to health. Many of the world's health systems have until relatively recent times been founded and greatly contributed to by Christian health services.

The approach of a Christian doctor, medical or dentist, is essentially unique. This approach will value the individual patient who being made in the image of God, also represents a flawed masterpiece. A loving God calls us to a work of bringing new life and hope into an environment of clinical disease, anxiety and inadequacy of meaning and hope. The Christian approach is uniquely embedded in a compassion, a willingness to engage with those who suffer physically, emotionally and existentially. This compassion, this willingness to be with those who suffer, is foundationally present in the story of Jesus of Nazareth, our great teacher and role model. He came to bring new life to those who were unwell, physically, emotionally or spiritually.

"This compassion, this willingness to be with those who suffer, is foundationally present in the story of Jesus of Nazareth, our great teacher and role model. He came to bring new life to those who were unwell, physically, emotionally or spiritually."

Traditionally, those who were unwell were often excluded from community because of fear of pollution or contagion, or because they were considered cursed and in a fatalistic world where there was no way to change these things, what else could be done.

A Christian approach always offers a hopeful, compassionate and respectful understanding of the patient. A Christian approach will continue to bring compassionate care into our world. We are called to bring the best of our clinical knowledge based on appropriate evidence and the highest standards of clinical competence which we are continually striving to maintain and improve, to our patient. With respect and sensitivity, we seek to understand the values and expectations of each, and to understand how they understand their disease so we can contribute to their better health physically, emotionally and spiritually. Also we bring hope. ●

References are available on request

Educational Partnerships as Ministry and Mission

by Dr Owen Lewis

PRiME (Partnerships in International Medical Education) is an organisation specialising in short term mission trips to minister through medical education opportunities.

The partnerships may become long term, building on what has gone before and building up local capacity. The personal relationships formed through brief encounters may last years through return trips and internet connections. Opportunities for sharing the gospel may be incidental to those relationships or softly prepared through the content and context of the education process.

There is a lot in it for the visiting teacher. The trip may be short and the connections all work, even the ATM machines. Local people appreciate you coming and while your contribution is limited it may be significant. As a little fish from a big pool of resources you find yourself regarded as a big fish. It gives you a break from what may have become humdrum at home but you return with a new appreciation of your facilities. The cross-cultural interaction and reflection in the educational process educates you to return wiser and deeper, spiritually recharged. The opportunity to be a partner in their program teaches you how to accept some uncertainty and sudden change. You appreciate the effort expended by your hosts and the constraints under which they have produced resources and programs. You learn a lot of medicine as it is applied in a different context, appreciating alternative ways of solving similar problems. Sometimes there is opportunity to share deeper things with trainees.

PRiME

This has been my experience as a recurrent visiting external faculty member for Christian Medical College Vellore over the past 5 years. I go under the auspices of Partners in International Medical Education to help in the Master of Medicine (Family Medicine) contact programs held in the Southern Railway Hospital in Chennai. It is one of ten centres where the contact programs are run simultaneously with an afternoon teleconference hook-up with CMC Vellore. At this point in time, CMC-V does not have sufficient general practitioner faculty to teach in all the centres. Hence PRiME has been asked to provide 5 tutors every 8 months to make a two week trip to India. PRiME UK and PRiME Australia have contributed equally to this on-going scheme. Ideally the same PRiME tutor goes 3 times over the 2 year course so the students have continuity. I recruit and coordinate potential visiting faculty with Dr Jachin Velavan in the Distance Education Centre, CMV Vellore.

The other main focus for PRiME Australia has been Papua New Guinea. A PRiME team has taken part in an annual Tertiary Christian Student's medical/nursing conference as visiting teachers, providing both clinical and spiritual input. Offshoots have been training in chaplaincy and in palliative care. In comparison to our role in India, it is necessary to be more pro-active in PNG in regard to developing curriculum and planning programs. In India we are definitely helping in an Indian program whereas in PNG ownership of the activities is less clearly local. This simply means that such educational activities involving us as visitors will find different

Christian Medical College Vellore.

expressions in different contexts according to readiness and need of our overseas partners.

Although PRiME specialises in the short term visits, personnel have taken on longer term assignments. Dr Susan Clark spent 2-3 years in Assam and Vellore after attending one of PRiME's trainings. There are many pathways apart from PRiME of course. There are untold numbers of jobs to be found in medical schools and other health training facilities in lesser and highly resourced settings in Asia and Africa. My wife Mary and I had the opportunity to set up a department of Family Medicine in a peripheral university teaching hospital in Nepal (2001-7). We went as rural GPs with minimal educator experience and learned to teach on the job. To our surprise we did not come with empty educator hands. Our ideas were radical for that place, but hardly original. With a good deal of adjustment to local expectations and ways of doing things, we made a lasting impact through our educational approach and ethos, which sets the department apart from other disciplines. There was resistance but also respect. Those years were exciting and tough. It is a joy to see what has been built on the foundations we laid. My biennial trips to see them and to meet subsequent cohorts of medical students and GP trainees have been a source of great satisfaction. We continue the thank God for the privilege he gave us and for CMS Australia who supported us so well.

Medical Education has become a strong theme of medical missionary activity. Traditional "jungle doctor" medical mission still has its place, but that mode of mission is analogous to evangelising unreached people groups. There are settings where there is still a niche for direct patient care due to the lack of a local health system or the specific needs of a marginalised group. The danger can be that the missionary doctor is there to compete with local services rather than to enhance them. If the local is outclassed it may be disempowered and become antagonistic. An argument then is that if people come to faith through such ministry and corrupt medical practice is antagonised that is a good thing. On the other hand western Christian health workers who feel God is calling them to serve outside their comfortable patch may have anti-colonial anxieties. Medical education may be for them! While there is paternalistic danger in being an educator there is also great opportunity to serve on the host's terms.

Photo: www.missionencounters.com

"...western Christian health workers who feel God is calling them to serve outside their comfortable patch may have anti-colonial anxieties... While there is paternalistic danger in being an educator there is also great opportunity to serve on the host's terms."

In what sense is medical education Christian mission?

We can see the Christian medical educator as providing a ministry in the name of Christ, fostering relationship opportunities for sharing the gospel, as I described earlier. PRiME goes further than that and does so through its specific philosophies and content. PRiME's good news is that reference to God's relationship with us transforms medical education with a fuller understanding. PRiME embraces a world view in which spiritual health is seen as an essential aspect of care of our students and patients. This has appeal to people of other faiths and refreshes medical teaching that has been simply materialistic up until now. There are a rich range of PRiME resources which may be used as the basis for a medical education event or as an adjunct to teaching specific clinical topics. The conversation about what it is to be human, naturally leads to deeper existential discussion. Christian values and ethos shared in this context are ones that may transform health systems! *Missio Dei* is a term that reminds us that it is God's mission so while we may not see the fruit of our labours immediately we enjoy its taste as we serve. ●

Transforming Communities with Good News in all its Fullness

by Dr Judy Fitzmaurice

Dr Judy and Dr Mark Fitzmaurice served at Rumginae Hospital in a remote part of Papua New Guinea for 12 years. Judy continues to be involved with equipping people for overseas work through CHE training. She is Chair of PIONEERS Australia and Vice-Chair of PIONEERS International, which has over 2000 cross-cultural workers worldwide. Judy is on staff at Uni Notre Dame Sydney and has been the Chair of CMDFA since 2008. Email judyfitz@securenym.net

"Jesus went through all the towns and villages, teaching in their synagogues, preaching the good news, and healing every disease and sickness. When he saw the crowds he had compassion on them." Matt 9:35-37

Jesus spoke to the spiritual need of the crowd; he touched their physical need in their sickness, disability and hunger; he cared for the social and emotional need of the outcast with demon-possession or a woman caught in adultery. Jesus considered all these needs important and worthy of his time and attention.

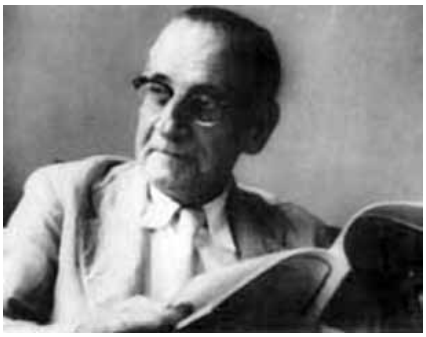
Jesus gave us an example. We spread the good news in words, for how else will people understand how to be saved?

"How can they believe in the one of whom they have not heard?" Romans 10:14,15

And we also know that compassion which translates into practical action is at the heart of the gospel. James 2:15-17 *'faith by itself, if it is not accompanied by action, is dead'.* We are to respond to the world with sacrificial acts of compassion as Jesus did.

In gospel outreach, we are to combine saving words with loving deeds as Jesus did.

Nowhere is the need more evident for the compassion of Christ to be demonstrated in words and deeds than where there is endemic grinding poverty and an ocean of unmet basic human need. These are often the same places where few have heard and understood who Jesus Christ is.



Dr John Grant, medical missionary, China.

It is not surprising then, that in the field of primary health care and public health in the developing world we find the names of Christian missionary doctors littered all over the pages of the story. Dr John Grant, medical missionary to China in the early 20th century is known as the 'father of primary health care' (PHC) with landmark definition *"Public health is the science and art of social utilisation of scientific knowledge for medical protection by maintaining health, preventing disease, and curing disease through organised community efforts"* (1940, John Grant). John Grant set up the first example of PHC, training up forerunners of the 'barefoot doctors', farmers who were trained to give simple treatments, health education, maintain wells, give smallpox immunisation and collect basic health data.

Dr Carl Taylor. Photo: www.jhsph.edu

Other Christian doctors such as Dr Carl Taylor (India Narangwal Project) and Drs Mabelle and Raj Arole were instrumental in contributing to the pivotal 1978 Alma Ata International Conference and Declaration on Primary Health Care. This called for "Health for all by the Year 2000''. The Alma-Ata Declaration was not a 'how to' manual, but rather a philosophy of wholistic health based on biblically-consistent concepts of equity and justice. Health was defined not simply as the absence of disease, but *"reaffirmed as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity'.*[1] Alma-Ata called for a commitment from all governments to provide affordable, accessible,

Jamkhed project: mobile health team visit to rural village. *Photo: http://lrrr.minigeek.org*

community-based primary health care, with an emphasis on health education, prevention, promotion and addressing health in its broadest concept to include multisectorial development issues such as employment, clean water, literacy, safety, nutrition, sanitation and much more.

Drs Mabelle and Raj Arole's were the founders of the world-changing Jamkhed project in India, which showed that a community initiative based on an army of trained village women participating as volunteers in regular home visitation and delivering of preventive health and health promotion messages, had reduced Infant Mortality Rates from over 150 per 1000 live births to 50 per 1000 live births in just four years.

Many other projects based on training community health volunteers, very often women, doing home visitation and preventive health education have been implemented all over the world and have also confirmed that for the majority of people who do not have access to hospitals, health promotion and simple primary health education bring results and save lives. Many of these initiatives have emanated from practitioners motivated by Christ's example to love and care for the lost, the vulnerable, the marginalised, the poor wherever they are.

"Nowhere is the need more evident for the compassion of Christ to be demonstrated in words and deeds than where there is endemic grinding poverty and an ocean of unmet basic human need."

Drs Raj and Mabelle Arole.
Photo: www.jamkhed.org

Community Health Evangelism (CHE – pronounced 'chay') is one such approach that is facilitating much effective wholistic and transformational development ministry based on sound primary health care and development principles, combined with a consistent Biblical framework.

Started in East Africa by Stan Rowland[2] in the mid-80's, CHE has now spread into over 100 countries, becoming a global network interconnecting hundreds of different individuals and organisations.[3] CHE is adaptable to a wide-range of situations – rural and urban (called Neighbourhood Transformation),[4] developing world and developed world, open and closed societies, and with range of CHE models for different social and political contexts. CHE has spread because it is an idea that has been

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freely 'given away' to people from all walks of life, trained in a 5-day course known as Trainer of Trainers 1 Course (TOT 1). Following this introduction to CHE ideas and frameworks, people have taken CHE and adapted it to their own contexts. CHE has proved to be an effective template and launching pad for initiating intentional community-based work with the goal of leading to individual transformation and eventually to community transformation. CHE recognises that for lasting impact to happen, deep change has to happen at the heart level, through Christ.

