Out of One Mission Flowed Another:

A look at the purpose and goals of our Central African Medical Mission and how they have been carried out over the past thirty-eight plus years by the Lord's grace and guidance

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Out of one mission flowed another. In other words, our mission to preach the gospel in Africa, not many years after the work was begun, led into another mission - our Central African Medical Mission. In looking at an organization like the Central African Medical Mission, it would be impossible for one to divorce the history from the purpose and goals for which the organization came into existence. Therefore, this paper will consider that very topic, namely to look at the purpose and goals of our Central African Medical Mission and to consider how they have been carried out by the Lord's grace and guidance over the past thirty eight plus years.

As is true in many of the other areas of our Synod's history, so it is also true in the history of our Central African Medical Mission that a great deal of appreciation and thanks must be given to those who laid the groundwork. Their insight and careful planning that considered and studied the founding principles, and in turn established the policies that were based upon those principles for our Central African Medical Mission, have served the Medical Mission well. In the Synod convention of 1957, the Board for Foreign Missions (present day: Board for World Missions) set forth the general mission policies that it had adopted over the previous two years. Included in those general policies are the founding principles to which one can trace the first roots of the Central African Medical Mission. In a portion of section II from those policies of 1957, the following is established concerning medical aid in foreign mission fields:

> 5. That, when it is found necessary, we assist in establishing limited health and medical services in our foreign fields.
>   a. although it is by no means as important as their spiritual wellbeing, the concern for the physical health of our people is not foreign to the spirit of Christ, as we see from the Gospels.
>   b. in some foreign fields it would be heartless and unwise to neglect some form of medical or health services…
>   c. however, such medical or health services ought to be limited…[1]

These policies from 1957 and their relevance for the Medical Mission will be covered in greater detail later, as well as the "Statement of Principles and Objectives of the Board for World

[1] *Proceedings of the Thirty-fourth Convention – The Evangelical Lutheran Joint Synod of Wisconsin and Other States* (Held at Dr. Martin Luther College, New Ulm, Minnesota, August 7-14, 1957), 35.

Missions," which was adopted in 1965. For the time being, it will be of benefit to simply note the clear, as well as scripturally sound, principles and policies, which were founded upon those principles, concerning the topic of medical aid early on in the history of our Synod's foreign mission fields. These principles and a number of the policies were already in place before the official work of the Medical Mission was begun in 1961.

Another word of appreciation and thanks must be given as well. This word of thanks goes to the people who have followed after those who laid the groundwork of looking at the principles and establishing appropriate policies for our foreign missions concerning the topic of medical aid. Principles are the foundation. Policies are established in order to guide future actions that will remain in line with the principles at all times. When looking back to principles and policies, the questions need to be continually asked: how do we apply these principles and policies to the situation at hand, to the present circumstances that are being faced; how do we best carry out the purpose and goals set before us, possibly at times having to adjust the policies, yet always remaining within the framework of the guiding principles. If these questions are not faithfully asked and answered, then problems are bound to arise. More likely than not, if these questions are not continually addressed, it will simply be a matter of time before the original principles are abandoned. Detours from the original purpose and goals will inevitably result. All the people who since the founding of our Medical Mission have served in maintaining and constantly applying the principles that guide our Medical Mission deserve a great deal of acknowledgement for the work they have done.

Above all else, we give thanks to the Lord without whose love there would not even be the possibility for a medical mission such as ours. The Central African Medical Mission is an opportunity for the people of our Wisconsin Synod to reflect the love of Christ that our Lord has shown to us. Without him, there would be no love to reflect. And, if it where not for the Lord's continual guidance, none of the purposes and goals of the Medical Mission would have been able to have been carried out as they have, in accordance with his abundant grace.

The Need that put us there

Before looking at the need that put us into Africa as a medical mission, it seems only appropriate that the primary and most important need that led us into Africa be discussed. The Medical Mission had its formal beginning in 1961 when Lumano Lutheran Dispensary in Northern Rhodesia (present day Zambia) was dedicated. The gospel ministry of the WELS into Africa began in 1953. This order is important to note, for it is of considerable importance when looking at the purpose of the Medical Mission. Pastor Theodore Sauer, who was called in 1961 to be the superintendent of our WELS mission in Africa, conveys the importance behind maintaining the proper order between our gospel ministry in Africa and the Medical Mission that followed only a few years after the gospel work was begun:

> We began work there in '53, and there was no intention at that time to go into medical work... In other words, it was not that we decided, "Ok, we are going to go in there, and we're going to do medical work, and we'll also preach the gospel." But, we went in there with the first and prime purpose of preaching Christ, and this came then as a natural outpouring of the love and faith of our people back here, some of whom were of course over there.[2]

The purpose of the Medical Mission from day one was to be a supportive branch to the gospel ministry being carried on in Africa. This purpose has been maintained throughout the history of the Medical Mission.

With that fact being established, that the gospel ministry was begun first, note how only a relatively short amount of time passed before the medical work was begun as well. When our first missionaries arrived in Africa and began their work in Northern Rhodesia, it was abundantly evident that medical care was lacking in a large degree in the area in which they were working to share the gospel.

Numerous sources and people retell the story of how the homes of these first missionaries were flooded with people coming to their door looking for medical assistance. Actually, one might say that a medical mission among the people of Africa was begun long before our actual

[2]Pastor Theodore Sauer, interview by author, 20 March 1999, Manitowoc, Wisconsin, tape recording.

Medical Mission got its start in 1961. The truth of this statement is picturesquely explained in the following statement of Pastor Sauer:

> They (the missionaries and their wives) simply did not feel that they could let this condition exist. The long and short of it was that their back door, or front door as the case may be, became actually a "doorstep dispensary" where people came by the dozens at first, and then larger numbers after that, looking for help. Well, there was no way we could expect the missionaries' wives in addition to all their other duties including their families to take care of this work. So that was really the impetus.[3]

Looking back one can see the tremendous blessing from the Lord that was present in the fact that many of our first missionaries' wives to Africa were in fact nurses. They desired to help the people and were able to help the people in many cases. More help would soon be on the way to lift the burden from these early missionaries' wives.

The Board for World Missions was not only concerned with the strain that this additional work put on the missionaries' wives, it was also concerned with the health of the missionary and his family. Obviously, it was not an ideal situation to have people with contagious and infectious diseases coming to a home. This was neither the most adequate nor most appropriate setting to undertake this medical assistance. In addition, the Board for World Missions was concerned with "permit(ting) our missionaries to assume such a responsibility without making some provision to protect them from possible reprisals in case of unfavorable results of their medicine."[4]

One final reason should be considered in connection with the need that existed to start a Medical Mission. In order to understand this final point, one must consider the cultural context of the African field into which our missionaries were reaching out with the gospel. It was a cultural setting where medicine men and witch doctors, sad to say, were entrusted with both the physical and spiritual wellbeing of the people. "In their way of thinking we who supplant their medicine men and witch doctors in matters of the soul, are also expected to supplant them in matters

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[3]Pastor Theodore Sauer, interview by author, 20 March 1999, Manitowoc, Wisconsin, tape recording.

[4]*Proceedings of the Thirty-eighth Convention of the Wisconsin Evangelical Lutheran Synod* (Held at Northwestern College, Watertown, Wisconsin, August 4 to 11, 1965), 247.

pertaining to their physical well-being."[5] For this reason, our Synod acting in love toward these people, many of whom were still infants in the faith, established the policy that "until the matter has been made clear to them, we would be acting unwisely by refusing them every kind of physical aid." Yet, the caution is immediately added, "however, such medical or health services ought to be limited, and our people trained to think of the mission in terms of spiritual services and encouraged to seek physical help elsewhere."[6]

The principles that are at the foundation of our medical work

As is proper, our Wisconsin Synod has taken its founding principle for doing medical work, such as the work that our Medical Mission in Africa has undertaken, directly from Scripture. Obviously, the forms for providing this medical and health assistance are not prescribed in Scripture, but the principle that undergirds our Medical Mission, as well as other forms of humanitarian aid that our Synod has undertaken, is clearly set forth for us. The principles and policies that our Board for Foreign Missions, and later then Board for World Missions, established reflect this solid scriptural foundation.

Earlier reference was made to the Mission policies that were established and subsequently recorded in the Proceedings of the 1957 WELS Convention. Note how reference is clearly given to the scriptural reason for carrying out limited medical assistance where the need for such assistance is present:

> 5. That, when it is found necessary, we assist in establishing limited health and medical services in our foreign fields.
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> a. although it is by no means as important as their spiritual wellbeing, the concern for the physical health of our people is not foreign to the spirit of Christ, as we see from the Gospels.[7]

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[5] *Proceedings of the Thirty-fourth Convention – The Evangelical Lutheran Joint Synod of Wisconsin and Other States* (1957), 36.

[6] Ibid., 36.

[7] Ibid., 35.

For the time being, we note two things from this statement. First, our primary concern for people is their spiritual wellbeing. The first and most important thing that we want to do for people is to bring them the gospel. The message of the gospel, and it alone, has the power to bring healing that will last for more than simply a limited number of days or years. It has the power to bring eternal healing and eternal life. The account of Jesus and the Samaritan woman at Jacob's well immediately comes to mind. Jesus turned this woman's attention from the thought of physical water that quenches thirst, to the spiritual water of life that he had to offer her that imparts life eternal. Yet, Christ also commands, as well as setting a perfect example, that as Christians we are to provide for those whom we see in need of physical aid.

The section entitled "Primary objectives" from the "Statement of Principles and Objectives of the Board of World Missions" adopted in 1965 by the Wisconsin Synod further delineates the scriptural reason for undertaking this work of providing for the physical health of people who are in need. Under the eighth primary objective, where limited health and medical services are encouraged in foreign fields where the need is seen, the following is set forth:

> A. Although it is not the primary purpose of Christian mission work, the concern for the physical health and healing of the people among whom we are called to work is not at all foreign to the spirit of Christ and the apostles, as is evident from the Gospels and the Book of Acts (Mark 6:7, 16:17,18; Luke 10:9; Acts 3:6, 19:11-12, 20:35; Matt. 25:36,40; Jas. 5:14; Matt. 5:7; Luke 10:37).[8]

For the benefit of the reader, it might be good to note one or two of the above scriptural references. In Matthew ch.25, Jesus commenting on what will be said to the believers on the last day says, "I needed clothes and you clothed me, I was sick and you looked after me... I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me." In Luke ch.10, Jesus at the conclusion to the parable of the Good Samaritan states, "Go and do likewise." Christians strive to follow both Jesus command and his example in this area of providing physical help for those in need.

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[8] *Proceedings of the Thirty-eighth Convention of the Wisconsin Evangelical Lutheran Synod* (1965), 247.

Since this is the underlying scriptural principle, our Synod has wholeheartedly supported the work of our Central African Medical Mission, which strives to carry out this work of providing for physical needs in an area where medical aid is tremendously lacking otherwise. The following statement shows the support that was given to the Medical Mission, both for the reason given above, as well as for the reason discussed earlier of removing this burden from the missionaries:

> D. The World Board, therefore, welcomes and encourages the work of the Medical Mission committee and its support from the women's societies in establishing medical mission services, wherever these are considered necessary. Through the employment of a competent, trained nursing staff much of the medical and health burden is removed from the missionaries.[9]

The goals of the Medical Mission – and the policies put in place to accomplish those goals

In addition to the goal of fulfilling the medical need of the people in this area of Africa, covered in depth previously, there were other goals that our Synod saw as both legitimate and beneficial. One must always keep in mind the close bond that has been maintained between the medical ministry of bringing physical healing to the people of Central Africa and the gospel ministry with the goal of the even more important – spiritual healing. One cannot help but note the fact that in many places Scripture uses the truth of Jesus bringing healing for the physically lame, the physically blind, the physically ill, and then corresponds that truth to the even more important healing that Jesus brings, namely healing for the spiritually lame, the spiritually blind, the spiritually ill. Throughout its history, our Central African Medical Mission has had as its goal to continue to portray this close connection between a person seeing their need for physical assistance and healing, and then also Lord-willing seeing their need for spiritual healing as well. In 1965 this goal was stated by our Board for World Missions: "The missionaries are expected to make use of the medical and dispensary services to bring to the patients, above all, the spiritual healing through the Gospel."[10] This goal has always remained before the eyes of the Central

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[9] *Proceedings of the Thirty-eighth Convention of the Wisconsin Evangelical Lutheran Synod* (1965), 247.

[10] Ibid., 247.

African Medical Mission, as the current mission statement of the Medical Mission reflects: "The Central African Medical Mission operates with the philosophy that it serves as the supportive branch to the gospel mission..."[11]

"...And affords an opportunity to reflect Christ's love and concern for the physical needs of our fellowman." This is the second half of the mission statement begun in the previous paragraph. As Christians, we are to let our lights shine to the world, to those who have not yet come to faith in Christ. By letting our lights shine through these physical deeds of love, the Lord may open the door, present the opportunity, for us to share the message of the gospel as well. In this way, we are given the opportunity to carry out our lives of faith as we strive to share the gospel message with others who have not yet heard or believed. Also, simply through the physical acts of kindness carried out by the Medical Mission the opportunity is given to live lives of faith. This is one of the intents of the Medical Mission, namely to present the members of the WELS with opportunities to display and carry out their sanctified lives of faith. Not only are the people who serve in Africa given this opportunity, the WELS members here in the United States are given the opportunity as well. Through the offerings that are given to support this work of the Medical Mission, countless WELS members have displayed the faith that the Holy Spirit has worked in their heart and the faith that he has moved to service.

Before moving on to the next point, it should be noted that the budget for the Medical Mission from the very beginning was kept separate from the overall budget of the Board for Foreign (World) Missions. In this way, a clear distinction was maintained between money being given for the gospel ministry in Africa and money being given for this very specific purpose of Medical Mission work. More will be said concerning this aspect later.

A number of other very useful purposes are served through our Medical Mission. It has already been mention how the Medical Mission has as its purpose to be a bridge in order to arrive

[11]The Central African Medical Mission Committee, *The Central African Medical Mission Personnel Handbook* (reviewed annually).

at the opportunity, Lord-willing, to share the gospel message. The connection was previously noted between relating the need for physical healing to the need for spiritual healing. This is only one of the ways that the Medical Mission serves as a bridge in order to arrive at the opportunity to share the gospel message. The Medical Mission serves as a bridge in another very important way as well. The Medical Mission provides the opportunity to build a bond of trust or confidence with the people among whom the work is being done. Right from the beginning years of our Medical Mission this fact was recognized. The Board for World Mission states concerning a medical mission on a foreign field: "This medical mission arm is to be used as a valuable means of approaching the people, especially in primitive areas, to win their confidence and to demonstrate Christian love in action."[12]

In connection with the topic of the Medical Mission leading to opportunities to share the gospel message, another very important point was recognized right away. In order even to receive permission to enter certain areas in order to carry on the gospel ministry, some form of a medical program is either requested or expected of an organization. This was noted by our Board for World Missions in 1965.[13]

The reality of this truth was later seen on the African field when there were a number of uncertainties concerning if we would be allowed to continue our mission work into Malawi. In their presentation in support of starting a medical mission program in Malawi, Pastor R.G. Cox and Pastor E.H. Wendland explain the situation that arose. In the process of going through the proper government officials and agencies in an attempt to establish a good rapport with the government and receive their permission to carry on our gospel ministry in the area, a bump in the road arose:

> On March 26th, 1968, we received the following memorandum from the District Commissioner: "With reference to your letter of 31st October, 1967. I have been directed to

[12]*Proceedings of the Thirty-eighth Convention of the Wisconsin Evangelical Lutheran Synod* (1965), 247.

[13]Ibid., 247.

