Chapter 11

Missionary Nursing

Life among an Indonesian Tribe

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"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? Dear children, let us not love with words or tongue but with actions and in truth." 1 John 3:17-18

INTRODUCTION

My wife and I are missionary nurses living among a remote tribal group in the jungles of Indonesia. We use the local language and live among the local people in an attempt to serve them holistically in any way that we can. While we feel that we have already adjusted and adapted much (and are still adjusting and adapting), we now have a much healthier respect for the huge role that culture and worldview play in every person's life. People strain and can even break, when trying to cross cultures. We ourselves felt that strain. Culture and worldview impacts every major decision of life, even how we filter and interpret the world around us. We are unaware of it mostly, and yet, it envelopes us like water around a fish.

We know the stresses of nursing and ministering to others in a culture not our own. Yet, we also know the deep joys of enlarging one's view of the world. We are now enabled to better see this truth: the whole human race is but one solitary quilt or fabric, though woven with many different types and colors of thread. And the world is a much more beautiful place because of it.

OUR PREPARATION

We are both graduates of Deaconess College of Nursing's B.S.N program (now Chamberlain College of Nursing), in Saint Louis, Missouri. An ROTC scholarship through Washington University paid my college education in full in exchange for active duty time spent in the army.

I chose nursing in order to serve God by serving others. The Catholic saint Teresa of Avila once stated that Jesus has no body on earth now but ours, "…*Yours are the feet with which he walks to do good. Yours are the hands through which he blesses all the world..."* I desired to follow such a calling, to be the hands and feet of Jesus in some small way, particularly to those living remotely and without access to other medical help.

This sense of calling was confirmed during a short-term trip to the remote Amazon River. There, I delivered a baby on the floor of a dirty hut along the banks of that gargantuan water. Lacking proper supplies, I tied off the cord with a hammock string boiled over an earthen clay hearth and cut the cord with a Wilkerson Shaving Razor. Dogs underneath the house peered between rough-hewn floorboards and lapped up the drippings. We used our drinking water for the infant's first bath. Returning home via small metal canoe (a mere speck on that wide expanse of water), we wilted under the searing sun until we stopped at a village to seek refreshment. My thirst was quenched by a strange frothy, orang cassava drink. I queasily learned later that women

sat around such vats, spitting into these concoctions in order to ferment the mixture into a form of local beer. Yuck!

Two days later in another village, a man with a gray and sweaty pallor rasped out a plea for help. He was suffering chest tightness and clutched at his left shoulder with numb fingers. I was able to give him donated nitroglycerin tablets. Within minutes his color returned and his breathing stabilized. This greatly impacted me. This truth dawned on me: In America I could get a decent job with a good wage. Every major town has a clinic or hospital. In remote regions like this, on the other hand, I might very well be the difference between life and death. I pondered, *"If ten men are hoisting a heavy uneven log, and nine of them are heaving on the little end and only one is laboring to hold up the heavy end — and I want to help, which end should I lift?"* I resolved then and there to find the most remote peoples left on earth and to seek to serve them.

I gained not only a solid degree from nursing school, but I also gained a wonderful wife. Teresa was not only smart and well-trained, but was pretty as a doll in her nursing uniform. What a perfectly suited partner she makes now as we labor together in an unhealthy jungle region and treat the sick. How my heart is pulled as I see her unselfish compassion towards others. To watch her play with our children is as close to heaven on earth as one can get. Our home is very well-lived in. It is raucous, and messy, littered with battalions of army men and ruined remains of Lego cities. Child art taped at all angles adorns every wall (mostly

unicorns or army men…and, at least once, army men riding unicorns). I wouldn't have it any other way.

