Best Practices

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Mission Hospital Best Practices: Kiwoko Hospital Uganda

'Cure the sick who are there, say to them, "The Kingdom of God has come near to you."'
Luke 10: 9

Best practice articles are often an opportunity for someone to brag about what they have done. While preparing this I thought I should get some guidance on what best practice in healthcare mission is by doing a search on the net. There are over 460,000 sites related to "Best practice" and "healthcare" and 85,800 related to "Best practice", "Healthcare" and "Mission". Not all of them Christian. Add in the word church and that becomes 8,970. For "Best practice" and "Healthcare mission" there are only 47.

However, when it comes to thinking about a chapter on best practice in health care as mission, I might wonder what I had to contribute to these sites. After all, I have not got a management qualification and the only management course I did was four days long. When it comes to management, I remember the story of a junior who went to his boss and commented that the boss was a really good manager.

"What is your secret?" he went on.
"Good decisions."
"Yes - but what is the secret of making good decisions?"
"Bad decisions."

What I can bring to the table, therefore is experience - the experience of running a hospital in the Ugandan bush for six years and my theological and theoretical reflection on those

experiences. These reflections have also been shaped by my reading of scripture devotionally and as a leadership manual. It is also from learning to make good decisions through having made mistakes and bad decisions, which often one is blind to because they are made in another culture, the rules of which have not yet been learnt.

BACKGROUND

Kiwoko Hospital is under the auspices of the Anglican Church of Uganda. It rose out of the desolation of the Luwero District, called the killing fields of Africa, since at least 250,000 people were murdered there during the 1980s when a guerilla war was fought between the now President, Yoweri Museveni, and the Government of Milton Obote. When the war ended in 1986 with Museveni victorious, the people returned to their fields to start digging again, and as they did so dug up the bones of those killed. These bones were heaped at the side of the road and eventually collected to be buried in mass graves.

Into this came Dr. Ian Clarke, a doctor from Northern Ireland, to start a health work. The only building which still had a roof was the local church, not because it was the church but because it had been used as the army barracks and the soldiers had burnt all of the pews for firewood. The queue used to stretch twice round the church as people came to see the mzungu (white) doctor. A clinic was built but this could not deal with the workload, especially of pregnant women needing caesarian sections, and a hospital was constructed which was formally opened in 1991, three years after the work started - a remarkable rate of

growth for an African hospital. This is based a lot on the confidence of the donor population in an organization of integrity – itself a sign of best practice, but more on the faithfulness of God who heard the prayers of a group of visitors, some of them church leaders, who prayed on the foundations of an abandoned school building that God would do a great work in that place. Those foundations became the foundations not of a school but of the hospital, for the first answer to those prayers was the death of the wife of one of the visitors a week after returning to the West during the showing of a home movie about the needs at Kiwoko. This tragedy led to a memorial fund being set up which raised the first grant to build Kiwoko Hospital. In fact, Kiwoko has been called the fasted growing hospital in Uganda – true because the staff does not just talk the talk but walk it.

INTRODUCTION

On September 12, 1978 the World Health Organization, as part of its aim to bring *Health for All by the Year 2000*, met in Kazakhstan and produced the Declaration of Alma Ata. Paragraph 1 states that:

> **The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.**[1]

The Declaration of Alma Ata was never going to achieve its aims because it depended on an unselfish co-operation between individuals, groups and Governments[2] – something that will never happen! This is again an area where the church is important, because only the gospel has the power to change the human heart. Yet even the church, which must surely be the largest health care provider in the world when one counts up all the different Christian organizations that exist, from community-based organizations through dispensaries, health centers to hospitals, unfortunately again is not an example of unselfish cooperation.

One of the achievements of the Alma Ata conference was to put the philosophy and principles of primary health care on the map as a strategy for

[1] See http://www.euro.who.int/AboutWHO/Policy/20010827_1

[2] "An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share." (Alma Ata, paragraph X)

health development. However noble a goal, aimed as it was especially at the millions throughout the two-thirds world dying young, it missed one of the key elements of health, which is spiritual well-being. This is especially true given the awareness of the spiritual realm among those societies where most of the 30,000 children who die every day for lack of basic health resources live. Health care in those societies is usually sought at the hands of the traditional healer, and then later from Western (scientific) health care systems when the traditional approach has failed. Christian health care systems should, however, differ in having a truly holistic approach to healthcare, being able to deal with both the physical and the spiritual. However, often the Christian health system is simply a Western one Christianized by being owned by the church or by having clergy on their Boards or in management positions. Instead of having the values of Christ and his Kingdom deeply embedded in their ethos, their mission may be having a chaplain who visits at bedsides or simply preaches the gospel to all the staff through a speaker system.

