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PREVENTION IS BETTER THAN CURE

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COMMENT

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We have received reports recently of the progress of gospel witness in parts of the diocese of Cuttack, India, resulting in between 300 and 400 converts being added to the church. News from Zaire speaks of baptismal services, not in ones and twos, but in hundreds. We hear, too, of the increase in members of the Baptist churches in Brazil. All such reports are encouraging to the hearers and, most would claim, are a justification for all the effort put in by missionaries and all the support offered by those at home in declaring the gospel overseas.

Such accounts are often judged to be the yardsticks by which the success or failure of our mission overseas is to be assessed. But are we to assume that when there are no reports of conversions or when an area has no returns of recently baptized members then mission in that area has failed? The seven uneventful years, as far as converts were concerned, through which Carey laboured before Krishna Pal was baptized, are they to be reported as unproductive?

A different way of reckoning

Numerical growth, of course, is not unimportant. It can be indicative of the obedience or disobedience of a church, but we need to remember that God's arithmetic is different from ours. So often it is concerned with representative numbers: the few which stand for the many, the part which represents the whole.

When the letters of the New Testament are read it is hard to discover in them any exhortation to conduct evangelistic campaigns, or any methods to increase numbers. The thought of mission in so much of this correspondence is to do with sacrifice rather than statistics.

It is not out of place to pray for the numerical growth of the Christian Church in such places as Bangladesh, Sri Lanka and other places where the Christian community is a tiny minority of the whole. Without any hesitation we can rejoice when new members are added to those Churches, but we must also remember that God's power is not weakened or his glory diminished if, as with Gideon, numbers are even reduced.

Faithful witness counts for much

In a book published a number of years ago Roland Allen urges us not to forget that the Alpha and Omega of mission is Christ and his appearing. We are engaged to manifest him, to unfold his nature, to demonstrate his power and to reveal his glory. With such a Christ-centred hope statistics are put in their right place. The value of the human soul can never be exaggerated, yet Christ is more than Christians. Our hope is Christ, not men and if we are forever thinking in terms of converts we tend to exaggerate the importance of numbers, whereas if the question which occupies the focus of our thinking is 'Can I find signs of Christ?' 'Is he being revealed?' 'Are we manifesting the nature, the power, and the grace of Christ in bringing back to the Father a world which has gone astray?' – then numbers assume their proper place. We are not indifferent to them, indeed we become more eager to reveal our Lord to all people. While rejoicing in the increase to the Church when it occurs let us also rejoice in the faithful witness through frustrations and disappointment of our missionaries even when such increases do not happen. Their very presence in a land, far from home, speaks of a caring God who has called them to serve in his name and reveal the glory of his love. Their being there makes real the presence of him who called them 'To be where he is'. Their service declares the one who came not to be served but to serve. In this we can rejoice.

WADING UP TO ONE'S THIGHS

by **Sheila Brown**

When David my husband and I came to Brazil in 1977, my role was principally that of wife and mother to work alongside my husband and care for the family. But being a nurse I felt sure that the Lord would find work for me to do using these skills.

We had heard about the state of Paraná and believed that that was where the Lord wanted us to work. We had also heard of the witness being made in the association of the *Litoral* (this means coast). After several visits to the *Litoral,* one being a four day stay, we felt sure that the Lord was calling us to work in this association.

One thing I should mention at this point is that no doctor, nurse or teacher coming from another country is allowed to practise his skills in Brazil without revalidation. This is an assessment, by the Department of Education and Culture, of the foreign qualifications compared with the Brazilian. Therefore, before leaving Curitiba to live at Paranaguá, I started the long process of revalidation. First, several translations of my qualifications were required plus authentications, letters and certificates. When these things were in order, then I could begin – but the beginning is most definitely not the end, especially in Brazil. To cut a very long story short suffice it to say that now, after nearly three years, I have just completed all the necessary examinations. These included papers in Geography, the History of Brazil, Portuguese, Social Studies, Hospital Administration and Public Health. I asked why I had to do Public Health since I had done all that in England. The Director of the Nursing School said, '. . . because it's different here!' and it is! Perhaps the length of time taken was partly my fault. I chose to take each subject separately, but it was a valuable experience.