> inform you that the Lutheran Church of Central Africa may not commence or continue its activities in Lilongwe District."
> We appealed to the Office of the President for further consideration of this matter. The Secretary to the President asked our church to send to the President "information about the secular, as opposed to the ecclesiastical activities of your Church" (letter dated 17th April, 1968). This was done. Supt. Wendland and Missionary Cox, in a letter dated 7th May, 1968, wrote that although the primary purpose of our Church is to preach the Gospel of Christ, our church is concerned with the physical needs of people. In support of that we made mention of dispensary work in Zambia and also gifts to the Red Cross in both Zambia and Malawi. In reply to that letter we were informed that since it did not appear that our church "has any secular, as opposed to ecclesiastical activities in this country (Malawi), I regret to inform you that no further representations can now be made to His Excellency the President on your behalf."[14]

In the following months the opportunity was presented to engage in medical mission work in Salima, Malawi. In their "conclusions" to the presentation requesting that medical mission work be begun in Malawi, Pastors Cox and Wendland note:

> It is difficult to say to what extent our engaging in this work is vital to our position as a church in Malawi. We know that the government looks with special favor upon church bodies which demonstrate a concern for the physical needs and improvement of its people... To what extent failure to engage in such work would jeopardize our position, both present and future, is unpredictable.[15]

A Medical Mission mobile clinic was subsequently begun in Salima, Malawi (later moved to Lilongwe, Malawi). Thus, the Medical Mission in Malawi didn't serve so much as a source of entrance into the country, but it certainly appears that it served as a solidifying element in the continued ability to work in Malawi with the gospel ministry. It also served one of the purposes previously mentioned, namely establishing a bond of trust and confidence with the people among whom the gospel was being shared.

Another very important policy of the Board for World Missions must be considered in connection with the Medical Mission. This is the policy of planting indigenous churches. Some very important points must be considered here in connection with the indigenous aspect of the Medical Mission. It is apparent from the original founding document for the Medical Mission,

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[14]R.G. Cox and E.H. Wendland, "Survey of Salima Area for a Medical Missions Program" (April 1969), Archive file of the Central African Medical Mission Committee.

[15] Ibid.

entitled "Blueprint for Establishing a Medical Dispensary in Northern Rhodesia," that the intention was to have the Medical Mission fall in line with the indigenous policy of the Board for World Missions. This is seen by looking at the basic outline for the establishment of the medical dispensary: "I. The Immediate Phase – from now until assumption of work by the African staff; II. The Transitional Phase – during time of only periodic European supervision; III. The Long-range Program – under completely independent African operation."[16] Since this is the historical background, it would be wise to first take a rather cursory look at the policies set up by the Board for Foreign (World) Missions concerning establishing indigenous churches.

Although the word "indigenous" is not used in the 1957 Synod Proceedings, the concept of establishing churches in foreign fields that would eventually become self-supporting is clearly present in the mission policies of the Board for Foreign Missions. The reasoning for this policy was presented as follows:

I. God willing, our foreign fields must gradually become self-supporting.
1. Both as to the staff and the material means.
2. This is God's will: 1 Tim. 2:2; Gal. 6:6.
3. This is for the welfare of all concerned:
   a. the mission fields will achieve a full measure of joy only when they support a part, or even all of the work in their midst and may, in turn, help to carry the saving Gospel to others.
   b. the Church has been exhorted by the Lord ever to expand and extend her missionary activity (Isa. 54:1-4); yet, she may be prevented from so doing unless the mission fields gradually achieve self-support, both as to men and means.[17]

The purpose given for the policy of striving for the establishment of indigenous churches is explained very concisely, at least in this authors opinion, in a phrase taken from the above quoted material: "this is for the welfare of all concerned." The two sub-points under this statement further explain how this policy is intended for the welfare of all. It seems the policy can be boiled down to a matter of encouraging the sanctified lives of all the people involved. The sanctified

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[16] *Blueprint For Establishing A Medical Dispensary in Northern Rhodesia*, (Phoenix, Arizona: March 4-6, 1961). See Appendix #1 for photocopy of document.

[17] *Proceedings of the Thirty-fourth Convention – The Evangelical Lutheran Joint Synod of Wisconsin and Other States* (1957), 33.

lives of the native members are to be encouraged by encouraging them to become involved in the work of supporting their church, including the work of sharing the gospel with others (c.f. I.3.a. above). The sanctified lives of the members of the mother church body are to be encouraged by encouraging them to continually do further gospel outreach in new areas, not simply resting upon the work already done (c.f. I.3.b. above).

This aim of fostering the sanctified lives of all involved is more fully explained in the objectives set forth by the Board for World Missions in 1965. The following is given as one of the Board's primary objectives:

> 3. The policy of planting indigenous churches, rather than long-dependent missions is another objective which will be followed wherever the Board conducts mission work.
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> A. Our aim under this objective is to awaken and foster in newly converted children of God the awareness, the willingness, and the joy of using the gifts which are given by the Holy Spirit as fruits of faith for the administration, the support, and the propagation of the work of the Church in their midst.[18]

So, the policy established in 1957 remained and was reflected and further explained in the objective of 1965.

Having looked at the reasoning behind the policy of establishing self-supporting churches, let's now look at what is included in becoming self-supporting, as well as looking at how we as a Synod intended to accomplish this fact in the foreign fields we were entering. There are two key elements to the aspect of self-support: "self-support, both as to the staff and the material means."[19] It is important to keep these two elements in mind. The policy of establishing indigenous churches is not simply a matter of money. One part is financial. Another very important part is getting the native people involved in other aspects of Christian stewardship beside money. Once again, the primary goal of encouraging the sanctified lives of all involved must be remembered.

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[18] *Proceedings of the Thirty-eighth Convention of the Wisconsin Evangelical Lutheran Synod* (1965), 242.

[19] *Proceedings of the Thirty-fourth Convention – The Evangelical Lutheran Joint Synod of Wisconsin and Other States* (1957), 33.

The objectives established in 1965 reflect the original policies laid out in 1957. Further detail is given in 1965 in respect to how we as a Synod sought to carry out this policy. A condensed portion of how this was to be carried out follows:

> "This will be achieved on our part by encouraging: ...the early development of responsible Christian leaders after thorough instruction; ...more and more active participation by the converts; ...the early inclusion of the converts through elected representatives in the administrative body of the new national church; ...the early assumption of offices of trust in the national church; ...the early training in the responsibility and method of evangelizing activities; ...the early acceptance of partial and, as soon as possible, full support of the national church by its members..."[20]

This shows that the aspect of being financially self-supporting was not the only concern, and one might conclude that it wasn't even to be the primary concern necessarily over and above encouraging other forms of Christian stewardship as well, such as the involvement of the people in carrying out the work of the church.

In all this discussion concerning the policy of establishing indigenous or self-supporting churches, a very important emphasis of the founding policies and objectives from 1957 and 1965 must be constantly kept in view. I will simply supply a handful of quotes in order to bring this all-important aspect out. The following are taken from 1957 (emphasis is added by this author): "God willing, our foreign fields must *gradually* become self-supporting; ...That our foreign fields supply *as early as possible*, simple buildings... *eventually and as soon as possible*, the running expenses for the field; ...That our Mission Board will continue to send men into the field *as long as necessary*."[21] Please look back to the quote from 1965, which is found in the previous paragraph, in order to see similar phrases emphasizing the same point. The aspect of acting in love at all times must be kept in view and not neglected simply for the sake of carrying out indigenization as quickly as possible. Another statement from the Board for World Missions' objectives of 1965 draws this point out even more clearly:

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[20] *Proceedings of the Thirty-eighth Convention of the Wisconsin Evangelical Lutheran Synod* (1965), 243.

[21] *Proceedings of the Thirty-fourth Convention – The Evangelical Lutheran Joint Synod of Wisconsin and Other States* (1957), 33.

> The Board will work toward the achievement of this objective wherever it is active. However, there will be phases, areas, and conditions in mission fields, when it may be inadvisable, possibly even contrary to Christian love and the best interests of the work, to try to reach this goal very soon. The indigenous church policy is considered the ideal, but it is not an inflexible prescribed code. Rather, understanding, consideration, patience, and love for the souls for whom Christ died will always govern the application of this policy, with the ideal always kept in view.[22]

Keep this last quote particularly in mind. Later developments in the history of the Medical Mission concerning the topic of self-support will be highly dependent on these founding words concerning the policy of indigenous churches.

The first steps of the Medical Mission -
Establishing a structure that, God willing, would accomplish the goals

In 1957 the recommendation was given and adopted that limited medical aid be given by the Synod to the area of Northern Rhodesia.[23] As mentioned earlier, this was an area where we as a Synod were already active in carrying on gospel ministry among the people of Africa. The additional recommendation was made to encourage ladies' groups and other societies to contribute toward the support of this medical work.[24] This policy of receiving financial support from sources other than the World Mission budget is one that would remain throughout the history of the Medical Mission.

By 1959 the report was brought back to Synod that plans for the medical work were "slowly crystallizing."[25] All this while, the need among the people remained urgent. It took a great deal of time and effort, not to even speak of the insight and wisdom required, to determine what type of medical program should be undertaken, the goal being to best supply for the need of the people while staying within the means at our disposal. After undertaking a medical survey in Africa in

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[22]*Proceedings of the Thirty-eighth Convention of the Wisconsin Evangelical Lutheran Synod* (1965), 243.

[23]*Proceedings of the Thirty-fourth Convention – The Evangelical Lutheran Joint Synod of Wisconsin and Other States* (1957), 64.

[24]Ibid., 64.

[25]*Proceedings of the Thirty-fifth Convention – The Evangelical Lutheran Joint Synod of Wisconsin and Other States* (Held at Michigan Lutheran Seminary, Saginaw, Michigan, August 5 to 12, 1959), 66.

order to best determine what type of a medical program we should establish, Mr. and Mrs. Edgar Hoenecke returned to the United States. (For more information on the topic of the work done in order to determine what type of medical program to undertake, the reader is referred to "Healing in His Wings: the Story of Medical Mission Beginnings in Central Africa 1960-1961," *WELS Historical Institute Journal*, Vol.4, no.1 and 2, Spring and Fall 1986.) On June 27th 1960, Mrs. Edgar (Meta) Hoenecke presented to the Medical Mission Committee the recommendation of her husband and herself to establish a primary care bush dispensary. The recommendation was accepted by the medical committee, the executive committee and the Board for World Missions, and thus the preliminary path for our Central African Medical Mission was charted.[26] By 1962, the report was brought back to the nine districts of the Wisconsin Synod that "the medical mission program... is a reality."[27] A 35x40-foot dispensary, along with living quarters for the staff, had been built, and the dedication service for the Lumano Lutheran Dispensary was held on November 26, 1961. With that brief history being given, it is now time to look at the guidelines that were set down for the establishment of this medical dispensary program.

The Blueprint for the Medical Mission

The basic outline of the "Blueprint for Establishing a Medical Dispensary in Northern Rhodesia" was given previously in looking at the topic of the goal of our Board for World Missions to establish indigenous churches. This goal of indigeniaty was one which the Medical Mission had from the beginning as well. The Blueprint for our medical dispensary was submitted on March 4th through 6th, 1961 by Arthur Tacke, Meta Hoenecke, and Heinze Hoenecke.[28] The basic outline is as follows:

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[26]Edgar Hoenecke, "Healing in His Wings: the Story of Medical Mission Beginnings in Central Africa 1960-1961," *WELS Historical Institute Journal* Vol.4, no.2 (Fall 1986): 8.

[27]*Report to the Nine Districts Wisconsin Evangelical Lutheran Synod – May 1962*, 52.

[28]*Blueprint For Establishing A Medical Dispensary in Northern Rhodesia*, (Phoenix, Arizona: March 4-6, 1961), 7.

I. The Immediate Phase – from now until assumption of work by the African staff;
II. The Transitional Phase – during time of only periodic European supervision;
III. The Long-range Program – under completely independent African operation.

The immediate phase is the only part of the blueprint's basic outline that is then set down in greater detail. Edgar Hoenecke, who was present as well at the meeting on March 4th through 6th, explains why only this immediate phase could be set forth with any detail at this time. Commenting on phase II, he states:

> Since this is still thought to be attainable only after a period of complete stateside control, the details of this phase of the program are not spelled out in the "Blueprint." The important thing to remember, however, is that the goal and plan of the medical care program is to phase out foreign conduct and control of the facility. Even though this will be done gradually and carefully, it must always remain uppermost in our minds. Just as we are working to build an indigenous African church that is self-governing, self-propagating and, ultimately, also self-supporting, so each part of our foreign mission operation must strive toward this goal.[29]

Hoenecke adds a similar comment about phase III as well.

Appendix #1 gives a copy of the original "Blueprint." The reader is referred to that at this time. A brief overview of its expanded contents on "the immediate phase" is in order. The first section details the philosophy of the Medical Mission. The fundamental purpose in establishing the Medical Mission was to respond to the demonstrated need of the people among whom we were working with the gospel. This was discussed in detail earlier. The emphasis is stated that this medical program is to remain limited, "always bearing in mind that what we inaugurate in establishment, staff and service will soon be within the range of the ability of the African themselves to assume as an independent, self-supporting service."[30] The fact is stated that support would not come from the regular synodical mission budget, but instead would come from "the ladies and ladies' societies of our Synod." Finally, a second purpose is given in this section entitled "philosophy":

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[29]Hoenecke, Vol.4, no.2, 11.

[30]*Blueprint For Establishing A Medical Dispensary in Northern Rhodesia*, (Phoenix, Arizona: March 4-6, 1961), 1.

> "Our purpose will be, from the beginning, also to enlist and to train an indigenous African staff, whom we will, in the transitional phase of the program, be happy to assist by periodic counseling and supervisory visits, but to whom we will be more than glad to transfer the entire project and its operation as soon as this is indicated to us and the Advisory counsel which from the beginning will include native Africans."[31]

Once again, the point is made that when speaking about the goal of an indigenous Medical Mission, as with an indigenous church, it is not simply a matter of self-support in respect to finances that is being discussed. It is also a matter of encouraging the native people to become involved in the staffing and governing of the Medical Mission. Also, note that there is no strict rule or law that said how fast this was to take place. There were no strict guidelines designating how much, at specifically established intervals was to be taken over by the native people and the native church. It would be wise to consider once again the indigenous policy of the Board for World Missions, which was looked at earlier. The Board for World Missions states:

> The Board will work toward the achievement of this objective wherever it is active. However, there will be phases, areas, and conditions in mission fields, when it may be inadvisable, possibly even contrary to Christian love and the best interests of the work, to try to reach this goal very soon. The indigenous church policy is considered the ideal, but it is not an inflexible prescribed code. Rather, understanding, consideration, patience, and love for the souls for whom Christ died will always govern the application of this policy, with the ideal always kept in view.[32]

It is important to keep these words in mind.

After the initial section on philosophy is finished, the following topics are discussed within the blueprint: personnel, both European and African; lines of communication and responsibility; physical plant; and fiscal set-up. In connection with the focus of this paper, it might be beneficial to look at a few details contained within these remaining sections.

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[31] *Blueprint For Establishing A Medical Dispensary in Northern Rhodesia*, (Phoenix, Arizona: March 4-6, 1961), 1.

[32] *Proceedings of the Thirty-eighth Convention of the Wisconsin Evangelical Lutheran Synod* (1965), 243.

Concerning African personnel, the point is again stated that right from the beginning an effort would be made to include native workers as "nurses, orderlies, midwives and dressers."[33] In connection with involving the native workers, the "Blueprint" states, "We will leave the details of these arrangements to the discretion of the staff in the field, subject to ratification by the Medical Director and the board."[34] A great deal of insight is seen at this point in respect to these founding policies that were set down in this blueprint. The framers of the blueprint acknowledged that those who were serving on the field would naturally have more knowledge concerning many matters that would arise in the operation of the medical clinic, such as: how many natives would be needed for the work, what work they would have the ability to do at first, and how soon they might be trained to gradually take over more of the work.

In the section concerning lines of communication, another important subject that was broached earlier is touched upon. The connection between the spiritual mission work that we were already carrying on at the time of the "Blueprints" writing and the medical work that was now beginning is addressed. "Inasmuch as we are conducting the medical program as an adjunct to the Spiritual mission work, the dispensary ought to make its facilities available for consultation periods with the people and provision for this function are being made in the dispensary plans."[35]

The reality: implementing the blueprint

The tremendous challenge that the newborn Medical Mission faced was to put into practice what had been laid out on paper. In order to do this a constant effort would be needed to keep the fundamental principles upon which the Medical Mission was founded constantly in sight. In addition, a continual effort would be needed to apply the principles to circumstances that were constantly changing. A constant evaluation of the policies would be needed in order to determine

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[33]*Blueprint For Establishing A Medical Dispensary in Northern Rhodesia*, (Phoenix, Arizona: March 4-6, 1961), 3.

[34]Ibid., 3.

[35] Ibid., 4.

if the policies were still serving to best accomplish the goals of the Medical Mission, all the while remaining faithful to the principles upon which our medical work is founded.

