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Free Medical Camps and Church Planting Campaigns

Global Missions Fellowship (GMF), headquartered in Plano, Texas, has led short-term church planting campaigns (CPC) to destinations around the world for the past 10 years. Although various campaigns have carried a limited supply of medications and have included some medical practitioners over the years, more recently, large-scale free medical camps (FMC) have been added to some of these campaigns. This report details my experience with several of these combined or holistic (body and soul) missions.

While on my third church planting campaign with GMF, I was approached by one of our in-country coordinators about assembling a medical team to put on an FMC in association with a planned CPC in northern Peru. I was unable to assemble a medical team for the CPC she had in mind, but she had engaged me in the concept of medical missions. After some searching for opportunities to learn more about medical missions, I was put in touch with Don Jones, of Birmingham, Alabama. Don was heading up a combined FMC-CPC to Lima, Peru, and kindly allowed me to accompany them to work in the medical clinic.

Figure 1. Drs. Lauree Jones and Winfred Bearden in Lima Free Medical Camp

There, in a squalid suburb north of Lima, I witnessed the brisk and seemingly endless demand, and heartfelt gratitude for what I considered to be a fairly meager level of medical services. Any skepticism I had harbored about the value of combined FMC-CPCs was quickly dispelled. The patients gave no indication of concern regarding

our lack of long-term follow-up, or plans for their ongoing health care needs. They were grateful for what we could offer.

The team from Birmingham had assembled a vision clinic staffed by optometry-trained laypersons dispensing used eyeglasses, a pharmacist-staffed dispensary with multiple trunk-loads of medications, a medical clinic (Figure 1) staffed by four physicians, and a team of triage nurses. On the last day of clinic, a local dentist was recruited to join the team. We had no access to medical imaging or laboratory services. Our diagnoses were prima facie - relying solely on physical exam and translated history.

Compared to the CPCs I had previously participated in, the logistical preparations for the FMC-PCP appeared to be a quantum leap in terms of both work and complexity. The team from Birmingham had prior experience in short-term medical missions and they demonstrated a high level of organization and flexibility. On arrival in Lima, we were dismayed to find that our medications and supplies were being held up in customs for some obscure reason. Fortunately, another team from Birmingham had been in Lima the previous week. Their medications had been held up in customs as well, and were released back to them just prior to their departure. They graciously donated these medications and supplies to our mission.

The free medical camp operated for five days in the same general vicinity as church planting teams. Evangelism teams typically included several Peruvian nationals and one or two US campaigners. They conducted door-to-door evangelism and afternoon Bible studies. Four churches were planted from nearby mother churches during that week and there were reports of hundreds of new believers composing the new churches.

One of the evangelism teams happened upon a woman who eagerly invited them into her home. She rushed to gather other family members so that they could hear about Jesus and join the new church being started in her neighborhood. In one hand she clutched a small plastic bag of pills that she had received at the FMC several days earlier; as if it were the most precious gift she had ever received. I returned home convinced that God had worked powerfully in our midst through the vehicle of this conjoined medical-evangelism effort. And so I watched for opportunities to serve again.

Figure 2. Dr. Harold Skaggs in Nakuru

In my watchful waiting, I encountered Dan Wilson, a GMF church planter with extensive, long-term mission experience in Africa, who wanted to put together just such an FMC-CPC to Nakuru, Kenya. He had been invited by Kenyan nationals to help with a church planting campaign there, and asked me to head up the medical portion. Using the Birmingham group's model as a template, my wife, Trisch (an RN), and I set out to recruit a medical team and acquire the necessary supplies and equipment. Eventually, a team of lay volunteers, three nurses, one other physician (Figure 2) and a dentist was assembled.

We acquired approximately 2000 used eyeglasses from the Seattle Lions Club. Volunteers from our church verified and cleaned them. We were able to purchase medication from a mission organization called MEDS, in Nairobi, at deeply discounted prices. I calculated a medication shopping-list by using disease

Figure 3. Janet Tangen, RN working the vision clinic in Nakuru

prevalence data from old published World Health Organization data on East Africa[1], estimating four physicians, seeing thirty to forty patients per day, for four days. The nurses took charge of registering and sorting the patients to the various clinical services offered (vision, dental, and medical). They also ran the vision clinic (Figure 3) and dispensary (Figure 4). Our clinic location in a fenced church compound helped with crowd control. But, we had two episodes of uncontrolled crowd surging past the registration area. The Kenyan nationals dealt with each episode swiftly and efficiently. Several Kenyan national doctors and other mid-level practitioners joined us and served in the medical clinic for various lengths of time. A number of Kenyan national pharmacists and nurses also joined the team in Nakuru and served in triage, crowd control, dispensary, and the dental clinic.