Tagaçaba church

The plans to give health talks

To go back to the *Litoral.* We arrived in Paranaguá, the main city of the coastal strip and a thriving port, in January 1978. Our two daughters were studying in São Paulo at St Paul's, the British School where they had been since our arrival in Brazil. Our son Paul was still with us and attending the local Brazilian school. I knew at the time that the Baptist Convention of Paraná had a medical dispensary at Tagaçaba with a Brazilian nurse in attendance, whose husband was the pastor of three churches in the region. My idea at the time was to visit this dispensary once or twice a month and give health talks to the patients in the waiting room and also to the women in the churches. At that time, Selma the nurse, was attending an average of 20 patients a day. This plan, however, did not come to fruition because in July 1978 Selma resigned. Both she and her husband had frequently been ill and so the dispensary was to be closed. Before taking this action however, the Secretary of the Paraná Baptist Convention asked if I would be prepared to take over the

The dispensary

work of the dispensary.

Tagaçaba is some 110 kilometres from Paranaguá where we were living. My son was in school in our town and if we moved to Tagaçaba it would mean uprooting him from that school and restarting him at Tagaçaba where there was only a very sub-standard school. We made this a matter of much thought and prayer and I was led to say that I could not take on the work completely, nor could I accept it permanently. I would, however open the clinic three days a week until such time as a new Brazilian nurse was appointed. When that occurred I would help in the way I had been thinking, namely, health talks.

I started there at the beginning of September 1978 opening the clinic on Fridays, Saturdays and Mondays. With these arrangements we were in Tagaçaba at the weekend using the house alongside the dispensary and we were in Paranaguá during the week. This enabled Paul to stay at his school and David to do the work of the association with which he was charged. Because the dispensary was open only three days instead of five, the people came in, what seemed like, droves. I was attending 50 or even 60 patients a day, starting at 8am. On one memorable day between 8am and 7pm I attended no less than 90 patients.

An unused asset

The people of this region are poor, living mainly off the land, or by fishing – the way their fathers have done for generations. The usual maladies which we treat are skin infections or infestations, anaemia and digestive disorders brought about through lack of hygiene and poor nutrition. The whole family, father, mother and, usually, seven or eight children live in a two-roomed wooden shack. Sometimes the roof is tiled but usually it's just banana leaves. The sad thing is that these families have six or seven acres of land, but do not have the capability to utilize it. It is a vicious circle. Lack of education leads to bad health and malnutrition leads to an inability to learn. As well as the normal ailments and childhood diseases, we have the accidents and the emergencies. Cuts and wounds at work or in the home are usually brought to our attention only after they have become infected. One of the emergencies which is most common is that of a woman in labour. Although they are given strict instructions to have consultations with the doctor and to arrange to have their baby delivered in one of the two maternity hospitals, it is not easy for them, in fact, to do this. The hospitals are 40 and 60 kilometres distant. The largest and most modern is in Antonina, 60 kilometres on the way back to Paranaguá, whilst the second is at Guaraqueçaba, 40 kilometres in the other direction. Both are on a dirt road which has been very bad lately because of floods. In fact for three weeks the road was quite impassable.

In May 1979 I was joined by a Brazilian nurse, Maria Luiza de Jesus Oliveira, who is a missionary nurse with the Brazilian National Mission Board. After doing her nurses training she felt God's call to missionary work and entered the theological seminary at Rio de Janeiro, her home city. Luiza completed her three years' training and although at one time she thought about serving in India,

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WADING UP TO ONE'S THIGHS

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she became convinced that the Lord was calling her to work in Brazil. It was at this time that the Paraná State Convention sent a request to the National Missions Board for a nurse to work at Tagaçaba. The General Secretary of the Board sent Luiza to visit the dispensary and, after seeing the work and praying for the Lord's guidance, she accepted the call. She was accepted by the Candidate Board as a missionary/nurse on the *Litoral Paranaense.*

The women are real workers

After Luiza arrived I was free to do more work with the women in the churches. I had been elected Leader of the *Sociedades Feminas do Litoral* (The Ladies Society of the Litoral). It was my job to coordinate the women's work in the whole of the association. The work of the Ladies' societies in Brazil is fundamentally missionary minded. There are State Missions, National Missions and Foreign Missions. There are special campaigns nation wide during certain months of the year, with particular programmes, weeks-of-prayer and special offerings.