I served 5 years active duty as an army officer in the Army Nurse Corps, a great place to gain experience in those first few years of nursing. The army provided some very helpful training for our future in the jungle, such as the TCCC course (Tactical Care of the Combat Casualty), and also some training such as ACLS (Advanced Cardiac Life Support) which, while much appreciated during my time working in a hospital, has not proved very useful in this low-technology environment. Machine-dependent nursing practices have largely given way to community health preventative measures (don't poop where you drink, boil your water, and bathe regularly) as well as a "ditch medicine" mentality here due to our locale. Teresa worked as a community health nurse at Fort Leonard Wood, Missouri, focusing on immunizations and communicable disease tracking and prevention. Her background has proven most useful in tribal work.

A SNAPSHOT OF OUR LOCATION

National Geographic calls the inhabitants of our region, "The Treehouse People" - four thousand semi-nomadic tribal souls. These tribal people live spread out over several hundred

Missionary nursing among an Indonesian tribe.
Trevor and Teresa Johnson

kilometers of dense lowland jungle in southern Papua, on the eastern end of the nation of Indonesia. The Mission Aviation Fellowship pilot who lands here calls our area, *"the most remote area in an already remote land*" and "*about the furthest place from anywhere."* On "plane day" his floatplane sets down with a splash on our narrow river (a river that is often not land-able due to wide fluctuations in depth, making medical evacuations dicey during dry season). There are no roads, no electricity, and no land airstrips yet in this broad region. Governmental presence is only now being felt. Two years ago, this tribe was counted in the Indonesian census for the first time.

Two dozen villages and many treehouse clusters dot this vast green expanse. Two dialects of about 2,000 speakers each divide this area roughly in half between north and south. A Dutch translator labors in the southern dialect of the Korowai and is making linguistic progress. We live in the centrally located village of Danowage further upriver among the northern dialect (*The Korowai Batu*, or Rock Korowai) and are partnering with 17 indigenous Christians from the highland Dani tribe trying to improve the lives of those living throughout this broad region.

SURPRISES UPON REACHING THE ISLAND OF JAVA

Let's back up a step or two, however, before we land in the jungle. Our first stop in Indonesia was on the island of Java, where we first learned the national language of Indonesian (and yes, they do, in fact, have great coffee in Java). The city of Bandung in West Java possesses many of the amenities of a modern city (they even have a McDonald's). Despite Java being a great place to "land softly" before moving more remotely, it was there that we first became deeply aware of just how much culture and worldview impacts all aspects of life, including healthcare. Below are some examples:

"Masuk Angin" (entering air): When we first arrived in West Java, we were baffled. The climate was very hot, yet lots of motorcycle riders wore thick leather jackets (and some even wore them backwards - across the front). Aren't these people burning up in this tropical heat? Why would they do this? The answer was, "To prevent *masuk angin* (entering air)."

What?!

Yes, many Indonesians believe that air rushing into your body can cause flu-like symptoms. The solution is to apply rubbing oil and scrape your skin with a coin (dermabrasion) to release this trapped air. If you prefer round, raised whelps as opposed to red stripes down your back you can always apply "Chinese cupping" to your skin, instead, to draw out this trapped air.

This was all intriguing to us those first "honeymoon" months in Indonesia. Then it grew infuriating. Many of the nearby hospital staff also believed in *masuk angin*. Feelings of cultural superiority rose in us. We fought against many arrogant and ethnocentric thoughts. We reminded ourselves that just a century or two ago in the West, people complained of "the vapors" – which was a similar belief. This miasma theory of disease stating that diseases were spread by

noxious air held sway for a long time in the West, in contrast to the much more recent germ theory of disease. The dread disease of "malaria" (which I have had 14 times now and is responsible for so many tribal deaths here in Papua) even gets its name from the Latin for "bad air." Remember, Florence Nightingale held to this miasma theory of disease! It led her to implement the beneficial practice of maintaining well-ventilated and clean-smelling hospital wards.

These historical excursions into our own mistaken health notions aside, let me ask you: what would you think if you worked with an Indonesian nurse who believed wholeheartedly in "*masuk angin?*" What would you think of your Indonesian nursing counterparts if you discovered red welts on their shoulders from this "kerok" coin-rubbing therapy?