> *"...The goal of CHE work is a transformation in lives and communities that is as deep as the human heart, and as broad as the whole range of the human experience in the world God made. We want Jesus to be recognised as Lord over all creation, and our development activities to reflect the depth and breadth of the kingdom of God. We are asking God to work in us and through us to transform beliefs and change behavior so that his peace, justice, compassion, and righteousness are reflected in the life of the communities we serve. CHE seamlessly integrates evangelism and discipleship with community health and development."*[5]

Some of the central planks of CHE are:

- Community Ownership
- Focus on Prevention not Cure
- Focus on Teaching not Doing
- Development not Relief
- Integration of the Spiritual and Physical
- Learner-Centred Participatory Learning
- Use of Local Resources
- Servant Leadership, *Multiplication.

Many of these principles can be found in any good primary health care project as CHE has fused primary health care and development principles with Christian values. The distinctives are the faithful servant leaders who model Jesus' love, the integration of spiritual teaching with health and development teaching, the prayer that undergirds CHE and the work of God who brings transformation. CHE recognises the need for curative health services, but CHE does not focus on providing them.

Community Health Evangelism in action. *Photo: www.brigada.org*

How does CHE work?

Through a process of steps over 12 – 18 months a Training Team enters a community through seed projects (e.g. water projects), school health screenings, and community awareness meetings. Using many interactive skits and role plays, the community is engaged. If the community wants to address identified concerns, they select people (often women) to be trained as Community Health Volunteers often known as CHE's, Community Health Evangelists/or Educators. These people form the backbone of a CHE programme and their job is to visit the homes of others in their community and with the use of simple resources such as picture books they demonstrate, teach and model simple health prevention and promotion, as well as Bible stories and values. As they share with their neighbours they live out what they say amongst them. They continue to be supported and trained by the CHE training team on a regular basis.

In 2005 I attended my first TOT1 course in India along with 30 young teachers about to disperse to rural Christian schools. My goal was to discover 1. How CHE model works 2. If CHE might be a useful tool to equip cross-cultural workers in developing meaningful presence in communities 3. Whether CHE represents sound health and development practices.

I found that CHE is able to equip people from both healthcare and non-healthcare backgrounds to take community health to villages, to places where the health system is practically non-existent. I was excited to discover a method that can extend the reach of 'healthcare' far beyond professionals in clinics, to reach even the remotest village and help those villages change.

Since then, over the last 8 years I have set aside one week a year to facilitate a TOT1 course (along with other trainers). Christian workers from many organisations, medical students and doctors have gone through the training. The beauty of CHE training is that anyone can do it, learning important principles as well as an accessible, affordable, adaptable framework. It is not a theoretical course; it is practical – it provides all the skits, role-plays, methods and resources for bridging the gap from our typically western-educated individualistic approach to a village community oral-based group learning context. Topics such as worldview and cultural understandings are also covered, making it useful for anyone heading to work cross-culturally, such as students before elective terms or doctors involved in short-term work. Participants come away with new ideas and principles that are transferable to multiple contexts. Following a TOT1 one participant said *"I learned that if a community*

has ownership of its project then there is a much better chance that it will continue long after I'm gone." The appreciation of this one important axiom of good community development may prevent a world of potential pitfalls!

In 2009 Melbourne medical student, James, visited South Asia for 3 weeks and met Doctor R. A year later James completed a CHE TOT1. James and other medical students then partnered with Dr R in establishing a community-based health project. Since then the project has established an expanding series of health initiatives, including a low-cost clinic. Now:

> *'Dr R and the team are taking on 5 new project villages, training more Village Health Workers to bring better healthcare into their rural village communities. A recent health audit is showing encouraging results in existing project villages, with child malnutrition essentially eradicated compared to high rates only 2 years ago. Other anticipated projects include a vocational program for computer skills training and implementation of a sustainable water project.'* [6]

From small beginnings, God is causing blessing to multiply as resources are harnessed that will bring lasting benefit to communities, showing God's love for them.

SAMPAN is a CHE-infused large Community Health project started by a CMDFA member. *SAMPAN* (a Hindi word which means "complete health and well-being') is in Northern India:

> *"SAMPAN is a community development program which was established to improve the physical and spiritual health of these people. This area has high infant mortality and malnutrition, and a low understanding of how to promote health and prevent disease. SAMPAN local staff are working with local community health workers in each of the 200 villages to achieve 'sampan' in the community. SAMPAN runs a number of public health activities to serve the health, in all its fullness, and development needs of the people. To do this Sampan is training and equipping hundreds of CHVs (Community Health Volunteers) to undertake clinics, organise immunisations, recognise and treat basic diseases, recognise and refer more serious illnesses, undertake health education in their villages…and to provide spiritual care.*
>
> *This program demonstrates the healing love of Christ to all, and supports Christian believers in the area'* [7]

Dr John Stott gave words to this seamless integration of word and deed.

> *'The gospel is like the two wings of a bird. One wing is deeds, one wing is words. The words explain the deeds, the deeds demonstrate the words. Both are needed for the bird to fly.'*

Lausanne Movement's 1989 Manila Manifesto also expresses integration so fundamental to the "how" of the gospel:[8]

> *"The authentic gospel must become visible in the transformed lives of men and women. As we proclaim the love of God we must be involved in loving service, as we preach the Kingdom of God we must be committed to its demands of justice and peace... Jesus not only proclaimed the Kingdom of God, he also demonstrated its arrival by works of mercy and power. We are called today to a similar integration of words and deeds. In a spirit of humility we are to preach and teach, minister to the sick, feed the hungry, care for prisoners, help the disadvantaged and handicapped, and deliver the oppressed… We affirm that good news and good works are inseparable."*

CHE-type approaches are helping many cross-cultural workers and national Christians find a way to do just this – combine proclamation with social engagement in health and development, in a Biblical framework. What is the role of doctors in the grass-roots work of village-based primary health care? We can be instrumental in being advisers, trainers and strategisers for community-based projects. Doctors can also help to also ensure CHE projects are linked in with the existing health system and services, so that people who are sick, and need acute care can receive it. ●

"...we are to preach and teach, minister to the sick, feed the hungry, care for prisoners, help the disadvantaged and handicapped, and deliver the oppressed... We affirm that good news and good works are inseparable."

For further information on the next CHE training in Bali (25-29 Nov 2014), please contact the author. Places are limited.

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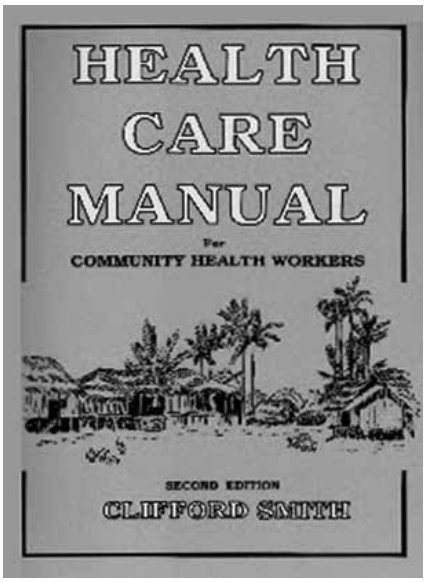
Providing Teaching Resources for Community Health Workers ...A lifetime of lessons

by Dr Clifford Smith

OAM MBBS, FRACGP, DRANZCOG. Cliff Smith is a Life Member of the RACGP, having worked in PNG, the Hills area of Sydney, and more recently on the Central Coast of NSW. He was appointed as the first Executive Officer of CMDFA, establishing the national office and the IMPACT work and was the founding CEO of HealthServe Australia. He is also the author of "A Health Care Manual for Community Health Workers in PNG" which has been used throughout that country for 25 years. He is currently enabling the development of locally produced and sustainable third and future editions of the textbook. More details of this work are available on www.healthserve.org.au

As we wended our way over several mountain ridges and then splashed uphill through the beautiful cool mountain stream, my two Aussie colleagues and I said in unison, "Ahhh!…the life of sacrifice, doing mission work in PNG!"

It was during my first few months working in the country in 1970, and I had been asked to join a group of five local workers, two Aussie pastors and two guides in visiting a remote highlands area where no other outsider had been. Word had been received of folk desperately wanting help because the tribe was slowly dying out. My purpose was to assess the health needs of the people and see what could be done about it.



A Health Care Manual for Community Health Workers in PNG by Dr Clifford Smith.

Arriving at Apyeraka where the nomadic Pinai tribe had come to settle, I quickly learnt that they had really serious health problems, finding that 80% had obvious significant illness, with such problems as pneumonia, severe malnutrition, purulent discharging otitis media, or with spleens enlarged to below the umbilicus.

I promised them that if they built a home for a health worker and a building for him to work in, that the Tinsley Hospital at Baiyer River in the Western Highlands would supply a Community Health Worker, at that stage called an Aid Post Orderly or APO. As a mission organisation we were training such APOs to diagnose and treat basic common diseases, provide basic first aid, obstetric and child health care, give nutritional advice and generally promote community health. Training was over a two year course in Pidgin English. An APO graduate was duly sent to them and two years later I was able to revisit Apyeraka and found the rate of significant illness had dropped from 80% to 40%. A further three years later the rate had dropped to 20%.

Experiencing such a graphic display of the benefits of grass roots community health workers set me on a path to future involvement in the broader work of community health, eventually leading to my writing and producing a training manual for them. My involvement continues to this day and I am currently involved with HealthServe Australia in the redevelopment of the manual. Lessons learnt in the lead up of the current project cover a lifetime's work.

The years of preparation

PNG in the early 1970's was rapidly moving into the modern 20th century. Only 30% of children had access to a primary school. Of these only 1% could eventually enter senior high school and seek

higher education with the first 2-3 highlanders entering University to study medicine in 1971.

Seeing the general community health need prompted my further study and first hand investigations. Some thoughts which were imprinted on my mind were:

> *"Axioms of health work in a developing country include:*
> *…giving health care to all people at the closest possible point of contact; and*
> *…a job should usually only be done by the least trained person able to do the job" Maurice King of Makerere University, reinforced by Anthony Radford of Port Moresby.*
> *"The nature of the church will be determined by its attitude to social services" Bishop Kevengere of Uganda*

In the early 70s as local workers were being trained and replacing expatriate staff, many mission groups started to withdraw some of their activities including health work. Outside financial help plummeted and locally trained church workers were finding that their salaries on average were only about 10% of what government workers earned. Many in the Church Health Services felt that without obtaining recognition from the government and extra subsidies, the whole of the church health services would collapse and the country would be the much poorer for it.

By the time independence arrived in September 1976 I was installed as the full-time government employed Liaison Officer between all the Churches denominations involved in health (about 20 groups) and the Department of Health, and had a direct voice to Provincial Health Secretaries, the National Secretary (or Director) of Health and the Minister. It meant travelling widely through the country, seeking to rationalise all the health services and bring better cooperation between all health workers in the government and all churches. Working in so many situations meant learning how to continually adapt to different cultures and situations, do a lot of negotiations and use a lot of my own basic statistical research to have all the facts clearly before me. A major achievement was that over a two year period I was able to get a fourfold increase of subsidies to the church health services.

"...the rate of significant illness had dropped from 80% to 40%. A further three years later the rate had dropped to 20%."

Need for training resources of CHWs

Things outside my job description which helped me in getting an across the board picture were being a member of the Medical Board of PNG, the Nursing Council of PNG, and the committee to review the curriculum of Community Health Nurses with the help of a French Canadian WHO consultant. This background gave me the standing to persuade the health department not to shift the training of nurses and community health workers from rural health centres to major regional centres by using graphics to emphasise that graduate nurses on the whole tended to work relatively close to where they trained rather than just where they were brought up.

There still remained the task of getting better health resources, but the survival of the church health services and the provision of rural health were virtually guaranteed where otherwise they might have ended in disaster. I therefore, on completion of my secondment to the National Department of Health, decided to return to clinical work. Those involved in training community health workers continued to depend on producing their own teaching resources through what could be gleaned from nursing textbooks, pocket standard treatment manuals for PNG in paediatrics and obstetrics,

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and training manuals previously produced with limited circulation such as those by Dr Peter Calvert in English and Ed Tscharke in Pidgin English. The whole teaching system was rather haphazard, but because of the huge commitment of many workers was surprisingly well done.