Figure 4. Kathie Burnside, RN and Kenyan nationals working the dispensary in Nakuru

We estimated that the clinical team served about 1200 patients in our three and a half days of clinic. During this time, small church planting teams were active in four adjoining neighborhoods or suburbs of Nakuru. Four churches were planted in those neighborhoods. For each daughter church, a mother church installed a pastor who began holding Sunday church services and leading weekly afternoon Bible studies. Then each mother church assumed responsibility for mentoring the pastor and praying for the welfare of each new daughter church.

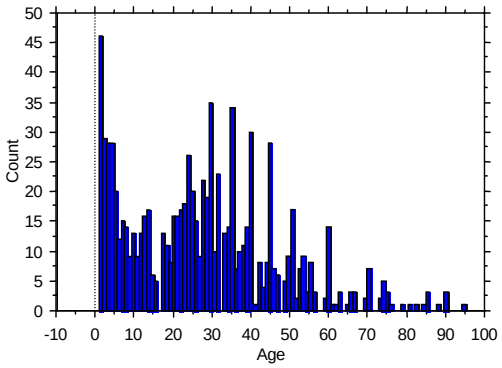

Figure 5. Age distribution of patients in Nakuru free medical camp

The average age of the patients was 27.3 years (SD = 19.1 years) in the 876 patients for whom we were able to find a suitable clinical record at the conclusion of the mission. The distribution of ages was bimodal (Figure 5). The great majority of patients were female (Figure 6). Interestingly, most patients claimed some type of church membership (Figure 7): 13% claimed to be Catholic, 12% claimed Islam, 7% had no response, less than 1% denied any church membership and the remainder were Protestant. Possible factors biasing toward stated church membership were: that pre-clinic publicity occurred largely through participating mother churches and that the question of church affliation was asked prior to receiving clinic services. Patients may have had incentive to claim church membership in hopes of preferential treatment.

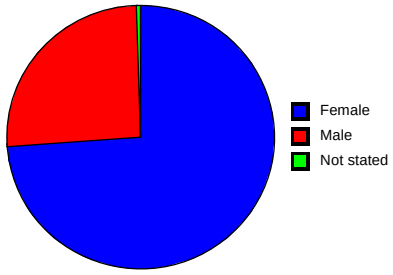

Figure 6. Gender distribution

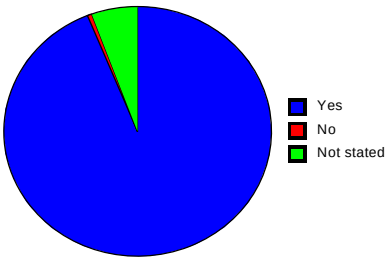

Figure 7. Church membership

The primary diagnoses for patients of record are graphically displayed in Figure 8. As in our prior mission to Peru, our diagnoses in Nakuru were made without the benefit of laboratory, imaging services, pelvic, rectal, or genital examinations. Diagnostic confidence