Each of these Ladies' Societies has *grupos de interesse* (interest groups). The number of such groups varies with the size of the Society, but always there are: *Cultural Espirutual, Evangelismo, Sociabilidade* and *Acão Social.*

The first is the spiritual culture or growth group whose task is to encourage the spiritual growth of individual members. It provides studies on prayer or stewardship and encourages the members to have daily prayer and Bible study times in their own home and with their family. The group also organizes corporate prayer meetings, house meetings and the like.

This house is typical of many

The second group, obviously to do with evangelism, concentrates on visitation, personal witness, including house meetings or home visits and on the distribution of tracts.

The third group concerns itself with the social side and arranges special teas or lunches, but more particularly with welcoming any newcomer, not only in the church but in the society also. This group has a part to play as well in visiting sick people and those who have shown an interest in the gospel.

Social action is the task of the fourth group. Their job is to help the less privileged. This group holds campaigns for clothing, for milk and for medicines. Most Societies also have what is called *Cesta de Amor* — basket of love — which is literally a basket or box. This is placed at the front of the church or in some other prominent place in the hall or doorway and, at any time, people can place in it their gifts of food. Yet another group in a Society is the *Rol dos Bebês,* or cradle roll. This also is a means of evangelism for they not only enrol the

Looking downriver from Tagaçaba

babies of members of the Society, or the babies of members of the church, they will visit any baby born in the neighbourhood, or a baby of friends of members.

Once again my plans for health education did not come to fruition, although I did give health talks in some of our churches. There is an organization for girls between 9 and 16 years old called *Mensageiras do Rei,* which translated means, 'Messengers for the King'. They hold an annual camp. The one for our association is usually held in July and for three years it was held in Tagaçaba and then last year in Guaraqueçaba. The fact that it was held in Tagaçaba helped Luiza and I to take part in the camp as well as attend the patients in the clinic. I have been able to give health talks in several of these camps for girls. This last year, however, it was not possible for me to attend apart from the first day.

It happened on a petroless day

Some of the people make no distinction between Sunday or holidays and ordinary days. They come at any time or on any day with something that is not an emergency. Often we have to be firm and insist that they attend at the right time otherwise we would be on duty all the hours there are. The dispensary is open Monday to Friday, 9am to 12 noon and 2pm to 4pm, but the patients are always there by 8am and the door is seldom closed until after 5pm. It is open on Saturday once a month when the doctor and dentist are there. But the last two or three months the doctor has not been able to arrive because heavy rains have made the road impassable. He is a doctor from one of the largest hospitals in Curitiba and works voluntarily. The dentist also gives her services free and has a practice in Curitiba. She only does extractions, no fillings.

One of the emergencies with which Luiza had to deal recently was a lady who had had a miscarriage. This woman was already mother to nine children and, at this time, was six months pregnant. Her husband had arrived at the dispensary at 1.30pm on a Sunday afternoon, asking if one of the nurses could go to his wife who had aborted at 7am. Our first question was, why had he waited until now to ask for help? He said they had tried home remedies first! The

David and Sheila Brown

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AN ELECTIVE PERIOD

by **Sarah Miller**

During their training, medical students are encouraged to do an elective period in a hospital overseas. A number of trainee doctors seek to do this part of their studies in a mission hospital. Sarah Miller did hers at a hospital in Nepal.

I had arranged through Mr Stanley Mudd, Assistant Secretary (Overseas) of the Baptist Missionary Society, to do my six weeks elective period of training with the United Mission to Nepal. The BMS is a partner in this cooperative mission enterprise and the hospital chosen for my stay is in the village of Amp Pipal in the Gorkha district.

