# The Center for Medical Missions' *e-Pistle* August 2009

Hi! This month's e-Pistle is blessed with a new author. Dr. Michael Soderling, who ministers in Central America, answered my plea for a contribution to this month's e-Pistle. Thank you, Michael. I hope his article will cause you to pick up your pen or peck away on your computer. I know Dr. Soderling is looking forward to hearing your response.

Are you going to be in the States in November? If so, I hope I'll see you at the Global Missions Health Conference in Louisville, Nov 12 – 14. Please look me up at the Center for Medical Mission's booth in the CMDA group of booths. We'll be in the first floor exhibit hall – usually the middle back of that hall. For more information visit www.medicalmissions.com

Even before that, if you are in the States at the end of September, we would love to see you at CMDA's national convention. This year's convention is in Ridgecrest, NC at the Ridgecrest Conference Center, September 24 – 27. It would be lovely to see you there. Visit the convention site by clicking here.

Here is a list of articles that follow:


- Cura Animarum – by Rev. Stan Key
- Healthcare for the Poor – by Dr. Michael Soderling
- Education Tool to Teach about HIV/AIDS
- Surplus Healthcare Supplies
- Culture Stress – by Ron Koteskey


Dave Stevens returns from his three-month sabbatical next week. I took him to the airport last Wednesday for a quick trip to Kenya and noticed he has lost weight. I think he may be happy to get back to his desk job since building a family room and bath in his basement has kept him working late hours. Thanks for praying for him during this break. Hopefully he'll be back contributing to next month's e-Pistle!
Susan Carter

## Cura Animarum

**By Rev. Stan Key**

Pete Rose finally apologized…. I think. After many years of loudly denying that he had ever bet on baseball and trashing anyone who dared to think otherwise, Pete suddenly wanted to make things "right" and move on.

*I'm sure that I'm supposed to act all sorry or sad or guilty now that I've accepted that I've done something wrong. But you see, I'm just not built that way. Sure, there's probably some real emotion buried somewhere deep inside. And maybe I'd be a better person if I let that side of my personality come out. But it just doesn't surface too often. So let's leave it like this: I'm sorry it happened, and I'm sorry for all the people, fans and family that it hurt. Let's move on.*

Huh?

Unfortunately, Pete Rose is not the only one who seems clueless as to how to make things right. Remember Richard Nixon's "confession" concerning the Watergate break-in? Wrongs were committed. Or what about Bill Clinton's explanation of his relationship with a White House intern? It depends what the meaning of the word "is" is. Then there is Martha Stewart, Michael Jackson, O. J. Simpson…. Does anyone know how to say "I'm sorry?" Does anyone know how to make things right?

Let me suggest three guidelines for offering an apology that can open the door to genuine healing, restoration and reconciliation with God and with man.

1. **Be brief.**
   Lengthy explanations of why you did what you did usually reveal that you have not yet come to grips with what you have really done.
2. **Be specific.**
   Name the sin. Don't be vague or generic. Label your attitudes and actions by the name they deserve.
3. **Take responsibility.**
   Don't rationalize, justify or blame. Don't use disclaimers such as "if" or "but." Don't play the victim. Simply say, "I take full responsibility for what I did."

It took just three words for the prodigal son to change the course of history and open the floodgates of grace: *"I have sinned" (Luke 15:18)*. Three words. Try it. You'll be surprised what these words can do.

Back to top

---

## Healthcare for the Poor

**By Michael Soderling MD, MBA**

The current healthcare debate in the US has sparked strong feelings on both sides of the political aisle as well as in many churches. Do we begin to go down the path of universal, government controlled healthcare for all? Or can we tweak the present system enough to satisfy most of society and the majority of those serving in Congress and the White House? There obviously is no easy answer for the richest country the world has ever seen. And as always, the situation for developing nations is far worse.

I live and serve in a Central American country where basic healthcare services, curative in nature, are inaccessible to the majority of the poor. And efforts in the direction of effective health promotion and disease prevention are minimal and those that do occur are largely scattered and uncoordinated with the efforts of others.

Here it seems the government is torn between two very strong outside influences which are trying to shape the future of the healthcare system.

