



# Center for Medical Missions

*A ministry of Christian Medical & Dental Associations*

## January 2013

Happy 2013! It is good to sit here, thinking of you and writing the first *Your Call* newsletter of 2013. I trust you had a wonderful time with family and friends celebrating the birth of our Savior.

Have you set goals for 2013? I've never been very good about setting goals for my personal life but my pastor shared some simple suggestions. So I'm sharing them with you. He suggested we should set spiritual goals, personal goals, family goals, practical goals and vocational goals. Within each of these we should consider finances, interests, relationships, schedules and troubles. Seems like good advice.

If you will soon be going to the field for an extended time, have you put the dates of **July 26 – 28** on your calendar? Those are the dates of our [Orientation to Medical Missions](#). We hope you will plan to attend because there will be a lot of helpful information shared. Equally important, you will meet and develop friendships with others who will be able to relate to your period of adjustment as well as the good things you experience. For more information, visit [www.cmda.org/orientation](http://www.cmda.org/orientation).

I'm including several short pieces of information this month as well as some thoughts about serving beyond a clinical setting. Remember we'd love to hear from you if there is something that is particularly meaningful to you.

### [Susan](#)

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## Think About This

by Rev. Stan Key

Cheap grace is the deadly enemy of our church. We are fighting today for costly grace....

Cheap grace means the justification of sin without the justification of the sinner. Grace alone does everything, they say, and so everything can remain as it was before....

Cheap grace is the preaching of forgiveness without requiring repentance, baptism without church discipline, communion without confession, absolution without personal confession. Cheap grace is grace without discipleship, grace without the cross, grace without Jesus Christ...

Costly grace is the treasure hidden in the field; for the sake of it a man will gladly go and sell all that he has.... Costly grace is the gospel which must be *sought* again and again, the gift which must be *asked* for, the door at which a man must *knock*.

Such grace is *costly* because it calls us to follow, and it is *grace* because it calls us to follow *Jesus Christ*. It is costly because it costs a man his life, and it is grace because it gives a man the only true life. It is costly because it condemns sin, and grace because it justifies the sinner. Above all, it is *costly* because it cost God the life of His Son... Above all it is *grace* because God did not reckon His Son too dear a price to pay for our life, but delivered Him up for us....

The only man who has the right to say that he is justified by grace alone is the man who has left all to follow Christ.

From *The Cost of Discipleship* by Dietrich Bonhoeffer

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**Scott Reichenbach – Happy to be a Resource for You**

Last month I introduced you to Scott Reichenbach who is volunteering with the Center for Medical Missions. I hope you will feel free to contact him when you have questions regarding medical missions. He has been helping get new medical missionaries to the field for several years so he will be a great resource. You can email him at [scott.reichenbach@cnda.org](mailto:scott.reichenbach@cnda.org).

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## **OPPORTUNITY TO RESPOND**

### **What does a Medical Mission Mentoring Relationship look like?**

In recent months, the Center for Medical Missions has received multiple requests to connect a person interested in medical missions with a mentor. We've also heard from sending agencies that their missionary appointees would like to have mentors. Initially, we thought we would develop some type of formal program to facilitate matching mentees with mentors, but now we realize that may not be what is needed at all.

If you have an interest in having a medical missionary mentor, will you tell us what that relationship might look like? Is it something that could be done by email or phone? Does it need to be with a medical missionary in the field today? Would a retired medical missionary be acceptable? How much time in a week, month or quarter do you picture this relationship requiring? How early would the ideal mentoring relationship begin – high school, undergrad, professional school, residency? We are looking for ideas that will give us a clearer picture of what you are hoping for.

Will you take a few minutes to write and send your thoughts to [susan.carter@cnda.org](mailto:susan.carter@cnda.org)? With the limited man hours budgeted for the Center for Medical Missions, the possibility of taking on another task is daunting. But if it is possible to put together something that will inspire, educate and equip an increasing number of effective and satisfied medical missionaries, then we want to do our best. The Lord is using medical professionals to take His message of love and mercy to some of the hardest to reach places. More workers are needed. Will you be one?

