July 30, 2014

Oliver's in Maxixe

January to July 2014

Reflections and observations

Background

We moved to Maxixe from Maputo on 27th December 2013 to work with the United Methodist Church. The United Methodist church manage Chicuque Rural Hospital in partnership with the government. It is situated five km from Maxixe on land which once comprised a 'mission station' including nurse training and a girls boarding secondary school. The government took control of the land, hospital, houses and schools leaving the church with their buildings. In the past few years the United Methodists have built a 'Centre of Hope' following the vision of the hospital administrator. This is a splendid conference centre and office facility and is currently the office of UM Health co-ordinator and accommodates overseas visitors working for the church. It also is booked by government, churches and NGO's for occasional conferences.

Following conversations between Bishop Dinis (Igreja Metodista Wesleyana) and Bishop Joaquina (Metodista Unida), Gina began nursing at the hospital with view to exploring medical outreach work and Malcolm was invited to explore chaplaincy. The primary concern was for Gina to maintain her clinical practice.

Gina's work.

Gina began work in the Surgical Ward. She was concerned about hand washing as there is only one wash basin in the nurses station and

none on the wards. Also of equal concern was the hygiene in the patients toilet/bathroom: No water in the taps, no cleaning brushes or equipment to clean portable toilet pans, wet floors, dirty toilets and a generally unpleasant odour at the entrance to the ward.

It cost around M5000 of personal funding to buy plastic water bowls and containers, brushes and cleaning equipment before the hard work of putting on rubber gloves and completing a deep clean. Her example encouraged others to join in and for a while a change occurred. The majority of the equipment is still around today.

In late January/ early February Gina began to explore the possibilities of Mobile Medical Outreach. Following discussions with Jeremais Franca the Hospital Administrator, Gina went out with an existing outreach program in a vehicle provided by Maxixe District. As discovered later, this program is replicated in other Districts and takes staff from various hospitals into rural areas with a focus on under five weighing, vaccinations, vitamins and health education. Gina added to this by HIV testing and Malaria diagnosis and treatment. It was not long before Gina expanded this work with other willing volunteers to visit twice a month the places designated as the responsibility of Chicuque . Gina was accompanied by other staff, sometimes including dentist, laboratory technician, Pharmacist, nurses and a doctor. The availability of a doctor meant that other drugs could be prescribed.

The management of the hospital was very supportive of this work, although there was a continued requested by some members of staff for 'incentivo'. This is a rather unfortunate word and in English it perhaps would be better to say 'subsistence allowance' or 'away from normal workplace allowance'. Various amounts have been suggested for this allowance ranging from $5 to $15 to $33 to $50. However as Gina only went out within a 20km radius and returned before the end

of the normal working day, she was able to provide a simple sandwich and can of drink as an 'incentivo'. HIV and Malaria testing kits were always taken along with Maleria treatment. A set of infant weighing scales were procured and likewise a blood pressure machine and digital thermometer. To this was added a small supply of antibiotics, paracetamol and blood pressure medication. Normally, unless Malaria, people were referred to the hospital for further treatment.

During March to June this mobile Medical Outreach program was going out 2 to 3 times a week. Gina observed the following:

(1) People welcomed the regular visits..although some seemed to see it a a social event to attend on a regular basis and thus had regular blood pressure/temperature checks.

(2) The number diagnosed with Malaria was often high both in infants and adults. Sometimes people had visited local health posts and been tested but were sent away without medication due to shortage. They welcomed the possibility of receiving medication (Malaria medication is provided free of charge). Sometimes people were convinced they had malaria although the test showed negative. There had been rumours about false positive tests. This was found to be without evidence as people almost without exception exhibited other signs (fever, vomiting etc). It is difficult to know how many lives were saved, however the impression is particularly with infants, early diagnosis and treatment prevented complications or even death. It remains uncertain if the the figures recorded would ever otherwise reached government statistic records.

(3) As confidence built more and more people welcomed the opportunity to be tested for HIV. This also included a growing

number of men. They were given primary counselling and referred to the hospital.

(4) Many people were diagnosed with high blood pressure. Some already knew this and had received medication from the hospital which they had not always taken. On occasions people produced stockpiles of blood pressure medication.

(5) Mothers with infants warmly welcomed the opportunity to have local facilities for baby weighing and monitoring.

(6) The places visited were comparatively close to the hospital and with reasonable transport possibilities to basic medical facilities. Clearly there are large areas in Moçambique where this is not the scenario.

