Glory
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GLORY attempted a model project, combining establishment of a health service, with the planting of the first church in a remote district in South Asia. This part of South Asia has a unique church history. Despite some level of religious freedom, there is stiff persecution for new believers. Missionaries came as "biprofessionals," generally using health and development as a means of entry. Most South Asians, who come to the Lord, still come as the result of a health event. Rapid growth of the church has occurred in certain areas of the country. The church has enjoyed rapid growth overall. Still there are geographic areas and people groups that have been untouched by the gospel.

Health care continues to be a huge need. GLORY was asked to start a hospital in a remote district. At this location there were no known believers. It was at the corner of three districts, at the second biggest commercial center in the district, on a major (pedestrian) trade routine connecting South Asia to China. So, it was seen as also strategically important.

Our goal was to plant a church that would be indigenous, reproducing, and able to run independent of expatriates. At the same time we planned to start a health facility (15 bed primary health care center and community health program) that would meet pressing health needs. An official agreement was signed with the government for the health services, providing places for 15 visa posts.

EVANGELISM METHODS

- Use a mixed team: Those initially involved included three South Asian women from another tribe, and another South Asian family (health worker) from near the project site. It gave us credibility, helped to deal with cross-cultural issues, and improved understanding with the community.
- Aim for a purely local church: While there were both South Asians and expatriates that came from "outside," we planned that the church itself would be made of local people who would stay, and transform their community.
- Live among the people: We felt that rather than living on a compound we would live in (modified) village houses, so that we would be closer to the people we hoped to reach. It allowed regular close contact.
- Evangelism primarily home-based: We chose a somewhat controversial strategy to NOT use the hospital heavily for evangelism. We had voluntary staff devotions, and talked often to the staff. Literature was available for patients, and we would share with them or pray with them if there seemed to be interest. We were concerned to not "impose" the gospel by having a loudspeaker in the general waiting room, partly because we had a captive population who had no where else to go for health care. For those who wanted to hear, there was ample opportunity. It was both safer and more effective to make friends, and to reach them in house fellowships.
- Coordinated method: We all agreed before we entered to use one single method—Chronological Bible Study—to teach spiritual truth. The different house fellowships stayed approximately at the same pace, so everyone heard the same thing. Chronological study was used because it gives an excellent background to the gospel for Hindus and animists who come from a totally different worldview.
- Reach the valley first: We planned to first establish a central church, then to use this as a kind of base to reach out to surrounding communities

- Quickly put in local leadership: We did not plan to have an expatriate "pastor", so immediately started to identify among the new believers those who had leadership potential. We discipled and trained these men and women so that they could move into leadership.
- Don't emphasize formal Bible schooling: In this area of South Asia there is over-dependence on formal education structures, with new graduates having a sense of superiority or accomplishment while being untested in the trenches of front line ministry.
- Church off the hospital grounds: There is no value, and some risk in having the church too closely associated with the "project," so church services were never held at or right close to the hospital.
- An exit strategy: Hospital associated churches in particular are prone to having expatriates present and influential for too long. We built in an exit strategy, intending to have both hospital and church ready for total national management within about 10 years (this time frame more influenced by the hospital).
- Team building: A carefully worked out team building exercise was done prior to entry allowing for a unified purpose and approach in ministry orientation and daily life issues.
- Priorities: The team set a clear standard that ministry was the priority (although it wasn't always easy to keep this perspective). We also agreed together that we should encourage and allow time away from hospital or technical work for ministry. There was flexibility in working hours, allowing us to avoid the trap of having doctors working 100hrs/wk, with no time for direct ministry.
- Prayer meetings with missionaries and South Asian co-workers, and quickly incorporating South Asian Christians were important.

By God's grace, a church has been planted. The church planting team rotated teaching responsibility for the first 2 years, with the South Asian brother doing more of the up-front preaching. After about a year people started coming to the Lord. Initially laborers came, with 60% low caste. There has been linear growth, with 4-5 per year coming to the Lord. Currently there are about 40 in attendance with 25-30 baptized. This includes many associated with the health work. All of the believers were from the immediate area. Increasingly the church is involved in releasing people from the control of demons—a large felt need of the community. This area of South Asia seems to be more resistant to the gospel, so this level of growth is fairly significant, though more rapid multiplication would still be desired.

We have regular nurturing contact with churches that have started in neighboring communities. Outreach was more feasible initially, but a guerilla movement centered in our district has made it unsafe even for nationals to venture into surrounding communities to preach.

There have been many significant and long-term positive effects. Because we are the only expatriates, the only Christians in the area, and the only operational NGO, most of the changes can safely be attributed to the project. Health care improved dramatically, with a 90% drop in local mortality. The community gradually discarded a multitude of false ideas, including health issues. Significantly fewer patients went to witch doctors first for their care (which would have been the standard previously). Presence of the hospital brought an economic transformation to the valley, with a burgeoning bazaar due to patients traveling long distances and then using the trip for shopping also. Education had been very poor, but inputs that we made into the schools (including health education and facility

improvement) have remained. The community's attitudes toward Christians in general have modestly improved, though many still are very hostile.

Initially there was persecution of the believers. The primary persecution was ostracism from the close fellowship of the village. They have said that though they still live there, have friends, and work there, relationships are more distant than they used to be. This subtle ostracism is more painful for them than a beating—they have said so. We have done everything we could to keep them in their community in every sense Biblically possible, but it has been only partly successful.

