

# ePistle

CMDA.org/CAHM

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## Pearl

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“My operating theatre became a circle of chairs under a mango tree, and now measles no longer kills a thousand or more children a year in our villages.” – [Dr. Daniel E. Fountain](#) in his book *Health, the Bible and the Church* (1989, Billy Graham Center)

## Introduction to this Issue

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I still remember my physician husband returning from monthly trips out into the small surrounding Kenyan villages. It was a rare chance to get out of the hospital and accompany his creative community health team. Such opportunities provided a brief connection with local leaders and a chance to get up stream from the daily flood of preventable

diseases coming into the hospital. Village health workers in each place were vital links to each small rural community. They were mostly younger women respected and selected by their own area elders to be trained in prevention and treatment of everyday illnesses. The community health team and village health workers would also facilitate clean water projects, building of family latrines and regular immunization visits. Neonatal tetanus was virtually eliminated through a vaccination program for pregnant women. Sugarcane was a common cash crop consuming much of the land, so nutrition discussions focused on home gardens. Every team visit included a deliberately humorous skit acted out to illustrate some aspects of improved community health. Refreshment, laughter, and renewed hope inevitably followed those experiences.



This issue of the *e-Pistle* is dedicated to the topic of community health.

Read Susan Carter's farewell as she steps down from her position as director of CMM. Her contributions to the Kingdom are many. She will be missed.

Judy Palpant, Editor

## A Joy to Serve You

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*by Susan Carter*



Thank you for allowing me to serve you the last 17 years. What a privilege it has been to put together the *e-Pistle*, help you make connections, assist students and residents in finding your ministry, sending out the CMDE Conference announcements and praying for you.

This position has allowed me to continue the work the Lord called me to 30 years ago. The Center for Medical Missions started off slowly in May 2003, since the only ones who knew me were those serving in Kenya. But over the years, my life has been enriched by getting to know many of you serving around the globe.

I haven't taken the time to count the number of medical missionaries passing through our pre-field training, but I know it is over 450 and approaching 500. Pre-field training, though challenging to prepare for, was one of my favorite responsibilities. I'm so grateful I got to know and serve so many who are now working alongside you. Some of those trainees are now senior servants in their places of ministry.



Though I'm not retiring quite yet, I have chosen to give my mission leadership role to Dr. Doug Lindberg. I met Doug when he and his wife Ruth took our pre-field training prior to serving in Nepal. Like for many of you, their first term turned out to be very challenging. Those experiences will serve him well as he serves you. I am so pleased he will be the new director of the Center for Advancing Healthcare Missions—the updated name of the Center for Medical Missions.

Until retirement, you will find me at CMDA leading the support services staff and being responsible for our human resources. I've been doing those things along with my Center for Medical Missions responsibilities for 13 years, so I am looking forward to having just one full-time role. 😊 You can still reach me at [susan.carter@cmda.org](mailto:susan.carter@cmda.org).

I know the past months have been extra challenging for many due to the Coronavirus. I am praying you will be sheltered by the Almighty. “He will cover you with his feathers. He will shelter you with his wings. His faithful promises are your armor and protection” (Psalm 91:4, NLT).

And I pray: “Now may the God of peace make you holy in every way, and may your whole spirit and soul and body be kept blameless until our Lord Jesus Christ comes again. God will make this happen, for he who calls you is faithful” (1 Thessalonians 5:23-24, NLT).

*Hallelujah!*

## Irrational Peace

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CMDA'S WEEKLY DEVOTIONS

*by Al Weir, MD*

*“Though he slay me, yet will I hope in him” (Job 13:15a, NIV 1984).*

**I was blessed to sit with them in their home to discuss a new medical problem. They did not need another problem. Early in their lives their 10-year-old son had died of cancer. More recently another son, suffering from schizophrenia, had blinded his father in a fit of rage. They were now planning the memorial service for a third son. They sat there with great peace, trusting God that His plan was good and that His love was constant. The husband spoke honestly as I commented on their amazing peace, “Of course, we certainly don’t like this.”**

There is no way to rationalize the peace that my friends displayed, and they would not deny the struggle that contradicted that peace. Within his statement, my friend and mentor was telling me this, “We know what real suffering is. Nevertheless, we rest in Him.” Jesus said the same thing to us, “In the world you will have tribulation; but be of good cheer, I have overcome the world” (John 16:33, NKJV).