Also unfortunate is that Western Christian health workers are trained in a rationalistic, scientifically based way that has no scope for the spiritual, and are trained to see holistic health as involving the physical, emotional, social and mental, but not the spiritual. Westerners are brought up in the "culture of disbelief" where "religion is trivialized, and supposedly has little or no political or social significance. Religious believers are forced to act as if their faith doesn't matter."[3] Therefore we develop models of disease care and not health care, and even in holistic programs the spiritual aspect is tagged on to the rest. We are able to deal with health issues, for which we are trained, and are so busy doing those good works that we take our eye off the real goal. "What is important to recognize about this culture of disbelief is that it is at odds with the way most people in the developing world live out their moral lives".[4] We try to work secularly in an outside world influenced by one of the great world religions. The World Bank recognized this too, since in 1999 health was redefined as "a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease and infirmity."[5]

Traditionally mission hospitals have seen themselves as bringers of healing - with the wider view of healing, *σωξω*, being healing of diseases and salvation form sin. Therefore the hospitals have been involved in social action and evangelism - the right and left hand of the body of Christ, so to speak. The good medical works are like social action and then for a mission hospital evangelism becomes one of the programs along with surgery. This has both advantages and disadvantages: the advantages that it will happen and can be

[3] Scott. M. Thomas, p. 22.
[4] Op cit
[5] At Kiwoko we came across this when working with a secular French organisation trying to develop community based health insurance schemes. The leader was frustrated at the inability to find cohesive community groups in a war torn area, but they had not considered the role of the church and mosque since their worldview was primarily secular, and once the religious organisations were included life became much simpler.

delegated to gifted and qualified individuals; the disadvantage is that it stops Christians from practicing the integrated Christian life, where faith and work are a normal part of life. It is true that Christian organizations have not implemented this to their cost: a person is employed because of a skill but whose faith may be deficient, or a strong Christian is employed who is weak practically. People would rather seek their health care from one who is medically competent rather than a strong Christian.

The Declaration of Alma Ata has stated that the "attainment of the highest possible level of health is a most important world-wide social goal". This is a noble goal - but some Christians would argue that evangelism and personal salvation are a higher goal and part of holistic ministry. There is, however, a wider view of evangelism as seen in the Lausanne Covenant:

"We affirm that God is both the Creator and the Judge of all. We therefore should share his concern for justice and reconciliation throughout human society and for the liberation of men and women from every kind of oppression…Here too we express penitence both for our neglect and for having sometimes regarded evangelism and social action as mutually exclusive. The salvation we claim should be transforming us in the totality of our personal and social responsibilities. Faith without works is dead."

Instead of thinking of the mission hospital having a well-defined role as a provider of a service, we should think of them as part of the church. Bill Hybels writes that, "The local church is the hope of the world." Mission (church) hospitals are part of the church: the global church expressing itself in local mission through the different collections of Christians working and fellowshipping together. Therefore the functions should be the same in the church and church hospital. These functions of the church are expressed in Acts 2:42-47. If both have the same function, then it is not enough to think of the hospital being involved in social action and evangelism and therefore fulfilling its destiny. The primary purpose for the existence of the church is neither social action nor evangelism nor both at the same time. As John Piper writes:

"Mission is not the ultimate goal of the church. Worship is. Mission exists because worship doesn't. Worship is ultimate, not missions, because God is ultimate, not man. When this age is over, and the countless millions of the redeemed fall on their faces before the throne of God, missions will be no more. It is a temporary necessity. But worship abides forever.

"Worship, therefore, is the fuel and goal of missions."[6]

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[6] John Piper, *Let the Nations Be Glad!* Second Edition (IVP, Leicester, 2003), p. 17

When one therefore asks the question, "Which is the senior partner, evangelism or social action?" the answer is "Neither." It is worship. This is the true human goal. Once this is at the centre the other ministries and works flow out of it.

Figure 1: From Acts 2:42-47

The story of Mary and Martha[7] is an example of this: Martha is the Christian health worker busy working hard to save lives, but she has missed the most important thing and lost sight of the goal, which is to worship Jesus. Mary is the one who has chosen the better way, to be with Jesus. "The divine priority is worship first, service second. Our lives are to be punctuated with praise, thanksgiving and adoration. Service flows out of worship. Service as a substitute for worship is idolatry. Activity may become the enemy of adoration."[8]

There is another side to this of course. The story is told of Hudson Taylor, the great missionary to China in the nineteenth century, who was a t a prayer meeting in London, when a child collapsed. He started resuscitating the child when someone said to him, "Mr. Taylor, we should pray." His reply was "You pray while I work." As the saying goes, we do not want to be so heavenly minded to be of no earthly use.

1. WORSHIP IS THE MAIN FOCUS

That might seem to be an odd thing to say for a hospital. If it is not the main focus it will lead to disagreements about which of the many alternatives it should be: community based health care, primary or secondary? Prevention or treatment? Training or employing?

[7] Luke 10:38-42
[8] (*Celebration of Discipline*, Richard Foster, (Hodder and Stoughton, Sevenoaks, 1980), p. 140

But it is the main focus of our whole lives: "One thing I ask of the LORD, this I will seek: that I may dwell in the house of the LORD all the days of my life, to gaze upon the beauty of the LORD and to seek him in his temple." (Ps. 27:4) This is the one thing we know we must do, and therefore in our work that one thing can also shine through. Therefore the mission hospital should at its heart be a worshipping community, but of course worship is the whole of our lives and therefore it covers both the physical and the spiritual aspects of life, and includes the whole of our work as if working for the Lord. Giving an injection or delivering a baby is as much worship as being in a church praising God. We as Christian health workers are not primarily defined by what we do (which specialty) but by who we are as children of God. Therefore our health units should not be defined by the types of work they do but how they are acting as communities of God's people meeting together. When one employs Christians who are competent God is glorified by the good job that is done, and the light of his presence shines through their character.

