Holistic Transformational Development through Surgical Care

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Introduction

"I have a dream…" The iconic words, spoken by Martin Luther King, Jr. during the 1963 address at the March on Washington for Jobs and Freedom (King 1963), resonate in the ears of all those who, like me, would like to see true transformational development be born and flourish through the church of Jesus Christ in global communities bound by poverty, sickness, injustice, and apathy. This is the dream which has led me to a more than decade-long health care career in Africa, and the dream which made me join, in 2000, BethanyKids, a small faith-based organization whose motto is "healing children in Africa, transforming lives" (BethanyKids 2013).

Twenty years after its foundation, BethanyKids has resulted in thousands of operations and equal numbers of therapy sessions on children with disabilities (BethanyKids 2016b), but have we really seen transformational development in the communities where we have worked? My motivation is a desire at all costs to see people and communities not only physically healed or improved, but actually "transformed into [God's] image with ever-increasing glory" (2 Cor. 3:18). The fulfillment of the dream is, in my view, only granted to those who are both committed and intentional—in God's words to Jeremiah, "You will seek me and find me when you seek me with all your heart" (Jer. 29:13).

My premise is that a health care ministry to children with disabilities and their families can—and should—be the springboard to holistic, transformational community development in low-resourced settings in Africa. I will develop this thesis in this blog series by first examining the context in which it is proposed with its social, cultural, and spiritual aspects. I will then define the specific bio-psychosocial and spiritual challenges that need to be met, and propose an elaborate, if hypothetical, plan of action.

Context

I have been intimately involved as clinical director and educational consultant for the past 15 years with BethanyKids—a charitable Christian organization founded in 1998 for the purpose of "transforming the lives of African children with surgical conditions and disabilities through pediatric surgery, rehabilitation, public education, spiritual ministry, and training health professionals" (BethanyKids 2016a). At the core of BethanyKids' *modus operandi* is the provision of affordable surgical care to children with surgical disabilities, particularly spina bifida and hydrocephalus, as well as cleft lip and/or palate, burn contractures, hypospadias and other surgical conditions (BethanyKids 2016c) in various African countries, coupled with spiritual ministry to their families. During the early years the surgical team was composed of expatriate surgeons employing African national clinical and chaplaincy staff. A prompt re-orientation towards surgical education and training has resulted in the increasing nationalization of the African team, now comprised of eight pediatric surgeons, only one of whom is still expatriate. An original commitment to the care of children with physical disabilities has been expanded beyond surgical care through the long-term involvement in occupational therapy and education at the Joytown School for the Physically Disabled in Thika, Kenya.

The geographic context of the project therefore includes the African countries where BethanyKids is currently operational: Kenya, Uganda, Madagascar, Ethiopia, and Sierra Leone. In each of these countries there is at least one national pediatric surgeon overseeing the local work. With the notable exception of Kenya, this work is limited to date to providing free or low-cost surgical care to children in need, with the additional help and ministry of a social worker cum chaplain in Ethiopia and Uganda.
The communities targeted in each country include children living with surgical disabilities, their parents or other caregivers,

and their families. While the surgical care sites are both urban (in Uganda, Ethiopia, and Sierra Leone) and rural (in Kenya and Madagascar), an organized network of mobile clinics (in Kenya) and informal referral networks (everywhere else) expands the potential impact of the ministry to large areas within these national boundaries.

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The Problem

The Bible puts it in no uncertain terms that "our struggle is not against flesh and blood, but against the rulers, against the authorities, against the powers of this dark world and against the spiritual forces of evil in the heavenly realms" (Eph. 6:12). Yet flesh and blood are real, obvious, overt enemies in health care provision, and the apparent discrepancy can be resolved by conceptualizing such material foes as tangible weapons of the evil spiritual forces engaged in the cosmic battle of Creation. In the words of medical missionary to India Robert Hughes, "this kingdom of disease, death, ignorance, prejudice, fear, malnutrition, and abject poverty [is] most surely a kingdom which ought to be overthrown by the kingdom of our God" (Snodderly 2009, 86). This battle cry constitutes the justification for BethanyKids' central ministry—health restoration—and the key to its broader transformational impact.

The Blessing of Health and the Burden of Disease

Health is a key concept to our project, and it is far more than the sheer absence of disease. The secular World Health Organization (http://www.wciujournal.org/journal/article/www.who.int/) (WHO) recognized this as early as 1946, when it defined health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity" (World Health Organization 1946). This definition points to the Christian understanding of health as part of God's broad concept of *shalom*, to be addressed later below.