We, as children of the King, live in a world where real suffering will sometimes lay its smothering blanket over us. From beneath that blanket it may take some time before we realize God’s peace and presence. But He is there, and once we find ourselves in His arms, the struggle is different, even irrationally different.

*“Nevertheless...”*

The prophet Habakkuk put it this way: “Though the fig tree does not bud and there are no grapes on the vines, though the olive crop fails and the fields produce no food, though there are no sheep in the pen and no cattle in the stalls, yet I will rejoice in the Lord, I will be joyful in God my Savior” (Habakkuk 3:17-18, NIV 1984).

In a beautiful rap and melody duet, Steven Malcolm and Natalie Grant put it this way:  
“Even if the drum stops beating, my soul will keep on singing, even louder, even louder...”

My experience and these dear friends have shown me that suffering really hurts...nevertheless, we can trust our God and, in His presence, can even find irrational peace within the pain.

*Dear Father,*

*Bless those who suffer in this world. Please remove all suffering that is not necessary for Your plan of love and redemption. Help those who love You, that they may rest in Your arms and know the irrational peace of Your presence.*

*Amen*

## Community Health: The Deadly Failure of the American Healthcare System

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*For some of you, the people living in nearby villages consider your community health visits to be among the essential services provided by your ministry. Dr. Donlon's article addresses community health in the USA and shows how physicians-in-training can prepare to serve overseas by meeting needs closer to home. Reading his story will hopefully inspire all of us to put a greater emphasis on preventative healthcare. – Judy Palpant, Editor*

**by Rick Donlon, MD**

I remember composing an essay for application to medical school in 1985, the year Magic Johnson's Lakers beat Larry Bird's Celtics in the NBA finals. *Back to the Future* was the top-earning movie. My essay featured all the themes you'd expect from an earnest Christian physician-to-be: I wanted to serve humanity, wanted to relieve suffering, wanted to make a difference, etc. As best I can recall, I wasn't insincere, just as I hope the majority of 2020 medical school applicants are pursuing medicine for the “right” reasons.

Sometime in August 1986, I remember walking into the big lecture hall at Louisiana State University School of Medicine in New Orleans on the first day. I was first struck by the fact that the 150 or so other people in the room didn't look much like doctors. I also innocently believed we were all on the same footing; no matter what branch of medicine we eventually pursued, we would always be colleagues, working together for the health and healing of our communities—like our essays promised.

We learned something about community health those first two years of medical school. Louisiana is a wonderful place, but it has a disproportionate number of struggling low-income people, including large communities of African Americans and Latinos. As is the case across the United States, racial minorities in Louisiana, especially in New Orleans, suffer earlier and more severely from all the usual killers: heart disease, cancer, stroke, diabetes, hypertension, kidney failure and more.

With the hindsight of 30 years, it's clear that the American healthcare industry, including academic medical education, is not primarily interested in addressing health disparities or the needs of our struggling communities. Those community health lectures in medical school were informative, but they were lipstick on the \$3.6 trillion U.S. healthcare pig.

The discipline of community health is a subspecies of public health. According to the Centers for Disease Control and Prevention (CDC), public health is “the science of protecting and improving the health of people and their communities. This work is achieved by promoting healthy lifestyles, researching disease and injury prevention, **and detecting, preventing and responding to infectious diseases.**” Community health, in turn, concentrates its attention on specific neighborhoods or patient populations. In a more-perfect world, we would marshal our biggest and brightest healthcare resources to achieve public and community health—bringing about the most good for the most people. In a more-perfect Christian world, that marshalling would take particular interest in the care of the poorest and most marginalized among us.