In asking Pastor Raymond Cox if there were any "bumps" in the road that needed to be worked through in respect to the original plans for the Medical Mission and then how things turned out in reality when the work was begun, he had this say:

> BUMPS ... oh, yes. A question that often came up in the 1960's in Zambia and then in the 1970's in Malawi was indigenization of the medical mission. [Maybe it is still being talked about]. I mention this as a "bump" because there was not (in my opinion) a clean understanding of what an "indigenous medical mission" should be. Did it mean a MM (Medical Mission) that was staffed, funded, governed by the national church? Did it mean that the national church should have a greater voice in MM? The national church - LCCA Zambia/Malawi were happy to have the MM working. They were not able to take this over... no staff and no $$$ money.[36]

The main issue that seems to repeatedly come up in the history of the Medical Mission concerning policy is this issue of indigenization. It was one of the original goals of the Medical Mission, as laid out in the "Blueprint," that eventually the African people would take over ownership. However, as was noted in connection with the Board for World Missions' policy concerning establishing indigenous churches, this is "the ideal, but it is not an inflexible prescribed code."[37] This statement of the Board for World Missions goes on to explain that love will always govern the application of this policy. In looking at the history, I believe this very thing has been done in respect to the Medical Mission's ongoing application of the original policy of indigenization that was established at its founding. At the same time, I believe that the Medical Mission has done a very good job of not going to the other extreme as well. The ideal of an indigenous Medical Mission has remained in the sight of those running the Medical Mission throughout its history. It has not simply been abandoned haphazardly for the sake of simplicity.

It appears that there has been a wealth of ongoing discussion, as well as different views, on the indigenous aspect of the Medical Mission. Concerns were raised by various people whether we

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[36]Pastor Raymond G. Cox to Thomas Glende, 25 March 1999, transcript via email.

[37]*Proceedings of the Thirty-eighth Convention of the Wisconsin Evangelical Lutheran Synod* (1965), 243.

were actually following the policies in place for the medical mission. Questions were continually struggled over. Are we involving the African people and handing things over to them in as timely of a fashion as possible? Are we maintaining a Medical Mission that is in keeping with the original intent of carrying on "limited" medical aid?

Part of the problem seems to be that a good deal of confusion seemed to be present over what exactly was entailed within the term "indigenization." Pastor Cox made reference to this fact in the quote given previously. Linda (Phelps) Golembiewski, who has served as both a nurse and now also as a committee member for the Medical Mission, commented on this fact as well in a paper that she wrote concerning the mobile clinic of Salima Malawi in August of 1978: "Although the medical work was always thought of and discussed as someday becoming indigenous, no strives toward such seemed to be clearly outlined..."[38]

Despite there being a lack of clarity, the goal of establishing a Medical Mission that would be taken over by the native church and native people was always kept in sight. This, however, created some tension when disparity between the cost of the work and the ability of the natives to financially support that work was seen. The following section of excerpts from the paper of Linda (Phelps) Golembiewski conveys the ongoing struggle to address the question of indigeniaty, even amidst the ongoing lack of clarity and the disparity that existed. While this is a rather long section of excerpts, I believe it is necessary to display accurately the history of this issue of indigenization. Linda states in her paper on the mobile clinic of Salima Malawi:

> The goal of someday having the SLMC becoming indigenous is still within the aim of the Clinic. This goal can further be broken into four areas: 1. One must know the areas being served. This includes knowing the people and knowing the needs of the people. 2. The medical services offered must be kept within the realm of the people... Treatments must be kept streamlined; this includes choosing drugs that are safe and effective and also the most economical. We are regularly evaluating our courses of treatment with neighboring health units, and especially our supervising district hospital, the Salima District Hospital... 3. Teaching continues on a daily basis. The teaching, of course, begins between the staff

[38]Linda (Phelps) Golembiewski, "The Salima Lutheran Mobile Clinic of Salima Malawi" (paper written at the request of Doctor David Morley and with approval of the Malawi Medical Council, August, 1978), Medical Mission History file of the Central African Medical Mission Committee, 3.

> members... 4. The cost of the program must be evaluated. We are presently in the process of evaluating the cost of our operation. (p.5)
>
> Questions as 1. What is the ultimate medical goal of mobile clinic? 2. Who should be carrying out the work of a mobile unit, the mobile clinic staff or the people within the clinical area? In other words, is the purpose of the mobile clinic then to give services or to supervise a static unit?... are causes for serious consideration in today's ever changing developing countries. And the medical work of the Salima Lutheran Mobile Clinic is by no means exempt from attempting to reach a clear-cut answer to such queries. Of equal concern is the thought of total indigenization. Especially when one considers the cost of such a structure and the concept of the Village Health Worker (VHW)... (p.7)
>
> In truth, the Mobile Clinic is actually giving the service and is not functioning in a supervisory position to a static unit. The concept of a Village Health Worker (VHW) has yet to be adopted in the country of Malawi. Without the liaison of the VHW it seems unlikely that the SLMC will ever be able to fully indigenize. The cost factor also makes us realize that the SLMC as such will financially not succeed into true indigenization. [A crude estimate of monthly expenditures follows] ...It is unrealistic to think that a given patient will be able to meet the ideal 50% of his total cost per visit, and impossible for a patient to meet the full expense of his required treatment. Therefore, it is not possible for the SLMC to completely indigenize. (p.11)
>
> We have concluded that the Salima Lutheran Mobile Clinic will not be able to totally indigenize because of the cost factor and because of the absence of the Village Health Worker in Malawi. (p.12)[39]

Eventually, an official study of this issue of indigenization was undertaken. A committee, entitled "The Mwembezhi Study Committee," undertook a fact-finding search concerning both the Medical Mission being carried on at Mwembezhi, as well as the Gospel Mission being carried on there. Once again, the fact is seen that some lack of clarity still existed surrounding the issue of indigenization. After looking at the present situation and the goals of the Medical Mission, the recommendation was made to have the Medical Mission Committee undertake steps to begin implementing the handing over of various aspects of the Medical Mission to the native church and people. I'll once again provide a rather lengthy portion of excepts in an attempt to accurately convey the findings of the Mwembezhi Study Committee. Keep in mind that this document is entitled "Mwembezhi Study Committee: Initial Impressions and Request for Reactions." From the mention of various dates within the document, it appears that this was written in 1989. At this

[39]Linda (Phelps) Golembiewski, 3.

point, I have not uncovered what the immediate results of this document were. Its contents still seem well worth considering in order to see the fact that an ongoing look at the topic of indigenization was always before the eyes of the Medical Mission and its leaders. Excerpts are as follows:

> 2. Long-term goals and the present situation: Clearly the Medical Mission is still in its Immediate Phase at this time. After all the good and preparatory steps which the Medical Mission has done in the area of health care, many feel that it is time to move on to the Transitional Phase of which Pastor Hoenecke talked. In addition, the Medical Mission has certainly gone beyond the "first-aid and elementary health counseling" envisioned by the founders. The services offered have changed from time to time. It is unclear to the Mwembezhi Study Committee exactly what the goals of the Medical Mission really are. Specifically, is it a primary goal to hand the work over to the Africans one day? If it is, we request that the Medical Mission Committee in conjunction with the on-field staff prepare a definite plan so that all concerned would know exactly what they should be doing to reach this goal. (p.3)
>
> Summary (under heading 2. Long-terms goals…): It should be emphatically noted, that no one is suggesting that we discontinue either the Medical Mission or the Gospel Mission work in Mwembezhi. But gradually, as possible and practical, this work should be handed over to Africans. This would allow the personnel from both the Medical and the Gospel Mission to do new work in new areas. But this cannot be done without a definite and well-thought-out plan for this transition. (p.4)
>
> 3. An analysis of the current situation: …It (the dispensary) is a way that WELS Lutherans in American can show their love for others in a humanitarian way. They are physically helping those in need without expecting something in return. All of this greatly helps the Gospel Mission work in the Mwembezhi area. All the people know the name Lutheran. All the people know that the Lutheran Church shows its love to others. Certain programs like the immunization and the nutrition programs have left the people… less dependent on the Medical Mission. However, are some of the programs more of the "perpetual hand-out programs"…? If that is the case – and we do not say that it is – then either our goals or our practice must be changed… Another aspect of concern is the involvement of the national church… But, without the continued influx of the U.S. dollars, the dispensary would just be another rural health centre, without dedicated workers, without medicines – in short, without a viable health care system. (p.4)
>
> 4. Short-Range Recommendations based on Established Goals: These goals are not to be viewed as the unalterable laws of the Medes and Persians. Rather with them, we hope to provide a well-marked path that will lead eventually to the goals which have been set for both the Medical and Gospel Mission work as Mwembezhi, namely the gradual handing-over of the work to the Africans themselves. In setting these into goals, we are not interested in speed, but a situation which takes into consideration the needs of both the people serving and those being served. We hope that all will think of other goals… We request that as soon as possible… A. The Medical Mission Committee review the goals and objectives of the Mwembezhi Medical Mission to ensure that the Medical Mission Committee and its on-field staff are in agreement in philosophy and implementation of their Medical Mission Goals. B. The Medical Mission establish a specific list of what services it wants to offer… in keeping

with the established goals of the Medical Mission Committee. C. The Medical Mission establish a specific five-year program which describes in detail what clinical work they want to hand over to capable African medical personnel during that time. (p.6)[40]

Changes in policy through the years –
Always maintaining the principles and continually striving to best achieve the goals

Is the struggle that is detailed in the previous section a bad thing? Disparity was present between the work being carried out and the goal of keeping the expenses at such a modest level that the Africans could eventually take over support of the work financially. The question was raised if the Africans were being brought into the work itself as soon as possible, both administratively and in respect to staff. Is it a bad thing that these concerns and questions were raised? Certainly not. In asking Pastor Sauer his view on if this ongoing struggle, discussion, and search concerning the purpose and goals for the Medical Mission was a positive thing, he said, "Very definitely, the moment we set up a program and feel that this is set in stone, except for the basic principles, then we are in trouble."[41]

The quote of Pastor Sauer in the previous paragraph describes what the present section of this paper is about. Principles always need to be maintained and held to. Policies based on the principles, which are intended to carry out the purpose and goals of the principles, can and even should be adjusted at times in order to continue to best achieve the goals of an organization like the Medical Mission. Circumstances change, opportunities change, and as a result sometimes the administrative body of an organization like the Medical Mission sees it as the wisest move to change certain policies as well.

Pastor Raymond Cox and Pastor Theodore Sauer, both men who served in Africa and who were deeply involved with the work of the Medical Mission, recognized the need for willingness to adjust policy at times to varying circumstances in order to continue to best achieve the goals. In

[40]"Mwembezhi Study Committee: Initial Impressions and Request for Reactions" (Guidelines/Blueprints file of Central African Medical Mission, photocopied).

[41]Pastor Theodore Sauer, interview by author, 20 March 1999, Manitowoc, Wisconsin, tape recording.

the following set of quotes, Pastor Sauer in his comment brings out the fact that changes in policy were made early on in the history of the Medical Mission, as seen in the fact that a revised set of guiding principles was submitted already in 1965. He also notes that adjustments and revisions need to be made from time to time in such a document in order to take into account changing conditions. Pastor Cox in his comment details some of the changing conditions that required adjustments in certain policies of the Medical Mission. Their words are as follows:

> [Pastor Theodore Sauer] You'll have to keep in mind that the blueprint was set up in advance of our beginning the work. Like every outline of policy and procedure that is going to develop as we go along... Back in '65... I was asked by the medical mission committee to review the blueprint and suggest whatever revisions might seem to be advisable. Now, rather than revise the blueprint itself, I felt it best to let it stand as it was, so that it might serve as a historical document. I took the material at that time and set it up into what I call "guidelines." These guidelines were adopted then. This was in '65. Like I said before, any document of this kind then keeps on being adjusted and revised to take into account changing conditions. When I was in the World Mission office, in '83, I once more went through the guidelines and then others made certain suggestions and proposals for amendments. Subsequent to that there has been a great deal of work done. I think the present Committee has done a great deal of work under Irene Brug in setting up... the set goals. This I think from the standpoint of history is important. The best would be to lay on top of this (the guidelines) the original blueprint... Here we have the luxury of hindsight.[42]

> [Pastor Raymond Cox] It may be interesting to go back through what was written 30 years ago, but would it be applicable today? I do believe that when it comes to "long range programs" for our medical work there are three major aspects to keep in mind. First, what is good and possible for our WELS (those especially who support this medical work)... after all, we initiated the program; we're funding it; we're supplying WELS nurses. Secondly, what is the desire and dictate of the government (Zambia or Malawi) under whom this program officially must operate... we need to remember that we do operate as "guests" of these governments, both as to the very presence of the expat staff and also the medical operation which comes under the Ministry of Health. Thirdly, in a long-range program the Medical Mission Comt (USA and local operation) need to consider the desires and abilities of the national LCCA. [next paragraph] Much could be written about each of the above. My point is that a program or strategy which was outlined 25-30 years ago may no longer work today. Scriptural principles will not change, but secular plans do.[43]

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[42]Pastor Theodore Sauer, interview by author, 20 March 1999, Manitowoc, Wisconsin, tape recording.

[43]R.G. Cox, Malawi, to Mrs. Esther Moldenhauer, Jackson WI, 1 May 1988, transcript typewritten by R.G. Cox, Guidelines/Blueprints file of Central African Medical Mission Committee.

In order to best allow the reader to view and determine changes made over the years, I have attempted to assemble the various documents that have been used as "guidelines" for the work of the Medical Mission. The following may be found in the appendices at the end of this paper:

- Blueprint for Establishing a Medical Dispensary in Northern Rhodesia (1961)
- Guidelines – African Medical Mission (1965)
- Guidelines – Central African Medical Mission (1983)
- Central Africa Medical Mission Guidelines (Central Africa Medical Mission Handbook 1995)
- Central Africa Medical Mission – Zambia, Status Report and Prospectus, 1996.

Throughout the history of the Medical Mission changes have been made as needed to these documents that have served as the "guidelines" for the work. Pastor Sauer in the "Guidelines" that he submitted in1965 states the reason for these changes: "After nearly four years of operation, it is advisable to redefine some of the original aims and objectives, and to re-evaluate the methods of operation in order to bring them more nearly into line with the experience of the past and the needs of the present."[44] This continued to be the case as the years went on.

An example of such changes would be that in 1965 an expanded listing of the duties of the American nurses, who were serving in Africa, was added. Since many of the details on this list of duties were unknown factors in 1961 when the "Blueprint" was drawn up prior to the work actually being begun, one wouldn't expect them to be included in the original "Blueprint." This list of duties in 1965 included the fact that classes were to be conducted on health and nutrition. This was a part of the ongoing effort of the Medical Mission to practice preventative medicine so that the Africans would become less dependent rather than more. Another example of a change brought about deals with the creation and subsequent revisions of a Medical Mission Committee. In the 1965 "Guidelines" the duties of a stateside committee are set-forth. In the 1983 "Guidelines" a listing of the five positions on the Medical Mission Committee and their specific duties are added. In the 1995 "Guidelines" a sixth position was added to the committee,

[44] *Guidelines – African Medical Mission (1965)*. See Appendix #2 for photocopy of document.

apparently due to the increased work- load that the committee acquired. These are simply a couple of examples of the adjustments that have been made in the guidelines over the years.

In the Prospectus for Zambia of 1996 a more major adjustment or change was made. In this document, the philosophy of seeking a completely indigenous Medical Mission is changed. The decision was made that in respect to finances there would no longer be an attempt to become indigenous. However, it is apparent that the effort to continue turning over management as well as staff positions to the native Africans would continue to be a goal of the Medical Mission. Excerpts from the Prospectus for Zambia state:

> Due to all the changes in part II, we no longer feel that the Medical Mission should be indigenized. It is felt that it should continue to be an expression of Christian love, supported by the gracious women of the WELS and operated by the CAMM which will work with the LCCA and the people of Zambia.
>
> ...The following prospectus will be adopted: ...continue to turn over authority for the management of above services to our clinical officers, provided they are active LCCA members.[45]

Therefore, it is seen that while the goal of indigeniaty is no longer being sought in respect to financial resources, the goal of an indigenous church in other aspects is still very much before the eyes of the Medical Mission.