The early work on health care manuals

In late 1980, I was asked to be a consultant to a workshop for Aid Post Orderly training run by the Department of Health with all the teachers of the schools participating. The main outcome of the week long workshop was that a textbook needed to be written as there were inadequate teaching resources for the schools. Many not at that meeting might well ask, "Why use a special PNG produced textbook instead of modifying or just using one of the many other manuals on community health work around the world?" Certainly there were some good texts around, but to utilise a textbook properly for this work, it needed to be

1. In simple English for those who use English as a second language
2. Written at the level suitable for those who may not have any scientific or biological knowledge
3. Culturally relevant
4. Written from a problem solving approach rather than on a disease basis which has been the approach of most textbooks written by medical workers
5. Include the wide range of subject matter covered by the CHW curriculum and able to be used for both a two year full time course text as well as field manual for graduates
6. In accordance with the accepted clinical guidelines decided on as appropriate for PNG by the clinicians of PNG.

Other known manuals or texts did not meet these criteria. I was asked to take on the task of writing and producing this text and because of her very acceptable previous work in Peter Calvert's book, Judy was asked to be the illustrator. The book was eventually published in 1986. A second totally re-written edition in 1996 contained 800 pages and 1000 illustrations. With two reprints a total of 15,000 free copies were distributed.

The redevelopment of the health care manual

Much has changed since the 1970's and early 1980s. The population has increased from 3 to 7million. Port Moresby has rapidly grown from being a sleepy town to being reported as likely within the next couple of decades to become the fifth largest city in the SW Pacific after Sydney, Melbourne, Brisbane and Singapore. Jet aircraft now fly in to most towns. Mining and other industrial enterprises dot the landscape and there are now four Universities.

"Most of these rural people have no running water supply, sanitation, or electricity which means no access to computers. Many are so isolated..."

However much has not changed. Rural areas still make up 80% of the total population and this percentage is not seen to be changing dramatically in the future. Most of these rural people have no running water supply, sanitation, or electricity which means no access to computers. Many are so isolated, that no matter what province they live in, it takes a full day's travel to reach the nearest nurse let alone a medical officer centre. The country therefore continues to depend, and will continue to do so for many years to come, on the services of Community Health Workers (CHWs) that have just two years simple English training. The Christian Health Services provide over 50% of all the rural health care, with all Community Health Worker training being done by them. All the government run CHW training centres have now closed down. Thankfully there are many dedicated and skilled workers trained in the country, but they need extra help, especially with the provision of outside human resources in community health, health education and management.

From mid-2007 I was approached to try and do something about the need for a new edition of the health care manual by numbers of church leaders, health workers and educationists in PNG, and even an Australian vocational publishing company which had helped produce health training resources in PNG. The main problem in getting action has been that while the churches are doing all the training of the workers in the country, the standards and overall control of the training is in the hands of the department of health. The work of producing health resources has fallen into the gap with no-one body feeling responsible for it. My experience in travelling to a number of countries and hearing from aid workers is that similar problems have occurred in these countries and that a similar need exists for help with producing resources for training basic health workers.

The net outcome is that over the past 18 months with some help from my local church and support from HealthServe Australia, I have made several trips to PNG and obtained a full consensus of the interested parties in PNG on a way of producing further editions of the manual. For example the Director of Medical training in the Health Department, said to me after one long discussion "Cliff, it is God's perfect timing for your coming to

PNG to talk about this matter." After many discussions a project proposal was accepted in full by the Church Health Service annual conference and requests have been made to the health department and through the Director of Medical Training and to the Church Partnership Programme set with the agreements of the PNG and Australian governments for funding. We praise God that all have acknowledged the importance of the resources, but still no one party has bitten the bullet yet and agreed to help fund it.

The lead organisation, the Baptist Union of PNG, which has been appointed by the Church Health Services, is very committed to getting the project started. When this will happen with available finance is not clear yet, but PNG colleagues are very confident it will happen soon. Whatever final form it all takes, the cost will be around Aus$2 million to cover the cost of numerous workers, many consultations with expensive air fares and accommodation, and a printed text of 15,000 copies over a 5 year period due to the absence of electricity and a computer network in rural areas. This will require extra outside funding. The BUPNG is also keen to continue partnering with HealthServe Australia in a) finalising these details, b) providing the services of the commissioning editor and c) providing a management consultant for the project. There are also ongoing discussions about how we might help with health management in rural areas and extra supervisory medical help to more remote health centres.

Conclusion

There is no doubt that Christians should be involved in international development and mission as a priority for the church generally. Health workers world-wide and particularly in the SW Pacific region have a special place as agents of change in this process. The training of health workers is vital in this enterprise and requires the best possible teaching resources.

Health workers from Australia are admirably equipped to fill this need, but it will require a consolidated and persistent group effort. ●

Luke's Journal

INSTRUCTIONS FOR CONTRIBUTORS

Members of CMDFA are invited to submit articles or letters to the editors for publication in **Luke's Journal**. Articles may or may not be on the advertised theme. Writers may wish to discuss their potential contribution with the editors or their state editorial representative before submitting.

Articles, letters, book reviews and lengthy news items should be submitted (preferably in electronic form) to the **editors** with a covering letter requesting their consideration for publication.

Advertisements and short news items should be submitted directly to the **sub-editor**. See page 2 for contact details.

John 3:16

If God loved me so much
That He sent His only Son to die
That such as I might have eternal life
What do I do?

How can I be born anew
When now I feel so dead inside
And all I want to do is fight
To flee from that marvellous light
That dissolves the darkness, banishes night.

How do I know
That there was such a man as He
Part of the Holy Trinity?
Oh, if I could only see
If only that were clear to me!

I take a look at that chapter again
And see that He came not to condemn
But that the world might be saved through Him
Do I reject? No, I just accept.

"For God so loved the world that He gave His only begotten son, that whosoever believes in Him should not perish, but have eternal life."

Written by Maria Haase
(nee Barlow, as Med. student)

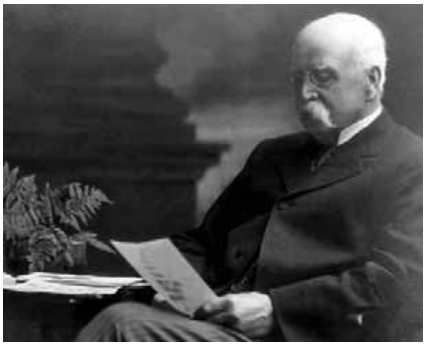
Mission to the Disabled and Mission of the Disabled

by Anon

Name withheld due to the sensitive nature of the mission work and the country involved.

I was sitting in a small village hut made of mud and stone and talking with Sunita, the mother of Rajan. Her wrinkled face hid years of pain and burden. She must have been only 35 but looked double that. Rajan had severe intellectual and physical disabilities and his mother had few resources to manage his condition. Emotionally, the trauma was magnified by the fact that the villagers around her believed that his condition was a curse. This was Karma. He or his parents had done something in a past life that meant he deserved this condition. Sunita was not invited to weddings as this would bring bad luck on a couple. This made me think: as Christians what can we offer such a woman? How does our theology inform our response? Where does disability sit in regards to mission?

Firstly, let's explore the background of Christian mission in disability. You don't have to search very far for examples of a compassionate Christian response to disability. Granted, Christians have made mistakes and often failed to go beyond a charitable and medical model. However, on the whole we can be proud of our Christian heritage in service to those with disability. The Christian community has led the world in its response to disability. A prime example is leprosy, one of the most disfiguring and stigmatising disabilities throughout history. **Wellesley Bailey** founded The Leprosy Mission (TLM) out of a compassionate reaction to witnessing the suffering and stigma



Wellesley Bailey founded The Leprosy Mission.

"...on the whole we can be proud of our Christian heritage in service to those with disability. The Christian community has led the world in its response to disability."

experienced by leprosy patients. And, until recently, leprosy care was largely the purview of Christians. In more recent times surgeons such as **Paul Brand** and **Grace Warren** pioneered and revolutionised Leprosy Surgery. A concern for the marginalised and outcaste has driven our involvement in mission to those with disabilities such as leprosy.

This response is not surprising in a place like (withheld), where disability can mean that a woman like Sunita is impoverished, marginalised and neglected. It is hard to ignore our God-given mandate to act. Our theology enables, if not demands, a compassionate and empowering response to disability.

1) We are all created in the image of God. A person with disability has equal value in that status. Genesis 1:27 (NIV) says, "So God created man in his own image, in the image of God he created him".

2) We show God's love in the way we respond to the least amongst us (eg. Matthew 25:31-46). Those with disability are indeed the least, with high rates of poverty, illiteracy and ill health. Like Sunita, they face social, spiritual and economic isolation.

3) God's love and concern for those with disability is clear. Nearly two thirds of all Jesus' miracles involved people with disability.

4) People with disability have inherent value in Christ. None of us have to earn our value or significance through our works. In God's eyes we are not made more significant by being a doctor, or having power or wealth.

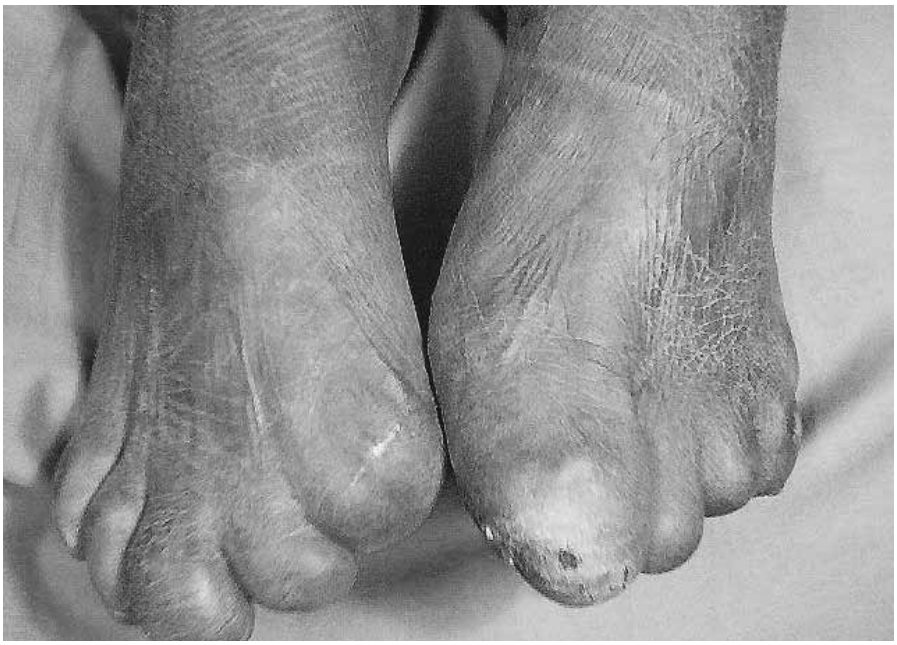
A Community Based Rehabilitation (CBR) program Sunita has been a recipient of this

love through our disability program, called (withheld for security reasons). As a father of a profoundly disabled child, I do, on one level have an empathy that my professional training could never have taught me. To cry with Sunita and empathise with some of her feelings crosses cultural, gender, age and economic gaps. I have been able to comfort her with the comfort that I have received. As 2 Corinthians 1:3-4 says,

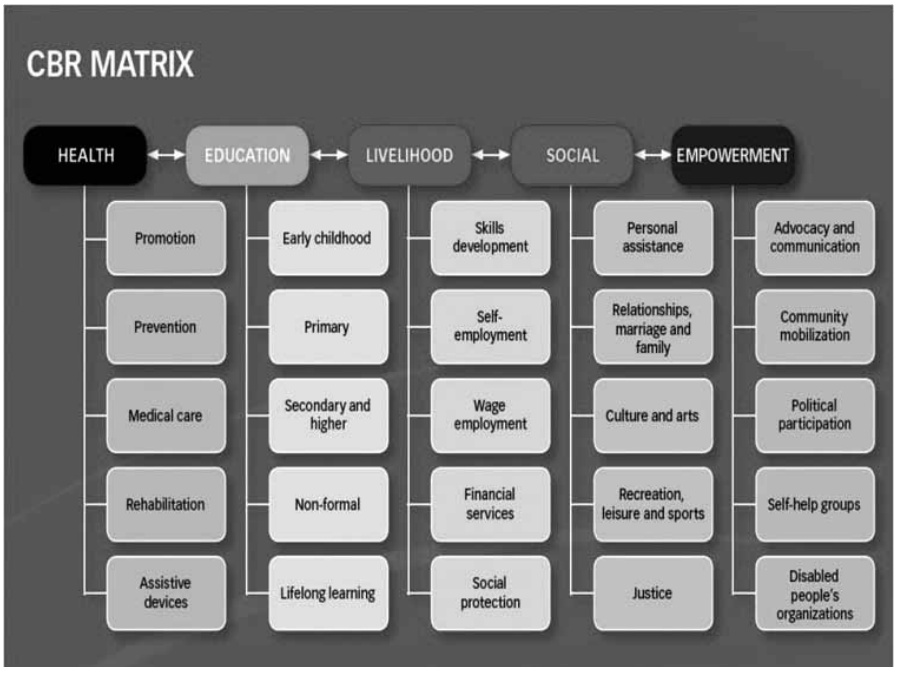
> *"Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God."*

Our program has been able to show Sunita that Rajan is created in God's image, is loved by God and has a special purpose, a truth I have come to undertake to share with others. Practically we have been able to maximise Rajan's function with orthopaedic interventions, link him to school services, and we even employed his sister as a volunteer. Being a sibling of a boy with disability she has much empathy.