Alas, we do not live in a more-perfect world. The United States is presently paying a high price for its lack of investment in national and local public health, with a novel Coronavirus spreading and killing aggressively. In my adopted hometown of Memphis, Tennessee, our two biggest hospital systems each have annual revenues in excess of \$2 billion. We spend less than 1 percent of that amount on the Memphis and Shelby County Health Department, the public health agency now charged with Coronavirus testing, contact tracing and otherwise fighting the COVID-19 pandemic that has killed hundreds of our local citizens. As with the diseases mentioned above, the Coronavirus is disproportionately infecting and killing people of color.

Why weren't we better prepared for COVID-19? Why haven't we pursued the goals of public and community health? Why haven't federal and state political leaders enacted public-minded legislation directing money and resources toward our shameful health disparities? Why do our nation's medical schools continue to produce large numbers of specialists and subspecialists, with only small numbers of primary care physicians and even fewer public health specialists?

Because we Americans don't value community or public health nearly as much as we value individualism and autonomy.

We may have begun our educational journeys with altruistic intentions, but we learned early on that if we got better grades and board scores, we could pursue higher paying careers and/or better lifestyles—and that everybody, our professors and parents included, expect us to maximize our professional and financial opportunities.

The same reasoning governs the pharmaceutical industry that expends far more energy developing medications for allergy symptoms, hair loss and erectile dysfunction than it does on worldwide killers like malaria and tuberculosis. They're just maximizing financial opportunities for their stockholders and leaders.

The same principles of self-promotion cause the leaders of hospital systems and universities to compete with each other in providing expensive high-end medical services for well-insured patients, while leaving large swathes of our cities without basic primary care services. They're just prudently assuring the long-term financial health of their institutions—and satisfying their board members.

As the COVID-19 crisis is showing us, an unbalanced commitment to autonomy and selfish benefit, from individuals and institutions, eventually fails everyone, not just the poor.

That shouldn't surprise Christian people, but somehow it does.

Jesus warned us in the Gospels that the concerns of this world and the deceitfulness of wealth will choke out our spiritual fruitfulness (Matthew 13:22), that it is impossible to serve both God and money (Matthew 6:24) and that if we live in comfort while the poor suffer nearby, we will end up in hell (Luke 16:25). Later, the apostle Paul warned us that people who want to be rich will wander from the faith and pierce themselves with many griefs (1 Timothy 6:10).

There's good news, however.

When God's people, redeemed by the blood of Jesus Christ and filled with His Holy Spirit, choose to serve Him, rather than money, big things happen. Jesus is the King of a great and glorious kingdom that inevitably brings healing, justice and righteousness (Psalm 89:14). The members of His body are agents of that kingdom. As they obey the biblical

directives to consider others better than themselves, to truly love their neighbors and to forgive their enemies, communities begin to change. It's an historical fact that a small movement of faithful Christian disciples eventually won over the Roman world. Time and again over the last 20 centuries, obedient disciples have promulgated justice, equity and freedom in many cultures and in many ways. No other movement or religion has done more for public and community health than biblical Christianity.

The present worldwide health crisis is a clear opportunity for the people of God's kingdom to again shine. If we have the courage to follow the leading of the Holy Spirit, to turn away from greed and self-indulgence and to pour ourselves out for our less fortunate neighbors, we will become God's champions of community health.



