Missionary
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The magazine of the Baptist Missionary Society

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'Without health life is not life' (Ariphron)

'and Jesus gave them authority to heal every disease and sickness' (Matthew 10;1)

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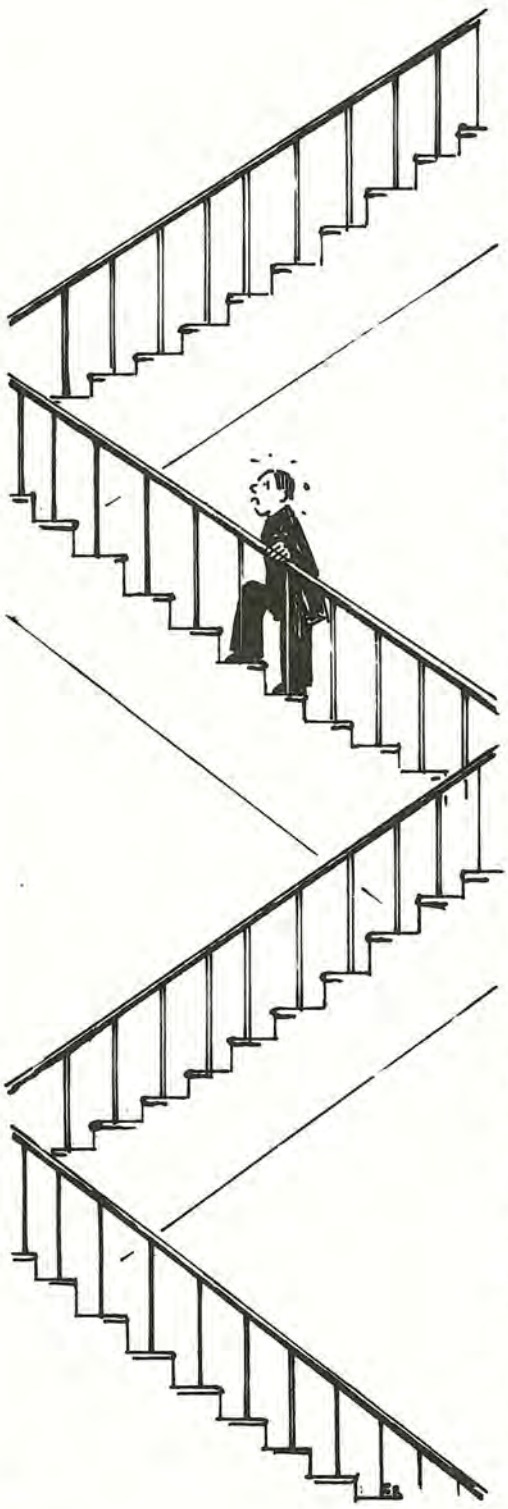
CLIMBING THE STAIRS TO A HEALTHY START..

by **Dr R Rathbone**



In order to reach the Medical Department at the Mission House it is necessary to climb four flights of stairs! Only those who are sound in wind and limb arrive. There was clearly planning with considerable insight at some stage in the past!

Making sure

A missionary will probably have had his or her first contact with the department as a candidate. Before being interviewed by the Candidate Board the applicant will have had a full medical examination to ensure that he or she is of sound health physically to live in a different climate and is emotionally capable of withstanding the pressures of missionary life overseas. Sometimes a problem is discovered and the Candidate Board is then advised whether or not the condition is likely to respond to treatment and, in the event of the candidate being accepted, how long it might be before he or she would be fit to commence service.

Once it is known that a candidate has been accepted and to which field he will be going, the medical department advises concerning vaccinations. It is not just a matter of conforming with the regulations of the country concerned but also considering which other immunizations would be wise in order to protect the missionary as fully as possible. Included in this is protection against malaria and tablets are provided for this purpose, usually for the whole length of the term of service. Information is also given about taking care of one's health in tropical climates. A few weeks before actually going overseas the missionary has again to climb the four flights of stairs for a final health check.

Circumstances alter cases

While overseas the degree of contact varies enormously. Clearly if there are no health problems then there is no reason to make contact. If however problems do arise then much depends on the services available in the locality. In some situations there may be a mission hospital to which the missionary can go, or the local care may be good. But sometimes it is necessary to advise a missionary to travel to a particular centre to obtain a specialist's opinion and occasionally suggest that they should return home for treatment. In the event of this happening arrangements will be made for admission to a hospital here in this country or an urgent appointment will be made with a specialist. The missionary will be met by someone from the department at the airport whenever possible and the appropriate help and information given. Happily this situation only rarely occurs.

When the missionary returns on a normal furlough they are seen at the Mission House for a full medical check as soon as can be conveniently arranged. An examination is carried out and a number of tests arranged to try to exclude any unsuspected tropical illness. The services of the Tropical Diseases Hospital, which is conveniently located, are used for this purpose. If something is revealed the missionary is advised how to obtain treatment. Should an illness or health problem come to light during the examination then, as at the candidate stage, arrangements are made for investigation and treatment, if necessary by a specialist.

The use of the furlough

It is during the furlough period we hope to be of particular help. There is a fully trained nurse in the department every day and available on the telephone. When someone is visiting the Mission House they often brave the four flights and have a word with her. Such a conversation will frequently dispel a worry or ensure that the correct medical advice is sought. In the event of someone being admitted to hospital she will try to visit them if at all possible . Towards the end of the furlough the missionary's health will be reviewed together with the vaccinations. He or she will be given another supply of anti-malarial tablets and perhaps be asked to take to a colleague on the field a special course of drugs which cannot be obtained locally. Supply of such drugs is arranged by the department and the cost met by the Society, as is a large proportion of the cost of medical treatment overseas.

The strains of service

In this day and age of easier travel terms of service overseas have tended to become shorter. Consequently furloughs are more frequent but proportionately shorter, which sometimes creates problems if a course of treatment is necessary. This trend means that a physical illness is less likely to reach an advanced stage and if an emergency occurs a flight home can usually be quickly arranged. However the pressure of working in some situations is perhaps becoming greater with the difficulties of the developing nations and the upsurge in nationalism. These pressures can, and do, influence health. The Medical Department tries to provide a service for those overseas in a preventive way and also be someone to whom they can turn in times of need.