Such volunteers are the key to the program. We have adapted the model from our community health program where we train one local health worker or 'barefoot doctor' for each village. This worker then provides basic health care and preventative health services. Likewise we train one multipurpose disability worker who acts as a grassroots therapist, legal advocate, community organiser, teacher's aide and gatekeeper to specialist services. Amazing! We have weekly trainings on therapy, advocacy, and value teaching from the Bible. These are similar to case conferences in Australia where we discuss difficult cases and work through solutions together. A number of our volunteers have a disability themselves and their empathy is the strength of our program.



Feet effected by leprosy.



These workers address the many different aspects that are important for a person with disability. WHO has summarised these areas into the Community Based Rehabilitation (CBR) matrix. Spirituality was a 6th pillar in the draft but it was removed. However, I believe that faith is a cross cutting theme that is relevant to every pillar of the matrix. *(See left.)*

Indispensable to the church and its mission

What really impacted Sunita was that we told her that Rajan was a blessing and has a purpose. That didn't fit within her worldview. It wasn't consistent with the worldview of our local staff either. To help them look beyond the person as an object of pity and healing we have trained them to see the blessing that each person is to a community and so to include people with disability as a valuable part of it.

Indeed as 1 Corinthians 12:22 (NIV) says, "those parts of the body that **seem** to be weaker are the indispensable parts". "Seem" is a key word here. When we see people with a disability we see weakness, but when God sees them He sees his

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The Leprosy Mission's Natalie Smith facilitates a health workshop in Nigeria. Photo: TLM.

image, He sees purpose, He sees an indispensable part of His body. Sadly, churches and missions miss this blessing and often overlook the gifts of those with disability.

> *"We encourage church and mission leaders to think not only of mission among those with a disability, but to recognise affirm and facilitate the missional calling of believers with disabilities themselves as part of the Body of Christ."*
> *Cape Town Commitment (IIB/4/B)*

For us medics valuing people in this way involves moving beyond a medical and charitable model. This is hard as we are trained to heal so we are very comfortable with "fixing" disability. However, this medical approach must not prevent us recognising and celebrating these people and their contribution to our churches and the church's missional calling.

Towards a social empowerment model

In our mission program we have moved beyond a pure medical model towards a social empowerment model. This model values the person, disability and all, and attributes part of the 'disability' to barriers and attitudes of society. To refer to another Lausanne movement article:

> *"Although physical or mental impairment is a part of their daily experience, most are also disabled by social attitudes, injustice and lack of access to resources. Serving people with disabilities does not stop with medical care or social provision; it involves fighting alongside them, those who care for them and their families, for inclusion and equality, both in society and in the Church.* ***God calls us to mutual friendship, respect, love, and justice.****"*

This requires those of us involved in mission and disability to move beyond the charitable and medical model. This demands us challenging, as the Hebrew prophets did, the societal structures or the "chains of injustice" that oppressed the vulnerable: the poor, the widows and the disabled (Isaiah 58:6, Proverbs 14:31). Jesus carried this message even further by coming to "preach good news to the poor" **and** to proclaim freedom for the prisoners and recovery of sight for the blind, to "release the oppressed".

What can you do in disability and missions?

My experience of having a child with disability in Australia has made me realise how blessed we are with so many skilled therapists, social workers, doctors etc. Many developing countries have few such people and there are many opportunities for Christian therapists and health practitioners to serve internationally and cross-culturally. In our programs we have relied on visiting occupational therapists, speech therapists, ophthalmologists, physiotherapists, orthopods and dermatologists to provide specialist services and train our volunteers. They have all been useful. They have visited from periods ranging from a week to half a year. We would welcome more!

We also work on disability research, in association with the University of Melbourne, around measurement of disability and associated barriers. This information allows us to better plan, advocate and serve people with disability. We have hosted Masters of Public Health students for this work and we are always open to helpers.

Our health missions have, and should continue to, follow the example of Christ and witness to his love for people like Sunita and Rajan. However, the challenge is not only to help them but allow ourselves, our churches and our missional movements to be helped by them. As Luke 14:13 says if we invite those with disability to be part of our community and missions we will be blessed. On the other hand, if we exclude them, we as a church and as a mission are missing an indispensable part! The body is incomplete and our mission is itself disabled. ●

"In our mission program we have moved beyond a pure medical model towards a social empowerment model."

A Journey in Wholeness

by Rev Dr Mary Lewis

Mary and Owen Lewis have worked as GPs in Adelaide and rural South Australia, served as missionaries with CMS Australia and currently are Field Workers in Roxby Downs, SA with The Bush Church Aid of Australia. Mary has served on federal bodies of CMS Australia and is currently a member of the Federal Candidates Committee.

I am Mary, currently the parish priest to the Roxby Downs Christian Community Church, a joint ministry of the Anglican and Uniting Church in Far North South Australia.

I have a previous professional life as a GP and medical educator and am mother to four amazing adult children and grandmother to six children aged between one and seven years. I am married to Owen, a GP and educator and string teacher extraordinaire. (Strains of a small ensemble practising *Madame Butterfly* come from our living room – why is a great story, but not part of this reflection). 14 years of our life together was spent in Nepal as medical missionaries with CMS Australia and Owen continues to support GP education through PRIME at the extension program of CMC Vellore. We met at medical school in Adelaide, two country Christians with embryos of conviction that God had a place for us in medicine and mission.

I was born and bred and nurtured in faith within a faithful and committed Baptist family in Broken Hill. I'm a late Baby Boomer and so my

Dr Owen and Mary Lewis.

faith nurturing was in the milieu of a devotional home life, Sunday School anniversaries and exams, Billy Graham crusades, ISCF, Beach missions, Scripture Union and medical mission – ABMS nursing sisters in Pakistan (now Bangladesh) visited us and were hosted in our home and *Jungle Doctor* books were read eagerly and viewed on film strip. I answered Jesus' call to follow him during a Beach Mission and his call to be a doctor during a local church mission. Sharing the good news of Jesus in medicine was a no-brainer. Jungle Doctor[1] did it; Val Beverley[2] did it; God was calling me to step up and do it too. And God took this naive enthusiast off to the city to be shaped by him for this calling and to meet Owen who was to be my life companion on this journey.

"We are called to a whole-of-life faith all of which witnesses to the truth of the gospel."

It would be some years before we "went to the mission field", but wherever we were living and working there was no separation in our understanding between our faith and our life. We trained in England and in the late '70s Owen took up General Practice in Mount Gambier in a partnership where John Foley and Philip Lind[3] were also partners. Integral mission was not a term in use but it was definitely in practice in the lives of these men and their families. Working in this partnership and living and worshipping in the parish of Christchurch consolidated our faith foundation that God is to be Lord of all our life. The saving and redeeming work of Jesus has no compartments, it's all pervasive and, as he works in us, his love and grace overflow and bring truth and grace to others. I confess that we fall far short of that being lived out, some times of our life being very far from God's plans for us, but the first commandment has been our foundation since we have known the saving and redeeming work of Jesus in our lives.

The Holy Spirit was moving in our church and in us (Frances Cook offered to SAMS, and three families offered for the ordained ministry at this time) to bring back our initial calling to "overseas mission". By now we had four children aged 3 to 8 years and headed to Nepal for a short term trip to relieve another GP. This was the beginning of our Nepal adventures. I still get the same butterflies in my stomach when I think about Nepal as I did then. Then they were all about the unknown and trying to be a sensible mother, a wise and understanding doctor, a quick and able linguist, an effective and sensitive community development worker, a warm and hospitable neighbour, an engaging and winsome Sunday School teacher, a prayerful and communicating mission partner and an encouraging and learning

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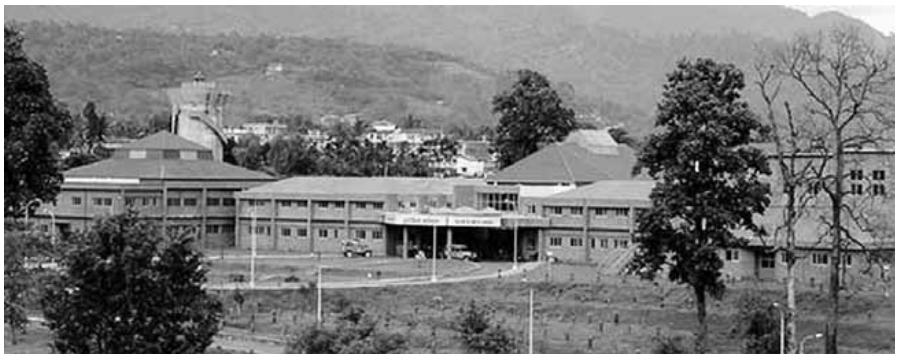

BP Koirala Institute of Health Sciences in Dharan.

member of the local church. Only this list!?... oh and of course to be a godly servant of God sharing the good news with all I meet, because of course now the pressure is really on to do this well because now we were "missionaries"! What happened to the integrated bit? Isn't the whole of life about godly living and lively witness?

After training at St Andrew's Hall we went to serve in Patan Hospital, a mission hospital in the Kathmandu Valley, a ministry of the United Mission to Nepal (UMN). We both worked as GPs and later Owen took up work in the urban section of the Community Development and Health Program. This program sought to integrate hospital and community health work, building referral links and continuity of care.

Our children were with us and grew up in the environment of a caring gospel-sharing mission community and Nepali church within the colour and buzz and uncertainty of Nepali life. We were truly blessed. God gave us an extended time in Australia while our children finished school and put down roots in Australia. We were given opportunities to extend our experience and training professionally, in the church and in mission.

Owen and I returned to Nepal in 2001 at the invitation from the BP Koirala Institute of Health Sciences through UMN to set up a GP training program for postgraduates as well as develop a curriculum within the undergraduate MBBS program. BPKIHS is in Dharan in the east of Nepal. It is a government hospital with most of its staff from Nepal or India. We learned the challenge of living our faith in a very non-Christian environment as we sought to build a culture among our trainees of patient-centred care, evidence-based medicine and appropriate health care both in the hospital and community.

"There's not a minute's rest from declaring the salvation and disciple-making glory of God."

We were blessed to begin a small fellowship of Christian students, join a welcoming on-campus home fellowship and be discipled by Pastor Philip Rai of the "Little Flock" church nearby. (There is much to tell of the partnership that developed between the church and the institute and the care of people with disabilities – Owen's story to tell).

We first went to Nepal in the 1980s. At this same time the evangelical world within which we served shifted. Gospel ministries were prioritised and the great debates returned between proclamation and action, word and deed. Many medical missionaries felt second class. Many felt that their support bases misunderstood what they were doing and why. Phrases like: "Medical mission is a good way to get into closed countries and get you an opportunity to speak. Praise God there are still places where we can just go straight in and speak." "You're a bright guy. Why are you wasting your time on a secular career? Get out of that and start training for real ministry and mission (in theological college)." "We support mission XXX because they take the gospel seriously and send out Bible teachers. We don't want to get caught up with groups that emphasise social justice and neglect the gospel" (We and many of our medical colleagues in Nepal served in mission XXX).

