The Center for Medical Missions'
e-Pistle
April 2010

Welcome to this month's e-Pistle. I hope you find it useful and encouraging. Let me point out one special request. The Medical Survey Working Group of the CMDA-CMDE is doing a global survey to analyze the experience and perceptions of cross-cultural medical workers globally. I hope you will take the 15 minutes required to complete the survey. The findings will be used to assist your mission agency in setting current and sustainable cross-cultural medical work strategy.

Please remember the Center for Medical Mission in your prayers this weekend. Starting at 8:30 Friday morning, April 23rd, we will welcome 31 participants to this year's Pre-field Orientation for New Medical Missionaries. Our schedule is packed through noon on Sunday. Pray for the participants' travel as well as the Lord's presence and blessing on this conference. We hope to inspire and equip these young people for many years of service.

Thanks so much!
Susan

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Situational Analysis

by David Stevens, MD

We were setting around the table on a Sunday afternoon in our team house in Mogadishu, Somalia. We had already had our service and as was our custom, we had invited some of the U.S. military personnel that worked with us to join us. Many were not born again but were just cultural Christians. Still, they flocked to that service for two reasons. One was to get some good home cooking at the meal that followed and the second was that there were often a number of single girls on our team about the same ages as these young fellows.

At lunch, there were lots of the chatter and laughter that we all longed for. It was a little normalcy in the midst of a city torn by a violent civil war. For a while, we could forget what was outside.

As some got up to help clear the table, I was in deep discussion with a soldier that had joined us a number of times. He was a little shaken up. His platoon had been ambushed the day before and one of his buddies had been wounded. I could tell he needed encouragement and support. He needed someone to listen to his story; someone who had also shouldered the burden of leadership in a dangerous situation.

When he told me that he had been ambushed, I asked, "What do you do when something like that happens?" He leaned closer and said, "It depends on the situation. They like to flank you shooting from all sides, so the first thing is to understand where they are coming from, and then you know how to respond."

This is good advice for a soldier, and a medical missionary. This is advice that we often are too busy to follow. We find ourselves "shooting" at the next patient's problem and fail to understand the big picture. It is not surprising that we feel like we have been overrun much of the time. In your clinic, hospital, community health program, academic position or whatever you do, this type of analysis is critical to do to understand trends, opportunities and problems. It tells you what you need to do to avoid casualties.

This has been on my mind because yesterday I finished up a presentation for my board on our next five-year plan. As part of preparing for that, we had stopped and done a situational analysis. Before we decided what we need to do, we needed an "inside/out situational analysis." You do too.

Inside there is plenty of data for a medical missionary to collect on an ongoing basis and to periodically evaluate it. One of the most valuable things we started to do at Tenwek was prepare an annual report. On an annual basis we collected all our data and organized it into a written report. The process and the results were very valuable as we looked at our bed occupancy rate, admissions, labs done, deliveries, death rates and much more. We would look at staff patient ratios, the disease numbers we were seeing and our financial collection rates. We took the most critical data and put it into a five-year table which clearly showed us trends in each area. That helped us identify problems, set development priorities, buy equipment and know what missionary and national staff we would need. Disease patterns helped us focus our community health work and monitor our success. For example, we saw that our new immunization strategy in the community was making a difference when over a five-year period, our annual admissions for measles complications dropped from 427 to 23.

This and other hospital data also gave us powerful information to motivate donors to give. They were thrilled to have hard data showing that we were making a real difference in health. An increase in major surgeries told us that we needed to be raising funds for more operating rooms a year or two before we desperately needed them. The number of multiple and premature births demonstrated we needed to train more nurses to staff the intensive care nursery.

There is more to doing a situational analysis than just studying statistical data. You need to collect qualitative information as well. How does your staff feel about their work conditions, salary and housing? How satisfied are your patients and would they recommend your health outreach to others?

There are lots of things to look on the inside of what you do, but you must look outside as well. We were doing a large survey of 2,000 homes every 2-3 years for our community health work so we started to throw in a few questions to assess the public's views of the hospital and to better understand their needs. This also can be done with focus groups of community leaders. It is best to have someone to lead those that the local people will be frank with.

Don't forget to analyze other missionaries' opinions and concerns. It is easy to believe you know what they are thinking, but an anonymous survey can reveal lots of things that are helpful.