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COMMENT

Anyone who has been abroad and suffered the misfortune of being ill will have no illusions about the boon of our national health service, despite its imperfection and its cut-backs. Even if an overseas traveller has avoided accidents or illness it is likely they will have gathered something of the cost of medical attention in other countries.

In these countries, which are often designated 'the west', whether they have a national health service or not, most have a very good ratio of doctors to patients. It is therefore not easy for those living in these favoured areas of the world to appreciate that in many parts of the so called third world the number of doctors to attend the sufferers is lamentably low and that many people are removed from a doctor by many many miles.

Even if it is possible to devise a means of getting a sick person to a hospital the family concerned is faced with a frightful dilemma. Who will go with the patients to prepare their food? How will the children who have to be left behind in the village be cared for? Who will cultivate the land while those necessary are away at hospital? Since in the village one lives off the land, how will one get money to buy food in the town where the hospital is?

These and many more such questions have to be faced and answered and this is no easy thing. Indeed the problems seem so great that many do not even bother to try and the one who is ill goes on suffering.

Advanced medical knowledge is able to protect us against so many things which a few years back were quite serious illnesses so that today we think nothing of such diseases because there are drugs to control them. But what happens when there is a disastrous shortage of drugs as in Zaire? What do you do when a simple children's illness like measles becomes a killer because the child's body just hasn't the natural resistance to it?

Prevention then becomes more important than cure. There is an urgent need to teach hygiene and to persuade people that nutrition can play such an important part in the well being of the community.

For example, smallpox, with its ghastly disfigurements and the scourge of so many parts of the world, has been practically eradicated through vigorous public health programmes.

Through similar campaigns measles is now being attacked, and hopefully, by immunization, this will be brought down to the level we enjoy in the west, but here again this process is hindered by a shortage of vaccines in Zaire.

The question we have to ask is, 'Is it the right of everyone to have medical help available in their time of need?' It is quite clear how Christ viewed disease. He regarded it as against His Father's will and as a disrupter of the fulness of life He proclaimed. As Christians then, walking alongside the Lord, we have an obligation to engage in the healing of the body and the prevention of disease as we declare God's love and concern for the whole man.

In so many parts of the world today our missionaries are engaged in this great battle against disease and against the causes of illness. Under fives clinics and public health programmes are organized to build up a knowledge among the population which will help them to combat the attacks of disease.

In this issue we have invited a number of those employed in this great work to tell something of their share in the work of healing but we have not only invited nurses or doctors to speak. We have also taken a look at the administration aspect and the building side of the hospital service overseas, and the part played by local custom and superstition.

New ward at Pimu Hospital, Zaire

HEALING IN CHRIST'S NAME AT PIMU*

by Kathleen Ince, nursing at Pimu, Zaire

As I was shown round the hospital for the first time I tried not to look horrified when I saw a nurse, wearing neither a sterile gown nor even a mask, deliver a baby by the light of a small hurricane-lamp. I was then taken to one of the main wards which sounded more like the local market place than a hospital; babies yelling, children playing and people talking nineteen to the dozen. There were some beds without mattresses, others without sheets and not a nurse in sight. The one nurse on duty that evening was delivering the baby. Such was my first taste of life in a mission hospital.

Finding the sick child

One of my early tasks was to nurse a seven-day old baby girl who was ill with tetanus. My attempts to give her sedation and quietness were somewhat frustrated by a convoy of wailing relatives. Having overcome this first problem, I would then, very often, find the room empty when I came to attend the sick child. Sometimes I would discover Mum sitting outside under a tree giving baby a bath. Other times I would be told that Mum had gone off with her child down to the river for water, into the next village for food, or to the local witch-doctor to find out why the baby was ill. My question, six weeks later, was not, 'Why was the baby ill?' but 'How on earth did she manage to get better?' I soon became aware that nursing in Pimu was very different from that prescribed in the text books!

I had much to learn about the life style of the people with whom I had come to live and work. Again in my early days there, I was with a group of student nurses dealing with fractures in a first-aid class and explaining all the correct procedures prior to transporting the patient to hospital. 'What do we do if we're thirty miles from a hospital?' asked one. 'Anyway' said another, 'the local medicine man can deal with fractures.'

The nagging question

I had to face many probing questions from the students but found that I was also asking myself questions. 'Why didn't the parents of this sick child bring him sooner?' 'Why didn't this mother in labour for three days come before her baby had died inside her?' I was angry and hurt by my failure to win the battle against pain and disease; angry and hurt that people suffered so unnecessarily. It was easy to blame them for not coming to the hospital sooner. 'But why didn't they come?'

Because first of all they would try their own methods of treatment, or those of the local dispensary. Perhaps they would go to the witch-doctor in order to find out the cause of the illness and to buy a fetish to protect the sick one. Even when all these failed, the decision to go to the hospital would still have been a difficult one because it meant leaving children behind, leaving the security of family and village and leaving the garden which was the source of their food. It meant having sufficient money to make the journey

A village clinic

Accommodation for relatives

and to buy medicine and food while at the hospital, and in the case of the young mother it meant finding someone to carry her there.

Going to the people

Sometimes the journey for treatment can take two or three days, as the hospital at Pimu serves an area the size of Wales. It can reach the people around its doors without difficulty but what about those who live further away? A minority will come to the hospital but many more will suffer in their own villages. A large number of the diseases encountered in Zaire are preventable, for example measles, whooping cough, polio, tuberculosis, intestinal worms, venereal disease, and dysentery. So public health work is of great importance. Each month 18 villages are visited by a team from the hospital and every effort is made to get the chiefs and the menfolk, the influential people in the village, to attend the sessions. There are antenatal clinics and clinics for children under five years old. Much can be achieved in the way of preventing diseases as long as vaccines and drugs remain available and vehicles and fuel continue to make the villages accessible.

