My Pilgrimage in Mission

Harry W. Williams

What a generation was mine—born on the eve of World War I, involved in World War II, living to experience the twilight of colonial empires and the subsequent transformation of nations. I served as a medical missionary with a career that spanned World War II, the war in Vietnam, and beyond. The field of medicine saw its own transformation, with the advent of antibiotics, intensive care, transplants (from skin to hearts), and a vast specialization, especially in surgery. All of this progress increased the cost of the maintenance of major hospitals, creating an impossible burden for most of the churches in the non-Western world that had inherited them.

The Salvation Army and a London Citadel

My paternal grandfather, Henry, was born in Bath in 1859, son of a master coachbuilder of a firm that made the landaus of Beau Brummel’s day. He was apprenticed to his father, but growing impatient with his lot, he walked the hundred or more miles to London. He found Christ at the famous Regency Church of All Souls, Langham Place. Had he remained a communicant of this fashionable church, I no doubt would have become a Church Missionary Society doctor. But he heard the blare of trumpets and a booming drum around the corner in Oxford Street, where the Salvation Army of 1882 had converted a skating rink into an all-purpose mission hall. He followed the band and was soon a sergeant, preaching in the West End with his own platoon.

These were exciting days of rapid growth and intense opposition. Left lying in a gutter blinded by bleach thrown by some roughs, he was rescued by Alice Page, herself a sergeant with a posse of six young women. Six months later he and Alice were married. Thus my father, Harry Stephen Williams, their eldest son, grew up in the evangelical climate of the Salvation Army. He joined the ranks. He was not a public speaker, but he gave all the hours when not at his office in the city to the furthering of the Army’s cause.

It is germane to my story to dwell on the Citadel, that famous Salvation Army center in London’s West End. At the opening of the new millennium it still sends its soldiers to the main thoroughfares, markets, and fashionable squares. It is also the headquarters for the volunteers who share steaming soup and friendly greetings with those sleeping on the streets. The several Indian hospitals where I was later to serve as chief medical officer—from the Himalayas to Cape Comorin—were run on the same theological premise, to wit, that the love of God in Christ must be expressed in terms relevant to the needs of, and intelligible to the understanding of, the poorest of the poor.

At Christmas, in the cold of the Punjab at the MacRobert Hospital, Dharival, the outpatient hall featured a stable complete with life-size baby and his parents, the animals, the shepherds, and wise men, with a painted backdrop of the Judean hills. We repeated the nativity scene at the Catherine Booth Hospital in Nagercoil near India’s southernmost tip, where there were 350 beds and as many places in the chapel. The sides were open, and the curious could stand in the roadway and watch and listen. Sparrows rested in the thatched roof. At any time one could see a non-Christian villager kneeling before the baby and placing an egg or a chapati in the straw.

In 1913, the year of my birth, the Salvation Army was only thirty-five years old. In the 1920s, when I was a schoolboy, loyalty to the Army and a flamboyant evangelism conditioned all my activities. While at grammar school I had little time for extracurricular social events. The Citadel program was always full. It might be thought that the unpredictable nature of worship, the absence of the sketchiest liturgy, would repel a sensitive boy, often charged with being a bookworm. But I found the services exciting. Leaders were not confined to pulpit or lectern but took the liberty to stride the platform to dramatically reinforce their message. Unrehearsed testimony was invited from the congregation. I have vivid memories of some of the worthies, who sat in a group well forward, jumping to their feet and striding to the rostrum to contribute in their own idiom.

The two main worship services were a contrast. In the morning, the Holiness meeting attracted some from other churches. It was devotional in style, with biblical exposition and an emphasis on individual dedication to Christ. To the preachers of that generation, the Old Testament patriarchs and prophets were their familiars—lively role models. The evening meeting was geared to the unconverted. It was preceded by a meeting held at the largest open space at the center of the London suburb, where a crowd of several hundred would gather. The crowd then followed the forty-strong brass band along High Street, blocking the thoroughfare to traffic. There were knowledgeable comments on the flying arabesques that the bass drummer’s sticks wove above his huge drum. Many unaccustomed to church or chapel crowded in, filling the hall to overflowing.