But it might be the reason that many mission/church owned hospitals are also malfunctioning – as seems to be widely recognized. I have certainly visited some where the Christian identity of the unit has been invisible – either they are mission units by virtue of being owned by the church or with a predominance of Christian staff, but they are not missionary units. They may be doing very good work, but it is not the role of the church to duplicate the work of Government but to model the kingdom. When worship is not the main focus the main focus becomes something different from God and his purposes – it turns around the medical programs one can run, or the denomination, which owns the unit. It may simply focus on money and how to get hold of more – which can also lead to compromise. This is especially important since organizations exist in partnership with overseas donors, who may want input on the values of the organization in order to give. Some do not want their money to be used for evangelism, which is impossible given what should be the true nature of a Christian organization. Worship allows one to realize who God is and what he can do – He is the one who owns the cattle on a thousand hills and when it comes to money one can ask him to sell a few of his cows to help out his children.

It also will help one to look at the area of employment. If the community at its heart is primarily a community of worship, the employment of Christians also becomes a priority, at least in management levels, since these leaders are both an example and set the tone and direction of the organization. If the organization is primarily one of doing good medical work, it does not really matter who is employed as long as they are competent in their particular field. Therefore in choosing leaders especially in management, there are three issues to look at:

- Their Christian commitment
- Their character
- Their competence to do the job

Often the area of competence is one that is looked at first – one needs a surgeon. However, this does not deal with the issue of whether they can lead a Christian organization onwards. Of course, one does not employ someone incompetent just because they are a Christian, and above all one wants the right character whatever their competence or commitment, since character defects in a small community can destroy the organization.

The other side of the management and leadership is that they have servant hearts, and are willing to submit to the authorities, whatever the color and nationality, and do a good job for its own sake because this pleases God.

Worship can be more closely defined through the Christian ministry activities. The focus at Kiwoko is morning prayers - 45 minutes of devotions at the start of each working day, which all staff were expected to attend. Medical emergencies took priority of course, and some would choose not to attend. This involves 15 minutes of singing, 20 minutes of teaching from the Bible, and then a time for prayer and notices. Many of our visitors found this to be the most inspiring part of the day.

Some of the sharing would also be about specific themes. In my final year I was wondering who should succeed me. I had a word from the Lord that I should not worry about which person was to take over from me but ensure that the hospital was built on the right values. Therefore it was less relevant who succeeded me but that the person who came would adopt the values of the organization. He or she would then be transformed by the organization, which was itself a means of transformation.

This helped me to focus on what those values should be and were we matching up to them. Hudson Taylor said, “God’s work done in God’s way will never lack God’s resources.” Having the right values would also help put that into practice. If we do God’s work in God’s way, then God will provide: not just financially but the right staff. We prayed that God would bring in the right staff and keep the wrong ones away. Best practice models should ultimately be based on scripture, and come out of worship. In the speech of modern medicine, they should also be evidence based.

There are a few verses that have become very important to me. I spent time in morning prayers before I left, sharing God’s values with the staff. These values should not just come from a leader, however, but all stakeholders should participate in formulating the vision, so that they incorporate Christian values into all their work.

General Principles:[9]

[9] See http://www.ccih.org/forum/0008-05.htm

"1. Justice, equity, access, and openness should be some of the fundamental principles.

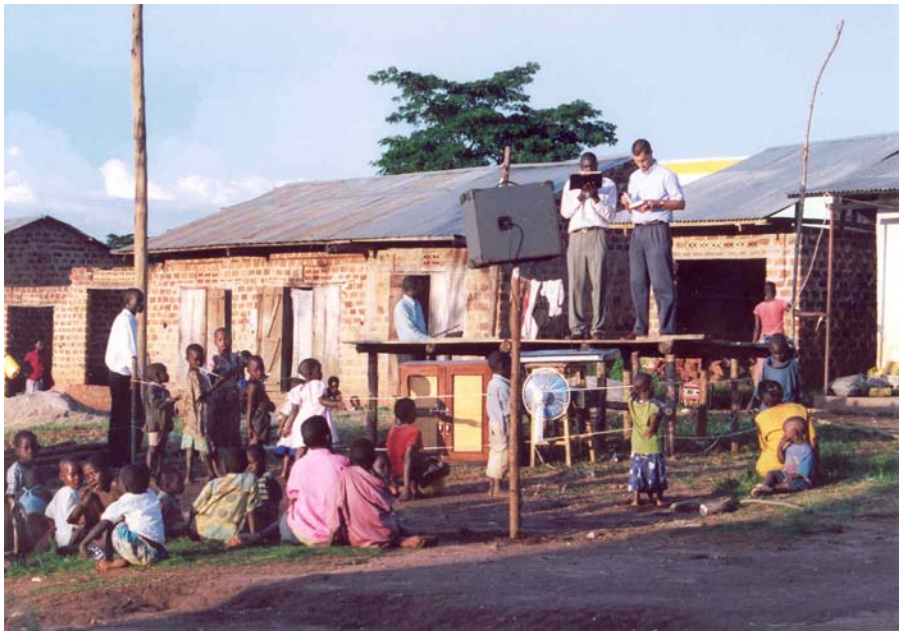
2. Institutions should reflect the Christian values of love, integrity, and dignity of each person."

