The Center for Medical Missions' *e-Pistle* January 2008

I hope your New Year has gotten off to a great start. Isn't it exciting to wonder what the Lord will accomplish through us this year! I trust each of you will have an unusually blessed year and that many of your dreams will be realized. For the majority of us, that will be our friends, loved ones and those we serve turning to the Lord. Let's be praying for each other, that we all might see the Lord's hand of blessing upon our ministries

Due to the length of this newsletter, I'm going to open with a list of what is included in this letter. There are some great thought-provoking articles and quite a few announcements/resources. I think you will want to go all the way through. Susan

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Medical Missions STAT!

by David Stevens, MD, MA (Ethics)

Increasingly, medical missionaries find themselves in proximity of or asked to respond to natural and man-made disasters, from tsunamis to earthquakes, famines to civil wars and epidemics to ethnic cleansings. If none of these have confronted you yet, just wait. Sooner or later they probably will.

I have a bit of experience in these areas. I led medical relief teams for Samaritan's Purse for two and a half years into Bosnia, Somalia, Sudan and Rwanda, so I am aware of the issues involved. Perhaps some of my reflections and considerations might be helpful to you when one day you face "medical missions STAT!"

If the catastrophe occurs around your place of service, it is obvious that providing medical relief has to be done. Your spectrum of disease may change, your volume of work will significantly increase and you will face many logistical problems, but you won't have the dilemma of trying

to decide whether you will be involved or not. You will be. But what if the catastrophe is in another section of your country or in a nearby one? Should you get involved?

Historically, medical missionaries have gone to the most dangerous and difficult places, though increasingly, secular groups have taken the lead as they have been favored by secular governments' and individuals' funding. Let's look at the benefits of what emergency medical relief can do. First, emergency medical personnel can get into countries or regions that have been traditionally closed to missionaries – radical Muslim countries for example. I know when I took a medical team into Somalia there were estimated to be only about 300 Christians in Mogadishu and only a handful more in the whole country. Christian organizations were not allowed in the country traditionally but with a civil war and famine, there was no government enforcement because there was no government. Military and UN intervention provided a small window of relative stability where Christian relief organizations and missionaries could have an impact.

Secondly, in the midst of tragedy, people who are resistant to the gospel may be much more open to it. When they see Christian charity, they wonder what motivates such risky love to be manifested. They are attracted to our Lord through love and service.

Thirdly, the Bible tells us to have mercy on those that suffer.

- Proverbs 19:17, *"Mercy to the needy is a loan to GOD, and GOD pays back those loans in full."*
- Romans 9:15-17, *"God told Moses, 'I'm in charge of mercy. I'm in charge of compassion.' Compassion doesn't originate in our bleeding hearts or moral sweat, but in God's mercy. Real wisdom, God's wisdom, begins with a holy life and is characterized by getting along with others. It is gentle and reasonable, overflowing with mercy and blessings."*

There are many more practical reasons to consider doing relief as well.

- Funding - It is often much easier to fund this type of outreach due to media attention. At least for a while, money will pour in to help people in need.
- Transport - Parastatal and government organizations may provide free transport. When I was doing relief work, often the UN or various government military organizations were willing to take us to needy areas and transport supplies and equipment. In Sudan, we were trying to halt the spread of an epidemic of relapsing fever. The UN let us fill most of a C-130 transport plane with tents, a large boat, motors, food, supplies and medical equipment and then dropped us off at a remote dirt strip next to a river leading to the epicenter of the epidemic.
- Church Expansion - Our presence was a great help in expanding the local church in that animistic area. It grew by leaps and bounds over the next nine months.
- Recruitment - Surprisingly, it is easier to recruit at least short-term personnel for emergency situations. Somalia was in terrible turmoil when I went in to survey the situation in 1992. I wondered if I could find anyone willing to go with our teams. We had medical personnel come out of the woodwork, many with significant experience in long-

term and short-term missions and others that were neophytes, but God had moved in their hearts. We had to turn people down for lack of room.