Many find doing a S.W.O.T analysis with your board and senior administrative staff revealing. Brainstorm and record what your strengths, weaknesses, opportunities and threats are. Is security getting better or worst? What new laws and regulations could be problematic? What new opportunities are there in expanding and strengthening the church? One of our situational analysis efforts showed that church leaders were eager to have formal leadership training that we were happy to provide. Without the situation analysis we would have missed this opportunity

Sometimes it is advantageous to go further in the field of your inside and immediate outside constituency to seek input. What does the Ministry of Health know about your ministry and what do they think of what you are doing? How do the police and local public officials see your ministry?

Here are some principles that can help you do a good situational analysis.

1. Put it on your 'to do' list with a due date. This won't happen by chance or when you have time to do it. Repeat the process periodically.
2. Decide who has the aptitude and the discipline to lead the process.
3. Start modestly. As systems are set in place, you can add to them. Get the most important information first.
4. Put the results in writing in a report that you can share with other leaders – your senior staff, board, church leaders, funding organization, mission executives.
5. Take the information from your situational analysis and use it to make and evaluate your decisions.

My soldier friend was feeling pretty guilty when I talked to him. He said, "I should have noticed that there were men looking down on us from the roof tops before we entered that street. I was on the radio talking to headquarters when I should have been assessing the situation."

Many good endeavors have ultimately failed due to lack of situational analysis. I challenge you be like "the men of Issachar, who understood the times and knew what Israel should do." You will avoid getting ambushed.

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Cura Animarum

by Rev. Stan Key

When we moved to Paris in 1983 I knew only two phrases in French: *Comment allez-vous*? And *Ou est la toilette*? During our first months in France, I found the culture to be both strange and incomprehensible. Why do they eat snails? Why don't the women shave their legs? If this is the perfume capital of the world, why do people smell this way? And why do they pucker their lips like that when they talk?

I still remember my language teacher reaching a point of almost total despair laboring to make me to pronounce the letter "u" correctly. During one particularly difficult language lab session, I simply could not distinguish between the words Louis and lui. Pressing my cheeks with her hands so that my lips attained the desired shape, she shouted so that everyone in the language lab could hear, *Ce n'est pas Louis*! C'est lui… lui… lui!!! My failure confirmed my teacher's worst fears about those unsophisticated Americans.

But I was motivated. And I was persistent. I kept working at the basics of French until I was able to buy bread (1 week), ask for directions and understand the response (2 months), have a "conversation" over coffee with a neighbor (4 months), tell a joke (8 months), preach a sermon (12 months), truly pray (18 months) and have an argument with my wife (I lost).

Learning another language is hard on one's pride but good for one's soul. I did not enjoy being laughed at or talking like a four-year-old. But if I was going to learn French, all my prideful posturing had to go. It is no secret that language learning is easy for children.

Learning to follow Jesus and live a holy life is like learning another language. Indeed, we are learning another culture, the Kingdom of God. Perfectionists and introverts may not survive. It is not a matter of intellect. What are required is motivation, discipline, persistence, and humility…. especially humility.

Humble yourselves. Become teachable. "Unless you change and become like little children, you will never enter the kingdom of heaven" (Matt. 18:3).

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Your 15 Minutes Could Impact the Next 15 Years!

PRISM Survey: Patterns and Responses in Intercultural Service in Medicine

Please cut and paste link: www.surveymonkey.com/s/PRIMS

The Medical Survey Working Group of the CMDA-CMDE is doing a global survey to analyze the experience and perceptions of cross-cultural medical workers globally.

- Over arching purpose of this project:
  We live in a time of radical global change. It is our intention to provide cross-cultural organizations and leaders of the medical aspects of this work with information which would assist them in creating appropriate and sustainable cross-cultural medical work strategies to guide current and potential workers into effective long-term service. We will do this by taking a snapshot of the current situation from the perspective of the expat medical workers themselves, who are the experts. The results will be disseminated through publication in professional journals and wide distribution of the research report.
- Survey purpose
  Analyze the experience of cross-cultural medical workers with a view to providing information to assist their agencies in setting a current and sustainable cross-cultural medical work strategy.

  Who is eligible (includes people on home leave)?