From a physical, material perspective, the burden of disease in low- and middle-income countries (LMICs) and in Africa is staggering, with a much greater health burden per person, expressed in disability-adjusted life years in the very areas where health care resources are most scarce (https://vizhub.healthdata.org/gbd-compare/). (The Disability-adjusted life year (DALY) is a health gap metric combining mortality, expressed in Years of Life Lost, and morbidity, expressed in Years Lived with Disease). (World Health Organization, 2017b).

Due to a variety of systemic causes, this large burden of disease translates into an even more striking lack of access to surgical care, as evidenced by many African countries having less than 20% of the population with access to surgical care (http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)60160-X.pdf).

These health care discrepancies are the subject of the emerging domain of global health, with its sub-specialties of global surgery and global pediatric surgery. Unlike its earlier counterpart of "international health," global health is primarily focused on equity in health care across the South-North research gap (Meara et al. 2015). Global surgery is a relatively new area of focus within global health, sometimes dubbed the "stepchild" global health (Meara and Greenberg 2015) to reflect the long-term neglect of surgery within the World Health Organization. The recent Lancet Commission on Global Surgery has changed this status quo, by not only showcasing the great burden of surgical disease and the challenges in access to care in low- and middle-income countries (LMICs), but also demonstrating the cost-effectiveness of surgery when compared to other basic health care interventions (typically in the range of $100/DALY, cf. $500/DALY for global HIV care) (Meara et al. 2015). Despite these advances in our understanding of global surgical needs, the specific needs of children with surgical disease are much less understood. In fact, global pediatric surgery has been dubbed the "unborn child of global health" (Sitkin et al. 2015). Early studies however have documented the great surgical burden among children in LMICs, the difficulties that families face in accessing care for their children, as well as the cost-effectiveness of pediatric surgical care (again in the range of $100/DALY for even complex surgical interventions) (Poenaru 2016).

Disability

Disability is a very complex term, encompassing disabling impairments, activity limitations, and participation restrictions (World Health Organization 2017a). The WHO clearly emphasizes that disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers (World Health Organization 2017a).

Children with disabling impairments are particularly vulnerable because of the combined effects of their health issues with mobility issues, poverty, and social isolation. A study from South Africa found that only 44% of disabled children attended school, 26% received rehabilitation services, and 28% assistive devices (Saloojee et al. 2007). Internal displacement and forced migration compounds these effects, as highlighted by a study on the burden of surgical disabilities among children in the world's largest refugee camp in Northern Kenya (Wu and Poenaru 2013).

Spiritual Perspective

While the above scientific review outlines some of the aspects of the problem at hand, it completely ignores "the spiritual forces of evil in the heavenly realms" (Eph. 6:12). And yet, as Christ-followers, we are convinced that there are spiritual "root" causes to all physical, psychological, and social issues that we encounter. This spiritual root cause is, in the Christian worldview, a personal evil—Satan—identified by many as the angelic being of Ezekiel 28 created by God and who has

rebelled against Him. This evil force and those aligned to it (the other "fallen angels" mentioned in Revelation 12:9) wage war against God and His creation, and are seen as largely responsible for suffering and disease, as a direct and indirect result of the fall of the first humans (Gen. 3:1-19).

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While the principle of intelligent, personal evil opposing God's creation and ongoing life on earth is firmly based in the Scripture, the actual mechanisms by which this is actualized are far less clear. The pattern clearly involved is one of distortion—"distortions of human social relations, distortions of nature ("natural disasters"), distortions by disease," paralleling the famous three horses of the apocalypse (war, famine and plague) of Revelation 6:3-8 (Snodderly 2009, 74). This distortion can be seen as an evil tendency towards an entropic return to the state of chaos, the *tohu wabohu* of Genesis 1:2, representing already a fall from an original created state of perfection (Snodderly 2009, 14).