People are created in the image of God, whatever their color, age, sex or religion, and there should be no favoritism in treatment. We should treat them as we would if Jesus was the patient and we should think that with each patient we welcome we are entertaining angels unawares.[10]

DISCIPLESHIP PRINCIPLES

● Firstly, we should be born again, or saved, as it would be called in Uganda. 'In reply Jesus declared, 'I tell you the truth, no-one can see the kingdom of God unless he is born again.'' (John 3:3)

● Secondly, the importance of world evangelism. '[18] Then Jesus came to them and said, 'All authority in heaven and on earth has been given to me. [19] Therefore go and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, [20] and teaching them to obey everything I have commanded you. And surely I am with you always, to the very end of the age.'' (Matt. 28:18-20).



Evangelism with translation

● Thirdly, the importance of reaching out to the poor and needy. Christianity has often been presented as a ticket to heaven, rather than a way of life, as salt and light that would transform society. However, when referring to King Josiah, the Bible has this to say: '[15] 'Does it make you a king to have more and more cedar? Did not your father have food and drink? He did what was right and just, so all went well with him. [16] He defended the cause of

[10] e.g. Matt. 25:31-46: "When you did it over the least of one of these of my brothers (or sisters) you did it for me."

the poor and needy, and so all went well. Is that not what it means to know me?' declares the LORD. (Jer. 22:15-16) When I first read that I realized that I cannot claim to know God yet ignore the needs of the poor. Much of what we tried to do in Kiwoko, with orphan sponsorship and the Good Samaritan Fund, was an outworking of that conviction.

● Fourthly, apart from a right attitude to God, and to the lost, and to the poor, we also had to have a right attitude to money. '7 'Two things I ask of you, O LORD; do not refuse me before I die: 8 Keep falsehood and lies far from me; give me neither poverty nor riches, but give me only my daily bread. 9 Otherwise, I may have too much and disown you and say, 'Who is the LORD?' Or I may become poor and steal, and so dishonor the name of my God.' (Prov. 30:7-9)

● Fifthly, there was the need for personal holiness and integrity, especially when dealing with other people's money. '16 for it is written: 'Be holy, because I am holy.'' (1 Pet. 1:16). '37 Simply let your 'Yes' be 'Yes', and your 'No', 'No'; anything beyond this comes from the evil one.'

● Sixthly, there was being a good father and husband in my own family.

● Seventhly, there was the right attitude to work as service.

It can be hard to maintain all these in our own culture, especially regarding money, possessions and power. My mother came to visit, a couple of months before we left, and advised us not to watch television when we returned home because all the programs were about home improvement, gardening or cookery. She was right. These all pander to a self-indulgent materialistic consumer culture, which, like acid rain, erodes our value system. This has to be balanced by the fact that our God is a God of plenty, who wants to bless abundantly, who supplies all our needs. He is not the God of mediocrity, but he wants us to 'have no other gods before me', so consumerism and the love of money is an on-going battle that we will all keep on having to face.

As an expatriate living in Uganda, it was also easy to push my anti-materialistic values onto local staff, without knowing their financial commitments: how many of their extended family they were looking after; what their commitments were to those who had invested in their training since this is the pension system of the village – sponsoring someone who in the future will support you in your old age. It was easy to think that I had given up a lot to live in Uganda, but they had given up a lot to stay, for instance for doctors who had stayed during the civil war when their classmates had left for the West.

Finances also required integrity in reporting and accounting. Web lost one large donor through not having written reports (before my time but these bad decisions lead to the lessons which bring good management).

OTHER ISSUES FORM ACTS 2

The strategies and activities should first and foremost be based around these core areas rather than the health services, and out of these core activities could grow the rest, being worked out once there is a community that worships.

1. Fellowship

This is about right relationships in the organization. Not just a place of work but family and community. It is harder to maintain community as both the staff age and the generation which was there at the beginning has left, and also as the organization grows. Sociologically, as an organization approaches the third generation of staff who have not seen the beginnings, nominalism creeps in. There a process of re-envisioning is important.

Fellowship comes out of the fundamental understanding that we are all equal in God's sight - whatever our color or tribe or religion or denomination or sex.

Denominationalism seems to be the new tribalism in Africa, and we spent some time trying to undo that. However, when it came to the crunch, it was generally the Pentecostals who were the most committed to evangelism. They were also unfortunately the most critical of other denominations that were not “saved”.

2. Prayer

With all the prayer movements currently around, it can still be hard to remember to pray. This is especially true for health workers who are overstretched. Any organization survives by prayer, and sometimes that means the prayers of other people supporting the organization. Prayer is the source of financial provision, for ultimately everything comes from God who owns the cattle on a thousand hills. In a culture where so many kept cattle, it was easy to pray to God to sell some of his to help us out financially! We saw money arrive in response to prayer, and sometimes after a lot of hard work fundraising, but at all times the source is God.