On the one hand are those that push the government towards a completely socialist system where the government is expected to meet the needs of the poor from their meager budgets. Meeting the healthcare needs of the poor using this approach will likely never suffice since it is unlikely poor governments will ever have budgets that are growing fast enough to meet the ever-growing demand from expanding populations. And with the level of corruption that exists within most of these underdeveloped nations it will be a long time coming before even half of the budgeted moneys for healthcare services reach their intended targets. In his book, *"The Bottom Billion,"* Paul Collier studied the flow of healthcare dollars intended for rural health clinics in an African nation and found that only 1% of the money actually reached the clinics. So expecting poor governments to meet the healthcare needs of the people they are supposed to be serving is unrealistic in the near term.

On the other hand, there are many healthcare providers in developing nations who want nothing more than a system not unlike what we have in the US. It does, after all, benefit the healthcare providers most if a private pay system predominates. That's the system that will afford the doctors and dentists and other fee for service health professionals the greatest income. But these services are absolutely unreachable by the poor, unless they are fortunate enough to have an advocate, such as a member of an NGO or FBO, who will arrange for care to be provided by a private physician working in a big city.

Anyway you look at it, access to good healthcare for the poor of the world is a distant dream at best and at worst is a dream that may never be realized. We want to be counted among those Christ speaks to in *Matthew 25:40* when He says, *"Truly I say to you, to the extent that you did it to one of these brothers of Mine, even the least of them, you did it to Me."* But as time passes it seems we are less and less able to do so. Long-term health related mission activity seems to be waning while the short-term juggernaut takes over. At one time, some 1000 or so Christian hospitals operated in India alone while now less than 200 survive. It seems many Christian healthcare professionals are trying to satisfy their "calling" to health related missions in the name of Christ by doing a week or two of short-term work a year. An article in the June 12, 1999 issue of World magazine entitled *"Not to Be Served"* is a must read for anyone contemplating how they are going to be involved in the immense challenge of getting healthcare to the poor.

So where does the answer lie? In God's word and in His people who call on Him as Lord and Savior. We, the true church of Christ, must regain an understanding of what God's design for man is. It is not that he live in poverty and filth but that he live a healthy life in Christ. The following principles are taken from a monograph, "Health, the Bible and the Church," (available at http://www.emisdirect.com/store/books/health-the-bible-and-the-church) written by Dr. Dan Fountain during a year spent at Wheaton College in the mid 1980's. Dr. Fountain's 35 years of

work in the DR Congo and his writings have inspired me as well as many others over the years and his approach to helping people live healthy lives is the most comprehensive and most biblically well founded of any I have reviewed. He states: "The following principles of a biblical world view are crucial for an understanding of health and healing."

1. Health means wholeness, with a person's body, mind and spirit integrated, coordinated and able to function creatively in the context of his or her particular community.
2. God intends all people to be healthy and He is actively working to move us toward wholeness.
3. Health involves the community as well as the individual.
4. An adequate understanding of health requires an understanding of the biblical worldview.
5. Disease is everything that makes us less human.
6. A complex relationship exists between our health and our behavior.
7. Jesus, the incarnate Son of God, is the key to life and health.
8. The church, as a whole, is God's chosen channel for healing, for the restoration of wholeness, and for the transformation of society.

Every individual who feels called to work in the arena of cross-cultural health related missions (a term I prefer to "medical missions" because it is broader in its scope) must have a basic understanding of these principles. My experience after eight years serving in Central America is that most do not. We are stuck in the western model of dualistic thinking which separates the physical from the spiritual and we are content to simply address the physical needs of those we serve with a token attempt at meeting their spiritual needs. We are overwhelming our hosts with high technology and drug based therapies which cannot be sustained after our teams leave. We continue believing that the western way is the best way and that our ideas will work the best if only we can find someone to implement them properly.

The time has come for us in the wealthy nations to humble ourselves and to begin working through true partnerships to carry out not only effective short-term health related missions but also long-term health related missions as well. These partnerships must be built on trust and must give the highest priority to the ideas of the hosts we work with. In William Easterly's book, *"The White Man's Burden,"* he outlines how rich nations have spent 2.3 trillion dollars these past 50 years with very little to show for the investment. In many cases we have created more problems than we have solved. The main reason for this seems to be that we have made plans to solve problems in the developing world under the assumption that they cannot come up with their own solutions. I know there are good examples we can turn to around the world but it seems they are few and far between and it seems we are not learning from each others' successes and failures (which is after all where we learn the most). We too often work in isolation in fear that our project may not be as attractive as another to potential donors. This lack of cooperation, collaboration and coordination in thinking amongst Christian health related agencies is preventing us from realizing synergy that could come from such efforts.