*Rick Donlon grew up in New Orleans and graduated from Texas Christian University in 1986. He completed medical school at LSU-New Orleans and a combined internal medicine and pediatrics residency at the University of Tennessee, Memphis. In 1995 he and three medical school classmates opened a primary care health center for the poor in Memphis' most medically underserved neighborhood. The work eventually grew to include eight health centers, three dental clinics and a family medicine residency program—providing more than 170,000 patient visits annually.*

*Beginning in 2003, many of the medical and dental professionals, including Dr. Donlon, moved into the underserved communities where they work. In those same low-income settings, they've planted more than a dozen house churches. That house church network has subsequently sent dozens of long-term medical missionaries to North Africa, Central Asia, South Asia and the Horn of Africa.*

*Physicians, dentists and other healthcare workers who've trained with Dr. Donlon in Memphis have started or joined similar ministries in low-income communities across the U.S. Dr. Donlon, his wife Laurie and their seven children live in the Binghampton neighborhood where he serves as an elder in the house church network*

## Seeking, Not Sitting

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**by Daniel E. Fountain, MD**

“For the Son of Man came to seek and to save the lost’ (Luke 19:10). Jesus did not sit and wait until the lost came to him. He did not set up an office or a clinic in the synagogue and expect sick persons to find him. Instead he went to the markets, to the shore of the lake, to public gathering places, and to village wells to seek those who needed salvation and health.

The hospital and clinic can never solve the health problems of people, nor can the church building on the corner solve our spiritual problems. I corrected a small boy's intestinal obstruction due to roundworms, but all of my surgical skills could not protect him from another infestation of worms...

Western civilization has a great genius for institutions, be they religious, medical, or educational. These institutions can effectively embody religion, medicine, and training, but they also entrap us within their walls and isolate us from the very ones who need the ministries of life, health, and wisdom. Our concern must be with persons where they are, in the midst of their situations and problems. Community health began in Galilee. Let's return to the 'Galilee Model' and go out to seek, find, and work with those who need health and healing.” – Page 158 in [\*Health, the Bible and the Church\*](#)



A graduate of Colgate University, the University of Rochester School of Medicine (1956) and Johns Hopkins University, Dr. Daniel E. Fountain served with his wife Miriam as a medical missionary in the Democratic Republic of Congo (formerly Zaire) from 1961 to 1996 with the American Baptist Board of International Ministries. During that time, he was the director of health services of the Baptist Church of Western Congo and the director of Vanga Evangelical Hospital. Through their efforts and those of the Baptist Community of Western Congo, the Vanga Hospital grew into a 400-bed teaching hospital with a nurses training school, family medicine residency, a rural health zone of 50 health centers serving a quarter of a million people, a church-based community health program reaching over 300 villages, and a whole-person care ministry to persons with HIV. He died in 2013.

*“Thirty years on mission in Central Africa changed his thinking about his professional training, about current medical practice overseas and at home and about the responsibility of the entire Christian community to promote health initiatives. Digging into biblical precepts and patterns, he has developed a theology of human wellness that in some ways rebukes his own profession, and at the same time summons churches to recover their rightful role as partners with physicians. His diagnosis of shortcomings by both will unsettle traditionalists. His suggested remedies will be controversial. But gainsayers will be hardpressed to refute the evidence from his diligent research and devout experience.” – Quoted from back cover of his book Health, the Bible and the Church*

## Put Out the Fire While It Is Still Faraway

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**by Jonathan Bii**

Tenwek Hospital Community Health and Development (THCHD) is a department of Tenwek Hospital, a ministry of the Africa Gospel Church located in Bomet County in the Southern Rift Valley in Kenya. The hospital is a 300-bed facility that provides tertiary care to a population of approximately 800,000. The THCHD office is situated within the hospital premises with two satellite offices at Sosiot and Naikarra, in Kericho and Narok Counties respectively. The project covers four counties namely Bomet, Narok, Kericho and pockets of Nakuru counties.

THCHD as an outreach department was started in 1983 with the motto: *Bir Mat Ko Loo—Put out the fire while it is still far*. The hospital management realized that 80 percent of the patients in the hospital suffered from preventable diseases. An even larger percentage of these patients could not pay for preventive or curative services being provided to them.