The dilemma

Yes, it is obvious in theory that prevention is better than cure, but not so easy to apply when on a public health trip you meet a family with a sick relative and they beg you to take them to the hospital, 20 miles back along the road. Is it to be prevention or cure? Do you deal with a 100 children waiting in the village ahead of you for vaccination or a sick person needing urgent treatment at the hospital? In front of a distressed family a calculated decision has to be made in terms of time, precious fuel and, of course, lives to be saved.

So the work at Pimu goes on. Diseases are prevented, sicknesses treated and nurses trained. The vision is there but often it becomes obscured by unavailability of drugs, shortages of fuel, broken vehicles, lack of trained nurses and tensions between national and missionary staff. However, all this is only part of the story; the treatment and prevention of disease is only one aspect of the ministry of healing.

More than physical health

It is easy to be so busy attending to the routines of medicine that people become excluded. I believe that if as a medical missionary I am only offering physical health, then I am failing my African brother and sister. Christ came to make people whole, and healing is more than an absence of physical symptoms. It involves more than pills and operations. The people we treat are not just a case of tetanus, a girl in labour or a child with measles. They are people who belong to a family, people who are part of a community and people for whom right relationships are so important.

They are also people whose body, mind and spirit are not segregated into separate compartments; together they form the whole person and illness must be seen in this context. So often people come to the hospital to find relief from their symptoms but they also visit the witch-doctor to find out why they are ill. Surely here is a ministry for the Christian nurse who serves the One 'in whom all things hold together'. Jesus Christ forgives the sinner, he heals the sick, he feeds the hungry, he casts out devils, he releases people from the fears and powers which control them. Only he can bring man true wholeness and healing.

A group outside the hospital

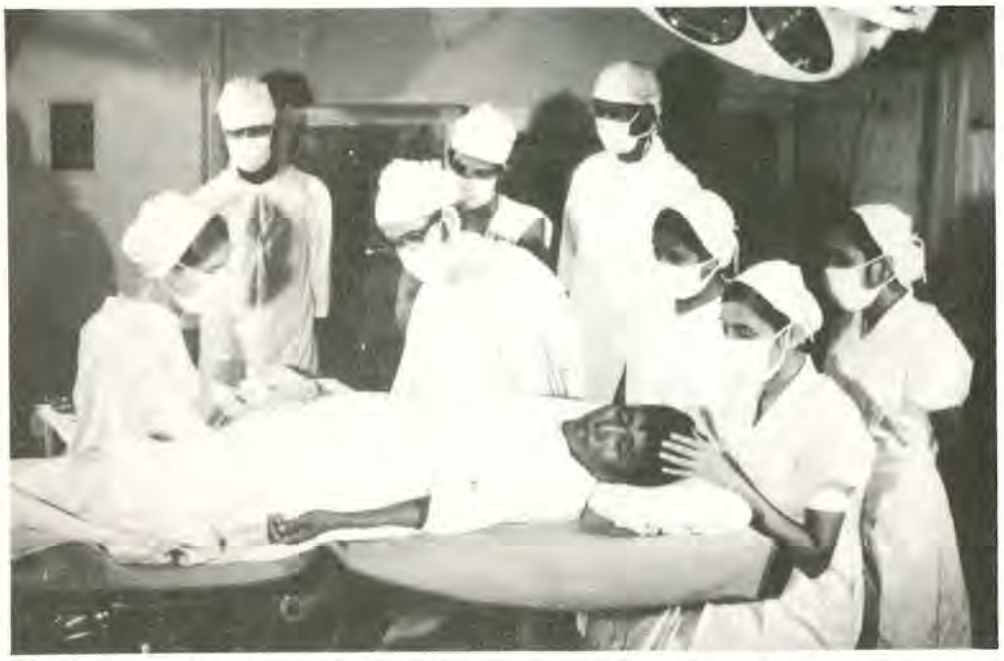
Wholeness means sharing

Wholeness does not come only from the surgeon's knife and the nurse's injections. Wholeness involves sharing life. So often it is easier to give than to share because sharing means involvement and this can be costly. But this is what healing is all about: sharing birth and death, work and relaxation, sharing joys and sorrows, sharing pain and fear, all the events which make up life, but above all it means sharing Christ who alone brings meaning to life. The medical missionary is then not totally absorbed with the temperature chart and the infected wound but is involved in counselling, confession, forgiveness, and helping people to find release from fears and powers which make them less than whole. In giving out pills to relieve a woman's abdominal pain, one can fail to see that the real pain is caused by fear, fear that her husband is blaming her for the death of their child.

Through sharing, life becomes so much the richer. Instead of seeing a ward full of relatives who are a nuisance one begins to see the value of people being cared for by a loving family who, though they do not appreciate the importance of quiet, certainly appreciate the strength of right family relationships and understand that life is not individualistic but is as a member of a community.

It is in sharing life, the good and the bad, the sad and the joyful, as well as in preventing disease, treating illness and training nurses, that we as medical missionaries can play our part in bringing true healing, that wholeness which can only be experienced through Jesus Christ.

*This is the address Miss Ince gave at the Annual Assembly medical session and which we were asked to print.



WORKING OF THE

Operation at Chandraghona Hospital, Bangladesh

'Would you care to join us in the Operating Theatre one morning when you are not too busy in the office? I think you would find it interesting. I have a gastrectomy booked for Thursday if you could be free then' said the doctor one day.

Lost in wonder

Thursday dawned . . . with some apprehension I, the hospital Administrator, prepared to enter the theatre wearing the regulation gown and wondering whether my head and stomach would rebel at the strange and gory sights. However, I need not have worried on that score. I found the operation so interesting and absorbing and the surgeon's skill as he undertook the intricate work so impressive that all else was forgotten.

What extensive knowledge of the human body is needed by the doctor and how courageous he must be to accept the responsibility under God for the life of another person and make the necessary vital decisions as the operation proceeds! I found impressive, too, the skill, knowledge and discipline of the supporting team in the theatre.