(7) Initially in some places large numbers turned up seemingly with the idea that it would provide evidence to the authorities that what was really needed was a local clinic and nurse. In one place there had been a health post built which was lying dormant. The Mobile Medical Outreach operated from a under a tree adjacent to the building. Whilst the building was structurally sound, it was so dirty, uncared for and smelly that it could not be used.

(8) The provision of Mobile Medical Outreach could transform a culture in which primary health care is often currently led by traditional healers without reference to medicine with a scientific rational. Care would be needed to ensure the best of both avenues were employed.

At the end of June, Gina ended the twice monthly visits to four communities and reverted to accompanying/providing transport for

the monthly outreach visits to two designated places. This still enables those visits to be greatly enhanced: They are restricted to weighing infants and vaccinations. Gina is able to provide blood pressure, health check, Malaria treatment and HIV testing and primary counselling. This decision was for the following reasons:

(A) We do not know how long we will be residing in Maxixe and it would be unfair to both hospital and community to create a long term dependency on something that will end when Gina leaves.

(B)The Hospital seem unable to make funding available even for fuel, let alone other on costs or 'incentivos' for mobile medical outreach.

(C)The existing program government seems only to happen due to external funding and support. There seems no real will to extent it from child health to Malaria control.

(D)The Hospital seem to show little constructive enthusiasm to work with NGO's who do related work.

(E)By providing transport we were putting ourselves at risk. What claim would be made on us in case of an accident?

Gina is currently gaining experience around the hospital in different wards, focusing on HIV, Malaria and TB related issues. This will continue for the forceable future. She continues to enjoy relating to her medical colleges and learning. However there is a feeling that we have done all we can and Gina has sometimes been frustrated from doing her work in the manner that is correct (sanitation etc) She would like confirmation now of what she will be doing in 2015 so that she can more effectively prepare herself for the challenge.

Language Learning

Language leading remains a challenge for all of us. This is partly due to the need to acquire two languages, one European the other African. Gina is rapidly progressing in her acquisition of Portuguese. She now understands much of a conversation and can dialogue with people, especially around medical matters. She can therefore communicate effectively in her nursing role with other professionals and with patients who speak Portuguese. Regarding the indigenous language(Chitwa & Bitsonga), although a few words are the same as her home Chitonga…most are vastly different.

Chipo and Luyando go to a school where Portuguese is the only language used. They are therefore exposed to it for most of the day and it seems to be coming embedded. At home they chatter away using both Portuguese and English…and teach mummy and daddy too. It is difficult to know if either language is dominant.

Malcolm is trying his best but language acquisition remains 'muito dificile' (very difficult) for him. After causing much laughter by mixing Chitonga with the little Portuguese he knew, he has now forgotten the Chitonga and still struggles to learn new vocabulary. He continues to try and with the right people speaking slowly he can understand and respond… but in a formal situation really struggles to be understood or to understand. The thoughts of preaching in Portuguese at present remain nothing more than a dream. Reflecting he thinks he should have been more assertive in requesting funding for Parafino..a young man in the church who translated for him into the local languages and because he is a teacher was able to assist greatly with language learning. He wonders if it would be better to try and learn the local language, Chitwa. He remains very concerned that the

longer he survives without mastering the local language the harder it becomes.

Malcolm's Work

The sort of work Malcolm has been doing has been greatly influenced by the language issue. He has been invited to preached only three times since being in Maxixe, once in the local congregation, another on a visit with the Igreja Metodista mission group to Zavora and lastly at a local pentecostal church. Hence its a bit like a chicken and egg situation… In Zambia he acquired language skills whilst preparing and leading worship with the help of a good interpreter. That opportunity was limited in Maputo and more so here. The ideal for him in learning Potuguese would be to speak in English and be translated into Portuguese…however people understandably prefer or need to hear the Word in the vernacular.

Language has also been a great concern for him in Chaplaincy possibilities. It seems to him unfair to visit patients who want or need to speak in Chitwa or Bitonga with only a very limited ability to speak Portuguese…a language which they may or may not understand. He needs a translator, but despite mentioning this to several people, they seem to show limited interest. The superintendent who is also a nurse at the hospital believes that the chaplain should broadcast a message each day on the hospital public address system.. hence reaching all in every ward. Malcolm is not prepared to do this for ethical reasons, even if he was able to communicate effectively.

The church near Chicuque has been welcoming, albeit services are very long, often with minimal reference to scripture and little preaching. As there are numerous preachers and Ministers, they clearly do not need another who has limited command of language.

He therefore has spend his time in the following ways:

(I) Language learning. Recently a good samaritan (God sent?) turned up and offered to help without charge to mutually benefit him with English)

(II) Supporting in prayer the work of the hospital staff and praying when possible with them.