In this constantly challenging environment, a visiting officer-cadet put me on the spot: “Are you converted?” He got no immediate response, for I was affronted. He was a stranger and did not realize that my father was a pillar of the corps! But I can still recall the week that followed—a week in which I felt alienated from God, devoid of prayer. On the following Sunday I capitulated and was born of the Spirit. I was a babe that grew in spiritual awareness. By the time I was seventeen, I was confident that I must be a disciple in the mold of St. Luke, a doctor with a message. How the medical component would work out I left with God. I was prepared to wait, sure that the way would open.

That way proved to be an intriguing blend of strenuous personal effort coupled with a profound faith that it would be of the Lord’s doing rather than by my skill or enterprise. I had plenty of role models. The Salvation Army of my youth was full of those who had walked a similar path. Frederick Booth-Tucker, who had landed in Bombay to pioneer the Army’s work in the 1880s, was still around in my teens. I heard him preach, his open Bible (frequently rebound in Indian village leather) balanced on the palm of his hand. I learned that what Christ had promised, he would fulfill.

In today’s Salvation Army, provided that one accepts the spartan terms and conditions, one can work as an employee or as a missionary for a short but fixed span. In 1933 there was but one

Commissioner Harry W. Williams, O.B.E., F.R.C.S.E., F.I.C.S, served the Salvation Army as an officer for forty-six years. For thirty years he and his wife were in medical mission work in India. He specialized in reconstructive surgery for the physically handicapped, in which he was one of the pioneers in its application to leprosy. For a further ten years he and his wife were engaged in international administration.
course: I must become a Salvation Army officer. After I had jumped that hurdle, I was reminded in writing that an officer's life was one of a discipline that left no choice of appointments or type of service. I even knew that there could be no guarantee that my assignment would be a medical one! I also knew that an officer was permitted to marry only another officer. Salvation Army officer personnel are severally and unitedly under orders. Nevertheless, I did marry, and from the beginning I received challenging medical assignments.

Medical Service in India

My wife, Eileen Neeve, was born in Plymouth, England, a few days my junior, daughter of Salvation Army officers. Our first appointment, in 1939, was to Moradabad, a walled Mogul city in the United Provinces of Agra and Oudh. In accordance with William Booth's advice to the pioneers he sent to India—"get into an Indian skin"—I lost my name on arrival in India but was allowed to choose my new one. Henceforth I was Bashir Masih—Witness to the Lord. I became the assistant to an experienced surgeon. The British Raj still had eight years to run; the pattern of life was still authoritarian. A small group of competent, dedicated officers from the various imperial services ruled with acceptance as far as the majority was concerned, although the Congress Party was soon to launch its Quit India campaign. In 1941 the Salvation Army had agreed to use the hospital for the care of Indian military casualties. By 1943 the pattern became an all-out takeover, the hospital becoming the nucleus for a 2,000-bed military general hospital.

In 1943 I was drafted into the Indian Medical Service, and we moved as a family to Poona, where I was to be assigned as a surgeon in the military hospital. Each department of the hospital was commanded by an officer who had been a consultant. We were virtually a medical college, and the eighteen months I spent there brought invaluable experience. Our eldest child—Ann, born in 1941 at Moradabad—died in Poona from an anesthetic mishap and is buried there. Her grave is marked by a brass plate engraved by a Moradabad merchant who remembered her from our first years in Moradabad; he used to walk to the Salvation Army hospital with an orange tucked into the back pocket of his achkan for the doctor's charming child.

Fleur (1943) and Jennifer (1945) were each born in separate provinces of India. For nine months of the year they were at boarding schools in the hills of North or South India. For the three coolest months they entered fully into the life of the hospital community. They still remember a little Urdu and love curries. Eventually we had to leave them in England for higher education. In the tight discipline of the day, we were not granted leave for their weddings or for our parents' funerals.