With specific reference to health and disease, Ralph Winter has suggested that the process might have included an evil "hack" into the genetic processes of creating life forms, possibly at the time of the Cambrian explosion (Snodderly 2009, 76-79). While this bold hypothesis might account for the apparent late phylogenetic appearance of predatory life forms (including vile microbes) and of the rise in violence in ancient history, it is less able to directly explain non-communicable disease causation. This latter group, predominant in the global North and significantly on the rise in South, appears much more socially determined than its communicable counterpart, thus lending itself well to social causation theories (Forouzanfar et al. 2015). Relevant to our discussion is particularly the concept of systemic (or structural) evil (as proposed by secular thinkers such as Jean-Jacques Rousseau and Thomas Nigel) (Grant 2008, 57-63; Goldburg, Blundell, and Jordan 2011, 100). From our non-secular perspective, systemic sin (or evil) is recognized as the structural and societal component of the "rulers, … authorities, … powers of this dark world" listed in the oft-quoted verse, Ephesians 6:12. Unfortunately, as Ron Sider sharply points out, this societal sin is often neglected within North American "evangelical hyper-individualism," deeply rooted in dispensational and Puritan theology (Sider 2014, 257-63). Yet poverty, injustice, inequity, and corruption are massive, real, and pervasive societal evils, maintained and encouraged by existing socio-political structures, and directly influencing both societal and individual health (Basch 2014). The connection between poverty and illness is even more striking in the case of surgical conditions, whose treatment often requires costly (even though cost-effective) interventions as compared to medical therapies, frequently resulting in catastrophic and impoverishing health expenses (Meara et al. 2015).

Current Situation

The enormous problem of health care delivery in resource-poor settings is not new—in our Lord's words, "The poor you will always have with you" (Matt. 26:11). So before we embark on "fixing the problem," we need to understand what has been done to date towards its solution. And if the root cause of the status quo is spiritual, we are particularly interested in what the Church, God's instrument for our era (1 Tim. 3:15), has done so far.

Role of the Mission Hospital and of the Church

Unlike the situation in resource-rich countries, medical care is frequently provided in African countries by Christian hospitals and organizations. In fact, between 20-40% of health care in sub-Saharan Africa is provided in church-owned facilities (Kagawa, Anglemyer and Montagu 2012; Boulenger and Criel 2012). This surprising statistic is a reflection of both the very limited resources allocated by African governments to health care, and the evolving understanding of Christian global missions as encompassing not only evangelism and church planting but also health care and other compassionate ministries. While health and healing have been an integral role of Christian churches since the earliest times (Swartley 2012, 150-51), early modern protestant missions have often seemed to ignore that. Among 307 new missionaries recruited by the Church Missionary Society between 1951 and 1870, only seven were doctors (Hardiman 2006, 10). In Ralph Winter's words, "we should never suppose that the gospel of Jesus Christ is purely spiritual. Christian insight has always involved salvation on a holistic scale, but Christians have not always understood that" (Winter 2009, 216).

Today's mission/church hospitals are appropriately poised to address illness and disease, yet in the process they have, often unintentionally, re-defined health more narrowly as the "absence of disease." This is a stark departure not only from their historic understanding of *shalom*, but also from the WHO definition of health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity" (World Health Organization 1946). Missionary and national doctors do their tireless doctoring and report on patients who were operated on, cured, or died. Chaplains, on the other side, do their daily rounds praying for patients, and write monthly "spiritual" reports on numbers visited and "saved." Through routine and habit, the two disciplines seldom meet. The result is fragmentation, professionalization, and, ultimately, poor care.

A Specialized God

This missed opportunity in Christian health institutions is representative of a larger problem besetting our churches. It reflects a gradual degradation of the church from a living, thriving body of believers connected through all spheres of life on earth into a social club gathering offering a very specific, and limited, range of "spiritual services" such as marriages, burials, childhood and adult Christian education, and the like. Within this specialization, the focus and expertise of the church becomes getting people to heaven, while their earthly problems, including health, are relegated to the appropriate other experts and professionals. This perspective may be a natural consequence of what Paul Hiebert referred to as the "flaw of the excluded middle" – a modernist worldview which relegates God to heaven, regular life to earth, with nothing to fill in between (or at least nothing for the church to concern itself with) (Hiebert 1982). The great, universal "*Eloheynu,*

melech haolam" (Hebrew for "Our God, King of the World"), the God "greater than all other gods" (Exod. 18:11; 2 Chron; 2:5; Ps. 135:5), has, over the millennia, "shrunk" back to the size of the specialized Canaanite deities, able to assure victories in battles and eternal life but "needing help" from others in the health arena (Loewen 2000, 106; Poonaru 2010, 13-14).

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The African Setting

In the African culture and tradition this "divine specialization" (Loewen 2000, 95-101) is particularly concerning. African (traditional) religion is both complex and holistic, "An essential part of the way of life of each people. Its influence covers all of life, from before the birth of a person to long after he has died" (Mbiti 1991, 15). Already home for myriads of specialized spiritual entities clamoring to fill the (spiritual) "middle," the African worldview easily adopted Christianity and its God as an expert in the afterlife and morality issues, quickly concluding that He is not to be "bothered" or even trusted in daily affairs such as health (Loewen 2000, 92-93). Moreover, the African animistic worldview, including elements such as taboos, witchcraft, and fatalism does not appear to be conducive to development (Ampadu 2009, 113-17).