Hygiene and cleanliness differences: Imagine our surprise when we witnessed used disposable latex gloves being washed with rubbing alcohol and hung out to dry on a clothes-line behind the first Indonesian hospital we toured! Trash, including some medical waste, littered the corridors. Then there was that huge rat that greeted me in the hallway.

Littering is a huge problem throughout all of Indonesia. We tried to convince ourselves that this was not a cultural thing, but merely due to inequality of wealth and lack of funding. Many traditional societies are accustomed to wrapping their food in bananas leaves and then throwing those leaves aside after use to biodegrade naturally. Some readjustment is required when mass importation of plastic arrives into such a culture. Also, when government infrastructure is limited and those limited services fail to arrange timely pick-up and disposal, garbage tends to accumulate (even when the average Indonesian family produces far less garbage on any given month than the small mountain produced by even the poorest Americans).

Pregnancy beliefs: We thought we were adjusting pretty well to Indonesian culture after 3 months. Then we got pregnant! With pregnancy came a whole slew of new cultural challenges. Have you ever been asked to drink a glass of water after religious teachers recited special prayers over it? Have you ever been told to wear a pair of miniature scissors at night around your neck to ward off evil spirits? Have you ever been under cultural pressure to bath in the waters of 7 wells, and change your clothes 7 times on your 7th month of pregnancy, even passing a live eel down your shirt to ensure a slippery and eel-like (smooth) delivery? Have you ever considered burying your placenta under your windowsill after offering ritual prayers to it and calling it by the name, "sister placenta?"

Cross-cultural communication and the relational 'yes': Cross-cultural communication also proved a challenge. Language-learning gaffes are always embarrassing. I once called the "village head" (*kepala desa*) the "village coconut" (*kelapa desa*). I once told of Jesus riding a soybean into Jerusalem instead of a donkey (*kedelai* versus *keledai*). I once told a group of men that men ought to make love to their wives publicly, my intention was merely to express that husband and wife should be able to hold hands in public and show some public affection. I once stated that I desired a "bad wife" (*istri jahat*) instead of a momentary rest (*istirahat*). At least I didn't become an accidental heretic by teaching that Jesus was a *hewan* (a domesticated animal) during Sunday School instead of merely being *heran* (surprised). I once heard of a visiting American speaker opening his overseas speech with the words, "It tickles me to death to be here," only to have this translated by the bewildered interpreter as, "The speaker says to scratch him until he dies!"

Even when we learned Indonesian words, we still had to learn Indonesian patterns of communication. Cross-cultural communication is more than google-translating replacement words; it means replacing your thought-patterns and ways of expression as well. As much as

possible, you must enter into the host culture's way of thinking. For example, change the active voice to the passive voice lest you sound rude and accusatory (even if this means that many cars seem to crash themselves and many cups drop themselves). Adopt local idioms, even if this means that a person harboring a hidden agenda has "a shrimp behind the rock."

Words do more than convey information. Cross-cultural communication is also about knowing how people use language relationally. The "relational yes" is one such example. People were always so helpful when I asked for directions in some parts of Java. Yet those directions often sent me even more awry and got me even more lost. Many Indonesians will give you a nice, affirming "relational yes" no matter the reality of a situation. They do not want to tell you "no" or fail to help you. This can be particularly frustrating when conducting health interviews or seeking medical compliance to given health instructions.

Confronting my own prejudices

At some point in adapting cross-culturally, you will find yourself growing judgmental when encountering different cultural values from your own. Your ethnocentrism will multiply ten-fold. Your prejudices will lie quietly hidden under a veneer of open-mindedness during good times, but will wait for just the right frustrating cultural moment to mutiny and hijack your best thoughts concerning your host culture during your not-so-good times. You will exult one moment in the cultural progress you have gained, and the next moment you will curse "the stupid ways of the locals" under your breathe. Theoretically you will long to love all of mankind, but the rub comes in loving those individual persons you encounter on a day-to-day basis.