There is also the ancillary benefit of being salt and light to other relief organizations and the military if they are involved. In Mogadishu we had military healthcare personnel come in droves to be part of our weekly church services and to assist us in our work on their days off. They were not allowed to use military medicines and supplies to help the local people, but they had a great desire to relieve the suffering they saw everyday. When they came as volunteers they brought all their security people with them, which made our job safer and more organized. On Sundays, we would make homemade cookies and other foods that gave them a touch of home in a country far away. Having a lot of single females on our team was an attractant as well! A good number of soldiers came to Christ and others grew in their faith because of our presence.

Another thing to consider is the medical and cultural experience of long-term missionaries and their language knowledge. They are invaluable in an emergency. They have learned to adapt and "make-do" in challenging situations. They know the illnesses and cost-effective therapies that work in their region of the world. They may know where to get supplies, food and other resources from local sources that are much cheaper than bringing them long distances.

Of course, the publicity that the home mission organization may get as they respond to urgent needs may be widely disseminated by the media which can increase the number of individuals, foundations and even government organizations that can provide support for more long-term endeavors.

But relief work has its downside as well. How will your present ministry continue to function while you're involved in this added outreach? Relief work requires a rapid almost instantaneous response and is very costly. In Mogadishu it could cost $400 a day to rent a vehicle and we needed a number of them to transport our team to feeding centers and other ministry sites. In the early days we had to transport all of our medicine, food, supplies and even water by air from Nairobi. Relief work is never self-supporting by patient fees. In most situations, even minimal fees can't be charged.

In civil war or other violent situations, relief can be dangerous. In Somalia we had 10 machine gun-carrying guards at our house compound and some in every vehicle that left through the gate. Without them, we would have been robbed and possibly shot and killed. In Sudan, our team did not have guards and we were kidnapped and held hostage for a couple of days. Another time, we had to do an emergency evacuation as a tribal conflict resulted in a raid of the village where we were working, and many were killed. In Rwanda, the killing teams used to wash the blood off their machetes in the hospital compound where we worked. There was no direct threat to the team, but there is continual danger in lawless situations.

One of the goals in missions is long-term sustainable development with ultimate nationalization and a long-term partnership with an indigenous church. In emergencies it is difficult to set up and maintain infrastructures long term. You have to make extraordinary efforts to work with the local church if there is one, even though it is often in disarray due to the catastrophe. The people of the church are trying to survive like everyone else.

I falsely imagined that all the relief organizations would have a sense of camaraderie and would work together. I was surprised to find that most agencies are uncooperative and territorial. Their existence is dependent on the press coverage they receive because the publicity brings in donations and grants to fund their group. There is competition for the most public, worthy work sites and sometimes even a deliberate sabotaging of Christian groups' work. In Sudan, a well-known international medical group down the river tried to get us thrown out of the country by complaining to the UN because we were "proselytizing" by showing the "Jesus Film." In reality, they could have easily gotten extra funding and publicity if they were involved in addressing the epidemic of relapsing fever where we were - at the epicenter.

A book called, "The Lords of Poverty" scathingly addresses this and other issues of secular relief organizations that run from one disaster to another following the money with little thought to proper disengagement or turning their work into long-term development. When the press coverage and funding dries up, they are often gone overnight no matter what the consequences to the local people.

In the above instance, the UN called me and told us that unless we ceased from witnessing they would no longer let us use their flights to ferry personnel and supplies into the country. At that time, all but their flights were shot down by the government air force. Their action would have driven us out of Sudan. This is only one example of how some organizations have considerable antagonism towards Christian organizations and may have to be dealt with. In this situation, I had to show them a copy of their own charter, which says everyone has a right to not only practice their own religious beliefs but also to propagate them.

Of course the hardest part of emergency medical relief is logistics. You are working in chaos without normal communication, transportation, housing or supply systems yet you have to move, lodge, feed, find clean water and have the medical and other supplies available that you need to make a difference. You must be able to communicate. Before satellite phones there were short wave and VHF radio networks from your base to mobile units. I can still remember hunching under the parapet on our flat roof house in Mogadishu to avoid sniper fire as I tried to operate our satellite fax machine to send a message to the U.S. I felt like James Bond!