We would pray for the right staff to be brought in and the wrong ones to be kept away.

Some of it was also focused – praying for some of the countries in the 10/40 Window, and mobilizing the incredible prayer life of the Ugandan Christians to pray for the unreached world. One of the problems in a rural area is getting people to see the outside world - it would arrive with news over the radio and mobile telecommunication was coming in. Operation World prays that Uganda will be a great missionary sending nation, and this was what we aimed at to promote a world vision, especially with prayer into the 10:40 Window.

3. Outreach.

The early mission hospitals were set up as a form of outreach, as were the schools. Social action was a front for evangelism. I am not sure I agree with that thinking. It is a question of partnership. However, some hospitals have neglected evangelism, and just do social action, which makes them no different from a secular organization.

Many of the health problems could be directly related to sin:

- Promiscuity and AIDS
- Alcoholism and poverty
- Injuries and domestic violence.

Therefore evangelism – putting people in contact with the living God whose Holy Spirit enters their lives when they commit themselves to Jesus Christ, and therefore gives them the power to live a changed life, is actually a form of health care. This should not be forgotten. These character issues are not dealt with by education and counseling but by inner transformation. There is a proverb I was told that goes, "What a person learns in the daytime they forget at night". It is all very well to educate people but when they go out at night and get drunk it all changes. Behavior change only really possible through the activity of the Holy Spirit and then AIDS would disappear in one generation.

Kiwoko started a mission team to facilitate the outreach into the community, and by 2003 had actually planted 5 churches. Quality work earns the right to be heard. This made evangelism easy since people were grateful to receive the hospital into their midst, since many of the locals had received healing through it at some point. This then led to understanding that there needed to be proper follow up. The first church planted had about 50 people in it. At the next visit half had left. This meant discipleship and leadership training was needed. A year later that church was planting one of its own. In 2005 Kiwoko ran a pastor's training conference for 100 pastors in order to equip them with the skills needed for effective leadership, and the mission team studied church planting material.

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As Bill Hybels wrote, "The local church is the hope of the world and its future rests primarily in the hands of its leaders."[11] This means that more local churches are needed, and more leaders trained. These can be through a CHE (community health evangelism) model, so that they are trained in holistic ministry. "The Church should incorporate health care in its mission, and health care should incorporate spiritual health in its mission."[12]

What sort of church should it be– which denomination? Kiwoko belongs to the church of Uganda (i.e. Anglican). However, we wanted it to function as part

[11] Courageous Leadership, p. 27
[12] See http://www.ccih.org/forum/0008-05.htm

of the wider global church, the body of Christ, where denomination does not matter, because it is the world-wide body of Christ stretching back into history and including all the Old Testament believers such as those in Hebrews 11, and stretching across continents and forward in history to include those as yet unreached. We tend to think about what denomination we belong to and duplicate it, but it does not really matter – what matters is obedience to God in the medium and culture which we are comfortable with. If the culture is hierarchical, an Episcopalian system is possibly best, if it has an eldership, maybe it should Presbyterian. In many places, however, a bishop acts like a feudal baron or an eastern potentate. One of the challenges here is not to bring a cultural but a biblical model of servant leadership.[13] This seems irrelevant when thinking about hospitals, but as mentioned before, the hospital is a part of the global church, and so there does need to be some form of partnership between the two.

This challenge also applies to hospital Boards. These are important in order that the organization is accountable. For a denominational organization it may be overloaded with clerics from that denomination. The important point is to make sure that Boards set strategy rather than do management, for which there should be a management committee. This is true if the leader in, say, an Anglican organization has the feudal baron mentality whereby he cannot help but interfere.

At Kiwoko the same ideas were brought into school's and adolescent work: not only were AIDS/Sexual health clubs set up, but also Scripture Union/Christian Union groups started in 7 schools to bring a holistic message. These centers were run by trained teachers who we recruited, and who were committed Christians, rather than health workers. Although we never managed to document exact numbers, when the Kiwoko Youth Friendly Centre was opened in 2003 the teachers present thanked us that girls were no longer dropping out of school through pregnancy.

Some of the Christian ministry was also built around disciple making in different groups using a homogeneous unit principle. There are many arguments for and against the homogeneous unit principle, but in a situation where nurses have come from all over the country and many different tribes to train, English is a better language that the vernacular, yet for group employees (cleaners, compound workers) where English was not the first language it was better to think in terms of using the vernacular.

4. Social action

[13] "Leaders should be Christ-like and develop a servant leadership style" See http://www.ccih.org/forum/0008-05.htm


Dr Nick Wooding working in the Pediatric Ward

Ministry to the poor and needy demonstrates the compassion of Christ to them, but is not a vertical top down action but should be part of a bottom up community orientated program. Social action and evangelism or like the right hand and the left hand of the body of Christ. The leadership needs to be development minded.[14] That is hard for clinicians who could not sit round and let people die while a community decides on its problems, yet not to do so means that a program may never be sustainable. The same applies to developing the individual's values and getting them aligned with biblical principles – it takes time but is very necessary.