Whole families coming to the Lord were sought from the start, but wives were particularly resistant. Only 5-8 years later did the first wives of Christian men start coming to the Lord. Women in rural animistic settings are conservative forces, resisting various kinds of change, including spiritual.

The guerilla insurgency has been a huge challenge. Leaders from the church have been threatened and interrogated. Guerilla workers will not permit open meetings, nor outreach with small group gatherings, which were previously used. It is hard for South Asians and expatriates to travel within, and outside the district. Eventually tension, constant fighting, destruction of the area's infrastructure (phone, planes, etc) made it infeasible for expatriates to continue to live there. The culmination of events happened about the time we planned to hand over the work to South Asians anyway, but this forced our hand.

The church has struggled to work together. From early on there were regular disagreements and fights. There has never been a major split, but they also don't work well as a single unified force. There is substantial petty jealousy that continues, often over occupation and financial issues. This fragmentation is reflective of the political situation, the state of the national church (where churches don't work well together), and even of local politics. There was a major split with one expatriate missionary leader (who left), but this example may have played a negative role. Another issue was the unstable and phlegmatic nature of the believers, with variable church participation, and fluctuating spirit within the group. We needed lots of patience and perseverance in helping them stay on course.

Rice Christians—those that were only interested in spiritual things for their personal financial profit—were a problem. These were hard to differentiate, and hard to deal with, since in reality many Christians had or got jobs, so some "seekers" came for that reason alone.

Outside Christian groups would stop by, encouraging new believers to go their training in the city. This emphasis pulled believers away from the village into often times useless or inappropriate training. It caused jealousy with those who got to go (and see the big world), and it often took decision making out of the hands of the new church elders.

We were able to reach both high and low caste South Asians, but were unable to penetrate the influential businessmen, the professional class, and the politically powerful. Even some businessmen mentioned this to us late in the project. Perhaps if we had targeted them from the start it would have been different.

We failed to include the national missionaries in our very critical early teambuilding exercises. They weren't always on the same page with the expatriate coworkers and had

different approaches/ideas that hadn't been ironed out before hand. This also left the South Asian workers feeling a bit like second-class citizens.

There was no cross-cultural training for the South Asian missionaries. We were amazed at how painful it was for them, even though they spoke the language and were from the same country. Some left prematurely due in part to issues of culture shock and burnout. We should have helped them prepare for the change.

Sometimes new believers who weren't ready were pushed too soon into leadership or people with wrong motives were allowed to take control, which weakened the group and actually left a dearth of Biblical leadership. We should have been more specific in our selection (rather than more like a political process).

We have been able to build a facility with interesting appropriate technology. Since this area is known as a difficult place, we were convinced that getting outside staff to work at the hospital would be hard. We decided to take only local residents as staff. We hired entry-level staff based on a heart for service, and success on our administered English/Math/science test. If they proved good workers, they were sent for further training. Using this technique, we were able to supply mid-level medical assistants, nurses, lab techs, and other needed health workers. The community also recognizes that we were able to get almost uniformly high quality workers. The doctor continues to be either an expatriate, or a highly paid national doctor from outside the project area.

The staff has had a high vision for serving their own community, and keeping the hospital working to serve the poor, even under very hard circumstances. The administrator, also a local man, has been well trained, and carries the vision for a clean, effective hospital that serves the poor.

The community health work has been effective in reaching out into the community to improve literacy among women, to teach health, to improve potable water access, and to address the problem of critical childhood malnutrition. A number of facilitators participating in the program have come to the Lord

The health work has made a huge difference. The hospital has earned strong credibility in three districts for skilled quality, and loving care. It is the only facility in three districts that always has a doctor and medicine at the same time. A patient was overheard telling another that this place was different because there was love here. Everyone knows Christians are responsible for this. Health conditions were so terrible before we came, that people would die with diarrhea and pneumonia for lack of treatment. Because of our work, mortality dropped 90% over the 10 years of the formal project!

The project has received recognition for excellence. The American College of Physicians gave the project a national award for innovation and excellence.

Handing over the hospital appeared for a long time to be impossible. We did not see South Asians in our area interested and capable of taking over a full health project in a remote and difficult area. However, God had prepared a national Christian mission organization to do this kind of work. SERVE is an indigenous South Asian Christian NGO committed to using development work (primarily health work) to further the Kingdom. It was their vision to take over established mission hospitals. They agreed to take over the GLORY Hospital.

The organization's leadership represents some of the country's key church leaders. Working in concert with them helps and strengthens the national church. South Asians often view Christians as interested in only spiritual things, ruining the "natural culture" of Hinduism, but doing nothing constructive for their community. By doing health work, this national mission agency intends to empower the believers in those communities to take a major role in the hospital, and so raise the status of national Christians in the esteem of the community.

The leader also has found that countrywide the upper professional class in South Asia has been largely unaffected by the gospel. Using his role as leader of a successful NGO doing health work gives him easy inroads into this unreached community, and he is building a church himself to meet the needs of this unreached people group.

We are pleased that the exit strategy developed at the start could be accomplished. God provided a very capable national mission agency to take over the work. It has been a boost for their organization (and by extension the national church). We trust it will develop from here into a model of partnership and cooperation with the national church.

Since 1993 GLORY has been able to start an effective health service in a very difficult remote area and have it totally nationalized. The church started there where there were no believers continues to grow and be stable. The national missions organization that has taken over the hospital and the oversight of the church is gaining national strength and reputation from this work. It is now time that the effective work done in Rukum should provide profit to the national church. Many challenges remain for both the hospital and the church, but it is in the hands of Christian South Asians now, who are full of vision, and skilled in health care management.