Because the situation is changing so rapidly, it is difficult to set budgets or project costs or impact. A relief team requires intense support from a well-run organization outside the disaster to perform well and meet the challenges it faces, and still everyone must acknowledge that the effort may end at any time due to circumstances beyond their control.

Let's talk about the mechanics of "medical missions STAT" … next month.

Cura Animarum

by Rev. Stan Key

I know of no better introduction to a sermon whose aim is to dethrone the "pleasure –god" than the words of a secular author who is an astute critic of contemporary American culture. Although

Neil Postman wrote these words almost 20 years ago, they depict in graphic language how the idol of pleasure has captured the hearts of millions of Americans.

> *At different times in our history, different cities have been the focal point of a radiating American spirit. In the late eighteenth century, for example, Boston was the center of a political radicalism that ignited a shot heart round the world… In the mid-nineteenth century, New York became the symbol of the idea of a melting pot America… In the early twentieth century, Chicago, the city of big shoulders and heavy winds, came to symbolize the industrial energy and dynamism of America…*
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> *Today, we must look to the city of Las Vegas, Nevada, as a metaphor of our national character and aspiration, its symbol a thirty-foot-high cardboard picture of a slot machine and a chorus girl. For Las Vegas is a city entirely devoted to the idea of entertainment, and as such proclaims the spirit of a culture in which all public discourse increasingly takes the form of entertainment. Our politics, religion, news, athletics, education and commerce have been transformed into congenial adjuncts of show business, largely without protest or even much popular notice. The result is that we are a people on the verge of amusing ourselves to death.*

(Amusing Ourselves to Death: Public Discourse in the Age of Show Business. Neil Postman. Penguin Books. 1985. Pages 3-4).

If we are honest, many of us need to confess that we too have worshiped this false deity and allowed his influence to poison our lives and relationships. We have been "pleasure-lovers rather than God-lovers" (II Timothy 3:4). The call today is to topple this idol from his pedestal and give again our entire allegiance to the Lord Jesus Christ.

Christian Hospitality Network

The Center for Medical Missions again has the opportunity to contribute names of missionaries to the Christian Hospitality Network for invitation to their annual GetAway. This is a 3-night, 4-day respite at the Seabank Hotel (www.seabankhotel.com) designed just to give the Lord's servants a chance to rest, relax and be refreshed. This year's resort is on the island of Malta and is for those serving in Europe, the Middle East and northern Africa. If you have a friend or colleague working in those areas who is well into his/her term and could benefit from a GetAway, please let me know and I will pass along the information. The GetAway is free except for travel and there are no expectations except that participants rest and relax. A doctor, chiropractor, massage therapist and multiple counselors will be available. Invitees should not have been home or be going home within a year of the November 2008 GetAway. They have reserved 150 rooms. I'll be happy to pass along a name and contact, if you get it to me (Susan.carter@cmda.org.

Called...to Love

Part Two
by Harry Kraus, MD

I started this article, writing in one of those places I call a Christian-theology-rubber-meets-the-road kind of place: a Somali Refugee Camp in Dadaab, Kenya. It's a place of scorching heat and sand, a place I can't believe anyone calls a refuge, but that's exactly what it's called by 160,000 Somali refugees.

I remember my first visit. I was helping run a surgery clinic, and short on time, late one afternoon. My translators kept telling me, "You have to leave. The driver is here. The other passengers are waiting."

I looked around and realized there would be no satisfaction for the dozens of patients that remained.

"Dhaktar! You need to go."

I held up my hands. I was missionary-tired and didn't want to be the bad guy to send everyone away. If I surrendered, at least I hoped the patients would see I was being forced to close the clinic for the day.

My eyes fell upon a woman sitting at the corner of my desk. She'd insinuated herself into position and had sat quietly while I'd been interviewing and examining the previous patient. Medical privacy, I've discovered, is a relative concept. A necessary and valued concept in the West, but in the refugee camps, giving the patient ahead of you privacy might mean that you'd never be seen, as so many others would crowd in before you.

I sighed. The woman had been waiting so patiently. I couldn't just leave her. "What about her?" I said.