Medicine (engineering, management, agriculture, teaching, nursing etc) was seen as just an excuse for getting in and getting an audience. There seemed to be a separation between secular work and Christian work. A country like Nepal was talked about as "a missionaries' playground" where people could just get on with "work as usual" and not face the "hard core gospel work" of evangelism and church planting. Not at all! What a gross misunderstanding and distortion of the truth. We are called to a whole-of-life faith all of which witnesses to the truth of the gospel. Of course we get it wrong sometimes and lurch with our human sinfulness between word and deed. But God in his wisdom calls us to be his co-workers and in his grace and power forgives us, sets us back on track and equips us for the task.

In the midst of this controversial time we returned to Nepal fired even more to live out the gospel in medical practice – the place that God had placed us.

In Exodus and Deuteronomy we first read God's clear commandment to his people. *"I am the Lord your God who brought you out of Egypt; out of the house of slavery. You shall have no other gods before me."* (Exodus 20:1; Deut 5:6-7). Moses continues in Deuteronomy 6 verses 1 to 9:

> *Now this is the commandment... that the Lord your God charged me to teach you to observe... so that you and your children and*

your children's children may fear the Lord your God all the days of your life... so that your days may be long... Hear O Israel: The Lord is our God, the Lord alone. You shall love the Lord your God with all your heart, and with all your soul, and with all your might. Keep these words that I am commanding you today in your heart. Recite them to your children and talk about them when you are at home and when you are away, when you lie down and when you rise.

Bind them – fix them – write them. There is no division here between secular and spiritual work; no division between home life and work life; no division between speaking and doing.

At the end of his life Jesus gave us one command.

"All authority in heaven and on earth has been given to me. Go therefore and make disciples of all nations, baptising them in the name of the Father and of the Son and of the Holy Spirit, and teaching them to obey everything that I have commanded." (Matt 28:18-20)

At the end of his life Jesus gave us one promise.

"You will receive power when the Holy Spirit has come upon you; and you will be my witnesses in Jerusalem, in all Judea and Samaria and to the ends of the earth." (Acts 1:8)

I don't believe for a minute that God gives this command and promise to all and then turns to some and says, "I don't mean you. You're going to be a physician, so forget about all the disciple-making stuff. And you; I'm calling you to be a surgeon so forget about the witnessing business." Not at all! It's both – and for us and for all Christians. Be disciple makers and witnesses in all of your life. There's not a minute's rest from declaring the salvation and disciple-making glory of God.

I have a bullish reputation in my mission when we get started on integral mission. Perhaps these days I think there's a fight where there isn't. My mission has developed a policy on wholeness in mission that is fair – I'd like it to be stronger. Some of my associates want to describe my move to pastoring a church as a move into "full-time ministry". It is full-time ministry, but it's not a move. God took away my passion for medicine but not my passion to teach; same call but different subject matter. And it's definitely missional. God taught us in Nepal; God taught us as we returned and reflected on "being missionaries". We are God's people on God's mission here in Roxby Downs equipping others to also be on God's mission. I am more aware of this than before going to Nepal, but it's the same mission.

"Be disciple makers and witnesses in all of your life. There's not a minute's rest from declaring the salvation and disciple-making glory of God."

May God lead us and bless us into lives that are integrated with him and by him; where he is the "Lord our God, the Lord alone", where we love him with all our heart, and soul, and mind and strength, where we serve him always and everywhere by witnessing and making disciples to the ends of the earth. ●

References

1. Dr Paul White, author of the *Jungle Doctor* series served with CMS Australia in Tanganyika (Tanzania) in the early 1960s and later was very influential in ministry amongst University students in Sydney.
2. Sr Val Beverley was a nursing sister with ABMS in the 1960s and 1970s in Mymensingh, East Pakistan, now Bangladesh (I think). My memory may not be clear.
3. Both well known to CMDFA members.

Preparation for Short- or Long-Term Work Medical Mission

by Prof Anthony Radford

Anthony Radford, formerly Professor of Primary Care and Community Medicine at Flinders University in South Australia has been a consultant in international health for numerous international, non-government and mission organisations and several governments over the past fifty years. He developed and implemented the highly successful program of orientation for those seeking to work overseas, which is described in this paper.

In current parlance, *Global Health* would seem to be making a bid to take over from *International Health* as the more politically correct term to describe the issues of health that arise in the less-resourced world, just as 'community health/ medicine' took over from 'public health' in the 1960-70s and now seems to have reverted again to 'public health' after a brief surge in popularity for 'population health.'

'International health' is often used to describe patterns of health services and 'global health' to describe disease matters. Most seem to use the terms interchangeably. The nomenclature issue in this field is further muddied in deciding which term is politically correct for those regions which we are considering, for example, 'less developed or less resourced', 'less or under-developed', 'North or South'. But where does that leave Australia and New Zealand? Australia now ranks 13th or 14th as a global economy, yet having numerous pockets of communities with some of the worst health statistics, namely, some of our Aboriginal groups, sometimes described as 'Fourth World'.

The old term 'tropical medicine' is being applied to many diseases whose incidence and prevalence in years gone by was significant in Europe, such as malaria in southern England, cholera in London and leprosy in Scandinavia. While there are some diseases which are specifically 'tropical' or 'sub-tropical' such as relapsing fever and schistosomiasis, the disease patterns of the worst resourced areas of the world are more determined by poverty, powerlessness, lack of education and lack of access to resources, irrespective of their latitude and longitude. These countries just happen to lie in the so-called '10-40 window'.

These four components are also the major determinants of those diseases that are geographical 'tropical' in that their incidence and prevalence are more determined by these factors than by climate, even though as McMichael has predicted climate change will/is altering our pattern of communicable disease.[1]

Few medical schools significantly address the occurrence of disease and access, or lack of it, to health services through a consideration of these factors.[2] Their curricula are largely based on that 'centrifuged deposit of the total world of illness', which as Osler over a century ago pointed out, 'may contain the weightier particles, but is open to the question as to whether they are the more important', and a practice of medicine heavily reliant on increasingly expensive high-powered investigations and third or fourth generation treatments.

While most universities now offer postgraduate degrees at a master's level in International Health/ Development, or its equivalent, there appear to be few intensives in Australasia which provide concentrated learning experiences in both clinical knowledge and skills, combined with public health in cross-cultural situations. Short three month courses leading to a DTM&H are offered in the Liverpool and now London Schools of Tropical Medicine in the UK.

This lack of orientation would also seem to apply to the increasing number of teams of professional health workers going out on short- or long-term mission work with various Christian churches and NGOs and the increasing number of teams of specialists.

Law et al (2013)[3] recently drew attention to the fact that some 60% of Australian medical students choose an elective in the less-resourced world, but many receive little or no preparation for the recognition and management of many of the diseases they will meet, and precious little related to the practice of medicine in a cross-

cultural setting, nor concerning the issues around delivery of services in the countries to which they seek attachments for six weeks to six months. They also receive very little related education in the preservation of their own health while there and when they return – 're-entry health.'

Few Australian medical schools have sought to address this issue directly. Flinders University introduced a 3-week, later 4-week, Summer Intensive in 1985 for health professionals going overseas, those on furlough from the less developed world and seeking a refresher programme relevant to their needs, and for senior students preparing to go on an overseas elective in their final year. This intensive was the most popular of all summer intensives offered by the university with an average of over 30 participants each year, the majority of whom were Christian. It was discontinued in 1994 but has continued externally since 1998 under a not-for-profit association called *Intermed SA*. It was founded specifically for the purpose of providing post-graduate education for Christian health care workers who sought to be involved in overseas and Aboriginal heath care programs. This elective has recently been accepted for a programme leading to a Postgraduate Certificate or Diploma award at Tabor Adelaide.

In 1998 Dr Owen Lewis, a former participant in this program, established a variation of it at the University of Adelaide for senior students looking for an orientation to international health prior to overseas placements and for foreign students who sought a greater understanding of the diseases and health issues akin to those in their own countries. This program continues as an elective taken by 10-20 students a year.

INTERMED, with staff from the Flinders University medical faculty, are currently exploring options for a short orientation program for students about to embark on overseas electives. This course is designed to enable students to gain maximum benefit from their time in such situations, and minimise 'culture shock' during and after their elective.

The origin of the *INTERMED* program followed the observation by the author, during a series of international health consultancies, of the lack of preparation of various health professionals for service abroad. This resulted in consequent feelings of inadequacy and stress, and lower levels of performance than might otherwise have been the case. Since this programme and its progenitor began in 1985 over 1000 health professionals and senior students have participated in variations of this programme on four continents in five countries, namely, Australia, the United Kingdom, the United States, Brazil and Taiwan.

intermed

A feature of the applications to this program has been the wide variation in backgrounds and former experience of participants from senior students to a Professor of Medicine, from junior nurses to an engineer interested in water supplies in developing countries, all being able to be accommodated in the same class. While the majority of participants have been nurses, midwives and doctors, over a dozen health professions have taken part in the program and, while the great majority of participants are from Australia and New Zealand, they have included health workers from Asia, Africa and Europe.

An annual review at the end of the *INTERMED SA* program, which has averaged over 20 participants each year for the past decade, has received universal plaudits regarding both the content and conduct of the course. It is believed to be the only such intensive available in Australasia.

No one should go out into medical mission without doing this course.

It was a fantastic opportunity to better prepare oneself for medical work.

New, broader perspective about global health problems.

5 shining gold stars.

This program, initially of three weeks duration, has been extended a further week following repeated participant requests to do so. This week concentrates on more practical aspects, was further extended in 2004 with a 2-week optional practicum. The practicum experience provided the opportunity to apply their recently acquired knowledge and skills, as well as to develop and apply new attitudes regarding the provision of health care in low-resourced areas and across cultures. These practicums, conducted in the latter half of the year, have been held in readily accessible overseas countries, namely, East Timor, Indonesia and Vanuatu.

The course can be taken for audit or credit, and was offered as an elective in the Master of Science (Primary Health Care) program at Flinders for those who took it for credit, when that option became available. It has since been accepted by every university or college for which participants have sought cross credit arrangements.

From January 2015 participants will be able to participate in either a Certificate or Postgraduate Diploma in International Health & Development, or simply audit the course. It will be conducted at Tabor Adelaide, which offers certified tertiary education up to doctoral level. This program is designed to be completed in 12 months, 6 months in the case of certificate candidates, but may be undertaken part-time. Most of the program will be taken as intensives, and a mechanism to allow part of it to be studied on-line is being explored. However, it is felt that the majority of teaching should continue to be taken in a class room context as the value of a group of health professionals with a common aim re-enforcing their motivation for mission work and their faith has been found to be one of the

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most positive components of the program.

A refreshing reminder of God's sufficiency in all situations that He calls us to.

There is a God and we are not Him. We can't do everything but we can do something.

Perspectives on the realities of the world, our role, God's health, friendship and discipline to study.

One of the best things I've done to prepare for my calling.

The *Intermed* program provides knowledge and skills in both public health and clinical medicine, and an opportunity to develop skills related to both improving professional satisfaction and implementing health services in a manner particularly relevant to less-resourced areas. It is designed to facilitate living and working with improved confidence in cross-cultural situations and making the most out of being a guest in another country. It is especially suited to those who seek an introduction to global health and development prior to working in such areas, as well as for those seeking relevant continuing education while on furlough. The course is primarily directed at Christian health care workers but is open to all.

While the program is open to all health professionals and senior students in their final year, exceptional entrants from other disciplines may be admitted provided they can demonstrate basic health knowledge and their prior career pathway has had a significant health component. This requirement is because the pace at which the course is conducted assumes a basic health and medical vocabulary and background.

Each participant is encouraged to set their own objectives at the outset of the program which is taught in adult education mode. It consists of interactive lectures, seminars, group assignments, practical sessions for skill acquisition and individual research.

For one component of the skills learning component the class is divided into:

1. Doctors and laboratory workers, who learn laboratory skills (direct smears, urine examination, staining for and recognition of faecal parasites), and
2. Others acquire clinical skills, such as examination of adult and child, basic plastering techniques and suturing.

The course covers the following five areas:

1. Biblical perspectives of community development and issues around living and working in cross-cultural situations.
2. Principles of delivering health services in less resourced areas, including the organisation, management and evaluation of health services.
3. Major public health issues including environmental, maternal and child health and water supplies.
4. Major issues in development and community participation.
5. Prevention, diagnosis and treatment of major clinical diseases. This includes basic surgical skills and the use of resources.