It seems an unfortunate aspect of human nature that we excuse faults committed by members of our own race, tribe, or in-group and justify them as mere isolated examples (one

"bad egg" among an otherwise good group). Faults committed by members of another race, tribe or culture that are not our own in-group, however, often get attributed to the entire group as a whole. A white person might steal, but blacks are thieves. A Westerner might tell a lie, but Javanese are liars. It is an ugly feeling, and shameful. For this reason, many Westerners will claim not to harbor such distasteful attitudes. But just immerse yourself in another culture for an extended period of time. Just let yourself experience yet another traffic jam in Jakarta, another pick-pocketing attempt, or another episode of smoking at right-up-in-your face-proximity on public transportation. Many prejudices are far from rational, and many people lack the self-awareness to even realize that they, too, hold such ethnocentric beliefs. The lens by which we see the world is so often smudged. The filter by which we process the raw data of reality is so often marred. We process reality with an empirical bias which gathers alleged "evidences" against our host culture when we grow frustrated with them. Instead of seeing their cultural diversity as a wonderful reflection of God's creativity, worthy of dignity and respect, we become quicker to judge than we are to understand. This happens especially in moments of stress.

Here are two examples. First, I grew up in the Mid-West among a farming community where it was a matter of pride to work hard and have calloused hands to show for it. Many upper-class store owners in Java, however, exhibit well-manicured abnormally long thumbnails as a status symbol. Why? It shows that they do not have to engage in manual labor. Every time I see these men, judgment wells up in my breast. Second, I still fight the feeling that many Javanese men appear very creepy towards my children. They like to pay compliments to my small children, especially my little girls. A matronly Javanese woman telling me about the cuteness of my 6-year old daughter's dress is endearing. A middle-aged chain-smoking Javanese

man calling my daughter pretty, on the other hand, just gives me the willies – even if they are just trying to be nice.

LIVING AMONG A TRIBE

After learning the language in Java for a year, we moved to eastern Indonesia, to the region of West Papua. There we built a house in a jungle village and settled in to live with a tribal group. We now live hundreds of kilometers away from advanced healthcare. We operate a primitive "health clinic" on our front veranda, our kids beating on a cooking pot to signify its start each afternoon. The walking sick climb our porch to have their symptoms checked. More serious cases involve me trekking out to their huts with meds stowed away in my rucksack.

Living here can be very isolating. As parents of 3 small children, we are their only healthcare providers. This can be anxiety-provoking at times of high tropical fever or other injury. As I write this, my daughter lies on a lawn chair, curled up in gastric distress with what seems to be amoeba (again). At least the lone barber in a town only suffers from bad haircuts. What a motivation to

stay on top of your craft. However, most tropical illnesses are very predictable and treatable.

What about the overall quality of our family life? Are my children deprived? Not at all! Their experiences are richer. They have three rivers to choose from; their usual dilemma is, "Where do I swim now?" They play soccer, climb trees, hunt bugs (collecting more than I would like to see). They shoot bows and arrows, attend school at home, get dirty and then visit the river again (wash, rinse, and repeat). They fall into bed at night, usually exhausted from having fun. Rather than entitlement and ingratitude, a sense of thankfulness and an awareness of being blessed develops. They see how the less fortunate live. They help me treat the sick who come to our porch. They see both the good and evil of multiple cultures and can weigh and question these worldviews. There is added risk, yes, but all lives are fragile, all plans uncertain, and no place in this broken world is truly safe.

TRIBAL NURSING STORIES

The following are several stories from the past several years that may better illustrate the challenges of missionary nursing among a remote tribe.

"You raised the dead!"