  - Cross-cultural medical worker with qualifications in your home country (including MD, DO, PharmD, RN, Dentist, MPH, DPH)
  - Expatriate medical workers (this survey is regarding your work in your host country, not your home country)
  - >2 years of time living in a host country (or multiple countries) other than your own
  - Must be officially associated with a sending company (regardless of the primary source of funding)
  - Able to read and understand English well
- Security: The survey is completely anonymous. The content of the survey is sanitized to make it safe in sensitive countries, and SSL encryption has been used throughout.
- IRB Approval:
  On 23 November 2009, the Institutional Review Board of the Center for the Advancement of Healthcare Education and Delivery in Colorado Springs, CO approved the research project entitled "PRISM Survey: Patterns and Responses in Intercultural Service in Medicine."

Go here and complete it in less than 15 min.
Please cut and paste link: https://www.surveymonkey.com/s/PRISM

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Resource

Development Dialogue of Values and Ethics
'Paying Primary Health Care Centers for Performance in Rwanda'
Paying for Performance (P4P) provides financial incentives for providers to increase the use and

quality of care. Basinga and others evaluate the impact of P4P on the use and quality of prenatal, institutional delivery, and child preventive care in Rwanda. P4P has a positive impact on institutional deliveries and preventive care visits by young children and improved quality of prenatal care, but no effect on the number of prenatal care visits or on immunization rates. The analysis isolates incentive effects from the resource effect in P4P, and the results indicate that an equal amount of financial resources without the incentives would not have achieved the same gain in outcomes. The paper is available as working paper 2010-2.

Portable Surgical Microscopes for Ophthalmology
The Morrell portable surgical microscopes are ideal for missionary expeditions, emergency or disaster relief, secondary offices, clinics that need a high performance, high quality, affordable microscope. The Morrell portable surgical microscopes provide crisp, clear, high resolution, with excellent depth of field, continuous manual zoom from 3x to 25x with manual fine focusing, halogen illumination. The spring arm has 17 inches vertical travel and 360 degree rotation for easy finger tip positioning with locking knobs. New removable leg extensions allow for quick assembly or packing in a single heavy duty case saving you money and giving you more time to see patients.

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Intentional Partnerships in Ukraine

by Miriam R Wheeler, MD ABWE

God called me to outpatient village clinic ministry in Ukraine in 1998 after working for 5 years in a very busy hospital in Togo, West Africa. The villages of these two countries look very similar! But the Ukrainians have to deal with severe winter weather as well. Both countries suffer from lack of access to good health care, lack of clean drinking water, terrible road conditions, and abject poverty. Nineteen years after the fall of the Soviet Union, the government and economy of Ukraine are still unstable. Vestiges of Communism are evident in the poor work ethic, suspicions of America, and mistrust of any strangers. Walking out of my 10-story grey dreary apartment building in Odessa, I see weary depressed people who do not even respond to a simple “Hello” (in Russian, of course!). It takes a lot of time to develop relationships and build trust. In the mid-90’s, there was great openness to the gospel, but now materialism and secularism have overtaken the cities while despair has sapped the villages. The traditions of the Russian Orthodox Church shape the culture and any religion that is not Orthodox is considered a cult. Ukrainians are very slow to accept anything new or different.

How does a missionary overcome these barriers to share the free gift of salvation through Jesus Christ? One must learn the language, study the culture, and develop relationships. What better way than demonstrating Christ’s love through compassionate medical care! Villagers tend to be isolationist with a small sphere of trusted friends and relatives. The depth of relationship needed

for a Ukrainian to listen to someone present the gospel cannot be developed in the few days of a hospital stay. It is necessary to spend time on a regular basis in the villages where they live, to get to know them and show unconditional love. I was the first American doctor to serve in Ukraine full-time. As I looked at the hundreds of villages just in the Odessa oblast that needed medical care, how could I choose where to work? The key in Ukraine is *intentional partnerships*. God led me to develop partnerships with pastors and church leaders burdened to give their communities the hope of heaven. A small vital church preaching the Word of God survived the 70 years of persecution under Communism. As I met pastors in Odessa, I sought their advice about how and where to start medical ministry.

A senior pastor in the area suggested Krasnosyolka as the first site for a clinic, located just a few miles from Odessa. A church was started there in 1991, as soon as freedom came to Ukraine, but they were struggling to make new contacts. In the 10 years I have been associated with that church, the leadership has developed a vision for evangelism throughout the area. We have started Bible studies through clinic contacts in 4 other villages and have more opportunities than we have time to meet. A number of people have come to know Jesus as personal Savior. In Kubanka, one of my supporting churches in America purchased a house as a center for our ministry of monthly clinics, Bible studies and children's Sunday school. Pastor Lonya has become intensely involved with the clinics, even advising pastors in other areas of the Odessa oblast. His family has become my "family" in Ukraine.