The purpose was to undertake preventive healthcare and development within the target communities. Its main focus to bring God’s hope to individuals, households and communities by improving their livelihoods. The department’s mission was primarily to serve Christ by providing/facilitating change through service delivery; initially focusing on community health, but later broadened its scope to include other significant variables such as economic empowerment, water and agriculture.

Since its inception, THCHD has been trying to reach out more effectively making impact through all the global development transformational trends that included the following:

- 1960s: Do development TO the people,
- 1970s: Do development FOR the people,
- 1980s: Do development THROUGH the people,
- 1990s: Do development WITH the people,

- 2000: Empower people FOR development
- Now: Development process BELONGS to the people.

THCHD made a major paradigm shift in 2008. It realigned its strategy from a service driven delivery agency to facilitation of communities to be empowered to take charge of their own dreams and health/development agendas. THCHD revised their mission statement from:

“Serve Christ by facilitating change through primary health care and appropriate development within needy communities” to “Serve Christ by facilitating change through **community-based** health care and appropriate development within needy communities.”

The focus of this shift in approach is people’s empowerment through a participatory methodology called People Owned Process (POP). Through this process THCHD facilitates communities to build *their own* capacities and abilities and be able to identify and address their own needs using locally available resources. This enables the communities to own the process as they work together in identifying, planning, designing, implementing, monitoring and evaluating their own development initiatives.

The underlying principle behind the POP methodology is to engage the full participation of people in the processes of learning about their needs and opportunities, and in the action required to address them. By empowering people to creatively investigate issues of their concern, the approach challenges preexisting biases and conceptions about people’s knowledge. As such, it offers opportunities for target communities/people to mobilize for joint action. All the POP tools are defined by interactive learning, shared knowledge and an adaptable, yet structured analysis.

THCHD’s engagement with target communities is carried out every day through a variety of outreach projects. These projects include:

- Food security and nutrition,
- Maternal and child welfare,
- HIV prevention – Community-based ART
- Orphan and Vulnerable Children Program (OVC)
- Pelvic Floor Disorder (PFD) – reaching out to mothers with Pelvic Floor Disorders
- Agriculture in schools,
- Water Hygiene Sanitation (WASH) in schools and at households
- Challenging the church for wholistic ministry following the model of Jesus Christ.

THCHD derives its support from the church with its operations concentrated in areas where the church has a presence. This provides it with a community-based infrastructure that has supported its initiatives.

In schools we use a Child to child to Parent (CtCtP) approach to primary healthcare. Instead of taking health teachings to adults, we target children who are more effective in passing health and peace and development messages without much processing. Adults will always process and sort messages before passing them on, especially if there are cost implications.

From the beginning the program has addressed spiritual needs in the community as well as physical. In the WASH program, we train community evangelists who are equipped with Jesus films to show in their communities, hotels, schools and families/homes that own television sets. The church leadership are also trained on wholistic approach to ministry following the model of Jesus Christ. Churches within target communities are sensitized on health and

development opportunities that are available, and they are to take the lead in mobilizing their congregations and community members to enroll and attend and fully participate in the program areas.

What we've learned:

- The people's empowerment has led motivated and passionate communities who are able to identify issues affecting them and addressing the same using local solutions.
- The participatory approach has empowered and made women to be more assertive, hence a greater gender equity and improved livelihoods.
- Communities, if appropriately facilitated, are able to realize their potentials and can successfully undertake development initiatives using locally available resources.
- The POP approach to development has shown that there is a wide range of resources and potential in the communities which, if properly identified/noticed, exploited and effectively utilised, have gains that far outweigh direct financial and material benefits obtained from development agencies.
- The approach of facilitating communities to establish and drive their own agenda is key in managing sustainable development.
- THCHD has established through its engagements with the community through the years that indigenous systems still work, provided there is proper facilitation of people and effective management of resources.
- Empowered communities who know what they want and are clear on the direction they want to go attract government and its agencies to work with them. Besides, the communities take an active role in setting their development agenda.