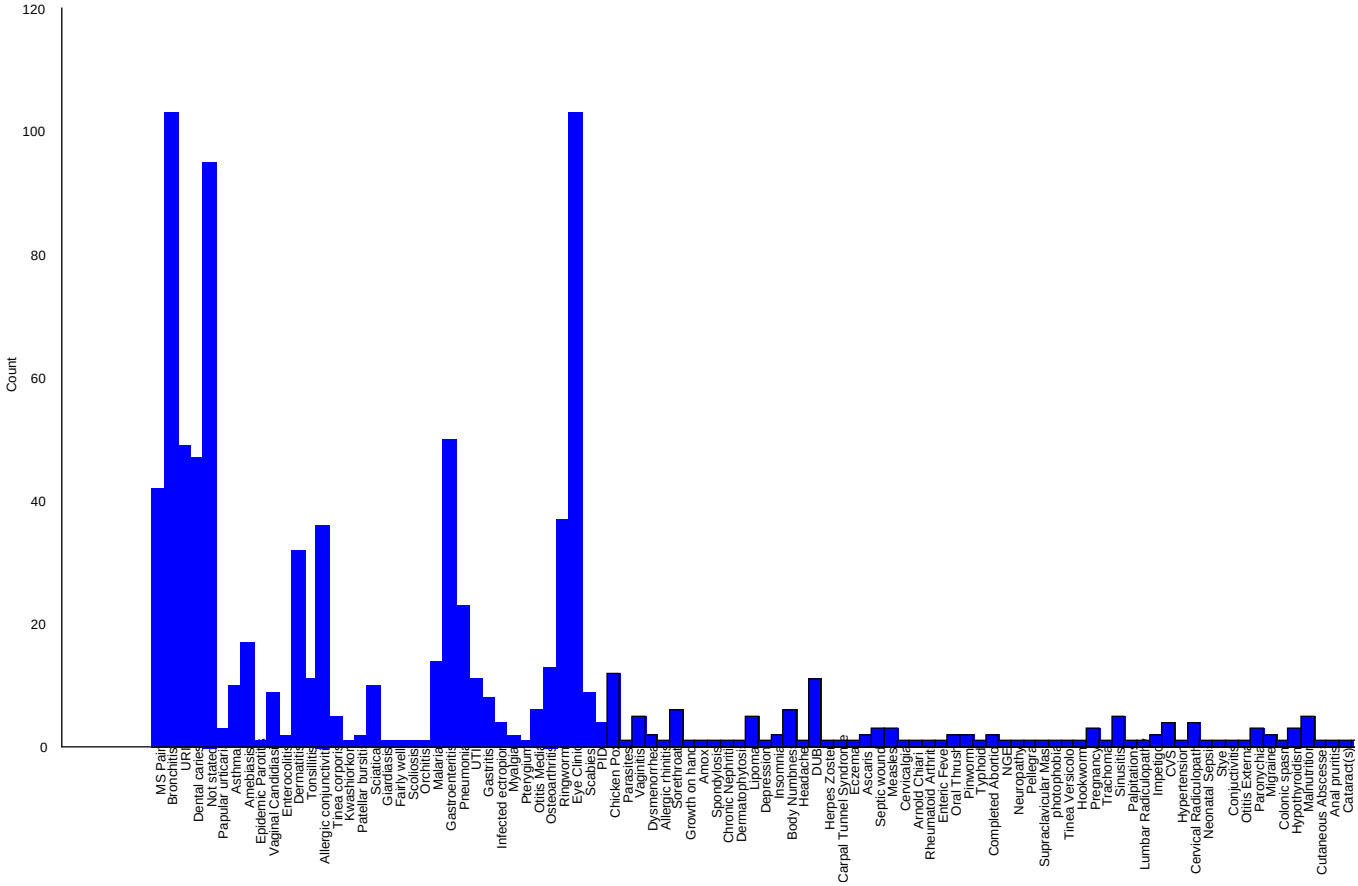

Figure 8. Primary Diagnoses in Nakuru, Kenya Free Medical Camp

may have also been affected by the background/training diversity of our provider team. At various times we had 9 different providers helping in the medical clinic. These included mid-level practitioners, a dermatologist, a pulmonologist (me), and a neurologist.

Figure 8. Amy Overland and Dr. Geoff Strange working the dental clinic

The following summer, using data on medication usage from the FMC in Nakuru, I was able to assemble a smaller list of medications and scale down some of the amounts of medications for a similar trip to Masaka, Uganda, with team leader Dana Crawford. I was told by an acquaintance involved in medical missions to Uganda, that medications were available there but that they were expensive. I could find no information about a medication source like the MEDS organization we had used in Nairobi. I was able to purchase the necessary medications through Blessings International (BI), Americares, and Costco (acetaminophen and ibuprofen), for about $4000. BI was our primary source for medications, equipment, and supplies. Americares uses close-dated medications and furnished us with a limited number, but a large quantity of each, with a suggested

$150 donation. We also purchased medication dose bags from BI and printed up labels for standard dosing of the medications to improve efficiency in the dispensary. This time we were able to recruit 6 nurses, 4 physicians, a dentist (Figure 8), a dental hygienist, and a good number of lay clinic workers (Figure 9) – in addition to the church planting crew. We packed the medications and supplies in ordinary luggage bags and asked each campaigner to carry a medication/supply bag as their second piece of luggage.

Figure 9. Vicki Braaten working the vision clinic

The largest group of campaigners flew from the US to London; and a second group flew to Johannesburg and then on to Entebbe and Masaka, Uganda. On arrival in London, we found that a baggage-handlers strike had forced the cancellation of our flight to Entebbe. A day and a half later we were able find airline seats to Entebbe although it took us through Lagos, Nigeria, and Nairobi, Kenya, en route. We arrived in Masaka two days behind schedule and without the benefit of our luggage, which included almost all medications, supplies, and equipment. Fortunately, we had entrusted the eyeglasses to our Johannesburg-routed group and these had arrived intact.