Office work laid bare

I then let my thoughts turn to comparison. Supposing I invited the surgeon to visit my department in return. Would he find anything impressive or anything to admire in the maintenance, supplies, general office or accounts work of the hospital? I felt he might well express surprise should he visit the stores and discover how wide a range of medicine is kept. Then again he would certainly feel exhausted at the end of the day if he joined the Stores Manager in a buying trip to the city, twenty five miles away. He would need to leave early in the morning by the hospital vehicle and spend the day, at some seasons of the year, in intense heat and humidity, or at other times in torrential rain, going from warehouse to warehouse in search of drugs which are in short supply yet so vital for the continuation of the work of the hospital. There are many other items also which need to be sought and bought at reasonable prices.

Emergencies happen

Of course there would be no need to remind the surgeon how dependent the theatre is on the co-operation of the Maintenance Supervisor and his staff. Their expertise in servicing equipment such as sterilisers and dealing with emergencies such as fixing up a temporary supply line in the event of a power failure is so important. What long and exhausting hours of work are put in by the construction and maintenance sections to restore the situation to something like normal in times of flood and cyclonic storms when power and telephone lines, water supply pipes, fences, even houses and other structures are damaged, often all at the same time. It is no easy matter either to maintain vehicles in running order when spares are practically unobtainable or very expensive and road conditions reflect the violence of the monsoon storms.

Four and eight are equal

Yes, there is certainly some drama and excitement, skill and endurance demonstrated in dealing with situations arising from the damage caused by storm and flood, and in other emergencies which arise from time to time. It is true that the office has a contrastingly quiet time on the whole but there are occasions when pressure of work can be great and certain qualities are called for which may well draw commendation. Those clerks, for example, whose mother tongue is Bengali. How persistently they work preparing, calculating the figures and typing bills in English. For them the figures can be particularly confusing because the figure four in Bengali is indicated by the same symbol as the figure eight in English! With most of the records written in English clerks, cashier and accountant must all be competent in that language as well as in their own tongue. It is true that there is not the inescapable discipline of having to meet the patients' needs on time, but there is another form of discipline provided by the deadline for the weekly payment of wages to the casual workers and the monthly salaries for the staff together with the stipends for the students. Woe betide the office staff if there is any delay with such payments! Dire penalties await, too, if the accounts are not complete in time for the annual audit and how many painful and exhausting hours can be spent balancing the books!

The main requirements

What, I wonder, would the doctors and nurses feel is most necessary and helpful to them as they carry out their 'front line' duties? Suitable staff and premises; an adequate supply of medicines, drugs and equipment; regular and expert maintenance of plant and machinery and the knowledge that this will be done promptly when requested. These, it would seem to me, are the main requirements, but sometimes the implementation is delayed or hampered by lack of funds at the time. This may be due to the fact that in a number of cases, for good reasons, treatment is not paid for on the spot and there is a waiting period while

AS ONE TEAM

The entrance at Chandraghona Hospital, with a baby taxi

bills are prepared and sent out to be settled when and how the patient can manage. This results in an irregular and often inadequate cash flow so help has to be sought from the Society or other Funding Agency towards this need of working capital. Budgetary control of expenditure is of course very important but how difficult to estimate future income from patients' fees and to ensure that, under the pressure of work with a limited staff, the books are kept up to date so that the present financial position can be speedily ascertained and steps taken to reduce expenditure as and where necessary.

A shortage of funds for day to day running of the institution may also be due to lack of faith in asking for help. It is well known that it is always easier to encourage donations for pioneer and extension work on new buildings and projects than for the maintaining of existing work and property because this seems less exciting and glamorous. There is therefore a tendency when budgeting to assume that annual grants for day to day expenditure will have to remain at much the same figure from year to year. If however certain essential expenditure is not being adequately covered, such as maintenance of property, depreciation of plant and equipment and the like, then to act on such an assumption is neither wise nor an act of faith. We should make the needs known and ask in faith!

John Davies

Extra activities

It is good to record that there are other areas in which faith is being exercised with the result that valuable grants have been requested and made available for the construction of essential new buildings. We thank God for these grants and for the builder provided to supervise the work. Furthermore the Medical Superintendent in recent years has prepared an annual budget covering the estimated needs for supplies and equipment unobtainable in Bangladesh and for special construction work and projects for the improvement of facilities within the compound. This budget has been very generously considered and implemented by a West German charitable Funding and Mission Agency.

The hospital does not receive any grant from the government of the country but good relations exist with various officials and help would not be refused without good cause. Leprosy patients are for the most part very poor and pay virtually no fees, but the leprosy work on the other hand is supported by an annual government grant. The work of clinics serving the people where they live is particularly favoured by government health officers.

There are many activities from time to time within the compound which do not come directly under any department but which are very much a part of the life of the community and benefit many folk. These claim much time, thought and energy on the part of those called to organize them. The Medical Superintendent is often to the fore in initiating and organizing such activities which may involve the setting up of a large marquee and other arrangements to make the compound a suitable venue for a Christian Medical Conference, a Training Camp or Revival Meetings. Many people can be influenced and helped by these occasions and such events are deserving of much prayer.

Very worthy of mention, too, are the activities organized at Christmas and New Year for which there are many helpers from the church and hospital. The weather at that time is perfect. Brilliant sunshine with a moderate air temperature during the middle hours of the day are ideal for organized sports and for the open air fellowship love feasts. These are of rice, curried fish and meat for the families of church members and congregation. Patients, too, are presented with a special gift of fruit and confectionery on Christmas Day and those able to walk or are easily transportable have the opportunity of seeing scenes from the Bible nativity story acted by the children of the Sunday School.

The healing ministry is undoubtedly the spearhead of the Lord's work in a mission hospital but as we have seen there are many sides to the work or as St Paul puts it 'the body has many members . . . set by God as it has pleased Him'.

by **John Davies**

Another View of Working

by L F Wallace

*This article has been reproduced from *Building Technology and Management* by kind permission of the Editor. The illustrations are by George Craig. Mr Wallace writes about work at Chandraghona Hospital.

I thought it might interest readers to hear a little about work in under-developed countries through my own experience as a happy and content voluntary worker, mentioning not money, but the problems, misunderstandings and confusions which can arise in the course of work.