Many tribal peoples here assume that the unconscious or unresponsive sick are already dead. It is certainly hard, after all, to verify shallow breathing while in a creaking hut bursting with family members and piglets and without any equipment such as a stethoscope. Upon climbing into the crowded home, I am greeted with the words "emilo" and "sudah mati" ("already dead" in two languages). I can count at least 4 clear cases now of rousing such slumbering cases with an injection, infusion, or even simply by wetting their lips with a moist towel or sugar.

"Did he just murder his kid on my living room floor?"

One such sick boy that was prematurely pronounced dead ended up finally dying, most likely by his own father's hands. His shallow breathing was barely perceptible. Further treatment was resisted by his parents. They had already lost hope, and yet there was a pulse. They wanted to bury him immediately and return to their treehouse. When we tried to convince the parents to move the child into our home for closer (and quieter) monitoring, the father was livid, "He's already dead, bury him, we need to get back to our treehouse!" The child improved after IV infusion, his pulse strengthened, and his breathing became perceptible. He had gone without eating or drinking for 3 days, however, and was very weak. The father grew almost violent in his insistence that the child had no hope. He seethed. We gave food to the parents to pacify them, and then put our own kids to bed. They had uneasy questions about our new houseguests, but having critical patients overnight with us has become the norm. We stayed awake and checked

on the child often. He had begun swallowing and moving his mouth on his own in response to spoonsful of juice.

About midnight in our living room, Teresa came upon the father hunched over the child's still warm body. He appeared to have his hands over the child's mouth. The child was no longer breathing. It seemed very suspicious. "He's already dead, let's go" he told his wife and then told Teresa, "I told you he was going to die." The man then demanded a flashlight from us and stormed out of the house. In the early morning they left the corpse to be buried by our Dani tribal co-workers and trekked home alone. The father was so convinced that the child would die, and so impatient to get home, we believe that the father helped the child to stop breathing.

"Oh no, the government health-care workers are coming!"

Many plans to help the poor are ill-conceived, and executed even worse. Two years ago, the Korowai people were "discovered" by the government and listed on the national census for the first time ever, the government census party trekking over two weeks to reach our area (I guess they didn't know about our water-strip). Since that time, the government has occasionally sent healthcare workers upriver to us – with mixed results. While we appreciate the fact that we can sometimes receive free medicine, some other practices are alarming. They mass distribute medicine to tribal people who have no understanding how to store or keep these meds. I have climbed into jungle treehouses only to find white, chalky heaps in the corner - rotting meds! I have seen small children grab and sample these pills (or at least the mush that those pills became). One healthcare worker was evidently too weary from the long trek to police his inventory, dropping supplies along the trail from riverbank to village. One curious small child,

Demianus, uncapped a syringe and tried to peer closely at the needle – only to poke it into his eye. He is now blind in that eye.

While we require patients to return on consecutive afternoons to our porch to complete multi-day dosages, some healthcare workers have given a week's worth of medicine to some of the sick tribal locals who can neither read nor write. They either take too many pills, too little, or trade the pills to others. Good intentions are not enough when it comes to healthcare. We should never justify shoddy practices in the name of charity, "Do no harm" being the first cardinal rule by which we abide.

Pulong Banop, a tribal child rescued from death

When we first met Baby Pulong, her body was limp and feverish with both vivax and falciparum malaria (she was plus-4 for both according to laboratory tests on the coast). Malnourished, anemic, and stricken by trichuriasis (Whipworm) as well, her rectum was prolapsed and she suffered up to 30 bouts of foul mucus-filled diarrhea each day. Pulong was too weak to walk or stand, or even to sit unassisted.

Pulong's mother has never resided even in a village. She lives in a remote treehouse over eight hours to the

West of my home in Danowage – a full day's walk and three river crossings away. She knows only her tribal dialect and the outside world is frightening to her. There is a local belief that the world will end when the outside world intrudes upon the Korowai region. My mere presence is a harbinger of the Apocalypse.