The actual fact that natives have been and presently are being involved in the work more and more is shown by the following comments of Kathie Wendland. She states how the Medical Mission is continuing to work toward the indigenous aspect in regard to everything except money. She then goes on to give a very pointed example of why this is the case. She states:

> So while people say, we're not... the word indigenization comes up often and they will say that you are not really indigenizing because you are continuing to put the money in, the only thing that we are not indigenizing is the money, because that's not there... I was able to visit congregation members with one of the women's leaders, and I knew it was there, but you see it again. You go into a house, this woman wanted to show me her house, and I was happy to see it. It consisted of about two rooms the size of a medium size bathroom. That is all the bigger it was. A door that didn't close, no windows, mud block - that is what she is living in. That is typical of the congregation members in that area. There is no money. She is

[45] *Central Africa Medical Mission – Zambia, Status Report and Prospectus, 1996*, p.6. See appendix #5 for a photocopy of document.

> a widow. She has no income. How is she going to feed her four children who are still at home? How is she going to send them to school? Much less support some kind of a medical mission. She doesn't have money for clean water for herself. You look at things like this – money they don't have. Is she bright? You bet. Can she work and learn and teach? Yes. And she is doing a good job of it already in the congregational setting. The only thing that we are not indigenizing is the financial support.[46]

Kathie also explained the extent of the work that the native Africans in both Zambia and Malawi are doing. She explains:

> In Zambia more so than Malawi. We have two ex-patriots. The one at clinic is almost entirely advisory. The clinic is being run by the clinical officer. It has been a very difficult process. We are just into it, and it is going to be 5 to 10 years before they can actually be making the administrative decisions, especially the discipline. Knowing how to do that - that is a very difficult thing. But we are in it. The development of the health education and outreach - again the only whiteface in it is the one who is trying to get things set up. Her experience here in the U.S. was with a huge company... Their job is coordinating people, getting people in and moving. She really is standing behind our African worker who is Mr. (Alfred) Mkandawire. He is well into his fifties, and (we are) looking at his replacement in terms of a national. He is the one who is setting up most of the classes. He is the one who is working with the government and being liaison with all these different government units and getting things coordinated. We are really already trying to take a step back. Inservices, teaching - community health worker teaching, our Zambians are teaching others. We are not at the front line of that at all anymore. And they are better at it than we are, basically. It has reached the point that teaching and all this kind of stuff is much better through a national who understands his own culture and understands the problems better than we do.
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> Right, that (Malawi mobile) clinic started ten years after the one in Zambia, and they are at a different stage of development. The two people who are there have done very well at working and developing our nation staff. When they were on furlough, things went on pretty well without them there. What we don't have in Malawi are any of our own members that we can really groom to take over this clinical officer position. I feel pretty confident that if something politically would happen right now and we would have to leave in Zambia, the work would continue. The funding would change, and even with that we are really trying to work with them as far as being able to procure government funding and outside aid funding in case we are not around to be behind them. In Malawi it is not at that point. If we would be actually gone, I think that the work would stop pretty quickly. I don't think that there is a national who would be able to even begin trying to get funding for the vehicle, and for a mobile clinic you've got to have a vehicle... I just don't think that is quite at that same point...[47]

So, while financial the goal of indignization is no longer being sought, at least for the present time, the goal of an indigenous Medical Mission in respect to the native people and the native

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[46]Kathie Wendland, interview by author, 23 March 1999, Mequon, Wisconsin, tape recording.

[47]Ibid.

church taking over ownership of the work as much as possible is still very realistically before the eyes of the Medical Mission.

A look at the goals accomplished by our Central African Medical Mission

A simple truth is that when it comes to an organization like the Medical Mission, one may be able to measure a number of the physical goals that have been accomplished through the years. One can keep a tally of the number of patients who have been seen and provided care, or one can state the number of years we have been active in supplying this urgent medical work. However, it is much more difficult to measure the even more important goals that the Medical Mission has attempted to carry out over the past thirty-eight plus years, namely the spiritual goals of the Medical Mission as a supportive branch to the gospel ministry. The opportunities to witness to the gospel, the contacts made with people that later, who knows when, led to an opportunity to share the gospel message – measurements can't necessarily be made of such things. Maybe the best that one can do is simply to give an indication by means of the witness of those who have actually carried on the work and who have seen it carried out firsthand. In this way one might hope to convey how the Lord has indeed abundantly blessed the work of our Central African Medical Mission.

First, let's look at some of the physical goals accomplished, namely the physical needs of the African people being filled through our Medical Mission. In a booklet commemorating the 25th anniversary of our Medical Mission in 1986, the following statement, which displays the tremendous amount of people that have been helped through the years, was given: "We estimate that when the 25th Anniversary of Mwembezhi Lutheran Dispensary is celebrated (1986), approximately 673,500 patients will have been treated."[48]

In addition to looking at the sheer number of patients helped, one must consider the fact that the Medical Mission's effort in large part has been to focus on preventative medicine. In this

[48]Central African Medical Mission, Anniversary Committee, *Thankfulness to Serve Him: Central African Medical Mission of the Wisconsin Evangelical Lutheran Synod - 25th Anniversary 1961-1986*, 23.

pursuit the Medical Mission has been highly successful as well. The Mwembezhi Study Committee, referenced earlier, states: "Certain programs like the immunization and the nutrition programs have not only offered immediate help, and coupled with teaching, have left the people not only healthier, but less dependent on the Medical Mission."[49]

Now, let's consider some of the more tangible indicators that point to the spiritual goals of the Medical Mission being carried out as well. The Medical Mission presents the opportunity for people of the WELS to be encouraged and grow in their sanctified lives as they are presented a very tangible way to display their lives of faith to others. The list of people who have served with their time and talents in the work of the Medical Mission is too extensive to cover in entirety here. For example, there has been through the years and there presently is a tremendous amount of contact woman in the various congregations throughout our Synod. A few people deserving of a special notice are the nurses who have served in Africa with their time and talents. The committee members of the Medical Mission who have served with both time and talents in the administration and leadership of the Medical Mission are worthy of special notice as well. If there were enough space in this paper, it might be nice to list all the people who have served in these positions over the past thirty-eight years. However, it might be even more beneficial to not mention the specific names, and instead to simply focus on how the Lord has presented a numerous amount of Christians with another opportunity to serve and carry out their lives of faith through the work of the Medical Mission.

The members of the WELS have also had the opportunity to give of their treasures. The fact is that financial support has been given willingly and abundantly throughout the history of the Medical Mission. An indication of this is given back in 1959, when the offerings for the medical work were present even before the work was ready to begin.[50] This support has continued through

[49]"Mwembezhi Study Committee... Request for Reactions," 4.

[50]*Proceedings of the Thirty-fifth Convention – The Evangelical Lutheran Joint Synod of Wisconsin and Other States* (1959), 66.

the years, even in years that were difficult financially. Pastor Sauer, commenting on how the medical mission budget was and is kept separate from the overall World Mission budget, states: "When the going was tough, I'm thinking particularly in the 1979, '80, '81 period, when we were really having difficulty, it would have been so easy to simply cut that (the Medical Mission funding), and yet the funding continued because it came from the love of our women throughout our Synod."[51] Support for the Medical Mission is still present today. At the present time, financial support for the Medical Mission ranges from $140,000 to $200,000 yearly, depending on large donations.[52]

What follows is a list of personal perspectives assembled from a number of people who have been involved in the work of the Medical Mission over the years. They have served as pastors in Africa, or as nurses in Africa, or as committee members for the Medical Mission. In each case, they have had the privilege of seeing the various goals of the Medical Mission being accomplished first hand. So, I will simply attempt to let their words support the fact that, thanks to the Lord's grace and guidance, the goals of the Medical Mission have in fact been accomplished through the years.

The intent behind looking at these personal perspectives is to gain some insight into the less tangible, yet most important, goals that the Medical Mission has sought to carry out. Once again note the emphasis that on both sides of the ocean goals have been met. Christians here in America have been given the opportunity to serve others in countless ways, living their lives of faith to the Lord's glory. The need of others has been filled in so many ways, both physically and spiritually. Christians on the other side of the ocean in Africa have been given the opportunity to live their lives of faith as well. As the Holy Spirit has brought many of them to faith through the Word of God that they have heard, in many cases through the opportunity to share the gospel presented in

[51]Pastor Theodore Sauer, interview by author, 20 March 1999, Manitowoc, Wisconsin, tape recording.

[52]Kathie Wendland, interview by author, 23 March 1999, Mequon, Wisconsin, tape recording.

connection with the Medical Missions' work, they in turn have begun to live their lives of faith as well, serving their own people in the work of the medical mission and even more importantly in the work of sharing the gospel.

The goal of being a supportive branch to our gospel ministry in Africa:

In the history of the Central African Medical Mission there has been the opportunity throughout to share the gospel through: daily devotions, Sunday school classes and Bible classes, and baptisms that were a result of witnessing to the gospel message to parents of newborn children.

> Pastor Raymond G. Cox, who served the Central African Mission and the Lutheran Church of Central Africa for over 27 years, from 1963 through 1992: On the mission field, both Acting Supt. E H Wendland (Zambia) and myself (residing in Malawi, and leading the search into the medical mission aspect) ... we were convinced that medical missions was the "way to go." The Zambia Medical program began in 1961. It proved to be a blessing to Gospel outreach. It demonstrated that humanitarian aid (medical) and proclamation of the Gospel is not an either/or situation. They can (when possible) work side by side. In 1970 the opportunity to do humanitarian aid came up in Malawi. A few were against this ... (both on the mission field and in the USA). The concern was that this medical aid work would become "social gospel" and be an end in itself. That, of course, is a danger ... but that has not been the way our WELS and LCCA (Lutheran Church of Central Africa) dealt with this matter.[53]

> Pastor Cox: Day by day... devotions were/are conducted by mission staff (missionaries, Africa pastors & evangelists) at the medical mission sites. Day by day... our nurses show their love and compassion to the sick & dying. Day by day... our mission staff and medical staff have opportunities to proclaim Christ. Day by day... "Hereby shall all men know that you are my disciples if you love one another."[54]

> Pastor Theodore A. Sauer, who was the superintendent of the Central African Mission in 1961, the year in which the Medical Mission began its work, and who later served on the Board for World Missions as well: These goals have been met. I had the privilege for nearly seven years to live in Mwembezhi and to really observe the Medical Mission... It was a joy to see how the people received our services. There was opportunity throughout to share the gospel. They had an evangelist who lived right there at Lumano, the village. He would be there first thing in the morning to open the dispensary with a devotion... And, perhaps this was something that was not really intended, but I don't know how many times that it happened during the course of a baby's birth that there would be some real problems, where the nurses, my wife included, I can't tell you how many (babies) she baptized while we were there. And then, we didn't just only baptize them, but we took the chance (opportunity) to

[53]Pastor Raymond G. Cox to Thomas Glende, 25 March 1999, transcript via email.

[54]Ibid.

explain to the parents, in case they were not of our faith or perhaps any Christian faith, just what this meant, and in each instance we also got the permission of the parents to do what we did... Some of those people then actually became members of the congregation. This is sort of an aside thing, but it was tied in with the real purpose for which we were there, and that was not just to give them help with their physical problems but above all to point them to the cross...[55]

Irene Brug, who has served as the Chairman for the Central African Medical Mission Committee from 1989 through the present time: I feel the goals and objectives of the Medical Mission are generally carried out in the day to day work very well, that is, assisting the Gospel mission work. Every day is started with a devotion. Many baptisms take place because of the opportunity to witness. In Malawi there are Sunday school classes and Bible classes being conducted at the mobile clinic on the day that the nurse team is working there. The missionary and/or evangelist also has the opportunity to talk to many of the people who come to attend clinic.[56]

Debra Kramer, who was currently working in Malawi (1986), when this quote was recorded: Mr. Pahuwa, a Bible Institute student, and Mr. Kandaya, a vicar, come with us to Suzi. They are there to bring the Word of God to the clinic population we serve. They start the day with a devotion and a prayer and talk with our patients waiting in line or the people of the village. There is a group of men who routinely come just for the devotion and prayer and then stay to talk with the evangelist. It's exciting to see this desire to learn more of God. It reminds us that what we are doing in our medical clinics is beneficial and appreciated, but it is secondary to the ultimate purpose of our being here; to bring God's Word and news of His saving love to these people.[57]

The goal of presenting our people the opportunity to let their light of faith shine:

The Central African Medical Mission has served throughout its history as a bridge, or means through which to arrive at the opportunity to share the message of the gospel. This has been done through abundant opportunities to demonstrate in a very concrete way Christ's love. The Medical Mission has served to establish a bond of confidence and trust with the people among whom we are working to share the gospel. The Medical Mission has often served as the first place that many have had the opportunity to be exposed to the gospel; the first point of contact with the gospel in many cases has come through the Medical Mission. The comment by Debra Kramer that ended the preceding section is very accurate: "what we are doing in our medical clinics is

[55]Pastor Theodore Sauer, interview by author, 20 March 1999, Manitowoc, Wisconsin, tape recording.

[56]Irene Brug, to Thomas Glende, 23March 1999, transcript via email.

[57]*Thankfulness to Serve Him: Central African Medical Mission... 25th Anniversary*, 20.

beneficial and appreciated, but it is secondary to the ultimate purpose of our being here; to bring God's Word and news of His saving love to these people."

> Pastor Raymond G. Cox: [In response to the question: From your personal experience in the field, can you comment on how well the goals and objectives of the medical mission were carried out in the day-to-day work of the medical mission?] The GOAL (has been served)... that the medical work was to be a way that we as Christians could let our light of faith shine before the needy peoples of Zambia and Malawi as a bridge to facilitate the proclamation of the gospel.[58]
>
> Pastor Cox: [In response to the question: From your perspective, how important is this work of the medical mission as an arm of our African mission?] VERY!!! Humanly speaking, I do not believe our WELS Mission in Zambia and Malawi would be as well known, as well received by the peoples and the government if it were not for the MM (Medical Mission). It is my considered opinion that God has richly blessed this mission of loving mercy to His glory. I believe that through our MM in Zambia and Malawi, the LCCA (Lutheran Church of Central Africa) has been able to have a point of contact with non-Christians which we would not have had w/o MM.[59]
>
> Pastor Theodore A. Sauer: [Speaking on the relation between the medical work and the primary objective of proclaiming the gospel] That is the way it works. It (the medical work) does give you access to the people. There is no question about that.[60]
>
> Pastor Sauer: [In response to the question: In practice to what extent did the physical work go hand in hand with the gospel ministry...?] It did serve to give the mission a good reputation in the area. Now, there were other medical dispensaries around, in fact there was one only about seven miles away or so... But, there would be people who would by pass that clinic and come to us. There were some people who came from as far as 30 miles away in order to get to Mwembezhi... [Speaking of how the established bond of trust often conveys over to the opportunity to share the gospel] It has to. If you have some good feeling on their part of the person that you are coming to before you even get there it surely makes it easier to deal with them.[61]
>
> Irene Brug: [In response to the question: How important is the work of mm as an arm of the African mission as a whole?] I feel that it is very important. There are many African people who are first exposed to the Gospel through the medical mission. It was also the means for beginning gospel work in Malawi. The government would let us in because of the humanitarian work that would be done. They weren't too interested in the Gospel message...[62]

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[58]Pastor Raymond G. Cox to Thomas Glende, 25 March 1999, transcript via email.

[59]Ibid.

[60]Pastor Theodore Sauer, interview by author, 20 March 1999, Manitowoc, Wisconsin, tape recording.

[61]Ibid.

[62]Irene Brug, to Thomas Glende, 23March 1999, transcript via email.

> Kathie Wendland, who served as nurse in our Malawi field of the Medical Mission from 1977-1980, as well as working on the Zambian field when she and her husband returned to Africa in 1989, and who has served also on the Medical Mission Committee from 1993 through the present time: I think goals have been carried out very well. When you look at it, the nice thing about looking backwards is that you begin to see what the Lord's goals were for it. It is not always the same as what we had stated, but the Lord has used the medical mission really to open up doors for the gospel, to make instances where we can demonstrate what Christ's love is to a people who have absolutely no concept of it. Their culture is in witchcraft. It's a religion of fear - you do things because you are afraid. And to have someone help you just because they want to help you is something that they are not familiar with. And we've been able to do that. There is a lot in medical mission work, and also in mission work, where they talk about the mistakes that were made years ago. Everything was given to people, whether you were giving people medicine or whether you were just taking care of them, whether you were giving them money, food, whatever. Those weren't mistakes when you look at it through the Lord's eyes, because what was going on was that his love was being demonstrated. That is what was necessary for people to understand what it was. As Christians, that is what we are supposed to be doing.[63]

The goal of striving "for the welfare of all concerned"

This point is not simply referring to the goal of supplying for the physical welfare of all concerned. Even more importantly, this point is referring to a spiritual aspect, namely the goal of encouraging the sanctified lives of both our American members in the WELS as well as the African members of the LCCA. As Christians are encouraged and strengthened by the Word of God, they are also empowered to live sanctified lives of faith to the Lord's glory. The Medical Mission gives Christians, both here in the United States as well as in Africa, the opportunity to joyfully carry out lives of faith that flow from the love that the Lord has shown to them.