The clinical component includes aetiology, recognition, management and prevention of major and significant diseases, not normally covered in any detail in a general medical education, such as malaria, tuberculosis, common skin diseases and common obstetric problems.

With respect to public health, major emphasis is directed to the design, conduct and evaluation of health services in small communities, especially related to Primary Health Care, such as maternal and child health; selecting and accessing scarce resources; water and health; and the selection, training and use of community-based health workers.

At the conclusion of the one month intensive all participants are provided with electronic copies of the power-point presentations and notes issued throughout the course.

Once in the field, participants are encouraged to make use of the *INTERMED* secretariat and staff on-line. For example, sending photos of skin lesions for diagnosis and management, and seeking responses to propositions or difficulties participants are having with health service delivery. The burgeoning growth of WiFi, Internet, telephone IT and Instagram communication allows rapid exchange of information and response to questions, and even prayer in times of distress, from all quarters of the globe.

In summary, few medical schools and fewer postgraduate clinical specialities prepare health professionals for working cross-culturally in the less resourced areas of the world. There are short courses available which can remedy this deficit, but these are largely provided overseas. This paper has described the development and conduct of a well-established and popular intensive course of orientation to International Health & Development available in Australiasia.

Further information concerning these programs is available at:
PgDIH&D Officer
School of Theology, Ministry and Cross-cultural Studies
Tabor Adelaide
PO Box 1777
Unley SA 5050
Or www.intermed.org ●

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The Mission Field in Remote Australia

by Dr Teem-Wing Yip

Teem-Wing, originally from Hong Kong, has been living and working in Central Australia since 2005, where she is currently working as a public health specialist. She speaks Pitjantjatjara and is very involved in Aboriginal ministry at the Alice Springs Lutheran Church. She has a very supportive adopted Aboriginal family.

When thinking and praying about where God might want you to do cross-cultural mission in a needy place, have you thought about remote Australia?

The need

The appalling health status of Aboriginal Australians in the remotest parts of Australia often gets at least a mention in undergraduate health professional education nowadays, and occasionally gets a mention in the media.

You may have heard about the need to 'close the gap' – but what is the gap? In the Northern Territory, the life expectancy at birth for the indigenous population is worse than that of Iraq, Bangladesh and Nepal (Table 1).

Table 1: Life expectancy at birth[1,2]

	Life expectancy at birth (years)
Australia, non-indigenous females	83.2
Australia, non-indigenous males	79.8
Iraq	69.6
Bangladesh	69.2
Nepal	69.1
Australia, Northern Territory indigenous females	68.7
Australia, Northern Territory indigenous males	63.4

Table 2: Childhood malnutrition[3,4]

	Underweight (%)	Stunted (%)	Wasted (%)
Kazakhstan	4	13	4
Palestine	4	11	3
Romania	4	13	4
Northern Territory	7.9	13.3	5.2

Amongst remote indigenous children aged 0-4 years in the Northern Territory in 2011, the prevalence of malnutrition was worse than that of Kazakhstan, Palestine and Romania (Table 2).

Countless other publications attest to the disproportionate burden of disease amongst Aboriginal Australians, especially in the remotest areas, yet those areas also have a shortage of health professionals.[5] In many places, the turnover of health professionals is high, meaning that those who need health care the most are disadvantaged by poor continuity of care; problems need to be reiterated, case management plans are frequently changed, and trust has to be continually rebuilt.

The past and the present

Missionaries have been active in many parts of remote Australia for many decades, and in some places, for over a century.[6] Despite the frequent negative mentions of the Aboriginal interaction with missionaries, the truth is that in many regions, missionaries have been well-respected by the people to whom they ministered, and by their descendants.

From the 1970s onwards, missions have handed their authority to secular local governments. But even now in many parts of remote Australia, Jesus is well known and regularly worshiped; where available, the Bible is read and studied in Aboriginal languages;[7] hymns and contemporary praise songs are sung late into the night; dozens of people are baptised at a time.[8] Numerous Aboriginal Christians continue to be ordained as pastors[9] or otherwise recognised as formal or informal church leaders. Nevertheless, the challenges of applying the Christian faith in a context of great social and cultural breakdown and economic hardship are significant, and many faithful Aboriginal Christians appreciate support from their non-Aboriginal brothers and sisters in Christ.

In the past, Christians would go to remote Australia as employees of a church or mission organisation, either as ordained pastors or ministers, or as laypeople practising their trade or profession with colleagues and supervisors who were also Christians with the same calling.

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Nganana mukuringanyi doctor Christian tjutaku pitjala nganampa ngurangka warkarinytjaku; Jesuku walytja tjuta, nganampa waltja tjuta.

We want Christian doctors to come to our land to work; Jesus' family is our family.

Message from Kanytjupai Armstrong, Nyukana Baker and Helen Martin in Pitjantjatjara.

Helen Martin is from Warakurna, WA; Nyukana Baker and Kanytjupai Armstrong are from Ernabella, SA. They have been forced to live in Alice Springs, NT, for many years due to dialysis. They are the author's family. (Warakurna is 9 hours' drive from Alice Springs; Ernabella is 5 hours' drive from Alice Springs).

"The mission field of remote Australia is no less legitimate than other mission fields outside Australia."

Nowadays, the reality is that remote Australia is no longer a 'traditional' mission field, where only a select few with particular skills (such as Bible translation) are sent as missionaries by a church or mission organisation to remote Australia. Church-based community service organisations exist, but they are generally not recruiting dedicated Christians as long-term missionaries but as short-term employees who may only be required to be sympathetic to the Christian ethos of the organisation.

Nevertheless, remote Australia should be regarded as fertile a mission field as ever before, even though the structure within which Christians operate is quite different.

The opportunity

There are numerous job openings in the health, as well as in welfare,

Remote GP work is exciting and rewarding. Sometimes you feel like you are in a different country. You may feel that you will never be qualified enough, but reality is that if you aren't out there, the community won't have a doctor. It comes down to team work with excellent nurses and knowing that you aren't there on your own. There is always someone on the other end of the phone who will give you advice!

Dr Sarah Luthy
Nhulunbuy, Northern Territory

education and other sectors to serve Aboriginal Australians remote areas; many of these jobs are well paid with other generous financial benefits.

Many of these jobs are very challenging. Professionals are often expected to deal with very severe and complex cases with fewer resources than would be available in other places in Australia. These jobs are situated in geographically remote areas, where professional and personal support may be limited. The risk of burnout is high.[10]

Any suitably-qualified person can simply respond to a job vacancy advertisement and then move to the remote location to take on a challenging job, but preparation is essential. Before 'traditional' missionaries are sent overseas to equally challenging environments, they would most likely have months of multi-faceted preparation, including intensive language learning and theological study, and be sent off with much long-term prayer support as well as practical support. The mission field of remote Australia is no less legitimate than other mission fields outside Australia, hence mission-minded Christian professionals who take up positions with secular employers in remote Australia deserve the same care and support that 'traditional' missionaries receive from churches and mission organisations.

What's not needed

We don't need health professionals who just come for the money – one of the strongest criticisms or insults that my Aboriginal family and patients say about poorly-performing workers is that they are doing it "just for the money". Conversely, they have high regard for Christians who come to work with them in the name of Jesus.

We don't need Christian health professionals who come because it's a great practising ground for 'real' missions overseas. The mission field here in remote Australia is just as real and legitimate, and we want you to serve the people here because you love them, and not because you want to use them to practise on.

We don't need Christians who want to set up new churches and lead churches in Aboriginal communities – the colonial era is over. Aboriginal Christians often have well-established churches and are keen to lead them, occasionally with the support of non-Aboriginal Christians in particular areas. Christian professionals should seek the local church and quietly support it.

I find work in remote NT to present the same challenge and difficulty found in any overseas cross-cultural mission destination. It is a place in great need of missionaries.

Dr Geoff Harper
Nhulunbuy, Northern Territory

The challenge

Will you, as a Christian health professional, consider giving a few years of your life and career to serving Aboriginal Australians in the remotest parts of Australia? Will you take responsibility in addressing some of the appalling health outcomes in the rich country of Australia? Will you refuse to be complacent about some of the most socio-economically and linguistically marginalised and disadvantaged Australians?

If you feel called by God to work in remote Australia, will you approach your local church or mission agency for support while you work in a secular job?

Will you, as a mission agency or church, support Christian professionals to serve in remote Australia, and consider this mission as legitimate as overseas mission?[11]

Contacts

If you are a Christian health professional, a mission agency or a church that is interested in this type of mission work and you'd like to find out more, please contact one for us for a conversation:

Dr Teem-Wing Yip
teemwing@gmail.com

Dr Sarah Luthy
luthygirls@hotmail.com

Dr Geoffrey Harper
geoffrey_harper@hotmail.com ●

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7. To find out more about Bible translation to Indigenous Australian languages, go to websites such as http://www.biblesociety.org.au/projects/indigenous and http://www.coordinate.org.au/
8. For example, on Easter Day 2014, I was privileged to witness 48 baptisms in Pipalyatjara, in the far north-western corner of South Australia
9. For example, the Lutheran Church of Australia has 26 ordained Aboriginal pastors in Central Australia
10. For an excellent but disturbing insight, see Kartiya are like Toyotas: White workers on Australia's cultural frontier by Kim Mahood, Griffith Review, Edition 36, 2012. https://www.griffithreview.com/articles/kartiya-are-like-toyotas/
11. CMS Victoria is willing to be a sending organisation. Please contact the State Director via the website (http://www.cms.org.au) and state that you have read this article.

Medical Missions in Nigeria

by Dr Phil Andrew

Jos, Nigeria.

In 1979 I arrived in Nigeria, with my wife Janne and 2 young children, to serve with SIM at Evangel Hospital in Jos, Plateau State. I had just completed residency and some time in general practice in Tasmania.

We served in Nigeria in various capacities until 1994 when we returned to Launceston and I re-entered private general practice. During this time I maintained some ongoing contact with Evangel Hospital and visited Nigeria on several occasions. I was also a member of SIM's Australia Council and represented SIM in Tasmania in an honorary capacity. In early 2010, by which time our now four children were independent, we returned to Jos, this time for me to serve as Director for SIM Nigeria. Although most of my time now is devoted to mission administration, I still have some involvement in the hospital and am an examiner with the National Postgraduate Medical College of Nigeria. I also provide some oversight of several SIM medical missionaries serving here so I do have some ongoing contact with what is happening in medical missions. I would like to share some things I have observed and learnt from my experience during these 35 years of being connected in some way with medical missions, especially in Africa and in Nigeria in particular.

When I first arrived in 1979, the church that SIM planted (called ECWA) was by then officially the proprietor of the hospital, as it was of almost every other ministry or institution that SIM had established since it first began work in Nigeria in 1893. However the hospital's medical superintendent and most of the senior doctors were SIM missionaries. There were a couple of Nigerian doctors who were employed by the hospital but they were relatively junior and most were not committed to the hospital long-term. As a general medical officer in the hospital my work was therefore typical of the traditional missionary doctor. We dealt with everything we came across, covering the whole spectrum of medicine, and took each case as far as we safely could. This meant I gave anaesthetics, performed surgery, practised obstetrics, single handedly looked after a children's ward and so on, just like many other medical missionaries.

However in the early 1980s an unexpected development took place. The hospital was approached to become part of a residency programme in General Medical Practice, under the auspices of the newly established Faculty of General Medical Practice of the National Postgraduate Medical College of Nigeria. Although this seemed like a good idea and the hospital agreed to the request, I must admit that this focus was not really on my agenda. I had come with a clear personal vision not to focus long term on hospital based curative care but as time passed to develop an increasing emphasis on preventive care. In fact at that time I was already beginning to move into a new role medically supervising and supporting the 120 rural health clinics that SIM had handed over to ECWA and which were badly in need of such support. However as it happened I was the only person in the hospital who had any formal qualification in General Practice (FRACGP) and therefore the Medical Superintendent told me very clearly: "this new GP training programme will be your baby". So, like it or not, through no planning or effort on my part, I found myself in the middle of what turned out to be one of the most strategic developments in medical missions in Africa. I still went ahead to follow my passion for community health work, but looking back I would have to say the strategic value of my part time involvement in supervising GP trainees was at least equal to, if not greater than, that of my efforts in community health.