*Jonathan Bii is the Director of Tenwek Hospital Community Health & Development. He has worked at THCHD since 1993. Jonathan received a bachelors in community development and a master's degree in agricultural marketing management from India. He is married with four children. Jonathan sees his work at THCHD as a ministry and not just a job and is excited to be involved in wholistic ministry and transformational development in South Rift Valley by building capacities of target communities to be able to access elements of dignified living (EEDL) using available resources.*

*Essential Elements of Dignified Living (EEDL) include:*

- *Food security*
- *Housing/shelter*
- *Land*
- *Income*
- *Functional education*
- *Sense of belonging*
- *Water and sanitation*
- *Healthcare*
- *Peace and security*
- *Information*
- *Institutionalization of action*

*Mr. Jonathan Bii*

*Program Director, THCHD*

*Tenwek Hospital Community Health & Development*

# Putting Truth into Action: Vaccinations

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*by Dr. Phil*

During the last century, vaccination has greatly improved community health. The rate of death from diseases like polio, tetanus and measles has dropped remarkably. Nonetheless, approximately three million people die unnecessary deaths each year, and many others are left disabled due to what we could call “vaccine-deficiency disorders.”

As people of the Word and as healthcare professionals, we need to model and encourage appropriate vaccination. In developing countries, it can be very challenging to convince new mothers to bring in their infants for a vaccination when the child is “not sick.” Preventing a disease rarely compels the immediacy of curing one. However, appropriate scientific truth can drive out fear and reduce vaccine hesitancy. We need to take advantage ourselves of routine vaccines and of special travel-related vaccines for use in areas where various tropical diseases are endemic. We need to make sure our own children are vaccinated appropriately without leaving them at risk of unnecessary disease. And, we need to encourage community-level implementation of programs that will reach all children, pregnant women and other adults with appropriate vaccination.

Every death due to tetanus, measles or polio marks a failure of our community health efforts. Every outbreak of pertussis represents a similar failure. The same holds true for sporadic cases of congenital rubella syndrome. Japanese encephalitis should not continue to plague people in Asia. Meningitis has become rare in some vaccine-rich regions of the world. Most cervical cancer is preventable. Vaccination is a great success of the last century’s community health efforts, but too many people still fail to receive appropriate immunization. Life-saving, disability-preventing work remains to be done.

COVID-19 has prompted a lot of popular enthusiasm for a potential SARS-CoV-2 vaccine. Hope for a vaccine to stop the pandemic, however, will need to be linked with future action to implement vaccine programs. The New Testament book of James highlights the difference between believing and doing. We must not just hope for and believe intellectually in a future vaccine, we must put these beliefs into action.

The current pandemic has interrupted vaccination routines in the U.S. and around the world over the last several months. These are considered “essential services” even in a time of pandemic. The focused attention on COVID-19 should not result in neglect of other contagious infections. Ensuring that immunization protocols are restarted is essential for protecting both individuals and communities from serious diseases.

Faith and works. Truth and fear. We can continue to model and facilitate appropriate immunization for our own health and for the health of communities.



*Phil is a professor of pediatrics at Mayo Clinic in Minnesota, served in Central Africa and has spoken at the GMHC about vaccination.*

## Announcement

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### Global Missions Health Conference

This year’s Global Missions Health Conference, normally held in Louisville, Kentucky, will be held virtually on November 13-14, 2020. To learn more and to register, visit [www.medicalmissions.com/gmhc](http://www.medicalmissions.com/gmhc). This will be the 25th anniversary of the conference, so you won’t want to miss it.

If you've always wanted to exhibit at GMHC but have not been able to register before all the spaces were filled, this could be the year. I believe they are accepting additional registrations since it will be virtual. There will be chat rooms where you can arrange to visit with interested participants. It should be a good way to talk with potential future colleagues or even just listen to those who are considering their future. You might be just the listening ear needed.

[www.medicalmissions.com/gmhc](http://www.medicalmissions.com/gmhc)