> Irene Brug: [In reply to the question: How important is the work of Medical Mission as an arm of the African mission as a whole?] ...It also is important for the people in the United States, especially the women of our congregations. (This is sort of "their baby" because when the medical mission was first organized the synodical conference turned the responsibility for its support over to the women of the WELS.) It gives them a very visible means of carrying out the Lord's command from Matthew, "If you have done it unto the least of these my brothers, you have done it unto me."[64]

> Irene Brug: Those who are being helped both spiritually and physically are blessed through this ministry. And it is also a blessing to those who are able to support and help with the "Mission of Love". Almost unanimously, the nurses who have served will say that having

[63]Kathie Wendland, interview by author, 23 March 1999, Mequon, Wisconsin, tape recording.

[64]Irene Brug, to Thomas Glende, 23 March 1999, transcript via email.

the opportunity to serve as a Medical Mission nurse was one of the greatest blessings of their life.[65]

Quote taken from "Thankfulness to Serve Him... Central African Medical Mission 25th Anniversary booklet" (1986): The Lord of the Church has given many gifts to many people. People using their gifts make the Medical Mission possible. The women of our Synod give of their time to attend meetings. They give their thoughts to prayer for the work and workers. They give unselfishly of their earthly wealth to support a budget of $125,000 a year. They give of their abilities, sewing layettes, pads, wipes, bandages, and other needed items. The gifts of love from all our people are a vital contribution to the Medical Mission.[66]

Kathie Wendland: [Discussing the present program of training representatives from the various congregations in Zambia to help address the AIDS epidemic that is present in the country] They (the native representatives from the congregations) also immediately, and this was in their own discussions, see that they will then be able to help their communities, and as they are helping their communities it will give them access to talk to people about Jesus Christ. So, they are seeing the connection immediately, as far as taking the physical help and using that as an opportunity to witness to their neighbors... (Interjection by interviewer: So, basically an offshoot of what we have been doing all the time with our medical mission.) That's right... We've got well over 100 congregations. So, you go from one spot at Mwembezhi to 100 congregations throughout Zambia. I would like to see a similar thing developing in Malawi... You have gone from one spot to a hundred.[67]

Kathie Wendland: That was one of the things that we talked about early on. One of the purposes of medical mission is, yes, to help the people. But, it is also - a big purpose - is so that our people here in the U.S., our Christians here, have an opportunity and an outlet to demonstrate Christian love and to share. (Interjection by interviewer: Our people are looking for more opportunities to do that.) They are. And God commands it. Those who have plenty should share with those who don't have enough so that no one has too little.[68]

Conclusion

Have goals been met? The Lord's goals have. That is the important thing to keep in mind when speaking of goals. We strive to set goals that are in accord with God's will. We strive to carry out those goals with the Lord's guidance. Amidst ongoing changes in the circumstances that the Medical Mission has faced, amidst ongoing struggles to determine how to best carry out the work, amidst it all, the Lord has blessed the work, carrying out the gracious good that he has

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[65] Ibid.

[66] *Thankfulness to Serve Him: Central African Medical Mission... 25th Anniversary*, 8.

[67] Kathie Wendland, interview by author, 23 March 1999, Mequon, Wisconsin, tape recording.

[68] Ibid.

intended, in accord with his set times and purposes. Our Lord takes the efforts of men and women such as ourselves, and he uses them for his purpose and his glory. The Medical Mission has been one of those efforts that the Lord has blessed. May this continue to be the case for as many years as the Lord permits this "Mission of Love" to continue.

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Appendix #1:

Blueprint for Establishing a Medical Dispensary in Northern Rhodesia

[Photocopy received from the files of Mrs. E.H. (Kathie) Wendland.]

BLUEPRINT

FOR

ESTABLISHING A MEDICAL DISPENSARY

IN NORTHERN RHODESIA

I. THE IMMEDIATE PHASE
from now until assumption of work by African staff;

II. THE TRANSITIONAL PHASE
during time of only periodic European supervision;

III. THE LONG-RANGE PROGRAM
under completely independent African operation.

* * * *

I. THE IMMEDIATE PHASE

Philosophy - In general, our Medical Mission Committee is responding to a demonstrable need which our Executive Committee for Northern Rhodesia has known to exist in this field ever since we began this work. This service of limited medical and health counsel and treatment has been taken care of by the wives of our missionaries to date under circumstances which involved them in considerable sacrifices of their time, energy and means, and the assumption of a responsibility which some of them were not professionally competent to discharge. Although our board tacitly assumed moral responsibility for their services, to date we have not accorded official recognition of the same or assumption of any part of the responsibility. Our plans for establishing this medical dispensary program are designed to assume that responsibility officially.

We plan to establish no more than what is immediately and temporarily necessary in line with an orderly assumption of that responsibility. We do not plan an expansion of our medical dispensary service, but rather are determined to keep the same within the limits of first-aid and elementary health counselling services, always bearing in mind that what we inaugurate in establishment, staff and service will soon be within the range of the ability of the African themselves to assume as an independent, self-supporting service.

Thus, we are enlisting no help from our regular synodical mission budget, but are determined to inaugurate and support this venture entirely as a non-budgetary enterprise, underwritten by the ladies and ladies' societies of our Synod.

Our purpose will be, from the beginning, also to enlist and to train an indigenous African staff, whom we will, in the transitional phase of the program, be happy to assist by periodic counselling and supervisory visits, but to whom we will be more than glad to transfer the entire project and its operation as soon as this is indicated to us and the Advisory counsel which from the beginning will include na tive Africans.

I. THE IMMEDIATE PHASE
from now until assumption of work by the African staff.

A. PERSONNEL - European

1. A person (either an M.D. or a mature nurse) with following qualifications:
a dedicated Christian attitude - member of our Lutheran Church - with wholesome initiative, sober judgment, attitude of proper caution and discretion especially in view of the unusual, unfamiliar circumstances, with saving flexibility and compatibility to both conditions and colleagues, consideration and interest in people among whom we work, of sound physical and emotional health and balance, with sufficient inner resources to find relief from daily routine with only limited social intercourse with other Europeans, willingness and ability to adjust to some isolation from normal society and activities, with sufficient professional and personal security to be patient and to delegate responsibility to others in order to train them for early assumption of duties.
This person is to inaugurate the work and to assist in setting up guidelines for its subsequent smooth functioning as a native, African enterprise.

2. Another nurse, or nurses, to take over the operation of the dispensary after the person inaugurating the program leaves the field - endowed with similar gifts.

3. If possible, we also intend to avail ourselves temporarily for a more or less extended period of people who because of previous experience are qualified to give our staff assistance in advancing the program.

4. Tour of duty - shall be two years in the field with free time of approximately 15 days per annum, not to be applied, however, to the regular furlough; and a furlough of four months, between tours of duty, and of two months, if only one tour of duty is undertaken.

5. Salary and other fringe benefits.
   a. The nurse shall serve at an annual basic salary of $3,000.00 per annum, payable monthly.
   b. Her housing, transportation, utilities, medical and health insurance shall be provided by the committee.
   c. During her preparatory schooling in subjects relating to her work in the foreign field, she shall be on regular salary, in addition to which her schooling and traveling expenses will be defrayed by the committee.
   d. She shall be allowed a one-day trip to town on the average for personal purposes and purchases, for which we will furnish car and driver.

B. PERSONNEL - African

1. In keeping with the general plan for encouraging the Africans to assume early and eventual operation of the dispensary, we plan to include African nurses, orderlies, midwives and dressers, as they are needed, in the staff from the beginning.

2. We will leave the details of these arrangements to the discretion of the staff in the field, subject to ratification by the Medical Director and the board.

3. We anticipate that, initially, the African staff will include one nurse, one orderly and one dresser.

4. The salary and wage schedule for this personnel will be set up by the staff in the field to conform with the accepted practice and not to dislocate the prevailing economy.

C. LINES OF COMMUNICATION AND RESPONSIBILITY

1. Meetings - for ideal working conditions it is imperative for the staff to maintain regular communication lines within the medical staff and with the spiritual staff in the field.
   a. To this end it will be encumbent upon the staff to hold regular, weekly, bi-weekly staff meetings, in which matters pertaining to the program are discussed and concerted upon mutually;
   b. For the same purpose regular meetings, perhaps monthly, will be held between the medical and the spiritual staff.
   c. In the event of a divergence of opinion in these meetings, it will be required that both opinions be submitted by each party to the Medical Director who, in turn, will be free to present the matter to the Executive Committee for Northern Rhodesia for adjudication. Further appeal may be made to the Board for World Missions by any of the parties involved.

2. Advisory Council - In order to implement our program of early indigeneity, the plan of operation includes also an advisory council, comprising the Medical Mission Staff, a representative of the spiritual staff, either the Chief or his representative, and someone to represent the government health department, Since the dispensary will be attached to our Lumano compound, a representative of the school at that place will also be included.
   This advisory council will be called together regularly to keep all groups fully informed and to give them an opportunity for suggestions before enacting any major measures. Also, this advisory council will become most valuable in communicating with and helping to implement the various phases and procedures of the medical mission program.

3. Communications - The staff will be held responsible to keep minutes of all meetings and records of all financial transactions and to submit full reports to the Medical Director each month. A copy of the minutes of the meetings of the Medical Staff could also be given to the missionary at the station as a matter of courtesy.

4. Co-Operation - Inasmuch as we are conducting the medical program as an adjunct to the Spiritual mission work, the dispensary ought to make its facilities available for consultation periods with the people and provision for this function are being made in the dispensary plans.

D. PHYSICAL PLANT

1. Dispensary Building - shall be of post and beam (metal girder) construction, the walls to be built of Kimberly brick, providing for adequate openings for light and ventilation, and access. The inside partitions are to be made of light, movable construction, providing in a general way for the rooms as shown in the accompanying floor-plan. - The size of the building without the optional rear porch shall be 35 x 48 feet.

2. Housing of staff - European
The houses for European personnel are to be of the type of Uniport Unit construction with separate rooms for each person, indoor plumbing and lighting, and possibly a common kitchen, living and dining room.

3. Housing of staff - African
This housing is to be in keeping with what is acceptable for people of this social station among the Africans, customarily built of burnt brick with an asbestos roof and some provision for light and water.

4. Water system
With the consent of the Executive Committee for Northern Rhodesia the water supply shall be from the main pump and tank on the school campus, providing for an independent storage tank near the dispensary. Consideration may be given to an independent water supply system, if this is found to be more feasible or practicable or economical.

5. Sewage system
This will be arranged strictly in keeping with government and health department regulations, taking the proximity of the school and the missionary residences into consideration.

6. Lighting and power
Actually, very little will be needed for the dispensary since sterilization may be arranged for without electricity and dispensary hours usually occur during the hours of daylight.
Electrical wiring may be wired to the central power system, or consideration may be given to an independent generator for the dispensary to avoid engaging the entire system, if service is required after dark.

7. Transportation
It is thought that a VW Sedan should be acquired for use of the medical dispensary staff under clear regulations.

E. FISCAL SET-UP

1. State-Side
   a. There should be a continuous effort to make the ladies and ladies' groups aware of the need for regular support;
   b. It would be desirable to separate the regular (annual or monthly) contributions from the special gifts in order to determine our real or dependable financial status;
   c. It will be desirable eventually to channel all contributions through the Synodical treasurer with reports to the chairman of the Executive Committee for Northern Rhodesia and the Medical Director;
   d. Since the Medical Director will have to pass on requests from the medical personnel in the field, it will be desirable that when the funds are being kept in the synodical treasury, he be the one to requisition for the needs;
   e. On extraordinary items it will be required that the Executive Committee for Northern Rhodesia be consulted.

2. At the Mission
   a. Funds will be sent to a special account in Lusaka directly and there administered by the appointed medical personnel.
   b. Accounting - The person appointed will keep simple records of receipts and disbursements, including governmental reimbursements;
   c. Utilities - There should be payment of a prorated amount for utilities, transport etc., supplied by the mission from regular synodical funds;
   d. Payment of fees - It is desirable to have villagers make a token payment for services received, and a nominal medical fee should be included in the school fee. These receipts must be faithfully accounted for, recorded and reported by the medical staff;
   e. Special funds - All funds given to the Medical Mission, other than bona fide personal gifts received directly by members of the staff, must be reported. Disposition of these funds must be approved of by the Medical Mission Committee; and therefore must be held in escrow in a special bank account;
   f. Annual report - An annual written report must be made in addition to the regular monthly reports (C,3); and a copy of this annual report must be forwarded to the Medical Director and the Chairman of the Executive Committee, as well as to the Advisory Council in the field and to the Chairman of the Board for World Missions.

F. RESPONSIBILITY, LINE OF

1. Medical decisions will be made by the nurse or appointed medical personnel. In some instances this will be in consultation with the Rhodesian Medical authorities and/or the Medical Director.

2. Matters which concern the Villagers or school children- On occasion it would be wise and practical to discuss such things with the people under whose supervision they are;

3. See C - Lines of Communication and Responsibility:
   1. Meetings
   2. Advisory Council
   3. Communications
   4. Cooperation

4. The line of responsibility goes through the Medical Director to the Medical Mission Committee, to the Executive Committee for Northern Rhodesia, and the Board for World Missions.

Submitted by Arthur W. Tacke, Medical Director, M.D.
Meta Hoenecke, R. N., Executive Secretary
Heinz R. Hoenecke, M.D., Medical Advisor

Phoenix, March 4 - 6, 1961

Appendix #2:

Guidelines – African Medical Mission (1965)

[Photocopy received from the files of Pastor Theodore Sauer.]

1014 North 17th Street
Manitowoc, Wisconsin
March 18, 1965

To the Members of
The Medical Mission Committee

Dear Friends and Co-Workers:

In the November 11th meeting I was asked to review the Medical Mission BLUEPRINT and suggest such revisions as seemed advisable.

I had hoped to have these suggestions in your hands long before this. The press of personal problems and the demands of new work and responsibilities in the Church have competed for the time and attention needed for such a study and have, at least in part, contributed to this delay.

It soon became apparent that a simple revision of the BLUEPRINT would not suffice. I have decided to let this original outline stand unchanged as an historical document, important in itself for the understanding of the beginning and development of the Medical Mission program.

In its place, the attached Guidelines are offered as the basis for the present and future operation of the Dispensary and Medical Program in Africa.

In presenting these Guidelines for your consideration, I am aware that they are the outline of one person's thinking in regard to the Medical Mission Program, although they do reflect three years of personal contact with the work and experience with the program.

Consequently, these Guidelines are not being given to you as a finished product for your adoption. Rather, it is my hope that they may serve as the basis for discussion of the matters involved, and that the Committee itself will be able to formulate and adopt a set of Guidelines which will serve as a sound basis for the future conduct of our medical work in Central Africa.

If I can be of further service to the Committee, please feel free to call on me.

Yours in Christ,

Theodore Sauer

Guidelines - African Medical Mission

I. Historical

From the very beginning of our church's work in Central Africa, those among whom we have worked have looked to the missionary or his wife for help and advice in matters pertaining to the treating of sickness and maintaining of health.

In 1959 our Synod in convention approved the idea of establishing a more formal program of medical aid to the people of Central Africa and gave the responsibility for its financial support into the hands of the women's societies in our Synod.

By 1961 there was sufficient interest in and support for such a program so that it became possible to establish a medical dispensary at Lumano. A building was erected and dedicated in October of that year. The dispensary was staffed by an American nurse, an African medical orderly and two African dressers. Subsequently, a second American nurse was added to the staff.

A BLUEPRINT, outlining the basic philosophies, method of operation and hopes for the future, served as the basis for the begining and initial operation of the Medical Mission.

After nearly four years of operation, it is advisable to redefine some of the original aims and objectives, and to re-evaluate the methods of operation in order to bring them more nearly into line with the experience of the past and the needs of the present.

It is to this end that these Guidelines are presented as a basis for the conduct of this phase of our church's work in Central Africa.