Since health care is not and never will be sustainable (since it is not in the West how can it ever be in the developing world) budgetary restrictions mean you cannot help everyone. Ways to help the poor need to be developed:

- Good Samaritan Fund for the destitute so that no-one gets turned away.
- Payment in kind[15]

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[14] "**Principles Concerning the Relationship with the Community:**

9. Integration with the community should be promoted, including shared ownership.

10. Leaders should be prepared to initiate and develop sustainable programs that address the health problems of the community served.

11. Communities should participate in determining the quality and appropriateness of care, and they should be assisted in meeting their own holistic health needs and even in reaching out to other communities."

See http://www.ccih.org/forum/0008-05.htm

[15] We ended up with a very large flock of goats which enlarged by breeding even more.

- Income generating projects: we had a piece of land where people with AIDS would grow crops to sell to the hospital for its kitchen and receive in turn free healthcare.
- Prisons
- Targeting women and children: antiretrovirals primarily for women who then can care for their families. This has a risk since targeting women disempowers men who become are not employed, and may spend more time in unsafe activities which lead to AIDS e.g. alcoholism.
- Targeting infectious diseases – mostly linked to poverty, and therefore affect women and children the most.
- Cultural issues on food distribution, which leads to malnutrition.

5. Teaching

The biblical teaching is of the whole counsel of God: both faith and works. Faith was taught as a ticket to heaven rather than a mark of obedience. The teaching as we left was divided into studying books of the Bible on some days, other days it would be someone sharing what God had put on their heart. This was to enable us to both hear the full message of scripture, but also hear God speak prophetically through those who felt they had a specific word. I used to preach once a week as part of our morning devotions, and decided early on to focus on primary issues of first importance - the death and resurrection of Jesus bringing salvation, and the ethical and moral challenges that brings, rather than secondary and therefore more controversial issues such as baptism and the millennium. When I did it had brought division. This means the person and work of Christ, the role of the church in the world, and developing Christian character and values. The hospital was made up of different denominations, and denominationalism in Uganda seems to have replaced tribalism in the church. It also means on the Christian side that the whole church is seen, and not a particular denominational branch of it.

The plan was not to get decisions but to make disciples. With the pastors' training this meant that the staff would have skills to train others. There are many new religious movements (cults), including Kanungu and Wilson Bushara during my time in Uganda, which led many astray to charismatic leaders. We needed to teach basic hermeneutical skills to prevent this happening in the churches we started.

Some of the teaching was by modeling – such as parenthood and marriage in the home, and compassion and service on the wards. Many Ugandan nurses have a reputation of sitting at a desk and ordering juniors about – at Kiwoko all cadres were hands on.

Teaching can also lead to good management principles being internalized because they are scripturally and theologically based. These three principles can be summarized as being:

- Firm
- Fair
- Friendly

- **Firm**: God has given us rules to live by and we should do so; to break them has consequences. Similarly an organization has rules and regulations with consequences for disobedience.
- **Fair**: God shows no favoritism; similarly, everyone in the organization is valuable, and the same rules apply to all of them as do the consequences for breaking them, whether they are a doctor or a cleaner, form instance.
- **Friendly**: God is a God who communicates – similarly we must communicate with our staff and supporters and be transparent so as not to discourage them.

Visiting medical students and student nurses had to abide by the rules to - after all they chose to come. This would apply to alcohol, smoking, dress codes and relationships, which those from the post-modern West sometimes found hard to abide by, since they infringed their individual rights.

6. Giving

Bribery is common in a culture where people might say, "They pretend to pay us, and we pretend to work." Receiving bribes from patients was one of the issues which led to instant dismissal. However, this did mean that the hospital should pay a competitive salary – it also shows that the staff are valued.

Apart from individual giving, some felt that the hospital should tithe its resources, which were often gifts. We never reached that point, though it would be interesting to see models where it had been done. Some of the giving was seen in terms of the Good Samaritan Fund for the destitute, and the mission outreach funded by the hospital.

CREATING THE NEW PARADIGM

Dan Fountain writes that in order, "To accomplish the mandate of *Christian Intercultural Health Ministries*, a whole set of interconnecting operational paradigms is necessary."[16] These operational paradigms are:

1. Good quality health care
2. Training paramedical health personnel
3. Community health

[16] See http://www.healthwholeness.net/articles_paradigms.pdf

4. Primary health care
5. Decentralizing health care
6. Care for the whole person
7. Training health professionals
8. Facing the challenge of HIV/Aids
9. Surveillance of new and re-emerging diseases
10. Partnership relationships
11. Research and modeling
12. Using Jesus as our model

This is not the medical model of disease but a truly holistic, whole person approach. The goal is not the absence of disease but Shalom (John 10:10). Some of these aspects link with the Alma Ata declaration.[17] This is one model of best practice that is a pointer to whether we are going in the right direction.

LESSONS LEARNED

Dr Wooding performing a fetal sonogram

1. Good quality health care: This should go without saying, but in a non-litigious culture there are sometimes not the same encouragements to quality care[18]. There are some areas of medicine that need to be phased out.[19] Standards and protocols are part of that and can be locally developed for the resources available. It means having time for people, and treating people not diseases.