I use my satellite phone to call for a medical evacuation by helicopter. The mother, terrified, wild-eyed and screaming, dashes into the jungle at the sight of the helicopter descending from the sky. We try our best to explain the situation to her. Even then, she will not climb aboard. She hands over baby Pulong to our Christian coworker, Perin Lambe, from the highland Dani tribe. Desperate with grief and fear, Pulong's mother lies in the mud beside the trail as the heli lifts off.

Perin helps us nurse Pulong in our home for the better part of the next year, where Pulong receives round-the-clock care. Her malaria is cured (both kinds), her diarrhea disappears, and the prolapsed rectum retracts. The lice are eradicated (after first spreading through my own household). Perin patiently helps us tend to the 2-dozen episodes of explosive diarrhea a day. Finally, this, too, ceases and Pulong becomes stronger. Pulong learns first how to sit, stand and then walk in our home. Suffering a jaw deformity, she only learns to talk with great difficulty. The sight on the face of Pulong's mother is of happy disbelief as Perin returns Pulong.

Two years later, we receive a visitor from the jungle. It is Pulong. Instead of being carried limply in a net-bag, Pulong has walked the 8-hours to my village along with her mother and father, her own small net-bag hanging from her head. They hand over a fish in gratitude.

Maltreatment of Papuans in city hospitals

Interior Papuans are black, Melanesian, and tribal. They are also generally poor (if we don't count the value of tribal hunting lands) and suffer from limited access to education. Most other Indonesians are brown-skinned and from Malay descent. They live mostly in Western Indonesia and along the more accessible coastal regions of Papua. Much inequality exists. While visiting Java, I've had Western Indonesians ask, "Do those Papuans have tails?" One Javanese doctor stationed (reluctantly it seems) at one Papuan hospital desired strongly to amputate one of our Papuan friend's feet after only a cursory examination and without first discussing any other options with the patient. His rationale: "Well, he's a tribal guy. They don't know much – the foot will just become infected anyhow, you know that these Papuans don't bath much. It is best just to cut it off now."

I believe nurses have a moral obligation to advocate on behalf of their patients. The Bible demands: "*Speak up for those who cannot speak for themselves, for the rights of all who are destitute*" (Proverbs 31:8). Advocacy (even loud advocacy) is thus a divine imperative. When our co-worker, Jimmy Weyato, was mauled by a pig and the bones in his toes were bitten through, amputation was also the first and only option considered. At least until two foreign nurses made a scene. We finally found a kind-hearted Christian doctor, a Javanese man who felt called by God to serve the medical needs of Papua. He took over Jimmy's care, operated before obtaining proof of any means of payment, discounted the fees when he learned of Jimmy's financial state, and placed steel rods to reposition toes that hung askew from the tusks of the attacking wild pig. Jimmy now plays soccer again just as before. He treks from jungle post to jungle post with me again, hours and hours on muddy jungle trail, just like before ("just like before," meaning barefoot).

Baby Sebideyos - suctioned to death by careless nursing

Sometimes the story does not end so well. We are always in a dilemma with difficult cases as to whether to treat the patient on-site (in our home) or send them out by heli to a bigger facility. Baby Sebideyos was Kesia and Yonas's first child and was suffering severely from RSV (respiratory syncytial virus). We improvised a croup tent with boiling water, Vicks vapor rub, and a plastic sheet. But we lacked oxygen or suction capabilities in our jungle post. Should we monitor Baby Sebideyos here, or should we send him out to the hospital in Wamena? The mother knew but little of the national language or the outside world. Most people in my village have never even seen a car before.

We sent her out by heli medivac. Back in Danowage, we waited for results. The next day we learned the awful news. The nurse in Wamena had inserted the suction tube to help clear Baby Sebideyos' congestion…and then left it in at full suction for over a full minute without pause. Baby Sebideyos died mid-suction with the tube still inserted. The hospital staff then shifted blame to Kesia, who had tried to breast-feed Sebideyos to calm him on the heli flight to Wamena, "He choked on your milk," the hospital staff told Kesia. We transported the tiny body back to Danowage the next day. We would normally bury the dead in the city, but the father Yonas had threatened to shoot us with his bow and arrows if the baby died. When Kesia returned, she seemed to defend our care and calmed the feelings of Yonas. Then she began her several days of ritual wailing at her baby's death.