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## **Beyond the Clinic Walls – A Few Thoughts from Susan**

The majority of you reading this newsletter are still in training – be that medicine, dentistry, nursing, pharmacy, PT, OT, dental hygiene, midwifery or a host of other health professions. You are gaining wonderful knowledge and skills that the Lord can use any place in the world. We here at CMDA’s Center for Medical Missions are willing to help you any way we can and are certainly cheering you on. I imagine the majority of you are focusing on using your knowledge and skills in a clinical setting. If that is where the Lord places you, you do not want to be any place else.

For the next few months, though, I am going to encourage you to at least consider the possibility that the Lord might have you look beyond the clinic walls. In some cases that may be in addition to clinical ministry and in others, it might be exclusive of clinical service.

I write from experience. I spent the first two of my 23 medical missionary years serving as a registered nurse in a large mission hospital. After seeing the same patients over and over again and doing a review of death charts that proved 50 percent of deaths were from preventable diseases, it became very clear that something needed to be done beyond the hospital walls.

Depending on where the Lord places you, the needs beyond the clinic/hospital walls may be totally different than what I found. But those needs will be real and very important to the well-being of the people you seek to serve. Accepting that the Lord demonstrated the importance of seeing the “whole” person, reaching beyond the clinic walls is demanded.

While a surgeon or dentist may not be the one the Lord uses beyond the clinic walls, they may be the ones the Lord chooses to champion the cause. The champion is at least as important as the ones who are working beyond the walls. Can you see the possibility? Are you open to it?

Following is the first part of Dr. David Stevens’ writing on community health ministry. It is from a chapter in his newest book, *Beyond Medicine: What Else You Need to Know to Be a Healthcare Missionary*. As the one who put my feet to the cause, I know the value of everything he shares. However, that was 30 years ago so things will be somewhat different today. The principles remain. We hope this will tweak your interest.

With Dave’s permission, I have added a few comments (italicized) where I think it can add value.

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# Turbocharging Community Health

by David Stevens, MD

A good community health program can save many more lives than curative services. I saw it happen as a young missionary doctor. When I arrived in Kenya, half of our admissions and half of our patient deaths were from preventable diseases. In those days, it was not unusual to do two to three cut downs a day on severely dehydrated children after multiple attempts to get IVs in them. We had an entire ward full of children with severe measles. A quarter of them died from complications. Next to it was a ward packed with TB patients getting their daily injections for a month or longer.

I saw diseases I never treated in training. I can still hear the paroxysms of whooping cough and see the convulsive spasms of tetanus. It broke my heart to see neonates die because their umbilical cord had been cut with the dirty garden knife. Severe worm manifestations were so common that we frequently operated to remove a large wiggly bolus of roundworms that had caused a bowel obstruction.

Add to that list marasmus, kwashiorkor, severe scabies, deaths from rabies, anthrax from eating raw liver from cows that died from the disease, leeches on the eyeball, malaria, dengue fever, hydatid cysts, amebic abscesses and a host of other preventable diseases. As we treated a never-ending parade of pathology, it soon became obvious that not long after we sent a patient home, that same patient was back with the same or another preventable disease. Sooner or later, something would take their life.

The problem seemed insurmountable. We were a 125-bed hospital for 300,000 people with three doctors and six trained nurses. We were so overwhelmed that the nurses were covering the hospital at night in addition to doing all the routine deliveries. We were on a treadmill that was going faster and faster in a country with the highest population growth in the world. We were going to finally fly off the end of the speeding belt and hit the wall if we didn't do something.

Fast forward just six years. Hospital statistics and disease patterns were dramatically changing due to a grass roots community-based healthcare program funded with money from secular organizations and requiring only one missionary nurse's full time involvement. The program was so innovative and successful that the American ambassador as well as healthcare professionals from 18 different countries visited us to learn the secrets.