II. General Principles

The Medical Mission affords an opportunity to express in a concrete way the love and concern which a Christian feels for his fellow man in his physical needs. It has in a very real way served this purpose also in the work which our church is doing in Central Africa.

As conducted in Zambia, the medical program involves a co-operative effort with the Ministry of Health of the national government, with our Medical Mission supplying the American nurses as supervisory staff, erecting and maintaining the dispensary building, and paying a portion of the cost of medicines and of the salaries of the African workers. The government supplies medicines and medical supplies at a fraction of their real cost and pays a part of the salaries of the African personnel. In effect, our dispensary is one link in the rather extensive chain of medical dispensaries which the government either operates or regulates throughout the country. Since it receives a measure of financial support from the government, our diespensary is required to meet the regulations of the Ministry of Health pertaining to this kind of medical service.

As required by these regulations, medication and treatment is provided without cost to the African people. However, opportunity is given to the patients to contribute on a free-will basis to the cost of the operation of the dispensary.

In line with the philosophy with which the dispensary program was originally begun, the program should be developed in such a way that it can eventually be placed entirely into the hands of the African people. Those who are in the

field will be in the best position to determine how and when such a step can be taken and should be ready to advise both the stateside Medical Committee and the African people most closely connected with our work concerning the steps which will lead to this goal.

III. Staff

1. American Personnel

A. Number - There shall, for the time being, be two American nurses on the staff of the Lumano Lutheran Dispensary.

B. Qualifications - The nurses shall be mature Christians who shall have demonstrated their ability to work independently and yet be able to live and work in close association with others. They shall possess the necessary professional qualifications and preferably have had training and experience in administration and in public health nursing.

C. Tour of Duty - The tour of duty shall be three years, followed by a furlough of three months. On the field there shall be a local leave or holiday of two weeks both after the first and after the second year.

D. Preparation and Orientation - Sufficient time shall be given for proper preparation and orientation after arrving in the field before any duties are assigned in the dispensary program itself. Upon arrival in the field, arrangements shall be made for six month's service in the local African hospital in order that the nurse may become acquainted with the prevalent diseases and their treatment as well as with the procedures of the hospital to which she will later be referring patients. Another month should be spent visiting and observing the work in various government dispensaries which may be located in areas similar similar to that in which our dispensary at Lumano is located. Simultaneously with this activity, or, if this is not possible, then subsequently, the nurse shall engage in concentrated language study so that she can converse at least in simple terms with the people among whom she will be working.

E. Duties - The duties and responsibilities of the nurse shall vary according to her time of service in the field.

The first 9 months	-	To be spent in preparation and orientation as outlined above.
The next 6 months	-	Work in the dispensary as an understudy to the Senior Nurse. Treat patients, using one of the dressers as assistant and interpreter where necessary. Accompany the missionary on village trips where requested by the missionary. Learn the mechanics of ordering of supplies and keeping of records.
The next 3 months	-	Basic duties same as above. In addition, do the actual ordering of supplies and keeping of records under the supervision of the Senior Nurse.
The next 18 months	-	Serve as senior nurse and administrator of the dispensary. Order Supplies, keep records,

conduct health classes and instruct individuals or small groups of patients in proper hygiene, nutrition, and health habits; conduct health classes at the Bible School, and instruct the Junior Nurse as outlined above.

Note: In the event of return to the field for a second tour of duty, the schedule shall be as outlined above, except that the period of re-orientation shall consist of three months service at the African hospital.

F. Compensation and Benefits - These are to be determined by the stateside Medical Committee and reviewed annually. Wherever possible, the same regulations concerning financial arrangements and the furnishing of housing and equipment should apply to the nurses as to the missionaries in the field.

2. African Personnel

A. Qualifications - African workers in the dispensary shall have the same training and general qualifications as those required by the Ministry of Health for those dispensaries fully supported by the government.

B. Conditions of Service - Clearly defined Conditions of Service shall be prepared by the Senior Nurse in consultation with the Superintendent of the Mission and his Advisory Council. Those Conditions currently in force shall be given in writing to the members of the dispensary staff and shall be on file in the Superintendent's office and a copy sent to the stateside Medical Director.

C. Compensation and Benefits - A complete schedule of salaries and other benefits shall be prepared by the Senior Nurse in consultation with the Superintendent and his Advisory Council. In general this schedule should follow as closely as possible, the schedule which applies to similar service in those medical dispensaries fully supported by the government. The schedule currently in force shall be on file in the Superintendent's office and a copy sent to the stateside Medical Director.

IV. Lines of Responsibility

1. In the Dispensary

The Senior Nurse shall be in charge of the dispensary and its staff. While she will give due consideration to the thoughts and suggestions of her co-workers and of others in the Mission and will seek the advice of others who may be qualified to give it, she has the final responsibility in the field in those matters which pertain to the medical and professional aspects of her work and to the ordinary operation of the dispensary. She shall also supervise and be responsible for the proper maintenance of the dispensary building, equipment, and grounds. Decisions concerning major projects or repairs shall be made in consultation with the Superintendent of the Mission and his Advisory Council.

In her absence, the Senior Nurse shall delegate authority as may be necessary for the proper functioning and good order of the dispensary.

2. In the Mission Field

Since the dispensary is a part of the total mission effort, it is important that the dispensary staff works in close harmony with the mission staff in general and with the local missionaries in particular. It is essential that the dispensary program be continually reviewed both by the dispensary and mission staffs with the view of fitting it into the overal mission program as effectively as possible.

The Superintendent shall be kept informed by the Senior Nurse of the progress of the dispensary operation. Copies of monthly reports, both as to finances and as to the general operation, shall be given to him, as shall copies of correspondence with the stateside Medical Director or Committee. Regular reports shall also be presented by the Senior Nurse, in person if at all possible, to the monthly meetings of the Advisory Council.

3. In the Community

It is desirable to make provision for hearing the voice of the community in which the dispensary is located. To this end the Superintendent shall at regular intervals call a meeting at which the following ought to be represented: the Senior Nurse, the missionaries at Lumano, the local headman, the headmaster of the local school, a member of the Native Authority, and the Chief of the Sala tribe, or such person as he may designate to represent him. This group shall be purely advisory in nature.

4. The Medical Committee

The stateside Medical Committee shall have the following duties and responsibilities.

A. In consultation with the Executive Committee for Central Africa to establish the policies which are to govern the medical program in our African mission field.

B. To gather and disburse the funds needed for the conduct of our medical mission program.

C. To engage the nurses who are needed and to outline the conditions under which they are to serve.

D. To maintain close contact through the Medical Director with the work and workers in the field and to receive regular monthly reports both concerning the finances on the field and concerning the overall operation of the dispensary itself. Copies of all official correspondence shall be sent both to the chairman of the Executive Committee for Central Africa and to the Superintendent of the Mission.

E. To make regular reports through the Medical Director to the Executive Committee for Central Africa and through the Executive Committee to the Board for World Missions and to the Synod concerning the medical mission program.

V. Financial Matters

1. Funds transmitted to the field shall be deposited in a checking account in a local bank and administered by the Senior Nurse. Regular monthly financial reports showing sources and amounts of all receipts and a reasonably detailed

account of disbursements shall be made, with copies being sent promptly to the Medical Director and to the Superintendent of the Mission. Books and financial records shall be made available at regular intervals for auditing.

2. Special funds sent directly to the field for the Medical Mission, other than bona fide personal gifts received directly by members of the staff, must be reported and deposited in the checking account of the Medical Mission. Disposition of these funds must be approved by the Medical Mission Committee through the Medical Director.

3. An annual written financial report must be made at the close of the calendar year in addition to the regular monthly reports, and copies forwarded to the Superintendent of the Mission, to the Medical Director, to the chairman of the Executive Committee for Central Africa, and to the chairman of the Board for World Missions.

VI. Amendments

Proposals for amendments to these Guidelines shall be submitted in writing both to the Senior Nurse and to the Superintendent of the Mission for comment. They shall be adopted by the majority vote of the Medical Mission Committee and become effective when approved by the Executive Committee for Central Africa

Appendix #3:

Guidelines – Central African Medical Mission

[Photocopy received from the files of Pastor Theodore Sauer.]

GUIDELINES - CENTRAL AFRICA MEDICAL MISSION

I. HISTORICAL

From the very beginning of our church's work in Central Africa, those among whom we worked have looked to the missionary or his wife for help and advice in matters pertaining to the treatment of sickness and maintaining of health.

In 1957 our Synod in convention approved the idea of establishing a more formal program of medical aid to the people of Central Africa and gave the responsibility for its financial support into the hands of the women's societies of our Synod. In order to promote interest and to gather regular funds and supplies for the Medical Mission in an orderly manner, a system of contact women officially appointed in each conference of the Synod was initiated.

By 1961 there was sufficient interest and support for such a program so that it became possible to establish a medical dispensary at Lumano, Zambia. A building was erected and dedicated on the last Sunday in November of that year, November 26, 1961. Due to the elements and conditions of the area, by 1967 there was need of a new building. In 1969, the new dispensary became a reality and was dedicated in May of that year. The dispensary was staffed by an American nurse, an African medical orderly, and two African dressers.

A blueprint, outlining the basic philosophies, method of operation, and hopes for the future, served as the basis for the beginning and initial operation of the Medical Mission. In 1970 the medical program was extended into Malawi. These guidelines are presented as a basis for the conduct of this phase of our church's work in Central Africa.

II. GENERAL PRINCIPLES

The Medical Mission affords an opportunity to express in a concrete way the love and concern which a Christian feels for his fellow man in his physical needs. It has in a very real way served this purpose also in the work which our church is doing in Central Africa.

As conducted in Zambia and Malawi, the medical program involves a cooperative effort with the health department of the national government. Our Medical Mission supplies and supports the American nurses as supervisory staff, erects and maintains dispensary buildings, and pays a portion of the cost of some medical supplies. In effect, our dispensaries are links in the rather extensive chains of medical dispensaries which the government either operates or regulates throughout the countries. Since a measure of financial support is received from the government, our dispensaries are required to meet regulations of national health departments pertaining to this kind of medical service. Where required by government regulations, medications and treatment are provided without cost to the people.

In line with the philosophy with which the dispensary was originally begun, the program should be developing in such a way that it can eventually be placed entirely into the hands of the African people. Those who are in the field will be in the best position to determine how and when such a step can and should be taken. They will be ready to advise both the stateside committee and the African people most closely connected with our work concerning the steps which will lead to this goal.

II. STAFF

1. American Personnel

A. Number - there shall, for the time being, be two Anericans on the staff of the MWEMBEZHI (Lumano) LUTHERAN DISPENSARY in Zambia, and two Americans on the staff of the SALIMA LUTHERAN MOBILE CLINIC in Malawi.

B. Qualifications - The nurses shall be mature Christians, from Wisconsin Synod or churches in fellowship with it, who have demonstrated their ability to work independently and yet be able to live and work in close association with others. They shall possess the necessary professional qualifications as required by the governments of Zambia and Malawi. Preferably, they shall have had training and experience in diagnosing, administration, public health nursing, obstetrical nursing, and, if possible, midwifery.

C. Tour of Duty - The tour of duty on the field shall be two years. There shall be a local leave of 14 days near the end of the first year and during the second year again as field coverage permits. Under normal conditions a nurse shall not succeed herself.

D. Preparations and Orientation -

1. Stateside
(see preparation sheet attached)

Instruction in driving manual shift operated cars and a simple auto mechanics course is also suggested.

The Medical Director will determine upon consultation with the future nurse regarding courses in special training for service in Africa.

2. Field
Three months of "phasing in" while the outgoing nurse is still present will assist with orientation and will accomplish the following:
a) Acquaintance with the immediate surroundings and mission family.
b) Meeting the African staff.
c) Observance of routines.
d) Learning drugs used for treatments.
e) Familiarizing self with office files.
f) Viewing slides of tropical diseases.
g) Receiving orientation in Zambia at University Teaching Hospital and in Malawi at similar available hospitals.
h) Practice driving on gravel roads with manual transmission.
i) Assisting with clinic operation under the direction of the present nurses.

E. Duties
The specific duties of the Senior and Junior Nurses are found in the procedure books prepared by the nurses and available on the premises. Generally, the nurses are responsible for clinic management, administrative duties, handling of financial matters, inventory and ordering of drugs and supplies, and maintaining correspondence with stateside contributors.

F. Compensation and Benefits - These are to be determined by the stateside Medical Mission Committee and are to be reviewed annually. Wherever possible, the same regulations concerning financial arrangements and the furnishing of housing and equipment should apply to the nurses as to the missionaries in the field.

2. African Personnel

A. Qualifications - African workers in the dispensary shall have the same training and general qualifications as those required by the national health departments for those dispensaries fully supported by the government.

B. Conditions of Service - Clearly defined Rules and Regulations shall be prepared by the Senior Nurse in consultation with the Field Superintendent of the Mission and the Medical Mission Council. Those Rules and Regulations currently in force shall be given in writing to the members of the medical mission staff and shall be on file in the medical mission office. A copy shall also be sent to the stateside Medical Director.

IV. LINES OF RESPONSIBILITY.

1. In the Medical Mission

The Senior Nurse shall be in charge of the medical mission and its staff. While she will give due consideration to the thoughts and suggestions of her co-workers and of others in the Mission and will seek the advice of others who may be qualified to give it, she has the final responsibility in the field in those matters which pertain to the medical and professional aspects of her work and to the ordinary operation of the medical mission. She shall also, together with the Missionary-in-charge of the station, supervise, and be responsible for the proper maintenance of the medical mission property, equipment, and grounds. Decisions concerning major projects or repairs shall be made in consultation with the Field Superintendent of the mission and the Medical Mission Council.

2. In the Mission Field

Since the medical mission is part of the total mission effort, it is important that the medical mission staff works in close harmony with the mission staff in general and the local missionaries in particular. It is essential that the medical mission program be continually reviewed both by the medical mission and the mission staffs with a view of fitting it into the overall mission program as effectively as possible.

The Field Superintendent shall be kept informed by the Senior Nurse of the progress of the medical mission operation. Copies of monthly reports both as to finances and as to general operation shall be given to him as shall copies of official correspondence with the stateside Medical Director or committee. Periodic reports shall also be presented to the meetings of the Superintendent's Advisory Council by the mission representative or by the nurse herself if deemed necessary. Since the nurses are part of the Christian community in which they live, they are under the spiritual care of the local missionary.

In the event of a difference of opinion between the nurses and the mission superintendent or his representative as to how far the medical mission program shall be carried afield, the view of the mission superintendent or his representative shall prevail.

3. Medical Mission Council on the Field

This council shall consist of the nurses, the missionary-in-charge from the station, and the mission superintendent or his representative. Any other interested parties may be invited to attend. The council shall meet at designated intervals to review old and present policies and to establish new policies when necessary according to proper procedures, as well as to coodinate programs and settle differences which may arise.

4. The Medical Mission Committee

The stateside Medical Mission Committee shall consist of the following women:

A. A chairwoman who shall: preside over the meetings of the committee and its executive board; execute the business enacted; make regular reports to the Executive Committee for Central Africa and field committees and councils; and be in charge of returning nurses' deputation work.

B. A secretary who shall: keep minutes and records; write general correspondence as directed; assist in nurses' field readiness programs; assist in the production and distribution of public relations materials.

C. A treasurer who shall: keep records of expenditures; make reports, budgets, and requisitions; be the official contact with the Synod's fiscal office and field personnel in the area of finances; serve as financial secretary to receive, record, and acknowldge all gifts; file regular reports of all income.

D. A nurse who shall: respond to routine medical questions; recruit new nurses together with the Medical Director; orient and help with re-entry of nurses; be in regular contact with both the stateside Medical Director and medical mission staffs.

E. A contact woman who shall: maintain the congregational contact women program; be responsible for public relations programs(e.g. films, letters, displays, etc.)

These five women shall live in a reasonably close area(e.g. 50 mile radius from Milwaukee) so that meetings may easily and economically be held at least quarterly or more often as necessary. Their appointments shall be for 3 years each, with replacement or reappointment by the Executive Committee for Central Africa each fall on a 2-2-1 consecutive basis.

A medical doctor shall be appointed by the Executive Committee for Central Africa to advise the Medical Mission Committee and attend meetings whenever possible. If the Medical Director is not also a member of the Executive Committee for Central Africa, another of its members may also be appointed as a liaison advisory member to the Medical Mission Committee. This advisor and/or Medical Director shall be appointed in the year when one member of the Medical Mission Committee is considered and the term of appointment will be three years.