Before I launch into my adventure story let me relate a few facts about this new country, Bangladesh, which covers 55,000 square miles and has a population estimated to be 80 million. The country, at the head of the Bay of Bengal, is almost entirely flat. It is a region of great rivers (Ganges, Brahmaputra, Padma, Jamuna and Meghna), lakes and islands. In the summer monsoon season the area floods extensively. Land is almost entirely used for agriculture and the countryside is lush, green and fertile. All the cities and towns, with the exception of Chittagong, lie on flat alluvial ground and each one is heavily populated with their streets very crowded.

From Northern Ireland to Bangladesh

When I left Northern Ireland for Bangladesh, I had eight years experience in the building and civil engineering industry with contractors and with the Local Authority.

When I arrived in the country and was driven from the airport to my first destination, I noticed many things: open drains, shuttered windows everywhere, flat roofs and steel security screens over the windows of large houses. Buildings were of many types 'pukka' (brick or concrete) and 'kutcha' (tin, bamboo, grass). But for countless people the road was the bed and the sky the blanket.

I remember saying to myself, 'No problem supervizing here; bricks and concrete seem to be well known materials and are much used, so I should have no difficulties'. With that I settled into my seat content that I would have my building up inside two years and return home to building sites in the UK.

The first two months were spent in language study, getting orientated and trying to fit into the culture, which is essential in order to have a happy relationship with the national fellow workers. For example, the simple sign of 'thumbs up' for okay is used for something very different here, so you can see how easily simple expressions can cause offence without your knowledge.

'Thumbs up' means something different...'

Unexpected responsibilities

Eventually I moved to my permanent base at Chandraghona in the Chittagong Hill Tracts, a district of hills rising to 3,000 feet, bordering on Burma, and largely inhabited by tribal people. It must be the most beautiful place in which I have ever worked, surrounded by hills and with a river close by which has a constant stream of boats ferrying people and their supplies to and from the 'bazaars' (markets). The people are the friendliest I have met. In spite of their poverty they are very hospitable and to refuse a cup of tea and a local biscuit would cause great offence. It can be very trying having to drink tea at every call but it is a blessing when you need a rest out of the heat and a drink to quench your thirst, as local water is undrinkable unless boiled.

Next I began to find out about my project. I made my way towards the main hospital building to enquire about my work and about the plans. I discovered that a building committee, to which I had been co-opted, would be meeting shortly. In due course I joined the other members and before I knew it I was secretary then before I had time to blink over that the convenor said he was going on six months furlough and proposed me as acting convenor. But there was more to come. I was told calmly that I had to build four buildings and that I had to prepare the drawings and estimates, order the materials, keep the accounts, and organize the construction work! I was getting into a state of mild panic and kept thinking that at home there is a person for each one of these jobs and how much more I would need the

g Overseas

assistance of these specialists in a strange environment.

Things add up to 'Help!'

I resigned myself to attempt the project, spurred on by one thought: I would be boss with no site agents to badger me. I began the process of gathering all the facts, design criteria, position of site, source of electric and water supply etc, and eventually after many sketches, produced a layout that was acceptable to all, and from there produced a detailed plan. During this stage I had begun to doubt my suitability for the job. Design was so different and I faced requirements previously not experienced. Verandahs were a must to provide shade from the sun; mosquito netting and security screens had to enclose this area and that; cross-flow ventilation with unrestricted passage through all the rooms was called for; as well as a damp course include an ant course; then, instead of 11" cavity walls you have 10" solid walls between the beams and columns of the structural frame because this is in an area which receives earth tremors. There were so many other things too, all of which added up to 'HELP!'

When I started on the job of estimating, panic struck. Where do I get my prices? Where are the timber merchants, the hardware stores, the concrete suppliers? Where are the manufacturers and all the other essential suppliers who make it possible for a building project to run smoothly?

'You can't just buy those!'

I contacted a member of the building committee and put these and other questions to him. He looked at me quite startled. He thought I was mad and said, 'Standard window sections? Door framing? You can't just go and buy those here son; Send men into the jungle to cut some trees and the joiner will make the doors and window framing and anything else you want, whatever size you want.' After a few moments of what appeared to me to be troubled thought he said 'Still, I wouldn't use wood if I were you. The white ants will eat it,' and he proceeded to show me where, sure enough, ants were merrily feasting on a teak door frame.

This was but the start. The problems began to thicken. For instance, there is no stone. You buy burnt brick and pay for men to break it up to the required size for aggregate.

Sand is obtained from three sources: (1) you don't ask (2) the river (3) the hills and it is all the same grade; 50% impurities, 50% sand.

Local cement was not good enough so I had to import about 300 tons.
Bricks are standard in only one way, you can guarantee they're all different dimensions.

I used bamboo for shuttering props and also for scaffolding. Factory inspectors would have a heart attack if they saw the precarious methods employed to carry out work. There are always numerous accidents because someone didn't tighten the cord (not bolt) enough when fixing the ledgers to the standards. Ladders are also a problem. They always break, but no one knows why. Yet there is a good side of using bamboo, its low cost and the enjoyment of going to buy it.

There are two sources, from the main supplier, or its offshoots. We chose the offshoots. So we set off up river in our speedboat and made our first stop at a small village. This village, like so many other villages on the edge of the river, was in a beautiful setting. There were boats of all sizes and canoes tied up at the bank with children playing pirates in and around, a haven of rest for anyone in search of paradise. People lined the bank to greet us, with the head man eagerly awaiting to find out how much bamboo we wanted.

Concreting at 80 in shade

We went to see an old friend who, as usual, brought out the tea and biscuits, and then we toured his garden where there were lemon trees, banana trees, pineapples, betel nuts, rice, wheat and even cattle, which turned the conversation to artificial insemination. As the monsoon was over I decided to see where I could obtain river

Another View of Working Overseas

(continued from previous page)

sand along the river banks. After that we had a swim, so you can see how enjoyable buying bamboo can be, especially with the hot sun.

The bamboo was later delivered by sampan and carried from the river by kullies to the compound.

But I really hadn't seen anything until it was time to concrete, with the sun blazing down, creating a temperature of around 80 in the shade. Well, as any good supervisor should, I worked out the mix accurately (1, 2, 4) and the water content. But on this occasion I was flabbergasted. No sooner was water added than it evaporated. I turned for sympathy to my 'mistri' (ganger), who quickly filled me in with the details, which were simply 'keep adding water'. So water was added, and added, and added, and added. By this time I had deduced that my mix was weakening just as my knees were, but this appeared to be the method employed, I left them and hoped for a miracle which so far has been granted.