Now my assistant sighed. "Ok. But this is the last one."

With the clock ticking and my driver waiting in the heat with all the other passengers, I waited impatiently for the answers to my questions.

"Why is she here?"

The woman sat in silence.

I repeated my question.

She leaned closer to my translator. He looked at me. "She won't say unless she's in private."

We retreated to a corner of relative privacy. Only then, the woman began to talk.

Now, I need you to understand that she was dressed like a typical Somali woman. Somali people are all Muslims. Ok, well not all, but 99.9% and this woman was clothed like most moderates. I could see the front of her face only. Her neck, cheeks and the top of her head were veiled. As I studied her face, I got a gut-check discomfort. My patient was just too masculine to be dressed the way she was.

After some discussion, which seemed intolerably long because the car was waiting, the translator turned to me with a matter-of-fact tone. "She wants you to tell her whether she's a man or a woman."

I began my exam with the genitalia and immediately understood the confusion. I was confused at first, too. I had suspicions that the patient suffered from a combination of common anomalies that were both easily correctable. The crime of it was that because she'd been raised in the bush with little access to medical care, her parents made an assumption based on a best guess. And so my patient had spent the first thirty-five years of her life as a female.

My heart was touched. Only where medical care is unavailable, only where despair and fatalism rule can such a tragedy unfold. *Africa*. "I'm not sure," I said. "But we'll bring you to Kijabe Hospital. A few easy tests will tell us the answer."

Why tell that story now? Because as we begin exploring the great metaphor which likens the church to the body of Christ, I wanted to go back to the very basic thing that defines us all, the very wonderful and marvelous molecule known as our DNA.

You see, from the very moment of conception, each of us inherit DNA from our parents. DNA is a helical shaped molecule with two strands. Think of a ladder that's been twisted so that the normally parallel uprights curl around each other. We got one strand from dad, the other from mom.

So, for my patient in the refugee camp, this was all true. A message resided in every nucleated cell revealing the identity as male or female. As far as determination of sex is concerned, we all learned in high school biology that XX equals female and XY equals male. The problem with my patient wasn't that the cells didn't have the message. The message had just been scrambled a bit in development.

DNA present within the cells provides an exact identification. What about the body of Christ? Is there a feature that can provide the proof that will convict us of belonging to Jesus? Is there enough forensic evidence left in our wake to identify us as individual members of his body?

Has a vital message been scrambled?

Take time this week and ask the people around you if there is any observable feature that sets a person apart and lets you know that he or she is a Christian. The answers you hear may be encouraging. Or a bit threatening.

Jesus gives us the answer.

"By this all people will know that you are my disciples, if you have love for one another." John 13:35

These words can be hammer-blows to our consciences. I wince at the memory of numerous times I've acted in ways that were nothing like love.

But the truth remains: love is to be the defining, dominant characteristic of the body of Christ, the evidence of our discipleship to a world longing for love.

If God resides in me and he defines himself as love, then I have to believe that love has taken up residence in me in some way. His character may not be completely manifest in me, but I believe that must be my fault, not his.

Let's go back to our analogy. The DNA sends a definite message to every nucleated cell. "Be male" or "be female." The message will be translated and retranslated, but the end results are structural proteins which make a person either male or female. In the case of my patient from the refugee camp, the message was clear at its origin (the DNA), but got a bit mixed during the last few steps, resulting in a male without all of the externals being completely developed. We made this diagnosis by doing a simple biopsy. The hard part was determining what to do next. Suffice it to say, I had a long conversation with my patient! Often, in these cases, there is a clear gender identification that has occurred because of the way the person has been raised. Not so in the case of my patient, who had always felt "male" and wanted to be male. Fortunately the man had a few relatively simple anomalies that combined to lead to his parents' (and his) confusion. Each defect was corrected surgically and he returned to a different refugee camp as a male.