Necessary Medical Mission Committee business may be conducted by its Executive Board consisting of the chairwoman, secretary, and nurse. Such business shall be retified at the following plenary session. The Medical Director reserves the right to make medical decisions as necessary.

The Executive Committee for Central Africa shall regularly consider the program of the medical mission and shall advise the Medical Mission Committee in the administration of this program. Minutes and treasurer's reports of the Medical Mission Committee shall be sent to Executive Committee for Central Africa members.

V. LINES OF COMMUNICATION

1. From the Medical Mission Committee to the Field

A. All official correspondence with the field shall be the responsibility of the chairwoman in the case of committee matters and the nurse in the case of medical matters. The Medical Director reserves the right to communicate directly.

B. Copies of all official committee correspondence as to be sent to the Field Superintendent of the mission and to the chairman of the Executive Committee for Central Africa. Copies of medical correspondence should be sent to the Medical Director and to the station missionary-in-charge.

2. From the Field to the Medical Mission Committee
All official correspondence and reports concerning the medical program are to be sent to the Superintendent of the Mission and to the chairwoman and nurse on the stateside committee. The Medical Director may request certain copies also.

VI. FINANCIAL MATTERS

1. Funds transmitted to the field shall be deposited in the checking account of the mission and administered by those charged with this fiscal duty. The Senior Nurse shall requisition funds as needed through the same fiscal persons. Regular monthly financial reports showing sources of income and amounts of all receipts and a reasonable detailing of disbursements shall be made. Copies of this report shall be kept on file in the office of the Senior Nurse and the Superintendent of the Mission. Copies shall also be forwarded to the chairwoman and treasurer of the stateside Medical Mission Committee.

2. Special funds sent directly to the field for the medical mission other than bona fide personal gifts shall be deposited in a separate fund and must be reported and deposited in this fund. Disposition of these funds must be approved by the Medical Mission Committee if the amount exceeds $500.00. Amounts below this figure may be spent with the approval of the Medical Mission Council.

3. An annual budget is to be prepared in written form for the fiscal year, July 1 through June 30, and is to be submitted to the Medical Mission Committee by March 1 of each year. The treasurer shall receive the initial input from the field and prepare the final draft.

4. An annual printed financial statement from the field is to be made at the close of each fiscal year and copies are to be forwarded to the Superintendent of the Mission, the Medical Director, all five members of the stateside Medical Mission Committee, three members of the Executive Committee for Central Africa, and to the Executive Secretary of the Board for World Missions.

5. Budgetary expenditures are to be made by the nurse without special authorization. Report of such expenditures is to be made by means of the monthly financial statement. For other than routine expenses, advice is to be sought and authorization received from those responsible for fiscal matters and later retified by the Medical Mission Council. If the nature and/or size of the expenditure warrants it, the request should be placed before the Medical Mission Committee for approval.

6. A Medical Mission Committee financial statement shall be prepared annually by the committee treasurer with copies forwarded to the nurses, Medical Director, Medical Mission Committee and Executive Committee for Central Africa members, to the executive secretary and chairman of the Board for World Missions, and to the Synod's Fiscal Office.

VII. AMENDMENTS

Proposals for amendments to these guidelines shall be submitted in writing both to the Senior Nurses and to the Field Superintendent of the mission for comment. They shall be adopted by the majority vote of the Medical Mission Committee and become effective when approved by the Executive Committee for Central Africa.

Revised and approved on April 12, 1983

Appendix #4:

Central African Medical Mission Guidelines

[Photocopy made from the Medical Mission Personnel Handbook, document dated 2-95.]

CENTRAL AFRICA MEDICAL MISSION
GUIDELINES

I. GENERAL PRINCIPLES

The medical mission affords an opportunity to express in a concrete way the love and concern which a Christian feels for his fellow man's physical needs. It has in a very real way served this purpose in the work which our church is doing in Central Africa.

The medical program involves a cooperative effort with the health department of the national governments in Zambia and Malawi. Our medical mission supplies and supports the expatriate personnel as supervisory staff, erects and maintains medical buildings, and assumes responsibility for financial support. In effect, our dispensaries are links in the rather extensive chains of medical dispensaries which the government either operates or regulates in both countries. A measure of financial support is received from the government. Our dispensaries are required to meet regulations of the national health departments pertaining to this kind of medical service.

In line with the philosophy with which the dispensary was originally begun, the program should be developing in such a way that it can eventually be placed into the hands of the Malawian/Zambian people. Those who are on the field (nurses, administrative coordinator and/or missionaries) will be in the best position to determine how and when such a step can and should be taken. They will be ready to advise both the Central Africa Medical Mission Committee (CAMMC) and the Malawian/Zambian people most closely connected with our work concerning the steps which will lead to this goal.

STAFF

A. American Personnel

1. Number:
   Two stateside registered nurses or a married couple, nurse and administrative coordinator, shall be on the staff of the Mwembezhi Lutheran Rural Health Center in Zambia or the Lutheran Mobile Clinic in Malawi.

2. Qualifications:
   The expatriate personnel shall be members of a congregation of the Wisconsin Evangelical Lutheran Synod (WELS) or a congregation in fellowship with the WELS. They shall be mature Christians who have demonstrated their ability to work independently and yet be able to live and work in close association with others. They shall possess the necessary professional qualifications as required by the government of Zambia or Malawi. They shall have had training and experience in diagnosing, administration, public/community health and obstetrical nursing.
   (See **JOB DESCRIPTION** pages 1 & 2)

3. Tour of Duty:
   The tour of duty shall be approximately four years:
   a. Three to six months of stateside training and preparation
   b. Thirty eight to forty months of service on the field which includes two to four months of field orientation and training
   c. Approximately three months of reorientation and deputation after returning to the States.
   (See **DEPUTATION** page 1)

4. Preparation and Orientation
   a. Stateside
      aa. See **PREPARATION** pages 1 - 7
      bb. Instruction in driving manual shift operated cars and a simple auto mechanics course is suggested.

   b. Field
      The two to four months of training and orientation with the outgoing personnel will include the following:
      aa. Acquaintance with the immediate surroundings and mission family.
      bb. Meeting the national staff.
      cc. Observance of clinic routines.
      dd. Learning medicines used for treatments.
      ee. Familiarizing self with office files and current written policies and procedures. (eg. Rules and Regulations)
      ff. Language orientation.
      gg. Receiving orientation at an acceptable hospital in the country of service.
      hh. Practice driving on bush roads with manual transmission.
      i i. Assisting with clinic operation under the direction of the present nurses.
      j j. Reading old retreat papers.

NOTE: The on-field orientation schedule will be previewed with the CAMMC nurse member prior to leaving the U.S.

5. Duties:
   In addition to the job description, specific duties of expatriate personnel are found in the RULES and REGULATIONS of each field. Generally the expatriate personnel are responsible for clinic management including financial matters. They are to keep inventory and order medications and supplies. Their administrative responsibilities are to be congruent with the national government regulations.

   They are to maintain monthly correspondence with the chairman of the Central Africa Medical Mission Committee and should send thank you notes to individuals or groups who send gifts (e.g. roller bandages, care packages, medical supplies, etc.) directly to the field.

6. Compensation/Benefits/Assumed Expenses:
   These are to be determined by the stateside Central Africa Medical Mission Committee and are reviewed annually: (See **FINANCIAL/BENEFITS** pages 1-5)
   a. Salary
   b. Education fee
   c. Travel and shipping expenses
   d. Health insurance
   e. Medical expenses not covered by health insurance
   f. Worker's compensation
   g. Housing and utilities in the field
   h. Use of vehicle in the field
   i. Vacation time
   j. Re-adjustment allowance
   k. Counseling services

B. National Personnel (Malawian or Zambian)

1. Qualifications:
   National workers in the medical units shall have the same training and general qualifications as those required by the ministry of health for government medical employment.

2. Conditions of Service:
   Recommended changes of the on-field RULES and REGULATIONS shall be prepared by the expatriate personnel in consultation with the mission coordinator and the medical mission council. Rules and Regulations currently in force shall be given in writing to the members of the medical mission staff and shall be on file in the office of the nurses residence and the missionary-in-charge. A copy shall be sent to the Central Africa Medical Mission Committee chairman, nurse and the medical advisor.

3. Compensation and Benefits:

   A complete schedule of salaries and other benefits shall be prepared by the expatriate personnel in consultation with the Medical Mission Council. In general this schedule should follow as closely as possible to similar services provided by the government. A current schedule shall be on file in the nurses residence and the missionary-in-charge and a copy be sent stateside to the CAMMC chairman.

LINES OF RESPONSIBILITY

A. In the Medical Mission
   The administrative coordinator shall assume the responsibility of the medical mission and its staff. He/she will give due consideration to the thoughts and suggestions of his/her co-workers and of others in the mission and will seek the advice of others who may be qualified to give it. He/she has the final responsibility in the field in those matters which pertain to the medical and professional aspects of his/her work and to the ordinary operation of the medical mission. He/she shall, together with the missionary-in-charge, supervise and be responsible for the proper maintenance of the medical mission property, equipment and grounds. Decisions concerning major projects or repairs shall be made in consultation with the mission coordinator of the field and the medical mission council.

   In his/her absence, the administrative coordinator shall delegate authority as may be necessary for the proper functioning and good order of the clinic.

   If there are two nurses in a certain field, the duties of the *Expatriate Nurse* and *Administrative Coordinator* can be shared as their individual talents dictate. The CAMMC will appoint one to assume the responsibility of the administrative coordinator and to be the official spokesperson for the expatriate personnel.

   If there is only one nurse in the field and there is no one available to fill the position of administrative coordinator, an administrative assistant may be hired by CAMMC to assist the nurse in the operations of the clinic. In this case the nurse would assume the responsibility of the administrative coordinator and be the official spokesperson for the expatriate personnel.

B. In the Mission Field

Since the medical mission is a part of the total mission effort, it is important that the medical mission staff works in close harmony with the mission staff in general and the local missionaries in particular. It is essential that the medical mission program be reviewed continually both by the Medical Mission Council and the mission staff with a view of fitting it into the overall mission program as effectively as possible.

In addition to the missionary-in-charge, the mission coordinator shall be kept informed by the expatriate of the progress of the medical mission operation. Copies of monthly reports, finances and general operation shall be sent to them as well as copies of official correspondence to the Central Africa Medical Mission Committee and the medical advisor. Periodic reports shall be given at the meetings of the Malawi or Zambia Mission Council by the missionary-in-charge or by the expatriate medical mission personnel if necessary. Since the nurse/administrative coordinator are part of the Christian community in which they live, they are under the spiritual care of the missionary-in-charge.

In the event of a difference of opinion between the expatriate medical mission personnel and the mission coordinator or missionary-in-charge as to how far the medical mission program shall be expanded, the view of the mission coordinator or his representative shall prevail.

C. Medical Mission Council on the Field

This council shall consist of the nurses/administrative coordinator, the missionary-in-charge, and the mission coordinator or his representative. Any other interested parties may be invited to attend. The council shall meet at designated intervals (**at least once every three months**). Council responsibilities include coordinating on-going programs, reviewing old and present policies, and establishing new policies with the consent of CAMMC.

D. The Central Africa Medical Mission Committee

The Central Africa Medical Mission Committee shall consist of the following women with voting privileges:

1. A chairman who shall: preside over the meetings of the committee and its executive board of which she is a member; execute the business enacted; make regular reports to the Executive Committee for the Lutheran Church of Central Africa, mission coordinator and missionary-in-charge; and be in charge of nurses' shipments to the field and returning nurses' deputation work. The chairman shall serve as a member of the Central Africa Medical Mission Committee Executive Board.

2. A secretary who shall: keep minutes and records; write general correspondence as directed; assist in nurses' field readiness programs; assist with correspondence to prospective nurse candidates. The secretary shall serve as a member of the Central Africa Medical Mission Committee Executive Board.

3. A treasurer who shall: keep records of expenditures; prepare reports, budgets and requisitions; be the official contact with the Synod's fiscal office and field personnel in the area of finances; serve as financial secretary to receive, record and acknowledge gifts, file regular reports of all income and expenses. The treasurer shall serve as a member of the Central Africa Medical Mission Committee Executive Board.

4. A nurse who shall: recruit new expatriate medical mission personnel and assist with preparation for field service; assume responsibility to secure a copy of the on-field orientation schedule to preview and discuss with new expatriate medical mission personnel; respond to routine medical questions; be in regular contact with the expatriate medical mission personnel and the medical advisor; help with re-entry of expatriate medical mission personnel.

5. A contact women coordinator who shall: coordinate the contact women program; maintain the congregational and pastor lists for the contact women; send periodic newsletters with information from the fields and supervise the project coordinator.

6. A public relations person who shall: be responsible for developing public relations programs (e.g. films, slides, videos, display boxes, etc.) and coordinating distribution of materials.

These six women shall live in a reasonably close area (e.g. 50 mile radius from Milwaukee) so that meetings may easily and economically be held at least quarterly or more often as necessary. The 3 year appointment or reappointment of each member shall be by the Executive Committee for the Lutheran Church of Central Africa each fall on a rotating basis.

Central Africa Medical Mission business, when necessary, may be conducted by its executive board consisting of the chairman, secretary, and treasurer. Such business shall be ratified at the following plenary session.

E. Medical Advisor

1. A medical doctor shall be appointed by the Executive Committee for the Lutheran Church of Central Africa to advise the Central Africa Medical Mission Committee and attend meetings whenever possible. The medical advisor shall be appointed or reappointed every 3 years.

2. The medical advisor reserves the right to make medical decisions as necessary.

3. The medical advisor shall receive CAMMC minutes and treasurer's reports.

F. Executive Committee for the Lutheran Church for Central Africa

The Executive Committee for the Lutheran Church for Central Africa (ECLCCA) shall regularly consider the program of the medical mission and shall advise the Central Africa Medical Mission Committee in the administration of this program. The ECLCCA may designate a liaison advisory representative to attend the CAMMC quarterly meetings whenever possible. Minutes and treasurer's reports of the Central Africa Medical Mission Committee shall be sent to the chairman of the Executive Committee for the Lutheran Church of Central Africa.

LINES OF COMMUNICATION

A. From the Central Africa Medical Mission Committee to the Field

1. Official communication to the field shall be in the minutes of the Central Africa Medical Mission Committee meetings. The chairman's letters to the mission coordinator and missionary-in-charge are official and may reflect/expand on such decisions but must always coincide with the minutes. The Central Africa Medical Mission Committee nurse shall correspond with the nurses in the same manner. The medical advisor reserves the right to communicate directly. All official communication to the field should be copied to all CAMMC members, the executive committee and medical advisor.

2. Copies of routine official committee correspondence are to be sent to the mission coordinator, mission-in-charge, expatriate personnel and to the chairman of the Executive Committee for the Lutheran Church of Central Africa. Copies of personal medical correspondence/records should be sent to the medical advisor and to the missionary-in-charge. At the discretion of the individual expatriate medical mission personnel copies of personal correspondence/medical records can be sent to CAMMC chairman and/or nurse member.

B. From the Field to the Central Africa Medical Mission Committee
All official correspondence and reports concerning the medical program are to be sent to the chairman of the stateside committee and to the mission coordinator. All official communication from the field should be copied to all CAMMC members, the executive committee and medical advisor.

FINANCIAL MATTERS

A. Funds transmitted to the field shall be deposited in the checking account of the mission and administered by those charged with this fiscal duty. The expatriate personnel shall requisition funds as needed through the same fiscal persons. Regular monthly financial reports showing sources of income and amounts of all receipts and a reasonable detailing of disbursements shall be made. Copies of this report shall be kept on file in the office of the expatriate personnel and the mission coordinator. Copies shall be forwarded to the treasurer of the stateside Central Africa Medical Mission Committee.

Special funds sent directly to the field or the medical mission other than bona fide personal gifts shall be deposited in a separate fund and be reported quarterly to the stateside treasurer. Disposition of funds that exceed $500.00 must be approved by the Central Africa Medical Mission Committee. Amounts below this figure may be spent with the approval of the Medical Mission Council.

The stateside treasurer shall receive the initial input each year by April 1 for the annual budget from the field for the fiscal year, June 1 - May 31. An annual budget will then be prepared in written form for the fiscal year, July 1 through June 30, and is to be submitted to the Central Africa Medical Mission Committee by May of each year.