After an eventful week in Delhi, supposedly finding my feet in Asia, I flew on to Kathmandu and stayed at the UMN House with BMS missionaries Trevor and Stella King. The few days in the capital was to help me to acclimatise to Nepal. Sadly I had a bout of 'Delhi Belly' but fortunately this did not last long and soon I was able to use my time to explore the fascinating capital city. It is a town full of Hindu temples, Buddhist shrines, bazaars and hash.

But the time came for me to move on. This meant a five hour bus journey as far as the road would take me. Then I had to use a porter to carry my luggage and begin the seven and a half hour climb up the mountains to Amp Pipal.

The hospital is a half hour's walk below the small village from which it takes its name — a village of some 300 people whose houses are scattered in groups over the hillside.

I stayed with another BMS missionary, Joyce Brown, the Community Health Organizer, who lives in a simple but comfortable house.

I think Joyce was very glad to have some company since she misses England and has to face considerable problems with the community health staff at the moment. They are not very cooperative and are demanding more money, together with an upgrading of their position. My time was divided equally between the hospital which is officially a 35 bed one, though there were never less than 60 patients and the Community Health Clinics in two villages a few hours walk away from Amp Pipal.

In the hospital I took part in the ward rounds, the out-patients' clinics and generally helped in the treatment room giving injections, dressing sores and extracting teeth.

The hospital itself was reasonably clean by Asian standards and was served by four western doctors attached to the mission, backed up by mostly Nepali nursing staff. Unfortunately there are a number of problems between the western and Nepali staff. These arise because the Nepali staff are agitating for more money and also because those employed by the UMN are not on a

The hospital in the hills

Nepalis by their home

pension scheme whereas government employees are. Because the UMN never know when their work may be taken over by the government they feel unable to enter into long term commitments such as pension schemes.

Common diseases seen in the hospital were tuberculosis (for which I did some statistical research), typhoid, dysentry, leprosy and chronic infections. There were limited medicines available and only the very basic laboratory tests to aid diagnosis. This was, naturally, a complete contrast with medicine as I knew it in Southampton.

The Community Health Clinics held daily in the hospital and weekly in the surrounding villages are run by trained Nepali Health assistants and Auxiliary nurse midwives under Joyce Brown's supervision.

The clinics were for Under-5s and patients were examined and given simple treatment or referred to the hospital when necessary.

I was involved in both, examining the children and giving injections. I also cleaned and dressed skin infections and assisted in rehydrating those whose moisture content was below par.

Basic medicines such as antibiotics and worm medicine, vitamins and 'super porridge' were dispensed and, surprisingly, most of the villagers could afford to pay for these. The clinics were well run and efficient with each of the staff having a particular job for that clinic, although whilst I was there it was the slack season, due to the monsoons and the rice planting.

Malnutrition increases the problems

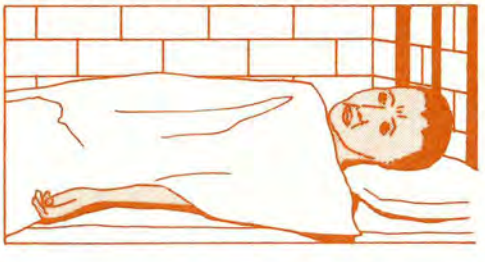
Most of the children had a second or third degree malnutrition, but the clinic records attempted to monitor weight gain. Common problems compounded by malnutrition, were gastroenteritis and resultant dehydration, worms, chest infections and skin infections.

Poor hygiene and sanitation were certainly a big problem and one of the main aims of the clinics was to re-educate the mothers and to dissuade them from using harmful traditional methods such as keeping a child with measles in a dark room with no food or water. The clinics also give ante natal care and contraceptive advice.

Overall I was impressed by the service the community health team offered and the standard of training of the Nepali staff. I also got a chance to see rural development schemes both in agronomy and water projects, that the team are running in the surrounding villages.

I feel that rather than learning all there is to know about tropical medicine during my elective, I was able really to see what life is like for people in the third world and to gain insight into the culture, traditions and beliefs of the Nepalis.

It was certainly an experience of a lifetime and I really appreciate the help afforded me by the BMS in arranging for me to do my elective in Nepal and for accommodating me while I was there.