(III)Working with the United Methodist Health Coordinator in preparing project proposals to acquire funding for the Centre of Hope.

(IV)Drafting reports, suggesting possible ways of collaborative working between the church and NGO's

(V)Supporting Gina in her work with the Mobile Medical Outreach (chiefly driving and record keeping)

(VI)Reflecting theologically, waiting on God and seeking his will.

(VII)Networking with others involved in God's mission. For example there is a family in Inhambane who are using a discipleship model of church with dual people… training local 'disciples' to begin churches.

(VIII)Offering pastoral support to those on the fringe of the church, or nothing to do with the church who speak English.

(IX)Exploring the possibilities of Chimoio. (Preparing budget and house plans* for submission to the Bishop) It has only been possible to visit Chimoio once because of danger with Renamo on the road 200km north of Maxixe.…he hopes it may be possible to travel again by road in the near future although that will also depend on funding being available. During conversations last October between the Mission Group and the Bishop it was

suggested suggested that Malcolm should be appointed as Superintendent of Central Zone Circuit. Malcolm remains unsure if this the direction the Bishop wishes to take. Since October 2013 he has been pondering and thinking about how best he could enable God's Mission in that part of God's vineyard. The visit in June 2014 with Bishop Dinis served to focus his mind further.

** Malcolm downloaded and learnt how to use Autocad..a drafting program to draw these plans to scale.*

(X)Most importantly being Dad to Chipo and Luyando

(XI)For the last two months, Daily prayers with Samaritans Purse Charity close to our home who are achieving the work that the Centre of Hope aspires to do…but has not got funding to achieve.

(XII)Recently exploring working with the English Department at the University regarding using exploration of religion as a means of teaching English language skills. Malcolm has also spoken with the University about helping teach Theology..again language is a barrier.

(XIII)Praying and trying to enable symbiotic relationships between NGO's/Churches.

(XIV)Pastoral work with English speaking people.

Living in Maxixe

We are enjoying living in Maxixe, albeit it gets even hotter than Maputo in the January to March period. It is a privilege to live in such a beautiful part of God's creation with sun, sea, golden sands and palm trees. We live in rented accommodation close to the centre of Maxixe

on the main EN1 route though Moçambique. Maxixe is classed as a city although apart from a market burgeoning out onto the streets and a range of other little shops , it bigger shops are one private food supermarket and supermarket packed with Chinese plastic goods

Crossing the inlet by boat (about a kilometre) is Inhambane which is the Administrative capital. Here there are government buildings and less shops. The twins enjoy travelling on either big or little boat to get there. It is a sixty kilometre car ride, so boat much more favourable. Once in Inhambane you are near the coast of the Indian ocean. A twenty minute car drive will take you to some beautiful beaches and resorts. We sometimes go there at the weekend.

Numerous expatriates (mainly south african) have settled on the Indian Ocean. We have met a pastor who runs and English/ Afrikaans service each Sunday in one of the many lodges. Through this contact we have discovered that most of these beautiful places stand empty. Tourists used to come..but in the last couple of years the industry has declined. They wait in hope! Despite this this is a through put of those coming to scuba or dive at Tofu or Barra beach and people continue to construct new lodges.

Opportunities in Maxixe?

1. MOBILE MEDICAL OUTREACH We came to Maxixe primarily for Gina to maintain her nursing skills. This she has been able to do. We have explored and written in another document the possibility of establishing Mobile Medical Outreach either here or elsewhere. We continue to consider it to be an opportunity for Integral Mission. However we think it is only achievable with some serious input by Moçambican Methodists. At present we are not convinced there is either the interest or the capacity within the leadership at all

levels for this to happen. If the Igreja Metodista Unida and/or the Igreja Metodista Wesleyana decided to commit themselves to the project then with modest help in the short to medium term from outside it could become sustainable and benefit both the local communities and congregations. However without a seed change in approach and thinking it will become yet something else which is unsustainable and creates dependency, depression and despondency within the church. Even if local congregations are unable to contribute financially…. one way forward could be to utilise the 'tithe culture' . Members who are medical or administrative could give of there time rather than making a financial contribution, thus they receive no 'incentivo' rather make an offering to God of their time and this is publicly recognised.

2. WORSHIP IN ENGLISH/PORTUGUESE. Malcolm has explored this possibility. It would seem there could be a real need and opportunity to begin worship in Portuguese/English. Recently a new manager of a large builders merchant store has arrived in Maxixe. He is a committed Christian and Malcolm has been exploring working with him and others he has identified in establishing English Speaking worship. It is doubtful however if the would wish to be too closely linked to the current Methodist culture of Mozambique. It would need to be a much wider ecumenical venture.