In 1944 I was technically put on the unemployed list to permit me to take over the Salvation Army MacRobert Hospital (1944–52) at Dhariwal in the Punjab, where our responsibilities included medical care of the 1,500 employees of the woolen mills that produced cloth for military uniforms and standard-issue blankets. In our seven years on this alluvial northern plain including the traumatic carnage that marked the first months of independence in 1947, in sight of Himalayan snows, we developed a pattern that was to be followed for the next twenty years, as we moved to the Salvation Army hospital in Anand, Gujarat (1954–59), and finally to the Catherine Booth Hospital (1960–69) at Nagercoil, Tamil Nadu, on the southern tip of India.

Since all expatriate staff received a living allowance on the same scale, and all fees went into the hospital funds, we were able to give quality care that attracted patients from a wide area. Income from donations and grants from development agencies maintained and expanded buildings and equipment as the program diversified. My wife claims that we were never free from the sound of donkeys, whose panniers were laden with bricks and cement. There was constant adaptation to meet the changing medical needs of the country. In many areas, such as the treatment of tuberculosis and leprosy, the missions pioneered, and government followed.

In 1953 I sought training in plastic surgery under Sir Archibald McIndoe. At his famous center in East Grinstead, England, he had remade the hands and faces of burned airmen of World War II. I became a member of the British Association of Plastic Surgeons. Both in Poona in 1943 and then with Sir Herbert Seddon at the Royal National Orthopedic Hospital in London, I worked at orthopedics. These skills combined in the development of reconstructive surgery. Commencing with congenital defects and the victims of accident, the program moved to the surgical rehabilitation of poliomyelitis and finally to an extensive involvement in leprosy. For facial deformities and the paralyses of hands and feet, adequate follow-up required the development of workshops to provide specialized footwear and artificial limbs.

When we arrived in India in 1939, an estimated 20 percent of all beds in the country were in the hands of Christian agencies. The field of nursing, outside the major presidency hospitals, was entirely occupied by Christians. We inherited or opened nursing schools in each of the four Salvation Army hospitals to which I was assigned. Initially these schools were supervised by a mission board in each province, which set the syllabus and conducted examinations, issuing diplomas that were registered by the state. One by one these elements were taken over by the state, usually unchanged. I lectured, examined, and, in Nagercoil, served as the president of the board, signing hundreds of diplomas every year.

The Christian Medical Association of India (CMAI) was a large and influential body, in close touch with missionary societies and government. It proved an ideal umbrella for controlling and developing paramedical education, which was springing up in various parts of the country. Increasingly, hospitals had specialist staff and facilities, which made such developments desirable. At Anand we opened the first school of physiotherapy. All of these disciplines were brought under the CMAI, which conducted the examinations and issued diplomas. Later at Nagercoil, with the development of specialty surgery, we ran postgraduate courses for nurses in these subjects, as well as CMAI courses in radiography and laboratory technology.

Reconstructive Surgery for Leprosy Victims

While staying with an old friend of medical college days, I was spurred to attempt to repair the facial deformities of leprosy. I
Recently I visited the Catherine Booth Hospital at Nagercoil. This hospital run by the Salvation Army has nearly 400 beds. From outside it looks small, housed in modest buildings in a limited area. Surprisingly the hospital is one of the best in the country, with experts attending patients, and the cleanliness is something that every hospital should emulate. This only shows that the lack of finances or limited resources need not stand in the way of having a good hospital.

His wife had been a patient, along with tea planters, civil servants, poor cultivators, and leprosy cripples. There was such a stream of young patients, physically handicapped from all causes, that we first of all provided physiotherapy, then occupational therapy, and finally a chain of vocational training centers, where we taught a livelihood to men and women reactivated by reconstructive surgery. The skills ranged from the traditional ones of weaving, tailoring, and embroidery to secretarial skills and printing for women and metalwork of all kinds for men. Eventually we ran a factory for the manufacture of hospital furniture and equipment, as well as three vocational training centers.