I say that not to blow anyone's horn but to make this point. I don't know the particulars of your present or future situation, but I know you can help people to be much healthier

with a minimal investment of staff. Whether you are envisioning beginning a program or already have one started, I'm going to share some principles that can turbocharge your program. I want you to know how a community health program can be your greatest tool for evangelism and church growth, and you don't need a MPH to do it. You will learn how to motivate volunteers to help them to be successful throughout the long haul and find out the secret of getting other people to fund your project.

Let's start with building a strong foundation:

1. Get Stakeholders' Buy In: There is often tension between those involved in curative and preventative outreaches. I know them well. Some hardcore community health purists maintain that prevention is more cost effective, requires fewer resources and is a better way to impact the community, all of which are true. But then they assert that curative outreaches should be abandoned. Of course, that is ridiculous. Community health can't cure appendicitis or prevent 100 percent of diseases. Both preventative and curative services are needed just like two arms are needed to carry a log. They complement and enhance each other. Curative and preventative outreaches need each other. Either alone is like a one armed wallpaper hanger.

Start out by seeking an understanding of an equal partnership. In the early stages, it is common for the overworked curative side to get strapped for staff and then demand the nurse or doctor involved in community health come back to help meet the urgent need "temporarily." Head this off at the pass by agreeing to take that option off the table before the issue even arises. Community health needs a full time champion fully dedicated to making it happen.

The community health side of the equation needs to recognize that the hospital or health center's good reputation is an enormous asset to what they are trying to accomplish. It saves years of time building credibility and trust in the community. In most instances it is a great advantage to be seen as an extension of that known ministry. It also makes it much easier to get funding as the program isn't seen as a risky startup without a history.

*It might be helpful to hold an open meeting for hospital/clinic staff during which you share your dream and listen to their concerns. If you have access to statistics from the hospital/community, use them to help the staff see the issue more clearly. Listen seriously to their concerns and ask for their assistance in finding solutions. There may even be a need to give missionary colleagues and their spouses a chance to share concerns. If a missionary is pulled from an existing service that will probably mean more work for those remaining.*

Don't forget to get support from other stakeholders. The national church is a major exponent. Take the time to discuss your plans and dreams with the national church leaders. Seek their advice and input. Deal with the sticky issue of whether this is going to be a church program limited to their members or a true community-owned program. Make the point that even the community health group you are starting is merely a facilitator and doesn't own the program. The local people do. They are the ones doing most of the work. Remind church officials that the program can be a phenomenal church growth tool, and they don't have to own or limit it to get the benefit they desire.

Depending on you location situation, you may need to secure the support of government officials. If nothing else, make a courtesy call to those overseeing your proposed service area. You are going to need their goodwill and cooperation.

I've learned that the key to keeping all your stakeholders happy is to give the credit away. Use every opportunity to laud your stakeholders as the program succeeds. You will get a huge return on your investment if you use public meetings, letters and phone calls to make them look good. It doesn't take much time; the more credit you try to give away, the more it boomerangs back as others say good things about you.

2. Imitation is the Nicest Form of Flattery – I knew nothing about community health when Susan Carter (now the Director of Center for Medical Missions at CMDA) and I started our community health program. We read books and articles as we contemplated our startup and then developed a list of all the questions we had and decisions we were going to have to make:

1. Should it be a church, hospital or community program?
2. Should it be volunteer-based or should we pay our community health workers?
3. Do we need trained supervisors or can we train them ourselves?
4. Do women or men make the best community workers?
5. Do we call them workers or something else? Does the term "workers" communicate the idea of a salaried position?
6. Who should select our community committees? And how should they be chosen? How big should they be?
7. What training will they need?
8. How and where should we train our volunteers?
9. How often do they need supervision?
10. How do we avoid dropout?