So it was that in 1982 ECWA Evangel Hospital, Jos, took on two registrars in general practice as a new venture. In the years since then we have trained a long succession of competent, capable, committed Nigerian doctors from all over Nigeria. We were not the only training centre of course, but because of the the high quality of service and commitment of the amazing range of missionary doctors God sent our way over the years, the hospital soon established a reputation as one of the foremost training centres in General Medical Practice in the country. Not only did these trainees receive medical experience and training, but this was received in a context of compassionate and loving patient care. They were all committed Christians and were discipled by their medical mentors during the 4-5 years of their training. The quality of the "product" varied of course, but by and large these young Nigerian doctors were outstanding examples of what a committed Nigerian Christian GP could and should be. It is a constant source of

rewarding fulfilment for me to meet doctors who were trained at Evangel Hospital and are now serving all over the country, or even in missions in other countries, in all kinds of capacities. One of these (Rev Dr Joshua Bogunjoko) has even become SIM's first non-western International Director!

Since those early days a lot of changes have taken place. The discipline is now called Family Medicine rather than General Medical Practice. ECWA Evangel Hospital has become Bingham University Teaching Hospital (BHUTH). The vast majority of the senior doctors are Nigerian. We only have two full time missionary doctors serving on the staff (one general surgeon from Korea and one gynaecologist from the USA). The Medical Superintendent is now called Chief Medical Director and is a Nigerian Family Physician (a product of our own training programme). Now we have university faculty and medical students on rotation from the university campus in Abuja. The range of medical services provided is much wider and the range of consultants in various disciplines is far broader. Nevertheless the strategic value of the training of indigenous doctors remains central. We now have 18 residents in family medicine, with four full-time family physician consultants and a number of part timers (including myself, the only expatriate in the hospital's Department of Family Medicine). The Faculty of Family Medicine of the National College is now a highly organised and efficient body (many of its senior officers being those who have been trained at our hospital in the past). Twice yearly when we gather in Lagos for the examinations there are about 50 examiners there, helping to ensure high standards for the future members of the profession.

The church leadership has embraced the concept of training whole-heartedly. They established Bingham University in 2006 arising out of a deep conviction of the priority of a solid Christian worldview as a basis for the education of their children. A medical programme was one of the first courses to be established – a huge undertaking! In Nigeria Christian health care services form an enormous part of the national health services for the country, usually with little or no financial support from Government, each service depending on patient fees, donations and some grants.

"Training of health workers must be a priority in Africa."

Not all medical missionary work in Africa will take the same form as it does at BHUTH. Other hospitals are located in different environments and may be nowhere near as far down the road of training as BHUTH is, but in all of them training is a growing priority. ECWA has a hospital in Egbe, about 10 hours drive from Jos, which is being revitalised and is in great need of medical and other missionary staff. It is not an urban university teaching hospital, but a smaller rural general mission hospital. However training of Family Medicine residents is a key priority here too. In fact it is central to the future sustainability of the hospital. There is an urgent need for committed GPs who can serve there and provide training and mentoring for family medicine trainees in a Christian environment.

Egbe Hospital also has schools of nursing and midwifery and the teaching and training of these students is a high priority. ECWA also has a College of Health Technology in a rural location about an hour's drive from Jos which trains community health extension workers who staff the many rural and urban health clinics that ECWA has around the country. In the 1980s I did quite a lot of teaching there and the now totally national staff would dearly love to have a missionary come to support and help them. SIM's Galmi Hospital in Niger is involved in training surgeons through the Pan African College of Surgeons (PACS). SIM's ELWA Hospital in Liberia is hoping to begin a training programme in Family Medicine in the near future. Training of health workers must be a priority in Africa no matter where the medical ministry is located.

So as far as medical missions in Nigeria is concerned, things have changed a lot. These days the need is for missionaries who are willing to teach. They need to be well-qualified, capable and experienced. They need to be able to deliver lectures, tutorials and ward rounds of high quality, just as they would in the home country. They need to be able to supervise research and academic programmes. Above all they need to be committed to building relationships in a cross cultural setting, and to mentor and disciple trainees – whether medical students, post graduate residents, nursing or midwifery students or community health workers. They have an opportunity to have significant input into the lives of the next generation of leaders in Nigeria, not only in medicine but in the church generally.

Is the job easy? Far from it! They will need to adjust to another culture, learn another language at least to some degree (although the official language and the language of teaching in Nigeria is English), get used to the unfamiliar medical diseases that are common in the tropics and cope with less than ideal equipment, drug and lab test availability, x-ray facilities and other support. They will also work in an environment administered by Nigerian colleagues and leaders, and this may not always be done the way they think it should be done. They will need extra doses of patience, tolerance and grace. They will learn to trust God in a new way. They will live in a difficult security environment, and learn to tolerate shortages of electricity, water, petrol, internet, good roads, McDonalds, and many other "essentials" of life.

However they will have great rewards, especially the opportunity to invest in the lives of the future leaders of Nigeria. Medical mission in Africa is still exciting, and it certainly looks very different, at least from my perspective, from what it did 35 years ago. ●

The Story of the Love India Project

by Dr James Wei

Dr Wei works as a HMO2 at the Austin/Northern health network in Melbourne, Australia. He has a passion for social justice – to see the poor and marginalised empowered to overcome their daily challenges.

In the same way the Church exists for nothing else but to draw men into Christ, to make them little Christs. If they are not doing that, all the cathedrals, clergy, missions, sermons, even the Bible itself, are simply a waste of time. God became Man for no other purpose.
C.S. Lewis, Mere Christianity (Lewis, 1952)

Everything was falling apart. A marriage on the rocks, a new clinic venture not having the expected success – debts were mounting. Out of the corner of his eye lay a Bible. That fateful day, something drew him to dust off the cover and pry open the pages. His gaze fell onto Luke 15 – the parable of the lost son. As he read, he grew increasingly transfixed to the story; it was as if God Himself were speaking to him in the emptiness of the consultation room. He fell on his knees, "Father, I am coming home to you now!"

A thick presence descended on the room. Immediately, he was filled with an overwhelming sense of his filth and sin. And then – an overwhelming sense of the love of God.

It was a cool evening in rural India as he told his story. This was 2006, and much had changed since then. He soon returned to working in Mission Hospitals in rural India. A brief tangle with a mafia boss left him and his family traumatised – a story for another time. Surfing the internet one morning, he came across the Community Project for Rural Transformation* in Ashoka* – reigniting his earlier dreams of bringing transformation to the villages he had known from childhood.

With little more than a few dollars to his name, he left to attend a diploma course in community health to learn from the pioneers of primary health care in a place called Ashoka in rural India. It so happened that I was in my third year of medicine at the University of Melbourne, and as part of an International Health Research module, was sent to do a similar three-week course in Ashoka.

I recall being in that large mess hall with twenty-five other Australians. It was a boisterous crowd. An Indian man was sitting in the corner by himself. Instinctively, I gathered my plate and moved over to where he was.

"Hi, I'm James."
"I'm Sam*", he smiled.

Little did I know that this was the start of a journey, a friendship that was to stretch over continents, cultures and language.

Months later, I returned to Melbourne, and went straight for the only medical student organisation I knew who might be interested in partnering with Sam in his new venture. We had spent hours in the library in Ashoka pouring over plans, proposals, budgets. I learnt that Indians can be disorganised, with little consideration for planning and structure. But their quality was in their bravado, their willingness to sacrifice for the sake of ideals or family – all traits that I lacked. Their spontaneity meant that there were pleasant surprises in one's everyday itinerary, but their notorious tardiness would sometimes be a source of frustration and angst for me. I had to learn flexibility and patience very quickly.

It would be two years before we were ready to send the first volunteers over to India. It certainly wasn't the intention from the beginning, but things just happened to evolve that way. In my mind, it was the perfect scenario – bringing non-Christians to India to meet genuine believers moved with compassion to address poverty, injustice and brokenness with the love of Jesus.

I had seen the beauty of this while in Ashoka. What had fascinated me was the fact that many of the Australians who were with me at that time heard the gospel for the first time in its unadulterated form from local Indians. Somehow, going to a foreign land and culture had the unexpected result of causing secular Australians to become spiritually open. What if this could be replicated once more? Possibilities abounded in my mind.

"I'm joining your organisation because it's not like one of those faith-based organisations", said a prospective member of the Australian team.

I was glad people passionate about social justice with a strong secular worldview saw value in joining our organisation in Australia.

Surprisingly, opportunities to share of the goodness of God back in Melbourne were readily available. Sam' conversion account was always a fixture whenever I was invited to share the story of the Love India Project, whether it was at team meetings, or conference speaking engagements. Even the story of how we finally received official approval from the Indian Government as a direct response to prayer after years of frustrating delays was not spared.

Gradually, I saw the walls to faith begin to fall away amongst our team members, and others in the global health sphere. I was most heartened when one of our team members remarked to me, "As a result of going to India, I'm going to seriously consider becoming a Christian."

Simply meeting the team in India with their heart of love and service caused her to question her fundamental worldview, and rediscover what true meaning in life really meant. Do pray with us that she will be the first of many to arrive at such a conclusion!

* * * * * * * * *

It was my first visit back to India since we parted ways. We now had a handful of volunteers back in Australia who were due to arrive, and my mission was to ensure that the accommodation was habitable. The next two weeks was a frenzy of activity – installing toilets, fans, lights, even an entire plumbing system. In the meantime, we visited traditional healers, cotton farms, even stopping once to purchase some 'jungle' honey from a tribal harvester. We wanted this to be the ultimate 'volunteer immersion experience' – give privileged people from the first world a real taste of the daily grind of an impoverished villager.

Just before my arrival, disturbing news reached us that operations at the clinic had to be suspended. A mob of villagers had descended on the centre, destroying equipment, and beating up our guard. Was this going to threaten the entire Australian-Indian partnership? We made the difficult decision of pulling out of that region entirely – the volunteers would not pass within forty kilometres of that area. We placed other security measures in place, and then left the decision to each individual volunteer. To my surprise, everyone decided to go ahead with the trip, this inaugural visit set the foundation for sealing the partnership between the Australian-Indian teams.

What was the motivation for such violence? Sam explained that it was political – one faction supported Sam and his work, and the other wasn't happy about the apparent favouritism. There was also the fact that Sam was a Christian, and this was a Muslim dominated area. Although there was no open proselytising, they had used this as an excuse to incite a mob.

Interestingly, a year ago, when Sam and his family were praying about which area to set-up their centre, they had decided intentionally to go into the most challenging, unreached area. About five years prior, Sam's sister, through her role in the government hospital, had developed relationships with villagers, and many of them were open to the team visiting them to conduct Bible studies and Sunday school classes for the children. As relationships developed, the need to address the social, economic and health challenges began to be more apparent.

"Persecution is a stark reality – at best, they face alienation from their families, if not overt threats on their lives. "

At that time, there was no clear strategy to help these villagers in practical ways. There was little concept of how to empower the villagers. When Sam returned from Ashoka with this new model of grassroots collaboration and partnership with villagers, the impact in the community began to be obvious.

What has been the fruit of this work?

From 2013 to 2014, there have been at least three clear accounts of village health workers intervening to save female children from being killed by their parents. Female infanticide is a common practice in India, with a strong cultural and social preference for male children. No clinic or hospital would have had the influence or position to prevent such tragedies, or change such behaviours – only the village health workers from the communities themselves could do such strategic work.

Last year, a few destitute widows approached Sam, describing their predicament. They were considering heading into the township to go into prostitution in order to feed their children – could Sam do anything for them? It so happened that he was scheduled for a Skype call to the team in Australia later that week. As he shared, the obvious solution seemed to be to provide some form of vocational training for these women. With funds raised from another university music group, the seed funding for the first sewing class was available, and within a month, Sam had sourced four sewing machines, trainers and the first class of twenty village women. Now, Sureka no longer has to go into prostitution, she has a new-found respect amongst her community, and many other women are emboldened to chart a new future for themselves free from the shackles of the past.

Through the Gospel witness of Sam and his family, many have placed their faith in Jesus. They are secret believers ranging from all walks of life – a local politician, brick factory owner, village health workers, and of course, villagers themselves. Persecution is a stark reality – at best, they face alienation from their families, if not overt threats on their lives.