Monsoon rain on cement

The project is not anywhere near completion yet, and I have had many other experiences such as the time I had upwards of 100 men unloading cement from a barge to the 'go-down' (store). This was really all head work for there is no other means of carrying than on the head. Then the rain started. Unlike home, I had to bargain for half an hour before the men would stop work. For the next 30 hours it rained and rained and rained. I spent the night lying on a camp bed, fighting the mosquitoes, waiting for a call to say the barge and cement had been swamped. It wasn't, quite, but I still lost about ten ton.

'Used bamboo for scaffolding'

As you may have gathered, one needs to be something of a nonchalant type to work out here and you have ample opportunity to mix business with pleasure.

There are many frustrations and problems but one can usually see the lighter side. The reason for my being here, and that of my organization, is for relief and humanitarian assistance in projects which help people in areas of special disaster and consequent need. With this aim for 'Working Overseas' a person cannot feel disappointed, for even a little effort on his part shows on the faces of those he seeks to help.

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The Secretaries acknowledge with grateful thanks the following legacies and gifts sent anonymously or without address.
(1-30 July, 1977)

General Work: Anon: £5.00; Anon: £5.10; Anon: (Cymro) £4.00; Anon: £5.00; Anon: £4.50; Anon: £25.00; Anon: £2.50; Anon: (Cymro) £10.00; Anon: £10.11; Anon: £5.00; Anon: £25.00; Anon: £1.20.

Women's Project: Anon: £5.00.

Legacies	£ p
Mr F Beazer	400.00
Mrs A A Bright	200.00
Rev H W Burdett	3,478.10
Miss O M Coats	5,771.67
M Horace Cook	500.00
Miss Ada Davies	823.90
Mrs W Davies	500.00
Mrs O L Day	400.00
Matilda V Eves	50.00
Miss D B Firth	100.00
Miss E M Forbes	300.00
Mr H D James	41.82
Miss K A Leigh	188.49
Miss D Lord	2,750.00
Mrs I A Mead	51.50
Miss S H Preston	181.90
Mrs M G Pritchard	54.93
Miss M P Shore	3,000.00
Mr V R I Suhr	1,185.00

MISSIONARY MOVEMENTS

Arrivals

Rev and Mrs A Ferreira on 6 July from Curitiba, Brazil for Porto, Portugal.

Miss E Newman on 7 July from Zaire British School, Kinshasa.

Miss B Draper on 7 July from Bolobo, Zaire.

Miss J Comber on 7 July from IME, Kimpese, Zaire.

Miss E N Gill on 7 July from IME, Kimpese, Zaire.

Dr and Mrs D K Masters and family on 13 July from Pimu, Zaire.

Rev and Mrs D C Norkett and family on 14 July from Kinshasa, Zaire.

Miss P Woolhouse on 14 July from CECO, Kimpese, Zaire.

Mr and Mrs C Sugg and family on 15 July from Upoto, Zaire.

Miss A L Horsfall on 18 July from Kisangani, Zaire.

Mr and Mrs D J Stockley and daughter on 20 July from Rangunia, Bangladesh.

Miss J Whitelock on 20 July from Dacca, Bangladesh.

Mr and Mrs P Riches and family on 21 July from Yakusu, Zaire.

Miss V Hamilton on 27 July from Dinajpur, Bangladesh.

Rev and Mrs P D Brewer and family on 27 July from Trinidad.

Departures

Miss G S Evans on 3 July for study in Brussels.

Miss S Finch on 20 July for New Delhi, India.

Rev and Mrs S B Christine on 26 July for Language School, Campinas, Brazil.

Death

In Cardiff, on 15 July, **Dr Alice Muriel Fellows,** widow of Rev B F W Fellows (India 1923-1951).

Thank you for your help!

Many people responded to our plea for help with regard to a source of supply of composition for the print rollers at Yakusu. We are pleased to report that this help has enabled us to obtain some. We are grateful to all who contacted us.

SERVING THE LORD

IN BRAZIL

John and Maria Dyer are in membership with the Crofton Park church, London. John's call to serve the Lord overseas came while he was at Spurgeon's College. However, he first became interested in missionary service through the work of Miss Marjorie Webber (now Mrs Hitchcock) who was then a member of his home church at Holmesdale Road, South Norwood and serving with the BMS at Bolobo.

He describes his call as coming to terms with the inescapable challenge of Christ to go into the world and make disciples of all nations. He was baptized and received into membership at Holmesdale Road in 1964.

He became engaged to Maria in 1973 and she readily accepted the missionary vocation as God's will for her. She, too, had a sense of the purpose of God for her life and was conscious that He was calling her to serve Him overseas. She was baptized and received into membership at Crofton Park Baptist Church, London. Until the summer of this year she worked among handicapped children at a special school in Birmingham.

John and Maria have completed three and a half years pastoral ministry at Saltley in Birmingham and, after a term at St Andrew's Hall, Selly Oak, hope to leave for Brazil in January 1978.

IN BANGLADESH

David and Yvonne Wheeler both committed their lives to Jesus Christ in their teens and undertook to go wherever and do whatever He directed. They were married in 1964 and now have three children, Julian, Graham and Rachel. David is a Civil Engineer and Yvonne is a nurse and Health Visitor. They have been active members of Kenilworth Baptist Church for six years; David has been a deacon and was at one time lay-pastor and Yvonne has been a Girls' Brigade officer.

About 2 years ago it became clear that the Lord had something more for them and after seeking His will for several months, this was revealed. They will be going to Bangladesh to be part of the technical team. David will be involved in building and engineering work and Yvonne hopes to be involved in community health work.

They are going at the Lord's command to 'Go into all the world and preach the gospel'. Please pray that He will give them perfect Bengali tongues so that they will be able to preach and teach and share their faith in the Lord Jesus Christ clearly and unambiguously.