And that was just the beginning. If I remember right, we had eight pages of questions ranging from what sort of transport we should buy, to what topics we should teach, to asking other groups where they were getting funding. After much discussion that led to few answers, we made our smartest move. We scheduled two one-week periods away from the hospital and tried to visit as many community health programs as possible. With questionnaire in hand we asked specific questions, as well as general inquiries that helped us troll for difficulties we might not have considered such as:

11. What are your biggest problems?
12. What would you do differently if you started over today?
13. What are the three most important things we need to know to be successful?
14. How are your relationships with your stakeholders? What has gone well and not gone so well? Why?

We even mailed our questions out to those programs we couldn't visit, in order to ensure we had as much information as possible. We then sat down and reviewed the answers, dividing the remaining issues into three categories:

15. It is obvious this solutions works for this issue, and we should do it the same way the vast majority found successful.
  16. The answer is not as obvious, but here is what seems to work best. How can we tweak this solution to make it better?
17. All of the programs have this problem, but no one has found the answer. What solution can we come up with?

Let me give you an example. We asked how often each program provided supervision for its volunteer Community Health Workers (CHWs), and most programs tried to do it once a month. When we asked them to clarify the word "tried," we learned it was actually only every two or three months at best for a litany of reasons mainly involving transportation. "The Land Rover is in the shop. The Bishop needs the vehicle. The Land Rover can't get to that site because the roads are so bad. We don't have the money for the fuel for the vehicle. Someone else in our program needed the Land Rover." Vehicles had a 100 percent import duty and were so expensive that most groups only had one. We learned that those employees hired to supervise and motivate the CHWs spent the vast majority of time sitting in their offices. Visits were sporadic and infrequent; as a result, programs were losing volunteers because of it.



Realizing that volunteers required more supervision than paid staff, we did something no one else had done. We didn't buy a Land Rover. Instead we bought each supervisor a motorcycle designed for herding sheep in the Australian outback. They were built like tanks with protective bars around all vital components with powerful engines, huge knobby tires to move more easily through mud and platforms behind the driver's seat for transporting goods.

We told our salaried supervisors that we expected them to be out in the community four and a half days each week with only a half day in the office to get caught up on paperwork. They were expected to meet with each of their CHWs three times a month. During their first year or two, they were expected to spend two to three hours individually with each CHW each month visiting homes. At the first home, the supervisor would do a home assessment, teach and share a witness. They would discuss what happened after leaving the home. At the next hut, the CHW did the visit, allowing the supervisor to critique the performance and point out ways for improvement. This modeling and teaching technique fostered rapid improvement in the first year or so after CHWs received training.

The supervisor would also meet with their CHWs at the monthly community health committee meeting and at the monthly immunization clinic the supervisor held in each community. Frequent supervision, role modeling and deep relationships including praying together fostered extraordinary achievement and low dropout rates as each CHW gave two half-days each week to help their neighbors.

We would not have come up with half of our ideas if we hadn't taken the time to learn from other programs' successes and mistakes. It enabled us to avoid many pitfalls and our new program took off like a racehorse. It is always easier to do it right the first time than to change horses in the middle of the stream.

It is never too late to learn from others even if you have already started your program. Take the time to visit other groups. If others come to visit you, pick their brains and continue to learn. You are either getting smarter or you are getting dumber.

*The needs you find where you serve may be totally different. The important thing is to learn as much as possible from people/programs doing projects similar to what you hope to begin. Every hour spent learning from those who have gone before will save you weeks of "do overs" and costly mistakes.*

3. Get Training of Trainers (TOT) Education – In our medical training, the worst type of educational techniques was applied to us. Lecture is a great way to dump large quantities of information quickly on students, but most of the information goes in one ear and out the other at the speed of light. Students have to go back and memorize much of their notes or digest a textbook to be able to spit back the information they were given. They cram for the test and then quickly forgot much of what they “learned.” It is unlikely there will be any changes in behavior even if the information truck dumped on them.

How many lessons have you heard about eating a balanced diet, exercising regularly or getting adequate sleep? You can quote the data to others who themselves are unlikely to change because of it. That is because God didn't design people that way. We are more likely to change behavior when we are emotionally moved as we learn. This not only better imprints information but also motivates change. Adults learn better through humor, stories, skits, songs, pictures and other psychosocial teaching methods.