Proposed Solution

The concept of transformational development stems from a desire to identify Christian development as qualitatively different from secular development, to drop significant value connotations associated over the past century with the root term, and to bring in a broader, holistic understanding. Thus the 1983 Wheaton Statement, "Transformation: The Church in Response to Human Need" offers the definition of "transformation" as "the change from a condition of human existence contrary to God's purpose to one in which people are able to enjoy fullness of life in harmony with God" (Samuel and Sugden 2003, 7). Identifying development as the answer to the question "Who will save us?" Bryant Myers of World Vision expands:

I use the term transformational development to reflect my concern for seeking positive change in the whole of human life materially, socially, and spiritually. … Changed people and just and peaceful relationships are the twin goals of transformation. … Changed people are those who have discovered their true identity as children of God and who have recovered their true vocation as faithful and productive stewards of gifts from God for the well-being of all (Myers 2011 (https://www.amazon.com/Walking-Poor-Principles-Transformational-Development-ebook/dp/B00653P7AE), 3, 17).

Kirk Franklin sees transformational development as the path to shalom, which he describes as wholeness, without injury, well-being, a satisfactory condition, health, completeness, soundness, peace, well-being, prosperity, and salvation. It is about the way the world ought to be. It implies a state of mind that is at peace and is satisfied, nothing is lacking, and social relationships are characterized by harmony and mutual support (Franklin 2010 (https://books.google.com/books?id=m_Qd4idU_SwC&pg=PA9&lpg=PA9&dq=Holistic+Help+for+the+Peoples+of+This+Earth+Kirk+Franklin&source=bl&ots=PPHTV4CBF8&sig=-T-UTcUOK7ZxMKxVWa59LHGzU98&hl=en&sa=X&ved=0ahUKEwjG-OLRyOfZAhUL_WMKHW9JCBsQ6AEIKTAA#v=onepage&q=Holistic%20Help%20for%20the%20Peoples%20of%20This%20Earth%20Kirk%20Franklin&f=false), 70).

This *shalom* has also been aptly described as the sum-total of "right relationships with God, people, and nature" (Snodderly 2010, 159), and it is likely God's solution to the *tohu wabohu* of Genesis 1:2, the restoration of creation to its original *tob* ("good") state (Snodderly 2009 (https://books.google.com/books?id=169iHOL77N0C&printsec=frontcover&dq=Goal+of+International+Development&hl=en&sa=X&ved=0ahUKEwib-YLAyefZAhUC1mMKHZkeAUgQ6AEIKTAA#v=onepage&q=big%20picture%20of%20Scripture&f=false), 16).

The key principles and values of holistic transformational development are well articulated by Samuel Voorhies. They include recognition of the value of people, understanding and respect for local culture, belief in people's capacity to contribute and determine their future, and involving the whole person—mind, body, and spirit, in any development effort (Voorhies 1999, 605). In this holistic scheme, the "signs and wonders" of health care ministry (God's healing, both by scientific and miraculous means) fill the "excluded middle" described above and thus restore the third facet of the Gospel (Gospel as sign) to the existing two (Gospel as Word and as deed), for a complete embodied witness (Myers 2011, 21).

Health Care Ministry as Transformational Development

Even from a secular perspective, community development is seen to share multiple features with primary health care and to naturally result from the latter (Foster 1982; Phillips and Verhasselt 1994). Spiritually, if God's desire for humanity is shalom or the restoration of His original tob of Creation, then physical healing naturally belongs, and contributes, to transformational development. In the words of David Bosch,

Those who know that God will one day wipe away all tears will not accept with resignation the tears of those who suffer and are oppressed now. Anyone who knows that one day there will be no more disease can and must actively anticipate the conquest of disease in individuals and society now. And anyone who believes that the enemy of God and humans will be vanquished will already oppose him now in his machinations in family and society (Bosch 1991 (https://books.google.com/books?id=qEpf6wqHcGwC&printsec=frontcover&dq=Transforming+Mission+bosch&hl=en&sa=X&ved=0ahUKEwiP9J-MyufZAhUBwWMKHX3BCcgQ6AEIKTAA#v=onepage&q=Transforming%20Mission%20bosch&f=false), 400).