We must make every effort to help the church resume its role in health and healing. This will need to start happening in our Christian schools (high schools, colleges and universities) and seminaries. I recently attended a conference on short-term missions at a well respected Midwest seminary and I am hopeful that this theme is beginning to be talked about by those who educate

our young men and women in seminary. Our churches should become beacons to those who truly wish to live healthy lives. Why aren't they the centers for conveying lifestyle principles that lead to healthy living? Yes, evangelism is of utmost importance but did not Jesus go around preaching, teaching and healing those He came in contact with? We need to see a holistic approach to evangelism in our churches. We need to be about getting people into the kingdom but we also need to be about helping our brothers and sisters in Christ live healthy and whole lives in Christ now.

Check out Dr Fountain's most recent work at: http://www.peeke.king.edu. Check the Best Practices in Health Related Missions website to see the beginnings of a project to learn from a worldwide network of Christian health workers what works best practices for doing both short and long-term health related missions: http://www.csthmbestpractices.org/.

Back to top

## Education Tool to Teach about HIV/AIDS

There is a new and exciting way to teach about HIV/AIDS transmission and prevention. It is called the HIV/AIDS HOPE Cube. The tool is about the size of a Rubiks-Cube, and has seven graphic panels that open in different directions, and explain the following about HIV/AIDS:

1. Introduction -There is a disease that can kill you, if you permit yourself to be exposed to it.
2. The four major transmission modes of HIV.
3. Stigmas and myths about how you are infected with HIV.
4. The importance of being tested for HIV.
5. If you are HIV Negative, how to remain that way.
6. If you are HIV Positive, how you can have a healthier lifestyle.
7. How you can minister to a person who is HIV Positive.

Since the HIV/AIDS HOPE Cube has no words on it, it can be used in any culture, especially oral cultures. To date, there have been over 20,000 Cubes placed in the hands of medical professionals. But the doctors and nurses are most excited about the fact that the Cube allows ordinary people to teach proper information about preventing HIV/AIDS. The HIV/AIDS HOPE Cube was introduced at Saddleback Church in 2007, and was developed jointly by e3 Partners and SIM.

**The Lausanne Strategy**

It is interesting to see how the features of the Cube mesh with the three focuses set out by the Lausanne Strategy conference in Budapest:

Evangelism
Oral Learners
HIV/AIDS

The HIV/AIDS Hope Cube, especially when paired with the EvangeCube (a tool similar to the HOPE Cube in size, but has pictures that show the plan of salvation) touches all three areas. Think of it, a simple tool like this - like one of the simple stones of King David that he used to slay Goliath - in the hands of caring Christian workers all across Africa and Asia can give the hope, not only to understand about HIV but to learn how to have eternal life.

The impact has continued to be immediate, significant, surprising and opening unexpected doors. A pastor in Uganda said "In my town they would never let us share the gospel with 600 school kids, but with the HIV/AIDS HOPE Cube we not only were able to share about physical life found in the knowledge of HIV and AIDS, but we were able to share eternal life in Christ."

Everywhere one turns in Africa, people have brothers, sisters, aunts, mothers and fathers being infected with HIV. It is constantly on people's minds, as they hear the wails of those dying in their own home, or a home in their village. Recently, on a mission trip to Uganda, doors that had been closed to gospel presentations were opened to this new Cube. When the HIV/AIDS Hope Cube was shared, Christian workers found that more people were willing to hear the gospel message.

**The Local Church and the Cube**

It also raised the status of the local church in people's eyes. Not only did it give a message of how to prevent HIV, but it gives hope to those with HIV. It is an easy conduit to the gospel. During and after the HIV presentation, listeners were found to be thinking about life and death. Questions were running through their mind such as:

Where do I find the power to abstain from sex?
Where does HIV come from?
How can you have hope in spite of difficult circumstances?