THE NEW PIONEERS

by **Susan Cousins**

'How many children do you have, Dona Maria?' I asked. 'Seven living and four dead.' It was the all too familiar reply.

According to the tourist brochures, Mato Grosso is Brazil's very own Wild West. Maybe the comparison is an exaggeration, but thousands of families are moving into the state to begin a new life and, like the pioneers of old, they face many hardships. Naturally, the children suffer too; polio, measles, whooping cough, malaria, tuberculosis, malnutrition and pneumonia are still very real threats.

Men died for the land

Gleba União, the rural community to which Dona Maria belongs, has only come into existence over the last few years. It began when 200 poverty stricken families moved on to 30,000 acres of virgin forest situated 70 kilometres away from the nearest town, Arenápolis. Their arrival was followed by disputes with the wealthy landowner, over the ownership of the area, which involved a lot of bloodshed and even several deaths.

Meanwhile, the families cleared the forest and planted both pasture for their animals and subsistence crops of rice, beans, corn, cotton, peanuts and coffee. Eventually the government stepped in, giving the families the right to use the land which they had cleared while compensating the landowner with an alternative piece of land. It is hoped that the families will one day be issued with documents to make them the legal owners.

Children in two categories

Peter and I visited the small Baptist congregation in Glebe União for the first

Arenápolis town centre

The Mato

time over three years ago and we noticed then how children were always mentioned in two categories — the living and the dead. On our second visit, after we had moved to Arenápolis from Cuiabá, we met the women after the church service to find out more about their living conditions and what we could do to help them. The government and Catholic Church had provided two small basic schools for the children, but there were no medical facilities whatsoever. The nearest doctor was in Arenápolis and the nearest vaccination post even further away in Norte Lârdia. The daily bus service stopped 40 kilometres short of where they lived. We asked if we could vaccinate their children against the most common diseases.

The various health departments we approached in Cuiabá were very helpful and willingly supplied vaccines and record cards, while the BMS supplied the syringes, needles and other equipment. So it was that shortly after the first tentative discussions, we set off for our first monthly visit to the congregation, wondering if any children would turn up.

We held the church service and Sunday School, as usual, in the open air, because the mud-brick and thatch home of the leader of the congregation would no longer hold the numbers who regularly attended. Afterwards we returned to the very smoky, dark kitchen of the house where all the vaccination equipment was boiling nicely in a large cooking pot on the wood stove. We need not have worried about the number of children, as the members of the congregation had told all their friends and neighbours and many had come along out of curiosity. They continued to come monthly until each child had completed the course against diphtheria, tetanus, whooping cough, measles, polio and tuberculosis.

It was bursting at the seams

Of course, there were always new babies being born to keep us in business and many of the expectant mothers accepted the tetanus vaccine which protects the unborn child. As more people moved into the area, the number of families grew and our little congregation increased in size as more and more people were baptized. The members themselves erected a small wooden church building with a cement floor, but very soon even that was bursting at the seams during the services. None the less, it provided much pleasanter surroundings for our little clinic. On one memorable Sunday we gave BCG vaccinations to no fewer than 140 children.

There were many encouragements but there were disappointments too. On more than one occasion, a mother arrived with one child less than the number of record cards for that family, because the child had died of pneumonia in the intervening month either at home or in hospital. Then there were the Sundays when we set out early, but never arrived because of the rain and mud.

Although dysentery and worms were very common, it was difficult to convince mothers of the need to boil or filter the drinking water from the river, which was also the communal laundrette, kitchen sink and bathroom. We seemed to have more success on a one to one basis, especially when it was the pastor himself who recommended these measures.

The vaccinations have ceased

Now we have left Arenápolis and will be returning to a different region of Mato Grosso after our furlough. Two Brazilian pastors have taken over the work in Glebe União, but are unable to continue the vaccinations.

However small and insignificant our help was when seen in the light of the needs of Mato Grosso as a whole, our health work was an attempt to show a little of God's love. Please remember these brave people and their families in your prayers as they struggle to make a new life for themselves in small isolated communities throughout Mato Grosso.