How this is actually realized in Africa is less straightforward, showing great regional, cultural, and ecclesiastic variations (Poenaru 2016). The central aspect of the physical care by BethanyKids (http://bethanykids.org/) for children with surgical disabilities in Africa is through one hospital-based site per country where the organization is involved. National Christian

disabilities in Africa is through one hospital-based site per country where the organization is involved. National Christian pediatric surgeons trained by BethanyKids provide the surgical care. Procedures and cost of care is provided at differential costs based on the families' incomes, and part of the costs are absorbed by the Kenya National Hospital Insurance Fund (NHIF), with families either encouraged to enroll in, or actually being offered the initial six installments as a gift from BethanyKids. As each country only has one BethanyKids surgical site, a network of regular (bi-monthly) clinics has been created across Kenya, allowing patients and families to be both initially diagnosed and followed up after surgery closer to their home. Of note, there are no fees or charges in the clinics, thus encouraging families to come without fear to the follow-up. The staff of each clinic includes specialized nurses, occupational therapists, and coordinators/chaplains. Families are given direct access by phone at all times with BethanyKids nurses. There is a need to expand the clinics in the other countries served by BethanyKids' hospitals.

Spiritual Ministry

Currently spiritual counseling is provided at two sites: in the hospitals through chaplain-social workers, and in the mobile clinics though the coordinators (and to some extent the nurses). While this system has been successful in the past years, it still lacks the integration needed for a holistic model. There is an increasing professionalism at the sites, which artificially separates the health care providers from the "spiritual providers" at all levels (nurses, therapists, doctors). Once outside the hospital, patients and families are in principle followed up through their local churches—though in practice this happens infrequently.

A holistic ministry does not separate between lay and pastoral/priestly roles. If the doctors are to be acting in a pastoral role, they must not only be given permission, but also encouragement, time, and training. The regularly occurring Bible studies must be aligned to this purpose rather than the traditional focus on increased Bible knowledge. Sunday "prayer rounds" could allow the members of the health care team to practice truly holistically, and be perceived as spiritual practitioners.

The greater challenge lies however outside the hospitals, in bringing the local churches into the health care process. Currently churches in Kenya are used primarily as vehicles for distributing health care messages (Campbell, Skovdal, and Gibbs 2011), but they rarely take an active part in the healing process. Specific improvements could include having health care providers run church-based workshops, not just for knowledge-sharing but for recruiting volunteers willing to bridge the gap and work in hospitals and clinics. This could generate mixed "shalom" teams, praying both at the bedside and "pew-side" in hospitals and churches, and this could even initiate church-based clinics on the field. An example of such a facility is the "Camp Brethren Clinic" started in the mid-2000's by a Kijabe pastor in a rural outreach ministry by Lake Naivasha, Kenya.

Community as Strategy for Connecting Physical and Spiritual

The ideal setting as well as strategy for connecting the parts of the whole—the physical with the spiritual—is the community. As Chong Kim asserts, "one foundational meaning of human beings being made in God's image is that we were created for relationship" (Kim 2015 (https://www.academia.edu/26840655/Agents_of_International_Development_and_Shalom), 19). The faith community is God's playground for human relationships. This primordial role of the community within health care is aptly recognized in Community Health Evangelism (https://www.chenetwork.org/)(CHE), a program which trains community members to share the gospel and promotes disease prevention and healthy living (Global CHE Network n.d.).

Mobile clinics may represent the best opportunity to integrate the holistic ministry within the community. This might be fostered by embedding a community advisor into the mobile clinic team, who may be a pastor/ chaplain and who will keep track of child/caregiver units in various geographic locations and maintain contact with them.

Within each locale the units could then join into a nascent community group (potentially called a "parent support group" or "parent cooperative"). A few such groups have already been created in Kenya but do not yet exist elsewhere within the BethanyKids network. Each group organizes itself as an advocacy/self-support group in the community. It identifies its strengths and resources as well as needs/wants, and identifies other external local resources/organizations available. It operates holistically and relationally, while also ensuring that the caregivers' voices are heard and taken in consideration. All this is based on the disability activism slogan, "Nothing about us without us."

Conclusion

Holistic transformational development is the ultimate goal of Kingdom work here on earth, both revealing the Kingdom to our contemporary society and speeding its arrival through its activity. Health care provision is a natural and strategic context for such development, meeting urgent physical societal needs and opening the door for addressing wider, underlying, individual and corporate aspirations.
BethanyKids, a Christian organization committed to holistic transformation through the surgical care of children in Africa, is well-positioned to enhance its activities to foster such transformational development. Should BethanyKids accept the challenge and transform itself for that purpose, it will have the opportunity to live up to its motto of not only "healing children in Africa," but also "transforming lives." And then it will be able to declare, alongside with all like-acting Christian churches and organizations: "[God's] Kingdom come, [God's] will be done, on earth as it is in heaven" (Matt. 6:10).

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