2. Training paramedical health personnel and health professionals: This is the training in practical skills but also in disciple making, i.e. it should be holistic. 80% of Ugandans live in rural areas and therefore one has to train at different levels. The nurses who are likely to stay will not necessarily have the academic standards of those who work in urban areas, but will on the other hand be willing to work there and also to stay there. This means health care assistants as well as nurses. It means medical officers to deal with outpatient/general practice type illnesses and act as the gatekeepers for the hospital. It also means having an on-going system of training for resident doctors who through isolation often develop bad habits when there is no-one to correct them. It should also be

[17] e.g. Point 3, Alma Ata IV, VII (1-2, 5), Point 10, Alma Ata IX.
[18] It is also arguable whether litigation improves quality of care.
[19] Such as aminophylline use as first line treatment for asthma, often given IV since there are no nebulisers.

care for the whole person – recognizing the psychosomatic elements of disease, and the cultural expressions of the sick role.

Leadership development is an important aspect of training – since not all the people who work in the organization will stay in it. Therefore by training them it will raise the standards of any organization in which they work, and will also impact the spiritual life of the area if they are properly discipled.

3. Community health: with evangelism as part of community health work, and health care not sickness care. Prevention is better than cure. There also needs to be the vertical primary health program supplementing the community program.

In Genesis 12 Abraham was promised a land, a people, and a blessing. If that is put in development terms, one is building God's kingdom through developing agriculture for the land, holistic health for the people, and bringing the blessing of God and his presence to all. This means care for the whole person, such as the woman with the hemorrhage who has become poor, been rejected by society and religion, and has a physical ailment which through anemia also stops her functioning to perform the activities of daily living. This is using Jesus as our model.

4. Decentralizing health care – this flows out of a community orientated approach, which needs community development but also leadership development for the health units. Success is succession so a brilliant program could collapse unless future leaders were being raised up continually. Since I was an expatriate there was always the chance that I would suddenly have to leave (health or family issues, war in some places), so we had a broad horizontal management structure rather than a very hierarchical one. The plan should always as an expatriate be to train others and therefore do oneself out of a job. It meant good handover. It meant not being a control freak but an enabler – letting others take the glory. Therefore leaders need first of all to have learnt to be good followers – first of God, and also to be under authority – in our case that of the Board. Such character and hopefully Christ-likeness of style would then also be modeled to others.

5. Facing the challenge of HIV/Aids is important. We as Christians cannot abandon a whole country because there is AIDS there and it is dangerous, as is the attitude of some medical schools to allowing their students to do electives in sub-Saharan Africa. Surveillance of new and re-emerging diseases applies to AIDS but also to diseases like Ebola. It means there needs to be a good system of epidemiological surveillance in place, and if not, someone needs to be trained up to do it.

6. Partnership relationships

Kiwoko Hospital had a wide range of such relationships:

- Friends of Kiwoko (supporting charity)
- Other donors
- With the local, national and global church
- With Government (national and local)
- Welcoming visitors whether official or interested well-wishers
- With the community and the people in it who were the past, present and future patients
- Medical students and other visiting specialists or students

Those around for a longer term would also need effective debriefing. One part of this was to raise up next generation of leaders and medical missionaries or mission supporters. Not all were Christians so this was another area for outreach. All visitors were expected to attend morning prayers.

7. Research and modeling are important weaknesses of the Christian health care system. It does a lot of work but no-one knows about it because it is never written up. Some of that is audit of activities to bring improvement; some is scientific research for the wider community.[20]

THE WAY FORWARD

Mission hospitals should see themselves as more than just hospitals, but instead as holistic mission centers. Coming back to the Declaration of Alma Ata, health care workers are not focused on health care as much as disease care, and in some cases disease prevention. However, the view of wholeness or shalom envisaged by this declaration cannot be brought about by either disease prevention or care, but instead by a much broader view of our role being in total community development. At the root causes of illness is poverty, and that poverty

[20] In terms of the way that faith based organisations are seen, especially in the secular West, this lack of research and even self promotion of the good work which they do has led to:

1. A lack of credibility: There is no defined and agreed good practice for the work of healthcare as mission. Faith based organisations have been poor at researching and documenting the work they do. Organisations such as the WHO do not know where, how, what or who FBOs are doing. There is often not a clear biblical foundation for the work of the organisation.

2. A lack of recognition: The Church is seen as irrelevant to health and development in some departments (especially in academia), whereas the role of the faith based organisation is appreciated by others (e.g. WHO, UNAIDS), but those organisations do no know the contact point, caused by:

3. A lack of cooperation: There is a lack of global connectivity, and between groups, networks and hierarchical organisations. This leads to:

4. Duplication: There is duplication of effort on the ground, but also in seeking funding whether from small donors or block grants. There is inefficiency in the duplication of administration

has many causes.

In some cases it is through sin - as in most cases of HIV which are related to promiscuity, realizing that of course one in six are from mother to child transmission and infected blood products, or someone infected because of the actions of their partner rather than their own actions, but even in those cases there is promiscuity in the background. Another cause is through alcohol abuse, which can lead to sexual sin, but also to 50% of the income that reaches the family being spent on drinking.