Likewise, a clear message has gone out to every member of Christ's body: "Love!" Over and over, like the DNA message sent to every cell, the message is unmistakable. Love! Jesus issues it as an order, calling it "a new commandment" (John 13:34) or "my commandment" (John 15:12). Strong language. Not a suggestion. A clear mandate. In fact, the language could not be more forceful, certainly as powerful (and more frequent) as the instructions we know as the great commission. I believe if we as the body of Christ would focus as much attention on loving each other and loving our neighbors (and the rest of a love-starved world), we might just find the great commission occurring naturally as smoke follows fire. Hand in hand. And maybe that was Jesus' point, after all.

Lots of things can happen to scramble a DNA message, to hamper its full instigation in every cell. Competing messages, inadequate nutrition, or illness can interfere with a cell's ability to respond. But the DNA reveals *the way things were intended to be.*

Some of you are uncomfortable with my analogy. We're uneasy hearing such stories of gender confusion. And yet I have the audacity to use it in a spiritual analogy. Why? Because a condition like my patient's is a tragedy, something that just hearing about makes us ill at ease. Don't get me wrong! It's appropriate to recoil at such an example, but I really want you to see the parallel tragedy that is occurring every day in the body of Christ.

My patient's life was a heartbreaking misfortune, a real tragedy. He lived for thirty-five years not understanding who he was. Because of access to medical care, calamities like this are avoided in the developed world. But not in the horn of Africa. We look on with a sense of shock and revulsion. *This all could have been avoided!*

But where is our shock over the defining condition of the body of Christ? God's clear message of love has been scrambled. We are carrying the DNA message that defines us, but we are confused about our identity. The world looks on and they don't know either. Is the Christian church known for love? Or something less holy? This is the true tragedy that should make us recoil in disgust.

Accepting God's love message accelerates a transformation of the heart.

When Christ, love personified, entered my heart, he sent out a message of love, a message of the way things were intended to be.

What are the things that keep me from responding? Has Christ's command been scrambled along the way?

How do we follow Christ's command to love, especially when the recipients aren't so "lovely"?

Realize that we are only channels. The hands, fingers and toes can only do what the head commands. God loves the world. We need only be the conduit.

Take inventory of your spiritual health. Are there spiritual illnesses that might be blocking the message? Have you been spending time in God's presence and with His word? We cannot expect God's intended message of love to be transmitted through us if our souls are anemic and immune incompetent.

Take time to meditate on God's love for you. Overflow to others rarely occurs when we've lost the thrill of being loved.

As you strategize and plan on the mission field, don't leave out the basics. Love is at the heart of the Gospel, and the center of our commission to the world. Understand, love isn't just another item on the checklist of things you have to do. Love will occur as a natural outcome of a heart transformed by the Gospel.

Love. It's our calling. Our identity. It's the message God is sending out through you and me.

Harry Kraus, M.D. is the bestselling author of multiple novels and *Breathing Grace: What you Need More Than Your Next Breath*. He is currently serving with AIM as a missionary surgeon in Kijabe, Kenya.

Matching Grants for Professional Volunteers

The Christian Medical Association participated in an event at the White House, Celebration of International Volunteer Day 2007, which observed the contributions of Americans who volunteer worldwide. The Honorable Henrietta Fore, Administrator, U.S. Agency for International Development, addressed the gathering, along with Henry Lozano, Deputy Assistant to the President and Director of USA Freedom Corps. Mrs. Fore highlighted the establishment of the Volunteers for Prosperity (VFP) - Matching Fund, a public-private partnership developed to improve the affordability of short-term international volunteering.

VFPServ is a public-private partnership that awards individual, non-renewable grants ranging from $500 to $1,000 to offset travel, insurance and local living costs for short-term volunteer service abroad by skilled Americans. These grants match at least an equal amount of funds raised by applicants in their local communities. Awarded monies are disbursed to the organizations that will supervise applicants' volunteer service assignments abroad. Applicants are responsible for identifying their supervising organizations from among the network of US non-profits and companies affiliated with the VFP Office.

The award process is competitive. A successful applicant will have at least 3-5 years' professional experience relevant to his/her anticipated assignment, and must demonstrate: an appropriate educational background/professional training; a significant level of commitment to, and capacity for, international volunteering; an expressed desire to share his/her "volunteer experience" with the local community; and finally, a need for financial assistance. The final decision to award a grant is contingent upon verification of at least an equal amount of funds raised by the applicant within his/her community and subject to the availability of VFPServ grant monies.