WATER — A SOURCE OF HEALTH OR DISEASE

by **David H Wilson**
Chairman of the Medical Advisory Sub-Committee; Consultant at the General Infirmary, Leeds and former medical missionary of the Society.

Water is essential for life — but it can so easily be a means of spreading disease. In Great Britain there are hundreds of millions of taps and the water coming out of any of them is fit for drinking because it is constantly being checked for germs. In many other places in the world, however, a traveller can go for a thousand miles and not find a pure source of water.

One complaint is exchanged for another

In most of the countries where the BMS works, obtaining a pure water supply is extremely difficult. The problem is most acute around the hospitals and dispensaries. People who are ill with diseases which are spread by water naturally come to the hospitals for treatment. Consequently the greatest risk of water contamination is at the very place where people seek healing. It might happen that someone, for example, who comes to hospital with a broken arm eventually goes home with their arm healed but carrying with them the possibility of suffering from amoebic dysentery or bilharzia and of spreading these diseases to people in their own village. Water supplies for these 'third world' hospitals are provided in one of three ways. From a local stream or spring, by collecting and storing rain water, or from a well.

Only enough for a bucket

Rules of conduct are set down

When a stream is used the local people will observe strict rules. Drinking water is taken from upstream, washing and bathing is done a little lower downstream, and the disposal of sewage is only done as the stream leaves the village. This would be quite satisfactory if there was only one village on the course of each stream. Unfortunately the stream carrying the effluent away from one village will soon be providing the drinking water for the next village a mile or two downstream. The village nearest to the source of the stream can be confident of having uncontaminated water, but at this point the stream is usually quite small and so can only support a small population. When other tributaries have joined it, it becomes big enough to provide for the large village or small town which has the hospital but each tributary has brought an added risk of infection.

Infected water will sometimes result in dramatic epidemics of typhoid, cholera or bacillary dysentery. These acute diseases cause severe symptoms which cannot be ignored. For a short time the population can be persuaded only to drink water which has been boiled. Boiling water to purify it is effective but costly and time-consuming. So as soon as the epidemic is over most people will slip back into their old ways of taking drinking water straight from the stream.

A greater risk to health than the occasional epidemic is the spread of chronic diseases which, because they are less dramatic, do not draw attention to

A bucket to be filled at the village tank

themselves. Most of the population in the developing countries, for the whole of their lives, suffer from intestinal worms. Some of these suck blood from the lining of the bowel and cause chronic anaemia. Others cause abdominal pain and also a feeling of general ill-health. People do not die from this type of disease of course but their quality of life is seriously impaired.

Some conditions are more serious

There are other waterborne chronic diseases, however, which can be fatal. Amoebic dysentery may be followed by the development of abscesses in the liver. Bilharzia, or schistosomiasis, causes bleeding from the bowel or bladder and may also damage the liver leading to cirrhosis or even cancer of the liver.

Collecting and storing rain water so as to give a pure water supply is a good method, but very difficult to put into practice. There are two basic requirements, a heavy rainfall all round the year and a large expanse of roofing

continued overleaf

A possible source of infection?

WATER – A SOURCE OF HEALTH OR DISEASE

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made of tiles or galvanized metal sheets. Most simple, rural dwellings have thatched roofs which are not practical for collecting rain water. When there are suitable roofs the rain water must be channelled along guttering into storage tanks. As most buildings are only one storey high and water only flows downhill the storage tanks cannot be very tall. Water tanks built above ground have to be very strongly built to contain the large volume of water needed. Tanks built below the ground, with earth around them to support them, are less likely to crack and leak, but then a pump has to be employed to raise the water for use. A hand pump is satisfactory to fill a bucket, but not to give a hospital its water supply. Power driven pumps are needed for this, but they are expensive to buy, costly to operate and prone to break down in a situation where spare parts and mechanical engineering skill are often not readily available.