3. SYMBIOTIC WORKING BETWEEN NGO's and CHURCHES. Malcolm has been exploring this with The Centre of Hope and Samaritan Purse and is convinced that exciting possibilities exist. However this again would need the support of the Methodist Church and education on the importance of integral mission.

4. WORKING WITH OTHER MISSION FOCUSED GROUPS. There are numerous traditional churches and new discipleship groups working in and around the area. There appears to be harmonious relationships between many of them. This spectrum of different Christians could perhaps be harnessed to explore a more united approach to God's Mission. The Council of Churches of Mozambique seems to have little or no impact at local level. Several of the newer discipleship groups possibly offer a more sustainable approach to Christian Discipleship in Mozambique without a structure dependant full time leadership.

Threats

Maxixe may or may not be like other similar places. people talk of a high crime rate when comparing it with Inhambane city across the water. We have felt safe and have not thus far been made to feel unwelcome or at risk. However we have been uneasy about the news of a security guard at the GULP petrol station across the road being shot in the head recently at 23 hours. He was dead on arrival at Chicuque hospital. He leaves a wife and a three day old child.

Also recently, I met with another pastor to pray with the manager of the largest building suppliers in Maxixe. He recently arrived here from Maputo and before his wife and family could join him, he had been poisoned (confirmed later by laboratory in Maputo) He is still recovering and determined to overcome in a loving way the obstacles put before him by those who seems to want his demise. Poisoning seems to be a common occurrence in these parts.. You hear one story and then another other follows. It seems to be based on wanting to keep jobs for local people.

Then of course there is the ongoing (and hopefully now ending) disagreement that is being played out between Frelimo and Renamo. The dangerous area on the road is around 250km north of here. Thankfully there has been no attacks for a few weeks now. The signing of a peace agreement is promised to take place in very near future.

Last but no mean least is the threat of money! In a country where the majority seem to have so little, whilst the few are obviously very rich, there seems to be an overzealousness for individuals to want to get rich quick… . The question for many including those who follow a faith seems normally to be : How can I use this situation to make money for myself? It rarely seems to be: How can I be the best I can be? or What does God want me to have or to do? This seems to be reflected in worship where the focus seems to be on finances: Numerous collections where people feel pressured to give, public acclamation given to those who say they tithe, collection counted during sermon so it can be announced at the end of worship. The big threat for those who say they are Christians seems to be the worship of the God of Money rather than the God of Love.

Conclusions

A. We are thankful for the time we have spent in Maxixe. It has been good for learning and reflection,However in terms of the Nursing and Ministry work, in the longer term we sense greater use of our skills could be made elsewhere. We are concerned that we are seen of benefit because people assume are expatriates with money, rather than people with skills to offer.

B. When it comes to engaging with the Mission Of God, The challenges facing the Igreja United Methodista are very similar to those of the Igreja Wesleyana Methodista. Both have huge opportunities and resources,.Both need to explore how to use external money for mission and reduce financial dependency on outside donors for the current maintenance style of Ministry.

C. Methodism could establish Mobile Medical Outreach work BUT ONLY with the right attitude and cooperation of the Methodist Churches both at local and national level. For example The Church could commit itself to funding a nurse without always depending on outside partners.

D. Much good work is done by both the Centre of Hope and Hospital. BUT to avoid duplication and wasted effort, they do need to work as partners with each other and NGO's.

Chimoio

E. We Consider that if the MCSA were to appoint* us Mission Partners to Chimoio we would be able to serve effectively. It remains important that Gina's vocation is of paramount importance. Gina could either be based in a clinic or if the church decided to prioritise it, in setting up Mobile Medical Outreach. We were pleased to be asked by Bishop Dinis for Gina's qualification portfolio so that he could begin discussions with the Provincial Director of Health in Chimoio. Also Malcolm was encouraged by conversations with Bishop Dinis that he understood to mean that he would be ministering in Central Zone Circuit. We remain concerned that there is no no seeming progress on the construction of a house or other preparations if we are to move at the end of the year. Also we are concerned that expectations

for our role and job description need to be explored and confirmed in writing. What would Malcolm's status be as 'Mission Partner' rather than 'stationed 'minister? What structure would the MCSA put in place to support Gina in her work?

* *'Appoint 'is used rather than stationed, because the MCSA has made it clear to Malcolm that his name will not be included in the list of stations' in the Minutes of Conference. He will be included as "Mission Partner." This would seem to indicate that the MCSA see our role as distinct from the role of a normal minister in MCSA structure.*

Malcolm and Gina

August 2014