Learn more at: http://www.volunteersforprosperity.gov/ (Support International Volunteers)

Free Resource: Ponseti Method for Treating Clubfeet

The Ponseti method is the leading method of treating clubfeet. There is free online access to Dr. Ponseti's book on the technique of treatment if you are interested. Maybe this would be a good resource for your medical students and residents. www.ponseti.info

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New Pathology Services Available to Missions Hospitals and Clinics

International Pathology Services (IPS) (www.ipathservices.org) is a non-profit corporation whose mission is to provide anatomic pathology services (biopsy/resection interpretation, bone marrow interpretation and cytology services) to Christian missions hospitals and clinics in the developing world.

Services are provided by Dr. William Walker, a Board Certified Christian pathologist (Anatomic Pathology, Clinical Pathology and Cytopathology subspecialty boarded). Specimens are

processed at Bronson Methodist Hospital in Kalamazoo, Michigan and formal reports are sent to the clinicians by e-mail.

As of December 2007, specimens have been received from 15 countries. The Lord has blessed this ministry in so many ways, and for this reason, there are no technical or professional charges for this service. Clinicians are responsible only for the shipment cost of specimens.

Presently, a majority of the specimens return to the US with visitors or missionaries returning to the States and are then mailed to IPS (packaging and shipment instructions are provided and there are no customs difficulties or need to declare specimens as "infectious"). IPS has also secured a discounted small package rate from FedEx so that this is a second shipment option.

If you are interested in discussing pathology services for your missions hospital or clinic, please contact Dr. Walker at billwalker@ipathservices.org.

New Fiscal Year 2008 Edition of the Users' Guide to USAID/Washington Health Programs

The recently updated Users' Guide includes an introduction to USAID, plus the Agency's health objectives, programs, and structure. It also contains a directory of USAID global health projects.

Access the new Users' Guide on USAID.gov

Opportunity – CMF-UK

Christian Medical Fellowship, UK, is looking for a new Head of International Ministries. They would like the individual to have international mission experience, among other requirements. If you might be interested, you can learn more at: http://www.cmf.org.uk/

ICMDA HIV Initiative 2007 Dignity and Right to Health Award

This announcement is late since we did not produce a normal e-Pistle in December. But do congratulate Dr. Nduati if you have a chance. We join others in congratulating her on this significant award.

The winner of the ICMDA HIV Initiative 2007 Dignity and Right to Health Award is Dr Ruth Nduati. Dr Ruth Nduati is a model for and encouragement to us all. She has through her work, service and witness achieved much for the Kingdom. She received Christ as Lord and Savior into her life at the age of 11 years. She is currently the choir mistress of her church in Karen on the outskirts of Nairobi, the capital city of Kenya. Ruth is a member of the Christian

Women's Doctors Fellowship in Nairobi. As a medical doctor she has over the years been a great leader and advocate for women and children's health issues.

Ruth NDUATI, MB.Ch.B., M.Med(Ped), Cert. Tropical Med., MPH (Epidemiology and International Health), Fellow of Primary Health Care East Africa.

As consultant pediatrician at Kenyatta National Hospital, Nairobi, Kenya, she teaches post-graduate doctors, undergraduate medical students and pediatric clinical officers in pediatrics. Her special teaching interests are prevention of HIV, treatment of HIV infected children and infant feeding. Through this training she has been instrumental in improving hospital service delivery. This has improved the quality of care available to the public.

Her current research focuses on prevention of mother-to-child transmission of HIV/AIDS, pediatric AIDS and child health and operational research on implementation of PMTCT and pediatric HIV treatment programs.

Her research on infant feeding and pediatric HIV is recognized by WHO and UN. Locally she is managing a grant that is integrating PMTCT into 338 government health facilities.

Ruth is married to Peter H. Nduati. She is mother to 3 children aged 23 years, 19 years and 6 years.

We congratulate Ruth Nduati on being a most worthy recipient of the 2007 ICMDA HIV initiative, "Dignity and Right to Health Award."

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