Let me give you a real life example. If you can convince people to use a clean water source, you will save lives. You could prepare a lecture, show pictures of bacteria, display graphs of cases of diarrhea from drinking river water and share drawings of fences protecting springs. It is unlikely that much will change after people thank you for bringing your presentation to the village. Here is one way we taught the subject of clean water.

Our local CHHs (we called our volunteers “Community Health Helpers” rather than “workers”) would take a donkey to the river and get a barrel of water. On the hillside in the village they would use a hoe to dig a shallow ditch down a small hill in the village and then dig a little pool at the end of it. Along the ditch they would place limbs broken off trees to imitate trees and bushes and put a sign up saying, “The Nyangores River.” It was the river that most of the people got their water from. The CHHs then invited the village people to watch as water was poured into the ditch.

First, a female CHH would come carrying a child on her back, her dirty clothes under her arm and a box of “Omo,” the local laundry soap. The “river” would fill with soap suds that washed down to the pool at the end as she washed the laundry.

Then a man would come pulling his cow to water it. The cow would dislodge lots of dirt, sticks and leaves into the “river.” The next man to arrive would look around pretending to find a private spot and then urinate in the “river.” Well at

least it looked like that as he used water in a squirt bottle hidden under a blanket draped around him. Finally the last man would come holding his stomach in obvious pain. He would squat by the river and appear to have diarrhea into the water flowing down the ditch.

By this time the women in the audience would be throwing their wraps over their heads, shaking with embarrassment and laughter. Another CHH actress would arrive, dipping some water from the pool, taking it to her “husband” for him to drink. Within minutes he would be yelling in pain and holding his abdomen while his “neighbors” put him on a stretcher to take him to the hospital with much shouting and consternation.

Then one of the CHH would ask the jabbering crowd some questions. “What did you see?” He thanked the attendees for their responses until all the elements of the skit were identified. Then came a very important question which helped the people take it from a humorous skit to applying it to their own lives. He asked the question, “Do you see these things happening in the river where you get your water?” When the community people said “yes,” he dug a little deeper asking people to share their own stories. This allowed more of the group to start thinking of this through their own life experiences. The next question was, “What was the problem?” That is when things normally started to get interesting. Eventually someone would say, “The water made him sick.” Thanking the person for that answer the CHH asked “Why did the water made him sick?”

Someone yelled out, “There was too much sugar in his tea!” Other responses also missed the point until someone said, “I think the water was dirty. I’ve heard that the river water has small animals in it that can make you sick.” After discussion, everyone agrees.

The next question would be, “How can you get water to drink that does not contain the animals that make you sick?” Someone may state they know someone who gets their water from a spring and they don’t seem to get sick. Other attendees may admit they don’t have a spring.

Then someone would say that they know people who boil the water to kill the animals in it that make you sick. When people agreed that could help, the question was asked, “How should you boil the water?” and the whole group would be invited to gather around the fire to see a demonstration on boiling water and protecting it from contamination. Of course, other options for clean water would also be discussed.

The training may take a couple of hours, but no one forgets what they learned and many change their habits. They not only had an emotional experience but they frequently say, "You didn't teach us anything. We taught ourselves." The TOT course teaches you to think differently, teach in a much more effective way, understand community dynamics and much more. It is now available all over the world. To find a TOT course check out:

<http://www.medicalambassadors.org/training.html> or  
<http://www.equipinternational.com/training-courses/schedule.htm>.

*I hope I do not offend anyone with what I'm going to write. I have a MPH from Johns Hopkins School of Public Health and I also completed TOT 1 and TOT 2. I am thankful for all my educational opportunities, but without hesitation I can say that it was the TOT courses that equipped me to work in the community. The MPH was important for credibility with some outside the community, but I was well equipped to be a community health champion after the TOT training. I counsel EVERY medical missionary to attend at least TOT 1 before heading to the field. Yes, I believe it is that important. Those that have attended TOT training agree!*

To be continued in February

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If you are interested in learning more, you may purchase Dave's book, [Beyond Medicine: What Else You Need to Know to Be a Healthcare Missionary](#), at the CMDA bookstore.