India was an old mission field when we went there. Denominational rivalries and one-upmanship were still current. After the disastrous riots in the Punjab at independence in 1947, mission resources were pooled; relief operations settled into permanent cooperation. Ludhiana Christian Medical College became a joint venture, and eventually the Punjab government participated. In the days of the Raj, both the Salvation Army and the London Missionary Society had opened medical schools with
the recognition of Travancore State. There was a 30 percent Christian population in this state and a keen interest in providing rural medical services. A similar school was opened by the American Presbyterian Church in Maharashtra.

After 1947 the united resources of Western missions could support only one modern college, and Vellore in Tamil Nadu was chosen. But subsequently the government found that it could support another training center at Ludhiana. The government also stepped in at Maharashtra. I served on the pioneer governing body of Ludhiana and subsequently on the central committee and executive committee of Vellore. Both the hospital and the medical college won recognition as among the best in the country. Many were committed to serve in church hospitals on graduation.

**From Vietnam to International Administration**

In the 1960s we were caught up in the war in Vietnam and responded to an appeal from the CMAI to provide twenty-five beds for children requiring plastic surgery because of war injuries. But the South Vietnamese government was not prepared to let the young patients leave the country. A New York organization, the Children’s Medical Relief, appealed for consultants to give three-months service in rotation, and a state-of-the-art hospital was built in Saigon. The government seconded doctors and nurses for training and invited us to visit hospitals throughout the country to choose patients suitable for special treatment. I also helped with the three hundred leprosy patients in the huge Cholon Isolation Hospital. We commenced a weekly session of rehabilitative surgery there, as well as clinics in a huge refugee camp run by the Salvation Army.

In 1969 the Army appointed me to senior administration, first in India, then New Zealand and Australia, and finally to serve as international secretary at the headquarters in London. Each appointment involved an integrated commitment to evangelism and community service, including medical programs, with an added dimension of training Salvation Army officers and soldiers. In New Zealand we became painfully aware that small was no longer beautiful. I had to close six excellent maternity hospitals. But a new field was opening. An old program in the treatment of alcoholism was expanded into a multifaceted one that included other addictions, and it won government financial support. In Australia the Bridge Program for addicts grew, again commanding government support. I found myself on two statutory committees, the Commonwealth Medical Research Council and the newly formed Health Board of New South Wales.

In Australia the command included Papua New Guinea. Here was a growing church and social work geared to the special needs of a population recently emerged from the Stone Age. Medical work demanded a new approach, small hospitals in scattered mountain situations requiring hours in a jeep from the nearest mission station. In fact, we had to use a helicopter to skim over the dense jungle. We were training indigenous officers but could not cope with the demands for instruction by Christian pastors in isolated villages. We invited villages to choose a young man who would serve them after a program of training that
included not only the Christian faith but rudimentary medical subjects, which enabled him to use a very limited pharmacopoeia, which we supplied. We brought these young pastors back for refresher courses at regular intervals. Each village donated land for a meeting hall and a pastor’s house as well as an allotment on which he could grow his basic food. These constructions of bamboo and thatch sprang up over a wide area.

Young men were being convicted of crimes that were considered serious in the eyes of the Western authorities but that from their cultural perspective were but peccadilloes. At the government’s request we opened a remote colony where education and practical skills replaced a prison sentence. A dispensary designed for the settlement catered to all the neighboring villages. Education also had to be tailored to a country where tribes in adjacent valleys were scarcely beyond the bitter enmity of cannibal days, a country without railways and with but one road into the mountains from the northern side. Mission Aviation Fellowship flew us from the coast, landing on a grass runway.

During the six years at international headquarters, I also held the post of international medical advisor. As other references in this article reveal, the cost of medical programs was rising inexorably. Even national health services were being forced to make painful decisions. It was time to further projects of a more homespun nature in the Third World. In some African countries I watched expatriate nurses managing health centers, where hundreds attended the daily outpatient session, receiving clever teaching on public health and hygiene as they waited, followed by practical demonstration on diet as well as laboratory investigations. A dozen local aides were being trained in the process. At one Zambian hospital, a village of rondavels (African huts) provided accommodation for mothers eager to learn how to feed and care for the family. Such centers have been spread widely not only in rural settings but also in urban areas.