Figure 10. Merrily Erickson, Carol Kessler and Ugandan national translators working triage in Masaka

For the first day of clinic operations, we were able to get our vision clinic up and running. That morning we also visited the local health clinic and were able to borrow some older dental instruments. We found a local pharmacy and were able to purchase some local anesthetic, syringes, needles, and gauze. So, by the afternoon of the first day, we were also able to get the dental clinic up and running as well as our triage clinic (Figure 10). Surplus clinic personnel joined the work in door-to-door evangelism that first day.

On the second day, we set up the medical clinic in addition to eye and dental clinics. Medical clinic patients were told that the dispensary would be operating in the afternoon. Some of us visited the local pharmacy again that morning and, using a scaled-back wish list, were able to purchase a surprising amount of medications for about $400. And so, on the afternoon of the second day of clinic we were able to open the dispensary. Miraculously, despite the loss of supplies, medications, and equipment, all of the clinic units were in operation by the afternoon of the second day (see Free Medical Camp schematic Figure 11 – next page). Our clinic registration, evaluation, and dispensary forms had been in the delayed luggage and paper was in short supply. Instead we quartered 8.5” by 11” sheets of paper and hand printed names, ages, diagnoses, vision testing results, and medication prescriptions. Evaluation of those records showed that in our 1.5 days of partial operation and our 2 days of complete operation we had served 663 patients (350 eye, 224 medical, and 89 dental). But, in the chaos of our make-shift operations some of the records were most likely misplaced.

As in previous campaigns, evangelism teams were working door-to-door in the neighborhoods surrounding the clinic site. Two mother churches planted six new daughter churches during this time. They installed six new pastors to begin holding Sunday church services and weekly evening Bible studies in each location.

In each of the free medical camps, we served those dwelling in the neighborhoods of the church plants and/or mother church, including members of the mother church. We also served national pastors, national campaigners, translators and their families, and