A church in Makarovo, a village of about 400 people, requested help. I started doing monthly clinics there, and had wonderful opportunities to share the gospel with patients as I built relationships with them in ongoing contacts. But the church leadership was not involved in following up these new contacts. When I was able to communicate on my own in Russian, I asked for a meeting with the "brothers" who led the church. I explained my vision of partnering with the church to reach this village for Jesus. A light of understanding flashed in their eyes, and one brother exclaimed, "You want to be OUR partner?!" YES! They never got the concept through the translator, but God helped me to communicate this vital principle at last. This ministry is not about Miriam doing medicine, but about the church developing relationships with needy people to show them the love of Jesus. The clinic is the arm of the local church reaching out to their neighbors. The Makarovo church has blossomed since then! They have seen many patients join their fellowship, and they have started outreaches through clinics in Berdinovo and Valentinovka and have assisted Sahanskoye.

The government-sponsored physician's assistant in Sahanskoye heard about the clinics in Makarovo, and asked me to come help her. For two years, I saw patients once a month at the government clinic. Styopa and Tanya were the only believers in the village of 600, and had not been able to bring anyone to Christ after several years of sharing. Styopa began coming to each clinic with me to meet patients. This gave him credibility in the eyes of his fellow villagers. As our partnership developed, the Holy Spirit began moving in the hearts of people. In the next two years, at least 10 people came to salvation! Our missionary team purchased a house in the village that became the center of ministry and now has a vital church and Sunday school in addition to the monthly clinics. Styopa is also reaching out to nearby villages through contacts that have come to the clinic in Sahanskoye.

I love doing mobile clinics so that I get to see where my patients actually live and better meet the needs of the whole person. As a family physician, I treat their medical illnesses, show them the connection to their spiritual needs and delve into interrelated problems in emotional, mental and social dimensions. Returning to the same village every month, I develop relationships with individuals and have opportunities in time to share the glorious good news of eternal life through faith in the Lord Jesus Christ. A typical way to open the door to talk about spiritual things is sharing with the patient how stress affects their physical health. My clinic assistants and I start each clinic with prayer, and I have been thrilled by the evidence in their prayers of their spiritual growth. This is no longer just a job for them but a ministry to people they love. Some clinic days we begin with an evangelistic preaching service. I also make home visits, which impact the family members as well as the patients. I often visit homes with the local pastor. In this culture, he would not be welcome in the house as a stranger, but he is accepted when he comes with the doctor. This style of ministry allows me to decide my schedule without being driven by the demands of a permanent facility. I can be involved in teaching seminars and Bible studies as well as practicing medicine.

God has given me wonderful partnerships with Ukrainian pastors who have found the clinics to enhance their ministry and broaden their outreach. *I do not start a regular clinic in a village unless there is a Ukrainian willing to assume responsibility for the spiritual follow-up of the patients*. Now I am praying for the next phase of ministry to incorporate Ukrainian health care professionals into this village outreach ministry. Ukrainian doctors are involved in evangelistic village clinics in other regions of Ukraine, but are not intentionally partnering with pastors to start regular clinics and build long-term relationships. I believe this is key to developing the Church of Jesus Christ--not a building, but a body of believers serving and sharing their Lord and Savior.

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Uncompleted Transitions

by Dr. Ron Koteskey

Talking about her director, a missionary said, “He has never lived on the field for more than a few weeks at a time. Even when he is here over a summer, he’s back and forth on weekends shuttling groups.”

She continued, “One thing that is adding to my problem is the fact that we seem to travel back and forth to the USA about every two-three months ourselves—so we never quite get used to one thing when we are doing an entry/re-entry type of thing.”

Though these comments could be said about many missionaries today, they would have rarely been said before the latter half of the twentieth century, and never said at the beginning of it. Earlier missionaries simply did not change cultures as frequently, so they got used to things and felt at home wherever they were.

Changes have occurred during the last couple of centuries that have led to many uncompleted transitions, to people changing cultures not knowing whether they are both coming or going—because they are coming AND going. Some of the changes have affected those serving cross-culturally.

A Transition Model

An intuitive model of what happens between people being fully involved in one culture and their being fully involved in another is that there are three stages.