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Health Challenges in Nepal

by Dr Bruce Hayes

The challenge for any health system is to provide affordable and available health care to its diverse population.

Globally there are huge disparities both between countries (often but not always related to available resources) and within countries (particularly rural urban divide and different ethnic groups). For the Christian health professional, it raises important questions of justice and equity and what should our response be under God, to tackle some of these issues to make a difference. I will reflect on some current challenges from my own experiences in living and working as a General Practitioner in Nepal since 1993.

On a positive note, there has been some significant progress made in Nepal in this time despite a 10 year civil war (1996-2006). Life expectancy in 2012 has increased to 67/69 years (males/females) from 55 /53.5 years in 1991, particularly reflecting marked improvements in maternal mortality (reduced from 880 to 281/100,000) and significant reductions in under five mortality (from 141 to 42/1000).[1] However, these still fall well short of what is acceptable.

Historically, many Christians have served faithfully in mission hospitals throughout the world, particularly in remote and under-resourced areas, demonstrating God's love and care for all people. This has been a powerful witness. In Nepal for example, since the country opened to foreigners in 1951, medical mission has always been prominent with the first hospital starting in Tansen in 1954. By the early 1990s, the four United Mission to Nepal (UMN) hospitals provided about 25% of all hospital beds in the country. For a persecuted church, the visible presence of hospitals, known to be Christian, were a great encouragement and created a positive image for the church in the community. They were an important point of contact (and bridge) for many non-Christians. We should not underestimate the validity of ministries of mercy. God gives mercy, love and compassion to all (Luke 6:32-26), Jesus demonstrated it in his incarnation (Phil 2) and so must we in response to God's grace (Mt 18:21-35) By loving actions and deed ministry, the word of the kingdom becomes visible. Good deeds glorify God (1 Pet 2:12; Mt 5:16) and support the validity of the gospel demonstrating the power of the Kingdom of God. This opportunity remains and goes on in places like Nepal.

"Historically, many Christians have served faithfully in mission hospitals throughout the world, particularly in remote and under resourced areas, demonstrating God's love and care for all people."

However, there have been increasing challenges in this type of service including sustainable funding and human resources, particularly in light of global financial issues and greater move to short-term mission involvement. As well, in most places like Nepal, the wider impact is less significant as populations and needs increase. It is recognised that for most remote and under resourced areas it is the government which provides most services. This is in a country with a gross per capita national income of US$1,470 with only 5.4% GDP and average $68/capita spent on health.[1]

In most countries there are an increasing number of national doctors and health professionals. From just one medical school (started 1978) before 1993, there are now 19 schools producing more than 1,000 Nepali graduates per year. However in a country of about 27 million people with 83% in rural areas,[1] there remains inadequate and markedly inequitable distribution of doctors – of 8,118 registered medical doctors in 2009, only 1,062 worked in sanctioned government posts of which only 64-80% of posted medical doctors were available at the time of surveys; two-thirds of doctors are in the Kathmandu valley or in other cities.[2]

As well, it is known that many doctors migrate from medically less-served to better-served areas. This paradoxical flow occurs over a continuum that includes internal migration (from rural to urban areas) and external migration (from developing to developed countries). Both result in adverse patient outcomes. In a study of 710 (97.7%) of the 727 graduates from the original government medical school in Nepal – 193 (27.2%) were working in Nepal in districts outside the capital city Kathmandu, 261 (36.8%) were working in Kathmandu, and 256 (36.1%) were working in foreign countries (188 or 73% of these were in the United States). Students from later graduating classes were more likely to be working in foreign countries.[3]

The current observed trend in Nepal and in the world towards specialisation and super specialisation is also concerning particularly in view of the evidence about the effect this has on the health care of populations as well as individuals. Countries with a strong primary health care system have lower premature mortality and better health care outcomes than those with a specialist focus (such as the USA). Research in the US has found that increasing the number of General Practitioners by 1 per 10,000 (33%) decreases mortality by 70 per 100,000 (9% fewer deaths). In the same study they found that increasing the number of specialists by 1 per 10,000 (8%) *increases* mortality by 16 per 100,000 (2% more deaths).[4] Other studies have confirmed this. Patients with a GP as their personal physician rather than a specialist have 33% lower costs of care and are 19% less likely to die prematurely.[5] Care by a General Practitioner reduces disparities in health (the gap between rich and poor), reduces the effect of income inequality and improves self-rated health.[6] "Primary health care also offers the best way of coping with the ills of life in the 21st century: the globalisation of unhealthy lifestyles, rapid unplanned urbanisation, and the ageing of populations."[7] (Dr Margaret Chan, Director General, WHO – 2008) It is with this evidence in mind that the World Health Assembly adopted a resolution urging member states to "accelerate action towards universal access to primary health care" and "to train and retain adequate numbers of health workers... including... *family physicians*..."[8]

To date, there have been just over 200 postgraduate General Practice doctors (MDGPs) trained in Nepal to handle a wide range of cases including difficult deliveries and operations. The numbers are clearly inadequate – 90 MDGPs were needed by government but only 34 were available.[2] In general, they are better retained in rural areas: in a study of all 99 MDGPs trained in Nepal between1982 – 2005, 87 were working in Nepal (11 overseas and 1 died) of whom 53 (61%) were outside Kathmandu and 30 (35%) were working in government.[9] A 2007 retrospective study of Nepal government district hospitals where an MDGP doctor was present for five or more years during the period 1996 – 2006 showed that the presence of an MDGP doctor was associated with more deliveries, more OPD visits and more operations – both by comparing years before and after an MDGP arrived in post and over the course of a continuous period when MDGP(s) worked in that hospital. Though other factors likely played a role, it suggested the value of an MDGP.[10]

Retention of an effective team of health workers may be the most critical challenge to the provision of long-term, quality health care service in remote areas of the world.

In light of these challenges and with an opportunity to do something different the Nick Simons Institute (NSI) in 2006, partnered with the Nepal government to address the problem of low performing government district hospitals. Based on international consensus about retention factors, experience in Nepal's health care system, and stakeholder consultations, a pilot program of supports for remotely-located, district hospitals was developed (Rural Staff Support Program RSSP). The central part was Nepal's MDGP within an enabling environment and management supports to facilitate a working hospital team. A bonded scholarship process was initiated with the first MDGPs posted in districts 3 years later. The program began in 2007 with three hospitals and following an evaluation and some important revisions, expanded to seven hospitals in 2011, all located in rural areas of the country, some in extreme mountainous regions. The aim was to take a long-term, iterative approach to build a scale-able model for Nepal.

All seven hospitals experienced increases in patient utilisation, even when compared to their neighboring districts' figures; all were converted into continuous providers of emergency obstetrics services (operations); and there was strong community satisfaction with the hospital changes. There was at least one MDGP doctor continuously posted in each of the seven hospitals – most comparable hospitals have significant gaps in service.[11] Five out of the first 20 MDGP doctors chose to pay off their bond before fully completing their service period but as of 2013, three of these doctors continued to work in rural hospitals for other organisations. During the 6th year of the program, the Nepal government suggested that the program be expanded to 25 more district hospitals; this was not possible due to the limited number of scholarship doctors. Currently the Health Ministry's program steering committee is exploring modalities for integrating RSSP into the wider government system and further evaluation is planned in 2014.

Two of our MDGP graduates in a remote hospital in Nepal related this account.

> *"An emergency call was from the maternity ward for a patient with a cord prolapse. Cord pulsation was present, liquid was clear with 6cm cervical dilatation. Two years previously, she had an IUFD. Caesarean section was planned but the one instrument set was unsterile due to low voltage of electricity for 5 days, there was no functioning suction machine, no Green – Armitage forceps, Doyen's retractor, Mayo's scissors etc. But there was a Mini lap set. Within 1 min and 22 seconds of incision, a live 4000gm, male baby, was delivered, with Apgar scores 6/10 and 8/10. Mother and baby returned home, 6 hours from hospital by local transport (stretcher) after 7 days of hospital stay." The doctors commented – 'Caesarean section is not difficult but doing in remote place with limited instruments and untrained staffs is the really challenging job.'*

This is in a country where despite significant improvements, a woman dies every four hours due to complications related to childbirth.

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There have been unique opportunities within this programme as a Christian doctor to be both a teacher and mentor of these national colleagues. Reports like this are very satisfying demonstrating the courage, versatility and perseverance of our graduates. I shared their satisfaction of having made a difference in the lives of people in remote areas who lack the services most of us take for granted. It has been clear that programme success has depended on the individual MDGP doctor – some doctors proved much more capable of taking on the rural challenge than others. All the supports cannot substitute for a highly-skilled and motivated doctor. The opportunity to model and encourage compassionate whole-person care, to support and encourage individuals in their daily work and life challenges has been both a privilege and very challenging. It has been a great and at times humbling learning experience but also reflects what is likely to be an increasing role and opportunity for expatriate (and Christian) doctors in many countries. ●

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THE STORY OF THE LOVE INDIA PROJECT – FROM PAGE 39

As I look back on the past few years, I am constantly amazed when I realise that all this started as an accidental friendship between a medical student and a local Indian doctor that grew into an international partnership to spread the good news of Jesus, and usher in the Kingdom of God. I see Revelation 7:9 before me,

> *"After this I looked, and behold, a great multitude that no one could number, from every nation, from all tribes and peoples and languages, standing before the throne and before the Lamb, clothed in white robes, with palm branches in their hands."*

Recently, I stumbled upon the story of Jossy Chacko, an Indian man who somehow found his way to Australia at the age of 17. He now heads up a highly effective church planting movement in North India, having planted 12,225 churches in just under two decades.

Jossy Chacko (Chacko, 2008) sums the future of Missions in the 21st century succinctly:

> *"The Western church… is very good on leadership, structure and strategy, planning and organising. I think the Asian church can learn from that. On the other hand, the Asian church has strengths in flexibility and faith, in waiting on God and being led by the Spirit, in sacrifice and commitment and fervency. If we put the two together, we have the church of Jesus Christ operating beautifully."* ●

*Names of individuals and organisations have been changed for security reasons.

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What is the CMDFA?

Aims

- To provide a Fellowship in which members may share and discuss their experience as Christians in the professions of medicine and dentistry.
- To encourage Christian doctors and dentists to realise their potential, serving and honouring God in their professional practice.
- To present the claims of Christ to colleagues and others and to win their allegiance to Him.
- To provide a forum to discuss the application of the Christian faith to the problems of national and local life as they relate to medicine and dentistry.
- To foster active interest in mission.
- To strengthen and encourage Christian medical and dental students in their faith.
- To encourage members to play a full part in the activities of their local churches.
- To provide pastoral support when appropriate.

Origins

Its historical roots are in the Inter-Varsity Fellowship (IVF) and the Christian Medical Fellowship (CMF) that started in the UK. Along with similar groups being set up around the world after World War II, separate Australian state fellowships of doctors and dentists were established from 1949.

These groups combined as a national body in 1962 and the Christian Medical and Dental Fellowship of Australia (CMDFA) became officially incorporated in NSW in 1998. In 2000 the work became centralised with the establishment of a national office in Sydney to assist with growing administrative needs.

CMDFA is governed by state branch and national committees elected at annual general meetings of its financial members.

CMDFA is linked around the world with nearly 80 similar groups through the International Christian Medical and Dental Association (ICMDA) which includes Christian Medical and Dental Associations of the US.

Why join the CMDFA?

• Fellowship • Evangelism • Discussion • Mission • Student Work

CMDFA seeks to:

- Unite Christian doctors and dentists from all denominations and to help them present the life-giving Christian message of God's love, justice and mercy in a tangible way to a hurting world.
- Help students and graduates of medicine and dentistry to integrate their faith in Jesus Christ with their professional practice.

Membership is open to students and graduates, who want to follow Jesus Christ as Saviour and Lord. Associate Membership is also available to Christian graduates in related disciplines.

By Joining the Fellowship you can:

- Be motivated in mission for Jesus Christ.
- Be encouraged in your growth as a Christian Health professional.
- Be committed in serving God and your neighbours in the healing ministry.
- Learn from others in integrating your Christian faith and your professional life, drawing on the experience of older graduates as mentors and facilitators.
- Encourage and support other colleagues in fellowship and prayer.
- Share your resources with those in need through special ministries.
- Network with others to effectively bring God's love to patients, colleagues and daily contacts.
- Collectively make an impact for Christ in heath care.

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