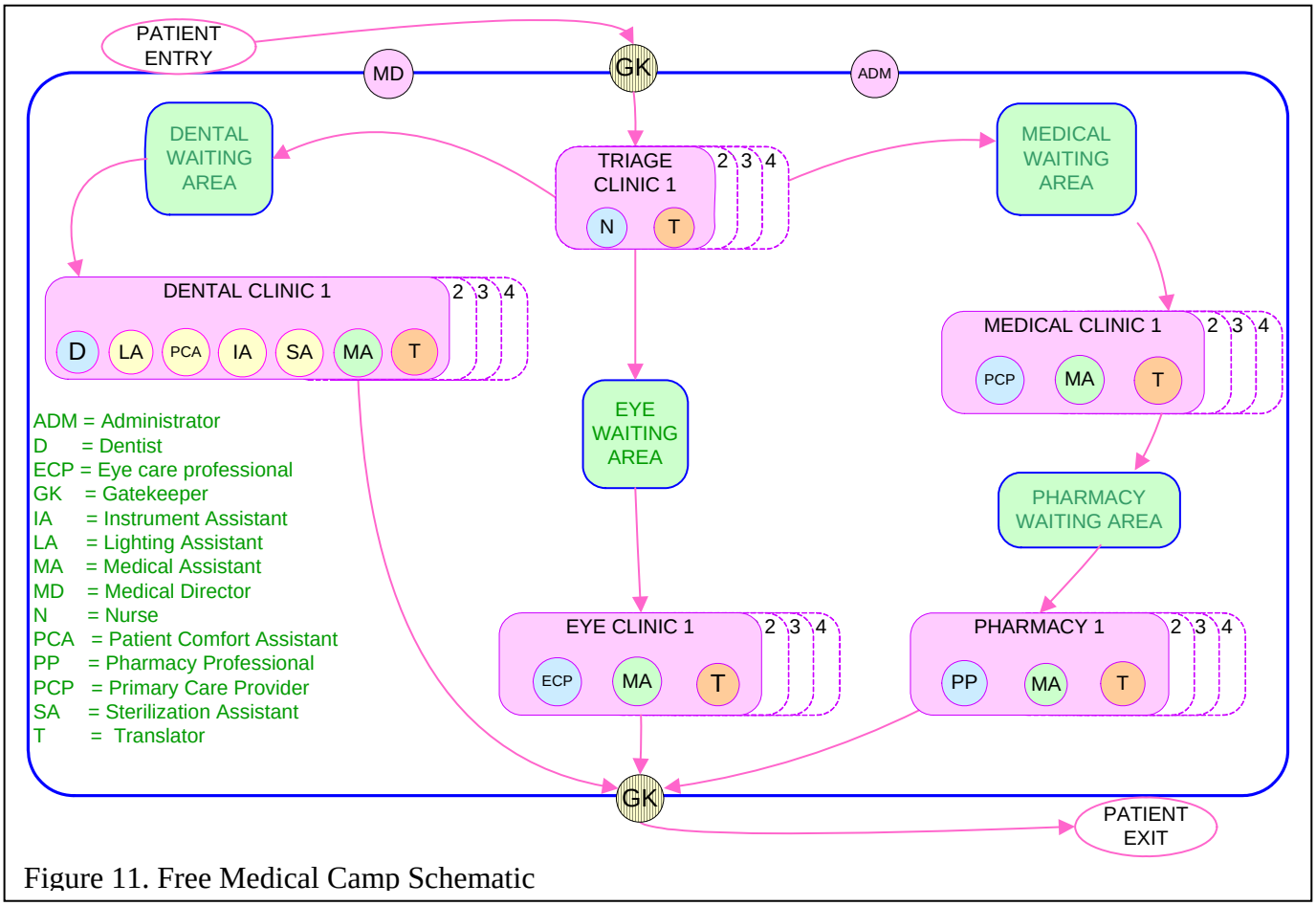

Figure 11. Free Medical Camp Schematic

transportation workers. In addition, and largely informally, we cared for any campaigners from North America who developed health problems during the missions.

The assembly, transport, and operation of one of these free medical camps is an enormous logistical undertaking for those sending and going. We also know that many churches have been planted, and that we have brought the good news of Christ to many people in the course of non-medical CPCs. And, since we have not offered long-term medical care of chronic diseases, considering that we have only diagnosed and treated our patients prima facie, and given that the medical services do not clearly affect or effect the eternal salvation of our patients, how can we justify such resource allocation?

First, it was Christ's example to minister to the bodies as well as the souls of people. He healed and fed people in addition to preaching and teaching about the Kingdom of God. And, Jesus trained his disciples to do likewise. Jesus even spoke of rewards for this type of ministry (Matt 10:42 "And if anyone gives even a cup of cold water to one of these little ones because he is my disciple, I tell you the truth, he will certainly not lose his reward." NIV).

Second, many of us (especially in North America) have educational and material resources, which enable us to serve on short-term holistic missions. We have medical training and have money for equipment, medications, supplies and travel. If we don't have the money, there are people around us who do. If we lack the training, there are still jobs in the

free medical camp in which we can serve. These resources and the love of God compel us to share in this way (1 John 3:17 If anyone has material possessions and sees his brother in need but has no pity on him, how can the love of God be in him? 18 Dear children, let us not love with words or tongue but with actions and in truth. NIV).

Third, I have witnessed how these short-term holistic missions serve as a unique vehicle for many North Americans (especially with a medical background or interest in medical service) to become personally involved in mission work - where they might not have otherwise done so. This applies not only to those who go, but also to the many that don't go but help prepare, fund, or pray for the mission.

Finally, there are the unique stories from this ministry which come back witnessing to the hand of God working in such a powerful way. One such story was about 12-year old Stephen who came on his own to the free medical camp in Nakuru, Kenya, with red eyes. He was irritable and short-tempered to the eye clinic workers who examined him and diagnosed acute, severe bacterial conjunctivitis. He was treated with antibiotic eye ointment and released. He returned to the clinic two days later with a near normal eye exam, in a much better mood, and now wanting to learn about Jesus. A clinic worker explained the story of salvation to Stephen and he was eager to accept Jesus as his savior. He enthusiastically returned to the clinic later that day with his mother and siblings so that they could learn about Jesus as well. From then on, Stephen seemed to be transformed into an evangelist. He insisted on staying in the clinic the remainder of that day and the rest of the following day, sharing the gospel story with as many of our waiting patients as would listen.

Acknowledgement: photos of Nakuru, Kenya courtesy of Dan Wilson and photos of Masaka, Uganda courtesy of Dana Crawford.

[1] Heath Care in East Africa. Buschkens WFL and Slikkerveer, LJ Van Gorcum, Assen. 1982.