Whether they find themselves before a secular, Muslim, or Hindu audience, it's easy for the workers to move from the disease prevention presentation to showing the EvangeCube, which explains how they can have hope through Christ. They find a natural tie-in by describing how HIV and all disease come from the fall of man and real hope comes in a personal relationship with Jesus.

One Indian pastor likens it to John the Baptist. "It's not the gospel, but is a bridge to the gospel." I shared Christ with a Muslim mom and her son at a public hospital in Uganda where 200 people heard the life saving message of the HIV/AIDS HOPE Cube and then 200 people were able to hear about eternal life found in Jesus right in the public hospital. Both the mom and her HIV Positive son professed faith in Jesus.

Saddleback's Pastor Rick Warren, spoke excitedly about the HIV/AIDS HOPE Cube "It's an incredible teaching tool! Pick up some of these and use them when you take your mission teams on the road and when you're (doing) ministry in your local area. It's a great way to teach people." For video of Rick Warren sharing about the HIV Hope Cube go to:

http://store.e3resources.org/Search?search=HIV+cube. Also, for a download of the HIV/AIDS Hope Cube insert sheet go to: http://www.e3resources.org/Download/HIV_AIDS_insert.pdf

It was very encouraging to have health care workers tell us that the HIV/AIDS HOPE Cube is exactly the message they try to share with their people, but this Cube makes it interesting, easy to share and easy to train others to share this life saving message. Doctors and nurses at a HIV Hospital ward begged us to get them more HIV/AIDS HOPE Cubes. After more than a year of prototyping, testing, reworking and getting advice from leading HIV/AIDS professionals it was very gratifying to hear from so many that we had a medically correct, effective tool to help stop this terrible disease. By God's grace, the Church will help lead the way.

Yoseph Mena, an Ethiopian Church Planter perhaps summed it up best as he held an HIV/AIDS HOPE Cube in his hand and said with twinkle in his eye, "I believe this is a key that will unlock closed villages for the gospel all over the world."

For more information about the EvangeCube and the HIV/AIDS Hope Cube contact Steve.McCool@e3partners.org at e3 Partners, or John.barnshaw@sim.org, Phone 704-587-1589 at SIM.

Cost is: 1-23 ($8) 24-95 ($6) 96-999 ($4)

Back to top

## Surplus Healthcare Supplies

A group of healthcare workers in Michigan have begun collecting unused medical supplies and are making them available to those involved in ministry. You can learn about this new opportunity at surplushealthsupplies.org. You will find an inventory tab on the website that is updated as supplies come in and go out. This is a totally volunteer run organization so things might move slowly. But, the inventory list looks like there are some very helpful supplies for your ministries.

Back to top

## Culture Stress

**By Ron Koteskey**

You feel tired, anxious, discouraged, isolated, angry and homesick but cannot think of any reason why you should feel that way. You have been on the field for several years, but these feelings always seem to be there - increasing and decreasing. You wonder what could be causing them. It could be culture stress. You may say, "I know about culture shock, but what is culture stress?" What is the difference between culture stress and culture shock? What causes culture stress? What are its effects? What can be done about it? Let's consider some of these questions.

**What is culture stress?**

Culture stress is the stress that occurs when you change to a different way of living in a new culture. It is what you experience as you move beyond understanding the culture to making it your own so that you accept the customs, becoming comfortable and at home with them. If you are trying to become a real part of the culture, to become bicultural, you are likely to experience culture stress as you assimilate some of the conventions to the point that they feel natural to you.

Of course, if you live in a "missionary ghetto," you may experience little culture stress. Early modern missionaries often lived in compounds, which were physically identifiable as missionary ghettoes. Today, even though some missionaries live physically in a national community, they have primarily relationships with other missionaries. A missionary subculture may develop which becomes focused on itself and preoccupied with group concerns so that the missionaries experience little culture stress. Those trying to become an integral part of the national community are the ones who experience the greatest culture stress.

**How is culture stress different from culture shock?**

As culture shock was originally defined (honeymoon, crisis, recovery, adjustment), culture stress was considered to be a part of it. However, the word "shock" connotes something sudden and short-lived. Thus, many people today think of culture shock as the crisis stage (confusion, disorientation, and lack of control) and the recovery stage (language and cultural cues more familiar). These stages begin when the new missionary leaves the enthusiastic, exciting, optimistic tourist mode, usually beginning in a few weeks, worsening for about six months, and basically ending within a year or two.