There are cases where poverty is caused by ignorance, and therefore one of the best means of alleviating it is education. Illiteracy rates were over 50% for women in Kikamulo Sub County, so that they could not read health education material, and were also unable to calculate shopping costs. Hence education to deal with this area was important.

There was also ignorance about agriculture and how to get the most from one's land, especially important for peasant farmers. There is also the whole area of health, so that families are now spending one third of their income on treating malaria, but instead investing it in the education of their children, in nutrition, and family development.

Therefore one's actions need to be holistic in addressing the wider issues relating to poverty and ill-health - including evangelism to deal with sin, and agricultural work to deal with the land, and health work to deal with prevention and cure

Therefore hospitals should be renamed as holistic mission centers or community development centers in order to have the wider perspective. That would be very hard for doctors, especially those not trained in public health, to get out of their box and start rethinking their approach to work beyond the realms of their specialty.

It is also a challenge to live the integrated Christian life, where all of the areas are encompassed in one whole approach. That is easier for people from the two-thirds world than Westerners who have never really integrated the two together.

LEAVING THE BOX

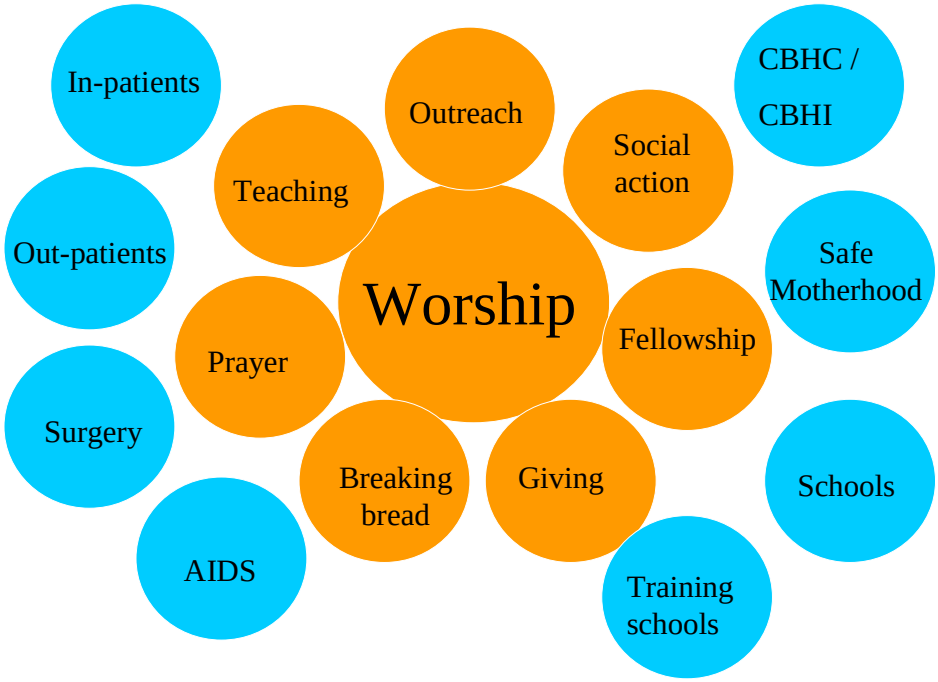
This will of course not happen overnight, and therefore plans to develop best practice are very important. What is also important is a formal approach to leadership development – once the model of best practice has been found, to develop a training course to teach that model to others.

One way to do that is with leadership development courses, in the two-thirds world so that people are not taken out of their context, to rise up mission

minded and mission-motivated personnel. One of the organizations doing that is the Global South Institute in Uganda, which is running training courses for Church leaders and also for Hospital leaders. I was part of the group running the first of these in September 2003, with a hope that missional leadership could be raised up who would not simply see their job as curative but have the theological and missiological training to plan their work around the core biblical values which have already been discussed. Therefore the organizations would have worship at the centre, and would consider their work to be both evangelism and social action. This is the extension of the Declaration of Alma Ata to include the spiritual.

This hopefully will be one means of breaking own the divide which exists between the two groups, so that church leaders for one will not simply see the hospital as a form of income generation for the diocese.

It does mean that tensions would come – if the hospital as an ecumenical group plants a church, who does that church belong to – the denomination, or could it choose to affiliate itself to anyone. We had this tension in Kiwoko when we had churches wanting to relate to us, but we did not want to start another denomination, and the churches that came were Pentecostal, so that they would have even unhappy to relate to the Church of Uganda. It takes very mature leadership to be willing to give their successes away.



CBHC - community based health care

CBHI – community based health insurance.

This would also detract from the true call of the church, which is the hope of the world, not a club or clique which exists to perpetuate itself but a group which lives to bring Christ to those not in it, and to be a blessing to the nations.

Therefore it takes more than the hospital to leave the box and become a holistic mission centre, but it also needs the owning denomination to leave the box to be the body of Christ, united through the ages back to Adam and the Patriarchs as the community of the followers of Yahweh revealed by Jesus and empowered by his Spirit, through history and geography, for both sexes and all ages. That might be the harder step.