- Leaving. The leaving stage begins when people first seriously consider leaving where they are, and it ends when they actually walk out the door on their way. Leaving often takes several months and sometimes years.
- In Transit. The transit stage of reentry begins when they leave their houses in one culture, and it ends when they unpack their minds, not just their suitcases, in the new culture. It may last only a few hours or days, but it may also last several weeks or even longer.
- Entering. The entering stage begins when their minds are unpacked, and it lasts until they are fully involved again in the new culture. Just crossing the border into a different country does not mean that they are integrated into that culture. It takes time and energy to fully become part of the culture.

Transitions are completed only if people have time to complete the entering stage and fully become a part of their host culture when they go or fully become a part of their passport culture when they return.

Completed Transitions

The earliest missionaries took months to cross oceans or continents to reach many other cultures. Ships under sail, wagons drawn by animals, and walking were slow enough to make it impossible to go home for a few days or weeks. So when people went, they stayed for years in their host culture. They did the same when they returned to their passport cultures. Their transitions were completed.

When William Carey and his family sailed nonstop from England to India in 1793, it took five months. Little had changed from the times the apostle Paul served in the eastern Mediterranean (Acts 21).

Missionaries often went expecting to return many years later, if ever. The threat of disease was so great that some people packed their luggage in coffins, expecting to remain there until they died. They were not even thinking about coming home when they went.

Uncompleted Transitions on Return to the Passport Country

The invention of engines to power ships on the ocean and locomotives on railroads made crossing oceans and continents possible in weeks instead of months. Missionaries could return to their passport countries for a “furlough,” and they did, often staying for about a year. Soon it was

common for them to serve four years in their host country, then spend a year in their passport country, and repeat this cycle for the rest of their lives.

Since it takes about a year to complete the entering stage, and the missionaries were planning to return to their host country all that time, they were entering and leaving at the same time. They were simultaneously in the entering and leaving stages, not knowing whether they were coming or going. The transitions into their passport countries were truncated. They never fully reentered. Coming "home" for a one-year furlough was quite different from coming home to stay.

Uncompleted Transitions into the Host Country

The invention of jet airplanes made it possible to cross oceans and continents in hours instead of weeks or months. Short-term mission trips a week or two long became common. The people leaving had no intention of fully entering the host country because they remained in "vacation mode" while they were there.

Even "career" missionaries anywhere in the world knew that they could get "home" in hours, and they sometimes did. Some still fully entered their host cultures and returned to their passport countries only for special events such as weddings, funerals, and graduations. Others never fully entered their host countries but lived in their two worlds successively, coming home every summer for several weeks or months. They were never quite full time in either host or passport country, but part-time in each.

Living in Two Worlds Simultaneously

The invention of the telegraph and telephone made communication possible, but it was quite expensive, not available in many places, and or relatively poor quality. However, the digital age came about the turn of the 21st century, and its amenities were available most places missionaries served, inexpensive, and of excellent quality. It made communication with people back "home" commonplace. Some popular options became available.

- Email allows one to send written materials and images to someone's computer where it is available whenever the person checks the mail.
- Instant messaging allows two people to send and receive written messages to each other live, while both are online.
- Voice over Internet Protocol (VoIP) allows people to converse orally while both are online, and they can even see each other if they both have webcams and a fast enough connection.
- Facebook allows people to post written information and images on their page and allow their "friends" to access it.
- Twitter enables people to send short text messages to whoever wants to receive them, often items about everyday life.

Today it is no longer necessary for people to travel back to their passport cultures to keep up-to-date (even up to the minute) on what their friends are doing back there. Information is posted on Facebook, in an email, or even available as twitter on cell phones. No transitions need be

completed because people can live simultaneously in two or more cultures. This has both advantages and parallel disadvantages.

Conclusion

Uncompleted transitions are advantageous for projects involving things but disadvantageous for those involving people. They are a plus for making people available to consult but a minus for keeping those people from getting a break. They are an asset for tasks where knowledge of the culture is not needed but a liability when nationals are offended. They are good so people can keep up with both cultures but bad when those people are marginalized in both cultures. They may not only give people more of a sense of accomplishment for what they do but also give them a feeling of a lack of identity because they don't fit anywhere.

For a more complete treatment of this topic as well as other topics please visit www.missionarycare.com. Also, please let your non-medical colleagues know about these free resources.

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