A new dam in Zaire

The best way to obtain water

Sinking a well to tap an underground reservoir of water is by far the best method of providing water in tropical countries. The vast expanses of water created by dams and reservoirs invite the breeding of mosquitoes, and recent bitter experience in Africa has shown that bilharzia becomes pandemic in the population around the large new dams which are built mainly to provide hydrolectric power. Searching for underground supplies of water is a skilled and costly enterprise but once the well is established it is likely to continue giving a permanent supply of pure water, even in regions where there is a 'dry season'. A good reliable well, of course, attracts people who will move in, not only to have a source of water for themselves, but also for their domestic animals and these have no understanding of hygiene. Strict rules must be observed and if possible several wells sunk so as to spread the use of the water over a wider area, so long as the water table does not fall.

Improvements are being sought

All the hospitals and dispensaries in which BMS missionaries work should have adequate supplies of clean water – but they do not. Some of the other articles in this issue mention the problems and difficulties and the risks which arise from contaminated water. Quite apart from the danger of cross-infection, water is such a basic commodity for the satisfactory conduct of any medical work, that the Society's Medical Advisory Sub-Committee has called for a review of the water supply in each hospital and dispensary. It may be that we shall have to seek expertize and extra funds so that, where we aim to show the love of Christ through the healing art, we shall eliminate the risk of spreading disease through contaminated water. We should be showing a better example in the provision of clean water. We must work towards the situation where no patient will leave one of our hospitals or dispensaries healed of one thing but having contracted a new disease resulting from contamination of the local water.

NOTES FOR YOUR PRAYER GUIDE

Laura Hinchin (4 Feb) has just started a literacy class for children.

Dr Barbara Boal (6 Feb) has been attending an international seminar and giving lectures by invitation of the Orissa Government. She has visited the Kond Hills where she once worked as a missionary.

Susan Le Quesne (17 Feb) has been appointed Assistant Secretary for Women's Work at Mission House and expects to take up those duties in the near future.

Neil McVicar (17 Feb) has been appointed Regional Representative for Asia.

MISSIONARY MOVEMENTS

Arrivals

Rev D Doonan on 16 October from tour of Brazil.

Miss P Walton on 17 October from Yakusu, Zaire.

Rev C Couldridge on 28 October from Kinshasa, Zaire.

Departures

Mr O Clark on 25 October for Kinshasa, Zaire.

Rev J and Mrs Passmore and family on 26 October for Khulna, Bangladesh.

Miss J Westlake on 26 October for Chandraghona, Bangladesh.

Miss M Hitchings on 3 November for Tondo, Zaire.

Mrs I Morris on 3 November for Tondo, Zaire.

Rev A T MacNeill on 5 November for tour of Asia.

Miss S Headlam on 9 November for Chandraghona, Bangladesh.

Dr S Roberts on 9 November for Ruhea, Bangladesh.

Rev G and Mrs Myhill on 9 November for Nova Londrina, Brazil.

Birth

On 19 October, in Harrow, to **Dr R and Mrs Henderson Smith,** a daughter, Abigail Dorothy.

Death

In Canada, on 8 October 1981, **Rev G Hedley Brown,** aged 74 (India Mission 1937-1952).

ACKNOWLEDGEMENTS

The Secretaries acknowledge with grateful thanks the following legacies and gifts sent anonymously (6-31 October 1981)

Legacies

	£ p
Olive Violet Bucknell	50.00
Miss J L Chappell	100.00
Mrs F M Dix	750.00
Margaret Flintoff Lee Trust	127.00
Mr J T W Green	507.69
Mrs D J Hassall	3,000.00
Mr G H Hooper	500.00
Ivy Gwendoline Janes	1,000.00
Miss E M Oliver	1,813.50
Miss H J Price	2,000.00
Miss R Shaw	1,266.50

General Work: Anon (GW): £10.00; Anon (Cymro): £80.00; Anon (FAE — Aberdeen): £10.00; Anon (Birmingham): £30.00; Anon (Bethnal Green): £5.00; Anon: £7.00; Anon (Durham): £5.00; Anon (Unity): £50.00; Anon: £20.00; Anon: £1,000.00; Anon (Scotland): £1,000; Anon (Gloucester): £5.00; Anon: £5.00; Anon: £58.00.

Gift & Self Denial: Anon: £2.00.

Harvest Appeal: Anon (Sutton): £5.00; Anon: £50.00.