EXILED FROM THE VILLAGE

by Margaret Robinson

Try to imagine what must have passed through the mind of a nineteen year old mother of two when she was left with her children and her mother-in-law, whilst her husband went off to a hospital at a distant place. There was a fear that his diagnosis and treatment would prove that he was suffering from leprosy. Sufferers of this are usually shunned because of the fear and stigma which are still attached to this disease.

A working family

The family had a little money, well enough to have a small area of land which they cultivated. But this plot of land was quite incapable of producing adequate food to feed them all let alone produce sufficient to purchase the other necessities of life. So, as with many of the Hill Tracts people of Bangladesh, this young wife had to go out to work to supplement the income. She earned a small amount of money by cutting down and clearing undergrowth on hillsides so that cultivation could take place. To add to her worries as she pursued this occupation one day, her little boy fell over the edge of a particularly steep part and was killed.

Taranga Lal was away from home at the hospital for many weeks. He had become quite ill when initial treatment was commenced for what was definitely leprosy. His body reacted to the disease so that the first drug had to be withdrawn and a second introduced very slowly. When it was apparent that there would be no problem with this new drug, the dosage had to be built up to an effective level, first to control the growth of leprosy bacilli and then to start the long process of destroying it. On hearing of the death of his son, this poor young man was, very naturally, distressed. However, because the second drug had discoloured his skin to quite a marked extent, and had caused it to become very dry and scaley, particularly on his legs, he did not hurry home.

Meg Robinson testing a patient's use of his fingers

Back to the village

The time came when hospital treatment for Taranga Lal had to cease, and he had to be encouraged to return to his home and family. To help him on his way and as a teaching aid, he was given a Certificate of Non-infectivity, which we hoped would convince the villagers that he could no longer give the disease to others. He was only away from the hospital about ten days

Damaged hands

when he returned, though he must have spent seven or eight of the intervening days in travel.

When he got to his home he found the villagers quite adamant that they would not allow him to remain, despite the certificate which he carried. He moved a little way from the village and sought work. After only a day or two he developed an infected wound on one of his big toes so he was readmitted to hospital for treatment and for a possible amputation of the toe. He confessed that his family were with him because the villagers had threatened, not only to burn down the house, but also all of their belongings if they did not leave. He was forced to sell that small piece of land for a pittance and with it went any hope of a livelihood. This staying together and coming to the hospital as a family was the only course left open to them.

A new start

A tiny room was made available for them in the Leprosy Home, whilst the husband remained in hospital. After he was fit again, having had the toe amputated, accommodation was found for the whole family in a somewhat dilapidated old farm house and work was given to the husband. The young wife, Indra Malla was also taken on when extra labour was needed, at such times as rice harvesting.

Later, when the rehabilitation work was restarted, Indra Malla was able to earn a little money working in this programme also, while her husband continued his farm work. The old mother-in-law, somewhat senile by now, does very little except complain that her daughter-in-law neither gives her sufficient to eat, nor treats her properly. However, when Indra Malla was delivered of another baby boy towards the end of 1976, the pride and joy of that little family knew no bounds. She is a good mother and a very gifted young woman, in her ability to do various types of handicraft work. She has learned to use a sewing machine, making such things as skirts and blouses for the women and dresses for the children. She also makes cushions from jute hessian, jute mats with the letters BMS in the middle, other types of place mats, tiny jute dolls and more beside. Other patients and wives of patients engage in this handicraft work also.

'A new creation'

This young couple have, thus far, been saved from becoming beggars and have been encouraged to use their skills sensibly and well. They take great pride in their work with Taranga Lal helping in the handwork at home. This is not all however . . . Taranga Lal, during his first admission period in the Leprosy Hospital, met Jesus for the first time and saw his need of a Saviour. Willingly he gave his heart to Jesus as Lord and in obedience, was baptized. After some time with us, Indra Malla, also met the Saviour and followed the example set by her husband. She too was baptized and both of them continue to take active parts in the Christian witness amongst other patients.

Meanwhile, Jinda Rani, their little girl, attends the local school and the Sunday School taking part in anything which goes on for the children. She gets very good reports and has proved herself a willing and quick pupil, even at the early age of six years. Her father seeks to further her education by encouraging and working with her at least twice each day.

A work to share

It has surely been a privilege to meet, get to know, and share fellowship with such a family as this. But this is only one family for whom Christ died. Oh that we could have both personnel and finance to care for the many, many, others who find themselves in similar circumstances! The Lord is waiting for some to walk with Him in this work and witness in that small area of Bangladesh which is so open to the Gospel of the Lord Jesus.

Taranga Lal and his mother take treatment several times weekly to get rid of the bacilli which are still in their bodies, whilst Indra Malla, Jinda Rani and her small brother take prophylactic treatment consisting of small doses of the initial drug which Taranga Lal had. This means that there should be no risk of the uninfected members of the family getting leprosy at all. This family has been helped both physically and spiritually, but there are many others for whom such help is denied. They live too far away from the hospital or they are too afraid or ignorant of the treatment which is available and many, many, of them end up begging . . . adding to the burden of that overcrowded, largely undernourished nation. Will you go and speak to them of Jesus and bring healing to their bodies?

The ravages of leprosy

Preparing the sterilizer

Establishing lasting health in Tondo

by **Susan Evans**

In hospital work it is only as one looks back through many experiences that one can appreciate the importance of a good basic training as a student nurse and I am most thankful to the Hammersmith Hospital, London, for giving me such a thorough grounding first as a student and then as a staff nurse.

There are many paths open to a qualified nurse and it was with the intention of working overseas that I left the Hammersmith Hospital in 1970 to train as a midwife, as a theatre nurse and also to gain experience as a night sister. Having completed this preparation I offered for service with the Baptist Missionary Society and was sent by the Society to Zaire.