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## **A Whale of a Paradox--Be Afraid and Fear Not**

by Judy Palpant

***Fear is a remedy against presumption. Fear is that flaming sword that turns every way to keep sin from entering. Fear quickens; it is an antidote against sloth. "Noah...being moved with fear, prepared an ark..." (Hebrews 4:1, KJV).-- from Puritan preacher Thomas Watson's sermon "The One Thing Necessary," preached in London in 1656***

"Nana, when you pray for me, sit on your knees!" insisted three year-old Madeline.

"Of course, honey!" I said as I folded down beside her bed. Trust me, on or off my knees, I was not about to pray a glib, perfunctory prayer for this grandchild of mine. Sweet sleep is rare for her. A recent tonsillectomy helps her breathing at night. Still, congestion persists. Not to mention night terrors and fear of the dark.

And to be honest, I rarely pray on my knees. When our children were teenagers, I occasionally fell asleep in that position by my bed. Here I was again, beside my granddaughter. As I began to pray for Madeline, Scriptures came to mind: Isaiah's vision--*and a little child shall lead them (Isaiah 11:6, NASB) along with Jesus' admonition--unless you change and become like little children, you will never enter the kingdom of heaven (Matthew 18:2, NIV 1984).*

Madeline called me back to an inward and even an outward position of humility before God. She reminded me of the young boy Pip, a character in the classic book Moby Dick. His fear drove him to prayer. At the end of chapter 40, Pip describes the night Captain Ahab makes his crew swear to kill the whale: *And only this evening--it makes me jingle all over like my tambourine--that anaconda of an old man swore 'em in to hunt him. Oh! thou big white God aloft there somewhere in yon darkness, have mercy on this small black boy down here; preserve him from all men that have no bowels to feel fear.* Ahab's defiant bravado forced Pip to fear and trembling. He cried out to God for mercy.

In my landlocked world, other reasons produce fear--that visceral response to dire circumstances. Friends with agonizing problems, including brain cancer, panic attacks and a fresh divorce, draw me into their pain. My prayers for them take on new urgency. Oh, for one of God's great angels to appear to them and say, "Fear not. The Lord is with you."

But Pip also longed to see Ahab exhibit "bowels to feel fear"--a healthy reverence for God that would guide his actions. Here we see the other side of the coin--a shift from "fear not" to "be afraid." The Apostle Peter describes this kind of fear: *Since you call on a Father who judges each man's work impartially, live your lives as strangers here in reverent fear (1 Peter 1:17 NIV 1984).*

There is something about serving in a foreign country that forces a person to live in this way. In Kenya, we struggled with inadequacy, isolation, lack of provisions and the unknown. We overcame initial worries and insecurities with time, perspective, familiarity and experience. But healthy fear remained. It kept us from self-sufficiency, ever aware of both real perils and God's promises wrapped into one package.

Years ago I read lines from a young missionary woman's journal. Krista, at 25 years of age, served with the Mennonites in Bolivia. Here is her "gratitude" list: *I thank God for*

*the women who get along, the stars, fear, answered prayer and the peacefulness of space.* We resonate with four out of the five blessings--but fear? I believe Krista refers to the healthy kind that keeps one alert, that guards and guides one's choices out of reverence for Almighty God. Trusting our all-seeing, all-knowing and all-powerful Shepherd allows us to fear God and nothing else.

A grandmother falls to her knees. A young sailor calls on God's mercy. A 25-year-old missionary recognizes her reverential fear as a good thing. So here is my short list of "be afraid's" to speak to my own soul:

Be afraid to allow resentment to swallow me whole.

Be afraid to squander time comparing myself to others.

Be afraid of shrugging off what I should shoulder.

Be afraid of hearing the Word and not doing it.

What would your list include?

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