Culture stress is the adjustment stage in which people accept the new environment, adopting new ways of thinking and doing things so that they feel like they belong to the new culture. This takes years, and some missionaries never complete it. This may go on and on.

**What causes culture stress?**

Many factors enter into the amount of culture stress one feels while living in another culture. Here are some of the major ones.

- Involvement. The more you become personally involved in the culture, the more culture stress you may feel. The tourist, the business person or someone from the diplomatic corps not committed to being the incarnation of Christ in that culture, may feel little culture stress.
- Values. The greater the differences in values between your home culture and your host culture, the greater the stress. Values of cleanliness, responsibility, and use of time may cause stress for years. Cultures may appear similar on the surface but have broad differences in deeper values.
- Communication. Learning the meanings of words and rules of grammar are only a small part of being able to communicate effectively. The whole way of thinking, the common knowledge base, and the use of non-verbals are necessary and come only with great familiarity with the culture.

- Temperament. The greater the difference in your personality and the average personality in the culture, the greater the stress. A reserved person may find it difficult to feel at home where most people are outgoing extroverts. An extrovert may never feel at ease in a reserved culture.
- Entry — re-entry. Most missionaries, unlike immigrants, live in two cultures and may never feel fully at home in either. Every few years they change their place of residence, never fully adapting to the culture they are in at the time.
- Multinational teams. Although effectiveness of the ministry may increase, working together in your mission with people from cultures other than your host culture often adds to the culture stress.

**What are the results of culture stress?**

Many of the results of culture stress are the same as those of any other stress.

- Feelings of anxiety, confusion, disorientation, uncertainty, insecurity, and helplessness
- Fatigue, tiredness, lack of motivation, lethargy, lack of joy
- Illness (stress suppresses the immune system), concern about germs, fear of what might be in the food
- Disappointment, lack of fulfillment, discouragement, feeling hurt, feeling inadequate, feeling "out of it"
- Anger, irritability, contempt for the host culture, resentment (perhaps toward God), feelings of superiority or inferiority
- Rejection of the host culture, the mission board, even of God.
- Homesickness

Some people seem to believe that they can adapt to anything, even continual stress, without it hurting them. It just does not work that way. In the 1930s, stress researcher Hans Selye put rats under many different kinds of stress. He kept some in a refrigerator, others in an oven, made some swim for hours a day, injected others with chemicals, others with bacteria, etc. The results were almost always the same. The rats went through the same cycle. First was the alarm reaction in which resources were mobilized. Then came the resistance stage in which it seemed like an adequate adjustment had been made. But if the stressor was intense enough or long enough, sooner or later the stage of exhaustion occurred when the resources were depleted, and the rats collapsed. If the stressor continued, they died. You probably have seen people who seemed to be making an adequate adjustment, suddenly break down. Uninterrupted stress of enough intensity leads to exhaustion sooner or later in most individuals.

**What can be done about culture stress?**

Much can be done to decrease culture stress and make it manageable.

- Recognition. Realize that culture stress is inevitable for those attempting to become at home in a host culture, and look at what factors cause you the most stress.
- Acceptance. Admit that the host culture is a valid way of life, a means of bringing Christ to the people who live in it.

- Communication. Beware of isolating yourself from everyone in your home culture, those with whom you can relax and be yourself, those with whom you can talk.
- Escape. You need daily, weekly, and annual respites. God made the Sabbath for people, so be sure you keep it. Reading, music, hikes, and vacations are necessary.
- Activity. Since stress prepares you for fight or flight, and as a missionary you can probably do neither, you must have some physical activity to use that energy. Sports, an exercise plan, and active games with family or friends can reduce stress.

Stress is a part of life, and everyone learns how to manage it or suffers the consequences. Remember that not everyone can become at home in two cultures, and it typically takes a very long time for those who do it successfully.

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.

Back to top

---

The fastest and most secure way to give to CMDA is through our secure online giving site. Your gifts will be used to continue and expand the critical work of CMDA as we minister to doctors, students and patients.

---

**Center for Medical Missions**
PO Box 7500
Bristol, TN 37621
423-844-1000
www.cmda.org/cmm

To unsubscribe, send an e-mail to susan.carter@cmda.org. Thank you.