Lessons from India for Africa

In the later years of my service with the Army, I related lessons from one area to the needs of another, as when the expertise of one of the vocational training centers in India came to the aid of a new scheme in Ghana. My career ended with a series of seminars in every continent at which nationals of adjacent countries learned how to develop projects to expand their own missionary endeavors, using capital from Western sources. The U.S. Agency for International Development approved a grant that permitted an international team of missionary experts in education, agriculture, medicine, and organization to travel to every part of the non-Western world. In these exploits my wife lectured on opportunities for women in church and society.

The six years spent as an international secretary for the Army’s London headquarters held a variety of responsibilities both in Army administration and in the universal church. I was a member of two councils that elected generals, and I chaired the Advisory Council to the general, a body of senior officers that considers changes in appointments, new developments, and responses to a changing world. On the wider front in the United Kingdom, I enjoyed the fellowship of the medical committee of the British Conference of Missionary Studies. One lasting production of those years was Heralds of Health: The Saga of Christian Medical Initiatives (ed. Stanley G. Browne [London: Christian Medical Fellowship, 1985]), which records two thousand years of Christian contribution to the development of medicine. Another lasting contribution to world health has been made by ECHO, a medical supply agency, of which I was a director. It evolved from a simple initiative of the Medical Missionary Association of London in collecting, sorting, and distributing second-hand medical instruments to mission hospitals. It now deals with all forms of medical equipment from bedpans to complete hospitals. ECHO can supply medicines of a basic pharmacopoeia at incredibly low prices.

During the same period, I was elected to a five-year term on the Central Committee of the World Council of Churches, which gave me an experience that confirmed for me the oneness of the spirit but the diversity of gifts. Ecumenism has continued to expand on this understanding of a rich diversity of worship and administration.

Some Personal Reflections

Long years among Hindus, Buddhists, Muslims, Christians, and animists have taught me that monolithic religious disciplines are inherently intolerant. Only as minorities are they in any sense open. Animism is the exception. All over the world, such people have heard the Gospel gladly and responded. Then again, Hinduism, ancient and amorphous, has always been able to admit new “prophets” to its pantheon without change in its framework. The Dravidian gods of southern India have been lost in the religion of the Aryan invader from the north. Gandhi was happy to include Christ alongside Vishnu and Shiva and to meditate in Christian ashrams.

This immersion in an alien brew helped to clarify my Christian faith. I could learn something from all but hold to Christ as the unique self-revelation of God. It confirmed me in the fundamental, emotional relationship of discipleship to a living Lord as the vital requirement of Christianity. If the great variety of Christian denominations were to merge, the superficial differences could be accepted as reflecting what the infinite variety of personality and culture requires for an individual believer to be happy in the worship of God.

Throughout the years I have written for the Salvation Army and various medical journals. Two books were published during these years, The Miracle of Medicine Hill (1970) and Booth-Tucker: William Booth’s First Gentleman (1980). Retirement has not meant a cessation of purpose. An autobiography I Couldn’t Call My Life My Own (1990) was followed by a trilogy of novels (The General Has Decided, The Sons of Want, and The Chota Sahib [1994–99]), covering three generations of Christian medical service in India.

During the years spent at Salvation Army international headquarters, I was able to find the staff and funds to open a primary health and community center in a shantytown suburb of Cochabamba, Bolivia’s second city. It developed into a small hospital specializing in obstetrics and pediatrics. The need for a community medical program was obvious, and in 1991, at the age of seventy-eight, I went to live in the hospital. The links I made in the community and a turnaround in administration and funding have meant that a health service is now spreading to other areas with a mobile clinic and a training program for paramedics.

On one or two occasions in the last twenty years I have visited “old battlefields.” The intensity of affection and the utter irrelevance of race have taken me by surprise. The missionary urge is now two-way; the cutting edge has shifted from the First to the Third World. But the oneness of all Christians must constantly be demonstrated, within denominations as well as between them. My pilgrimage is not over, but I have found fulfillment and contentment. I quote: “I couldn’t call my life my own; but what a life He gave.”
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