Cerebral malaria and no way to evacuate

Ledipena started seizing at 0530. She had been barely conscious most of the previous night after collapsing at the airstrip the previous afternoon. Ledipena is the wife of the highland church worker, Endiles, and they were together helping the local Korowai tribe continue their 5-year long labor of carving out a dirt airstrip from dense jungle foliage using only simple tools and back-breaking work. Ledipena had been sick for 2 days' prior and had barely eaten or drank during all that time.

We decided to medically evacuate her to the coast. Then we learned that the floatplane that services our village by landing on our river was experiencing mechanical issues and was not available. The helicopter that we often use for emergency medical evacuations was also disassembled for inspection. The weather was rainy and the river was flooded and only marginally safe for the full-day float down to Yaniruma by dugout canoe. She wasn't stable enough to tolerate that ride and the water was too choppy to safely transport someone who was not fully conscious. We felt trapped.

We started an IV and infused the WHO Standard high loading dose of quinine for severe cerebral malaria. All day Tuesday and Wednesday her breathing was labored and she suffered occasional seizures. It looked several times as if she was beginning to decompensate. At one point we concluded that she seemed to be in the process of dying. The highland Dani Christians gathered around her bed and began to pray. Her breathing normalized again precisely as they prayed.

Early on Wednesday morning, we ran out of IV quinine and fluids. We normally stock enough meds for most cases of most sicknesses, and we had enough IV quinine and fluids to

stabilize a patient in order to get them out to Wamena. But we did not have enough to keep and treat a critical patient locally for an extended period of time in the village without resupply.

Mission Aviation Fellowship came to the rescue. They flew slowly at treetop level over our village and chucked specially prepared padded boxes of meds and fluids out of the airplane window. These padded boxes thudded down in a perfect bull's-eye among the soft bushes near our simple church building (only 2 IV bags broke, but the rest of the meds were recovered intact). This allowed us to continue the quinine dosing and IV fluids for several more days.

Friday morning, Ledipena began to improve and follow us with her eyes. Then she began to cry for her children. We continued IV fluids, meds, and then progressed to oral rehydration with juice and then oatmeal through an NG tube until she could began eating on her own. During episodes of anxiety my 6-year old very blonde-headed son, Noah, would stand at the foot of her bed and smile, and Ledipena would immediately calm at his presence. The next week, she was able to walk by herself.

THE IMPACT OF WORLDVIEW AND CULTURE UPON HEALTHCARE

Culture may be defined loosely as those traits which make up a particular group of people (customs, rites, social practices). Culture would include things such as food and dress and music and language.

Worldview goes deeper. It focuses on the inner make-up of a person or group. Worldview (*weltanschauung* if you prefer German) is a lens through which we see the entirety of reality. Whatever worldview we hold becomes a filter, a

grid, through which we process the data from our senses. Our experiences of life and the moral and philosophical values we attach rightly or wrongly to reality are determined by whatever worldview we possess. Our worldview determines whether we suspect witchcraft when we fall sick, blame bad vapors, or attribute disease to germs.

Indulge me for just a second with this following mental exercise. Think about American cultural values. How do these American cultural values impact health, either for good or ill? How does belief (even religious belief) impact the following health care concerns in the West: heart disease, diabetes, obesity, STDs, HIV/AIDS, addictions, abortion, and trauma from domestic abuse as well as child abuse? All of these healthcare concerns have deep psycho-social implications and are closely linked to lifestyle or life-choices, which are closely linked to worldview.