WADING UP TO ONE'S THIGHS

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child had been born but the afterbirth was still in the womb! To reach us he had walked 14 kilometres through the jungle with mud over his knees because of the floods. This was indeed an emergency. The husband thought that an injection would be all that was required, but she needed to be taken to hospital as soon as possible.

David decided that he would take Luiza as far as he was able in the car and then, if needs be, they would leave the car and continue on foot. I could be no help for I was in bed with 'flu at the time. They managed about ten kilometres by car though in that distance it was necessary to drive through deep water on three or four stretches. The last four kilometres they had to walk — up to their thighs in water. They arrived at the house at last and found that it was just a bamboo affair thatched with banana leaves. The woman was lying on the only bed and on examination Luiza found that the dead baby was still attached to the umbilical cord and this, in its turn, was firmly attached to the afterbirth still in the womb.

After cutting the cord and bathing the mother arrangements were made to get the woman to hospital. She could not, of course, walk and no one could carry her through the water and the mud, so they searched for a canoe. The one they found was only big enough for the patient, the nurse and a man to paddle. David had to make his way back to the car while the husband had to look after the nine children, all under the age of 15.

The canoe followed the river until it came near to where the car was parked. Then between them they managed to transfer the patient from the canoe into the car. There was another problem which had to be faced. By law it is not permissible in Brazil to buy petrol between 8pm on Friday and Monday morning. As all this took place on Sunday it meant that whoever took this lady into hospital would not get back that day. They would have to stay over until the Monday to buy petrol for the return journey.

There was another matter too. By that time it was 6pm. At 7.30pm David was due to take the service at Potinga — the last time he would be able to do so for over a year. It was to be our farewell service and the church had arranged a fellowship hour after the service when we could say our farewells. It was therefore impossible for us to go on the hospital run, so we asked our friend and colleague Frank Gouthwaite to act as ambulance driver to get the patient to hospital.

They arrived just before midnight and the woman was rushed to the theatre where she was operated on. Frank snatched what sleep he could before facing the drive back next morning. The woman? Within three days she was back home looking after her large family!

Yes, there are often problems but it has been a pleasure to work with and serve these people, and when we return to the *Litoral* after our furlough, who knows? I may be able to put into practice my dream of health education.

STICK YOUR NECK OUT

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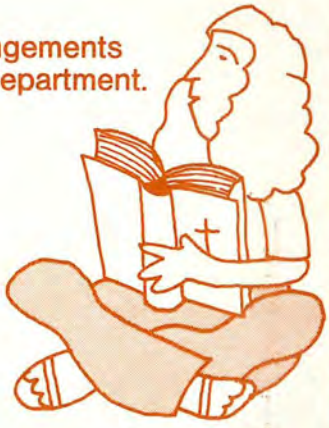
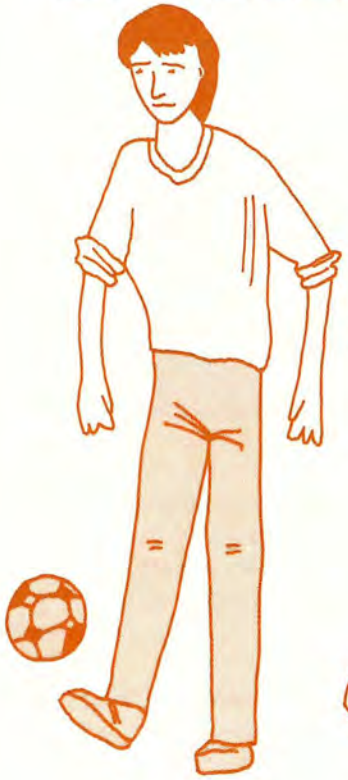
Fuller details of holidays, centres and travel arrangements can be obtained from the BMS Young People's Department.

- **BIDEFORD**
- **PENZANCE**
- **PITLOCHRY**
- **PHAB 82**

(A week of fellowship, fun and recreation shared by Physically Handicapped and Able-Bodied young people.)





APPLY NOW!
Bookings will be accepted from 21 January, 1982.
Send to: The Young People's Secretary, Baptist Missionary Society, 93 Gloucester Place, London W1H 4AA.