Tondo Hospital, Zaire

Make a trip to Zaire

I would like to share with you some of my experiences overseas so come with me, as it were, away from a London Hospital with its neat hospital beds, bouquets of flowers on bedside tables, respirators, the very latest in electronic aids, with its complicated chest and kidney surgery, to the small, rural mission hospital at Tondo in the Middle River Region of Zaire. The nearest doctor is not on the end of a radio 'bleep' but 100 miles away! For, in Zaire, it is estimated one doctor has to care for 27,000 people whereas in Britain 15 doctors are available to serve 10,000. The climate is hot with temperatures around 80 F and the humidity high. In your imagination come with me in the Land Rover on the 100 miles journey from the nearest town into the interior. The roads are but mud tracks, bridges consist of logs thrown across the small rivers and in the rainy season, as you can imagine, driving is often hazardous. The village of our destination with its population of about 3,000 is situated in a beautiful spot on the shores of a large lake.

The work begins with prayer

The day starts early in Tondo and by half past five in the morning there is plenty of activity. As we walk from the village to the hospital at seven o'clock the sun is shining brightly. The hospital, built in brick with a tin roof, has two small wards plus a maternity unit, a laboratory, an out-patients' department and operating theatre, just thirty beds in all. The nurses make their way to work and patients start to arrive. Some have walked for several miles while others have travelled

across the lake by canoe.

After staff prayers we start the daily ward round. No flowers decorate the wards as in this country, instead water pots and buckets are stacked along the concrete floor. The patients lie on mats on the beds and they have a sheet but no neatly starched pillow case. Children and adults are all found in the same ward while relatives are constantly coming and going, attending to patients' needs, cooking their food and fetching water. There is no running water or electricity in the hospital and at night it is poorly lit by small hurricane lamps. Before the ward round can be started it is often necessary to remove a patient's relative who is still asleep under the bed.

Simple illnesses can kill!

The patients themselves have various disorders ranging from respiratory infections, anaemias and gross worm infections, to severe dehydration, both in babies and adults, which must be treated by intravenous therapy. Malnutrition is a common problem amongst the children and severe complications from measles are frequently seen. In the developing countries measles is the cause of hundreds of deaths each year in children aged seven months and upwards.

Passing on from the wards to the maternity unit we see mothers happily breast feeding their babies, never needing to be taught how! This, I feel, is something we have sadly abandoned in our so-called civilization. Some mothers may be having their first baby, for others it may be their tenth or eleventh! Infant mortality is high and a mother having ten children may see only six grow up to be adults. As we continue on the round we see a woman who had to have a specially assisted delivery during the night. In obstructed labour, which fortunately no longer occurs in Britain, she had walked or was carried twenty miles to hospital. She had received no antenatal care and had laboured in the village until relatives realized she would not deliver her baby unaided. Not surprisingly, the baby was found to be dead on arrival.

Prevention better than cure

Having instructed the nurses on the treatment needed in the wards, we pass on to the out-patients' department. A young boy has just arrived to have a severely lacerated leg stitched and another 60 or more patients have gathered to be seen by just one African nurse and myself. Most of the diseases we come across are preventable diseases caused by poor hygiene, poor housing, inadequate sanitation, contaminated water supply, lack of nourishing food, poor agriculture and ignorance on basic health matters. Many people suffer from either tuberculosis or malaria.

What is the future for these people in rural Africa? Does the answer lie in their coming to hospital from time to time to receive worm medicine or pills for anaemia or some other form of treatment? Or should we be thinking more in terms of preventive rather than curative medicine? It is with this in mind that we travel into the district, as often as possible, to hold clinics. Here we teach nutrition and environmental health. For example, how to build a pit latrine or how to improve the water supply. At antenatal clinic we try to prevent complications in pregnancy and we give immunization to the mother to protect the baby from being born with tetanus. Under fives clinics are held, often in the open air, where we chart the weight of the child and vaccinate against smallpox, tuberculosis, diphtheria, tetanus and whooping cough. We use the measles vaccine when available but it is expensive and unfortunately deteriorates rapidly once out of the refrigerator. In short, we do all we can to prevent disease rather than have to treat it at a later stage.

Great rewards

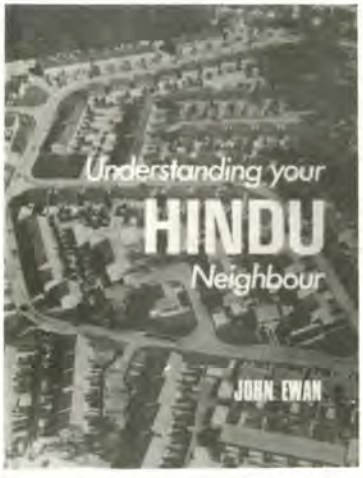
I hope, then, you have gained some insight into what my work has entailed over the last three years. There are some aspects which I have left untouched, such as the problems of language and a different culture, but that is another story. My work at Tondo has been the most demanding of tasks that I have ever undertaken, but it is equally true to say that it has been the most rewarding.

The medicine round at Tondo

Hospital kitchen at Tondo

Understanding Your Hindu Neighbour, by John Ewan. Published: Lutterworth Educational £1.95.

Any RE teacher who undertakes the very difficult task of teaching children about other religious faiths deserves all the help he or she can get, and this book will certainly be a help. The Hindu festivals are well selected and sympathetically described. The author sensibly chooses for his detailed description a Gujerati family, warning us that India is a big country and customs vary from one part of the country to another. There is both birth and death in the family so that religious customs relating to these two events are also described and enough background information supplied to make the Hindu family sufficiently alive for the purposes of the book. The English family, including the two children in their first year at the Secondary School, who make the acquaintance of the two Gujerati school children, remain very shadowy and one wonders whether their inclusion in the book is really worthwhile.



The author attempts, but does not entirely succeed in the near impossible task of conveying the religious as opposed to the social importance of the customs and festivals he describes. Can, for example, a reader be sure that Holi for the Hindu has more religious significance than Guy Fawkes Day for the British? Possibly the author would claim that such questions are outside the scope of a book of this kind.

The book is designed for Junior and Middle School children, but is packed with so much fact that it would have to be a very strongly motivated child who would sit down and read it. This is not a book that a teacher can hand out to children expecting them to read it by themselves. Indeed, at £1.95 a copy a teacher may well decide to make it simply a source book for himself, especially if his class, or some of them, were academically below average. Used this way it could be very useful.

An indication of the pronunciation of the many Gujerati words included in the text would have been a great help.

SM