As a nurse and a pastor, and one living overseas and keenly aware of the influence of culture on healthcare, I want to strongly assert that healthcare must not focus on the merely physical. We must ever be mindful of worldview when treating the sick and remember that we do not merely treat a physical body, but a human whole. We are not merely biological pieces of matter which sometimes go awry and need fixing. We are whole systems who have

psycho-social, spiritual and sexual components. In fact, the physical aspect is not even our most significant aspect. To summarize the theologians, we are not bodies possessing a soul, but the other way around. We are souls possessing a body. This most substantial part of us, the soul, is unable to be dissected by a surgical knife, subjected to lab exams, or seen under a microscope. If we dichotomize human beings and attempt to treat their biology without changing their habits and beliefs our success will be limited.

Being a positive change-agent while respecting local culture

Worldview changes lead to health changes. We desire to respect the local culture, even while serving as positive change-agents. Missionaries have a long history of impacting the health and well-being of local communities for the good. Baptist missionary William Carey helped end the brutal practice of Suttee in India (widow burning). Missionaries to Japan helped stop the foot-binding of Japanese women and helped advance their place in society. Until the 1970's, over half (some say nearly 75%) of all African schools were mission-run. William Wilberforce was a committed Christian who labored for decades to end the slave-trade.

The sociologist Robert Woodberry more recently claimed in the article, "The Missionary Roots of Liberal Democracy," in the May 2012 issue of *American Political Science Review*, "The work of missionaries . . . turns out to be the single largest factor in insuring the health of nations." Woodberry continues on page 39, "Areas where Protestant missionaries had a significant presence in the past are on average more economically developed today, with comparatively better health, lower infant mortality, lower corruption, greater literacy, higher educational attainment (especially for women), and more robust membership in nongovernmental associations."

Our beliefs about God, the world, and reality must impact how we treat our fellow man. Our culture and worldview (including our spirituality) must have practical social implications. I am glad to be a missionary nurse because it allows me to address the whole person.

It is true, that a careless approach to culture-change may result in unintended negative consequences for indigenous cultures. In an effort to end polygamy in Africa, some missionaries encouraged divorce for polygamous couples. In one fell swoop, this rendered many former wives destitute of material means of support and their children immediately changed in status and became "illegitimate" overnight because of careless mission policies. It is imperative for every missionary nurse to become a student of the culture which they are serving.

We desire to be positive change agents, but this does not mean that we desire to destroy indigenous cultures or become cultural imperialists. I want to see the end of witchcraft accusations. I seek the end of wife-beating. I long to see the extinction of tribal infanticide. I hope for the end of superstitious food taboos which steal vital protein intake away from pregnant and nursing mothers. I desire, however, in all of my efforts to preserve all that is noble and good about this culture. Each and every tribal person is a special creation of God, worthy of love and respect. Every human culture displays the glory of God's immeasurable variety and creativity.

ADVICE TO NURSES DESIRING TO SERVE OVERSEAS

What advice would I give somebody pursuing nursing in a cultural context not their own? Here is a short list; (1) be flexible, (2) be open-minded, (3) invest in language and culture learning, (4) look for things that you absolutely love about your new culture (and remember those things on difficult days), (5), make lasting friendships with locals – they can be gentle cultural guides, (6) if you are having a bad day, just withdraw and have a stash of good American

candy and movies for pure escapism. Then jump right back on that horse and get to work again after such a break, (7) see each patient as a Creation of God, with unique value and dignity, (8) think long-term, (9) focus on disease prevention and health education over merely just treating the recurring sick, (10) manage your expectations (sometimes this means "aim for the dirt and be happy with any results higher than that"), (11) take care of yourself and prevent your own physical breakdown lest you be no good to anybody else, (12) learn to disengage and vacation without allowing nagging thoughts about your place of duty to steal away your moments of relaxation (leave work at work).

A FINAL WORD

Though we live in a difficult area, we thank God every day that we can serve here. The quality of our lives is not to be judged by what we gather to ourselves, but by what we can give to others. We feel so very fortunate for the privilege of serving where we do.