An annual printed financial statement is prepared by the stateside treasurer at the close of each fiscal year and copies are to be forwarded to the mission coordinator, expatriate personnel, medical advisor, all six members of the stateside Central Africa Medical Mission Committee, three members of the Executive Committee for the Lutheran Church of Central Africa, and to the administrator and chairman of the Board for World Missions.

An annual financial statement of contributions shall be prepared by the stateside treasurer with copies forwarded to: administrator and chairman of the Board for World Missions; Executive Committee for the Lutheran Church of Central Africa; Central Africa Medical Mission Committee members; medical advisor; contact women and circuit pastors; WELS accounting office and the expatriate personnel of each field.

Budgetary expenditures are to be made by the expatriate personnel without special authorization. Report of such expenditures is to be made by means of the monthly financial statement. For other than routine expenses, advice is to be sought and authorization received from those responsible for fiscal matters and later ratified by the Medical Mission Council. If the nature and/or size of the expenditure warrants it, the request should be made through the Medical Mission Council and presented to the Central Africa Medical Mission Committee for approval.

AMENDMENTS

Proposals for amendments to these guidelines shall be submitted in writing to the expatriate personnel, mission coordinator and missionary-in-charge of the mission for comment. They shall be adopted by the majority vote of the Central Africa Medical Mission Committee and become effective when approved by the Executive Committee for the Lutheran Church of Central Africa.

2-95

Appendix #5:

Central Africa Medical Mission – Zambia, Status Report and Prospectus, 1996

[Photocopy received from the files of the Central African Medical Mission Committee.]

final

MWEMBEZHI LUTHERAN RURAL HEALTH CENTER

1996

INTRODUCTION

In 1961 a blueprint was developed to guide the on-field decisions of the newly approved Central Africa Medical Mission. This work was to be supported by the women of the Wisconsin Evangelical Lutheran Synod (WELS). That blueprint has served well as an original guide, first in Zambia at Mwembezhi, and later on in Malawi. There have been some changes over the years which now compel the Central Africa Medical Mission Committee (CAMMC), under the direction of the Administrative Committee for Africa (ACA), to reevaluate and revise that blueprint for the work which is being done 35 years later.

The changes which are compelling this reevaluation are listed on page 6 of this paper.

REEVALUATION OF THE BLUEPRINT and HOW TO IDENTIFY IT

To refer to this as a revision of the blueprint would not only be confusing but misleading, as it would imply that the blueprint as a guide had never been evaluated before. In fact it has, under the title "guidelines". There have been at least four previous revisions of the blueprint beginning in 1965. Changing situations require plan revision. To call this revision a new set of "guidelines" would cause more confusion as to which guidelines are being referred to. It also seems that in 1996, the word "guideline" is out of style and people have a hard time understanding what it is.

It has been suggested that we use the buzz words of the '90s and refer to this revision as a "**vision statement**". We need only to look at the dictionary definition of the words "vision" and "visionary" to see that, in fact, this title would be quite inaccurate. The dictionary defines the words "vision" and "visionary" as follows:

-to see,----We don't really see the future.
-to see by other than normal sight, perceived in a dream----We can't claim supernatural powers.
-a mental image, imaginative contemplation, ability to perceive something not actually visible through mental acuteness or keen foresight----We don't presume to have unusual mental acuteness or keen foresight.

What we are about to describe is an **expansion of work laid before us in a concrete way by God as an "opportunity to do good to all men, especially to those of the household of faith." (Gal. 6:10)**

The CAMMC, under the leadership of ACA chairman Pastor Dan Westendorf, spent its retreat on November 1-2, 1996 looking at God's Word as it gives guidance and direction to Christians, motivated by the love of Christ to reach out to fellow human beings, first of all with the gospel of Jesus Christ. Christ, by example in the New Testament, and the LORD God, by words of his prophets in the Old Testament, also clearly show that God's people are to reach out to help fellow human beings with physical needs as opportunity presents itself and as we are able.

With Pastor Westendorf, we studied the WELS principles of social ministry and gospel ministry, the distinctions and interrelationships between the two. We referred to writings of Pastor Karl F. Krauss, *Christian Love in Action,* who helped found the Committee on Relief in 1946; Pastor and Mrs. Edgar Hoenecke, Dr. Arthur Tacke, *Blueprint for Establishing a Medical Dispensary in Northern Rhodesia* (now Zambia), 1961; Prof. David Valleskey, excerpts from a paper presented to a mission conference in Nov. 1995; Pastor Ronald Heins, *Encourage One Another to Share the Promise of God's Unchanging Word in Our Changing World*, a Bible Study presented at the Southeastern Wisconsin District Convention, June 11, 1996; Pastor John J. Sullivan, *Humanitarian Services Within World Mission Fields*, World Mission Conference, July 1996; and Prof. em E. H. Wendland, *AIDS in Central Africa--Is There Any Hope?*, Aug. 1996. Another paper not ready for the CAMMC's first retreat, but worthy to consider carefully in the near future is *The Church's Social Responsibility as this relates to World Missions,* by Prof. em E. H. Wendland. This paper looks at "social gospel" vs. "social ministry" as evaluated by Prof. E. E. Kowalke, Prof. A. Schuetze, Prof. Habeck, and Prof. David Valleskey.

The study of God's Word and its application as stated by the above papers clearly shows that the future of the CAMM work in Zambia is anything but "visionary". Rather, the future of CAMM work in Zambia is based on God's Word, in response to his love for us and all mankind. We move forward to address demonstrable physical needs of our fellow human beings not because of vision, but in faith, "being sure of what we hope for and certain of what we do **not** see." (Heb. 11:1) We move forward sure of God's blessings upon this humanitarian work in his name and certain of the power of his Word to bring eternal joy, peace, and hope wherever it is preached in its completeness, truth and purity.

Would "**constitution**" be a better description, as a constitution is "an organization's structure, and the laws and principles which govern the organization."? The biggest problem with this definition and word is that the CAMMC doesn't operate according to laws, nor does the CAMMC set forth **laws** under which the humanitarian work is to be carried out in Zambia or Malawi. The CAMM is a "mission of love" to respond to "opportunities to do good" rather than a mission of laws.

Perhaps the best name for what follows is simply: **"Central Africa Medical Mission-Zambia, Status Report and Prospectus, 1996"**. A prospectus, according to Webster, is "a statement outlining the main features of a new work." A "prospectus", therefore, is being written in response to the changes listed on page 6 of this paper, after a study of God's Word and the history of humanitarian principles in practice in the WELS, led by Pastor Dan Westendorf. The outline of this reevaluation is:

I. CAMM work in Zambia, 1996 **status report**
II. **Changes which have necessitated a reevaluation** of the CAMM work in Zambia
III. **Prospectus** for CAMM work in Zambia, 1996

After approval by the Administrative Committee of Africa, this prospectus is to be the framework within which proposals from the Mwembezhi Medical Council (MMC), Zambia Mission Council (ZMC), and Lutheran Church of Central Africa-Zambia Conference (LCCA-Z), in regards to CAMM work in Zambia will be written, evaluated and implemented.

Central Africa Medical Mission-Zambia, Status Report and Prospectus, 1996

I. Status report of CAMM work in Zambia

A. Reliable, competent health care is available to the people living in the Mwembezhi catchment area.
   1. population of 14,500
   2. annual patient visits about 19,500

B. This work is a health service which emphasizes prevention of illnesses and patient education as the most affordable way to improve the health of all the people in the catchment area, not just to a restricted group.

C. This work is a health service which is able to treat the 19,500 patients listed above for $3,000 annually in medicine by utilizing available government resources, donated medicines, good management, and wise and appropriate treatment protocols.

D. Cooperation with and utilization of Zambian government immunization programs led to the fact that the "protected" rate (the percentage of children successfully completing under 5 immunizations) of children in the Mwembezhi catchment area in 1988 (village visits were made randomly checking under 5 cards) was close to 100%. This is even better than the excellent 88%-90% that Zambia has achieved as a nation.

E. Current statistics (1996) show that the percentage of under weight children at our Mwembezhi Lutheran Rural Health Center (MLRHC) is 11%-13%, depending upon time of year relative to the harvest. Again, this is better than the national percentages of 15%-20%.

F. The people in the Mwembezhi catchment area have more latrines, more protected sources of water supply, and greater knowledge of crop diversification, nutrition, and crop rotation than they did 7 years ago, due to an active and extensive community health worker (CHW) program (about 12 CHWs) and nutrition emphasis

.G. More women in the Mwembezhi catchment area have access to safer deliveries than 5 years ago, due to an active and extensive traditional birth attendant (TBA) program (about 41 TBAs).

H. Both the CHWs and TBAs are chosen and supported by their villages at no cost to CAMM. CAMM provides basic education, monthly inservices, distributes the government essential drug allotments, and provides on-site opportunities for them to assist and increase their knowledge at the clinic. The CHWs provide first aid and basic treatment in the village setting for over 25,000 annually. The TBAs deliver between 200 and 300 babies annually in the villages.

I. According to the original blueprint written in 1961 by Pastor and Mrs. Edgar Hoenecke and Dr. Arthur Tacke, the CAMM did "not plan an expansion of our medical dispensary service, but rather are determined to keep the same within the limits of first-aid and elementary health counseling services, always bearing in mind that what we inaugurate in establishment, staff and service will soon be within the range of the ability of the African themselves to assume as an independent, self-supporting service." The CHWs and TBAs who are supported by their villages, and the clinic staff who is subsidized, in part by

Churches Medical Association of Zambia (CMAZ) grants, fall entirely within the parameters of the original blueprint on this point.

J. According to that blueprint, the CAMM would be "enlisting no help from our regular synodical mission budget, but are determined to inaugurate and support this venture entirely as a non-budgetary enterprise, underwritten by the ladies and ladies' societies of our Synod." Our funding continues to be drawn from "non-budgetary" sources. Together with the support from the women of the WELS, this support has been expanded to include outer interested groups or individuals within our fellowship.

K. Indigeneity of the medical mission was defined in the 1961 blueprint as follows: "Our purpose will be, from the beginning, also to enlist and to train an indigenous African staff, whom we will, in the transitional phase of the program, be happy to assist by periodic counseling and supervisory visits, but to whom we will be more than glad to transfer the entire project and its operation as soon as this is indicated to us and the Advisory counsel which from the beginning will include native Africans." (This council apparently never functioned as it was planned and dissolved after Pastor Schweppe was killed in an auto accident in 1968.) We've seen from the experience of the national church, the LCCA-Z, that the readiness to become indigenous is not solely dependent upon economics and funding sources but upon thorough, quality education. In the case of the LCCA-Z, that education was centered in God's Word. With the power of the Word, the LCCA-Z seems to have matured and become ready to "indigenize" at a faster rate than the CAMM. However, the funding, through scholarships, of the education of two clinical officers, both LCCA-Z members, in addition to the CHW and TBA education and follow-up programs have established a firm base upon which to build and expand. This was exemplified by the AIDS counseling workshop held at MLRHC in 1996.

* The above statistics were compiled from the monthly statistics sent from MLRHC except where noted otherwise.

II. The changes since 1961 which necessitate reevaluation of the focus of the CAMM work in Zambia

A. The gospel mission work has expanded from the Lusaka area and a radius of 70 km (50 mi.) around Lusaka to an area of 752,614 sq. km (290,585 sq. mi.) including the entire country of Zambia except Western and Luapula Provinces.

B. The Lutheran Church of Central Africa-Zambia Conference (LCCA-Z) has grown from about 200 souls and no national pastors to more than 10,000 souls, and national pastors who outnumber the expatriate missionaries (15 national pastors [per chairman Kawaliza] 11 expatriate missionaries - World Mission Report, May 9, 1997).

C. The focus of the medical work, originally on first-aid and preventative health teaching to decrease malnutrition, diarrhea, pneumonia, communicable diseases, malaria, and improve maternal-child health, has recently been expanded to community health care, including care for patients with AIDS and efforts to control the spread of AIDS.

D. The economic outlook for Zambians is far less optimistic in 1996 than it was in 1961. The population of Zambia has increased from 5.7 million in 1980 to 7.5 million in 1995. The literacy rate remained constant at 54%. The per capita income rose from $228 in 1979 (commodities at 1965 US prices) to $570 in 1984 (commodities however had risen to 1982 US prices) only to fall to $400 by 1994 (commodities at or above 1994 US prices). The figures are from United States Department of State Bureau of Public Affairs literature.

It is difficult to explain fully the impact of AIDS upon the economy of the country. The bread winners and income earners are being decimated by the disease. An estimated 250,000 people will die of AIDS between 1994 and 1998. The vast majority are middle aged and providers of food, clothing, and education for families. Where can the money come from to take up the slack in a country with no welfare program?

III. Statement outlining the main features of "new" CAMM-Zambia work in response to changes under II

Due to all the changes in part II, we no longer feel that the Medical Mission should be indigenized. It is felt that it should continue to be an expression of Christian love, supported by the gracious women of the WELS and operated by the CAMM which will work with the LCCA and people of Zambia.

Recognizing that the decision has been made to continue to support the medical mission in Zambia through gifts of love such as financial support, materials, and/or expatriate staff, the following prospectus will be adopted:

A. **Continue** all current MLRHC services, including antenatal clinics and under 5 clinics, village and school visits, general clinics, emergency care, CHW, TBA, AIDS counselor programs and follow-up monthly inservices for all community and clinic workers.

B. **Continue** to turn over authority for the management of above services to our clinical officers, provided they are active LCCA members. Continue to support expatriate nursing personnel, who have the clinical, management, and teaching skills to prepare the clinical officers and other clinic staff to assume increased responsibility. The goal is that services, provided to the Mwembezhi catchment area by the MLRHC, might be maintained at their current outstanding levels.

C. **Develop an overall health education plan** that will also address the HIV/AIDS issue and bring the Word of God to bear upon it. Development of the plan will be based on an assessment of and input from: expatriate medical mission personnel, LCCA-Z clinical officers, Zambian missionaries, national pastors, and LCCA members. It will be designed in such a way that it may be adapted to not only the medical mission setting, but also to the LCCA in Zambia. The primary educational points of the plan will emphasize the HIV/AIDS disease process and seek to encourage God pleasing behavior through a proper application of Law and Gospel.

D. **Develop a protocol** to ensure routine input from all concerned sources, including expatriate medical mission personnel, our LCCA-Z clinical officers, Zambia missionaries, LCCA-Z national pastors in all decisions pertaining to the future of CAMM-Z work and implementation of any new or expanded service before being submitted to the CAMMC for approval. **Following CAMMC approval, any proposal would then be directed to the ACA for final approval prior to implementation.**

E. Continue to develop all new programs such that they can continue to operate in a manner consistent with the level of financial/material/expatriate staff support that the Mwembezhi Medical Mission Committee and CAMMC deem as appropriate.

F. Where the need exists, scholarship money will be made available to faithful LCCA-Z members, who meet the criteria of those funds, so that they can become registered nurses or clinical officers to better serve Zambians through the CAMM. The Hoenecke and Althea Sauer scholarship funds were established in part to meet these particular needs and have been utilized for CAMM Zambian personnel in the past.

G. Funding for special projects such as workshops, CHW and TBA training, development of teaching materials, building of a facility to conduct training sessions, etc., which are not possible through our CAMM annual support, would be considered and approved pending availability of aid money or special grants or gifts. An ongoing program which would demand an annual increase in support by CAMM is not possible at this time. (The annual cost of the medical work at MLRHC, after cost of support of expatriate staff is deducted, is approximately $30,000. In view of the current economic status in Zambia, the CAMM and the Christians who donate money to the CAMM see this support of $30,000 annually as an expression of Christian love toward fellow human beings and "an opportunity to do good to all men, especially to the household of faith." At present we see every reason to continue this annual stateside support.)

Upon approval of this prospectus by the Administrative Committee of Africa, it will be sent to the Mwembezhi Medical Council by the Central Africa Medical Mission Committee and to the Zambia Mission Council by the ACA. We assume it would then be shared with the LCCA-Z as well. We had a preliminary draft on the field well in advance of the January 1997 field visit to enable discussion and feedback to the ACA in person at that time.

We will await proposals for action/changes pertaining to the CAMM work in Zambia written within the framework of this prospectus by concerned groups closest to the work, i.e. the MMC, LCCA-Z, or ZMC.

The MMMC has requested that all proposals originating on the field be funnelled through them for coordination and fine tuning prior to being submitted to the CAMMC and ACA for input and final approval.

Drafted by the CAMMC, approved by the CAMMC, November, 1996. In October 1997 forwarded to the ACA for approval after field input and CAMMC revision.