This paper was presented during the APM Conference and then edited by the author. This is the final form. To reference all of the conference proceedings and papers, visit the link below.

Social Engagement: The Challenge of the Social in Missiological Education
The 2013 Proceedings of the Association of Professors of Mission
First Fruits Press, c2013 .74
Digital version at http://place.asburyseminary.edu/academicbooks/3/

First Fruits Press is publishing this content by permission from the Association of Professors of Mission. Copyright of this item remains with the Association of Professors of Mission. First Fruits Press is a digital imprint of the Asbury Theological Seminary, B.L. Fisher Library. Its publications are available for noncommercial and educational uses, such as research, teaching and private study. First Fruits Press has licensed the digital version of this work under the Creative Commons Attribution Noncommercial 3.0 United States License. To view a copy of this license, visit http://creativecommons.org/licenses/by-nc/3.0/us/.

Questions, contact:
Association of Professors of Mission
108 W. High St.
Lexington, KY 40507
http://www.asmweb.org/content/apm

Social engagement: the challenge of the social in missiological education.

xvi, 323 p.: ill. ; 23 cm.
The 2013 proceedings of the Association of Professors of Mission.
Includes bibliographical references.
ISBN: 9781621711148 (pbk.)


Cover design by Kelli Dierdorf

asburyseminary.edu
800.2ASBURY
204 North Lexington Avenue
Wilmore, Kentucky 40390

First Fruits
“Save the Mothers”

A Maternal Health Missiology

DANIEL D. SCOTT

DOI: 10.7252/Paper.000019

About the Author:
Daniel D. Scott is Associate Professor of Christian Ministries at Tyndale University College and Seminary in Toronto, Canada and the Managing Director of Save the Mothers—a maternal health organization.
Abstract

Some 287,000 women die yearly from something that is preventable; they die because of complications during pregnancy and childbirth. The risk of maternal death is particularly high in sub-Saharan Africa. Women in this region don’t have access to the care they need. The right of such access must first be embraced by the wider society so that women will seek maternity services and so that when they do, they are met by an effective maternity care system.

Reducing the number of mothers that die in childbirth is one of the United Nations’ Millennium Development Goals (MDG # 5). Yet the target set for 2015 is unlikely to be met. Indeed, the global picture of maternal mortality and morbidity has changed very little over the past twenty years despite isolated (and often medically-based) efforts to improve the situation.

A Canadian obstetrician, who is also an SIM missionary (named Dr. Jean Chamberlain Froese) has developed a multidisciplinary approach to this very complicated social and cultural problem; working with Ugandan colleagues, Dr. Froese founded the Save the Mothers’ program at Uganda Christian University. It offers a Master in Public Health Leadership with a focus on training national, primarily non-medical advocates to bring about political and cultural change. Using this program as a case study, suggestions will be given for developing a Maternal Health Missiology.
Maternal mortality and maternal morbidity are among the greatest tragedies in our day. In the 20th century, pregnancy and childbirth killed more than tuberculosis, suicide, traffic accidents and AIDS combined. During the same century, more women died in childbirth than were soldiers killed in both world wars. Today, for every woman who dies in childbirth, about twenty women suffer injury, infection or disease—almost six million women each year. Some develop a fistula, a tear in the bladder, rectum or birth canal that leaves them incontinent: these women will be thrown out of their families and villages, like lepers. Save the Mothers, a small Canadian NGO, is training cross-disciplinary professionals to bring about the systemic change needed to ensure that women are safe. This paper will provide a maternal health missiology, using Save the Mothers as a case study, by looking at the lives of three biblical women (Eve, Rachel and Mary) and one man (Boaz).

Dr. Eve Nakabembi is a Ugandan obstetrician. Recently married, and expecting her first child, she knows first-hand the tragedy of women and their children dying in Uganda from pregnancy and pregnancy-related complications. After carrying the child for a number of weeks, she experienced difficulty. Fortunately, Dr. Eve survived. Her child did not. But the danger of giving birth is something she also encounters daily in her professional work. One recent night, while on rounds at her hospital, eight mothers died in childbirth. Another time, while performing a Caesarean section, the power went out in the hospital. Left in darkness, she had to do the incision by the light of her cell phone—holding her phone in one hand and the scalpel in the other. In frustration, Dr. Eve said that something has to be done. She is a highly competent physician, but there are factors affecting the lives of women that are beyond her control.

The mothers who die in her operating theatre point to a larger, more horrifying reality. Eight hundred women die every day in childbirth--fourteen a day in her country of Uganda alone. If two jumbo jets crashed in one day, it would be the lead item in the news that day. If two jumbo jets filled with pregnant women crashed in one day, it would be the lead item in the news for weeks! Maternal death of that magnitude happens everyday and yet not enough is being done to change this tragedy. Reducing the percentage of mothers dying is a United Nations’ Millennium Development Goal (Number Five) and it is unlikely the goal set for 2015, “reducing the maternal mortality ratio
by three quarters between the years 1990 and 2015,” (UNICEF 2005)\(^1\) will be reached. In fact, high-level consultations are taking place to determine maternal health priorities, post 2015.

The statistics reflect the injustice wrought by acute poverty, that is, over ninety-nine percent of maternal deaths occur in developing countries (WHO 2012). Health care is simply unavailable, inaccessible, unaffordable, and frequently of poor quality to women in the developing world. Bleeding, infections, unsafe abortion and obstructed labour, are some of the preventable and treatable complications that lead to death (WHO 2005).\(^2\) There are three major delays that lead to mothers dying from pregnancy complications: the delay in the decision to seek care; the delay in the arrival at a health facility; and the delay in the provision of adequate care (Thaddeus and Maine 1994:1091-1110).

To stem the tide of maternal death, and to help address the first two delays, Dr. Eve Nakabembi became the Academic Director of a unique Master in Public Health Leadership (MPHL) program operated by Save the Mothers\(^3\) at Uganda Christian University (UCU).\(^4\) Courses are taught by local experts (in such fields as public health, obstetrics, gender issues, sociology, etc.) who have the necessary academic credentials to teach at the graduate level. Courses in the MPHL include: Foundations of Public Health and Safe Motherhood, Epidemiology, Biostatistics, Research Methods and Monitoring and Evaluation. As working professionals, students study on a part-time basis over two years. The program is designed so participants can continue to work while studying, and involves nine weeks of in-class training with two or three modules per year. Between modules, students are assigned supplementary readings and are expected to create, implement and evaluate a major project, or to carry out a research project that challenges them to prove that their new skills will make a difference in and through their own professional sphere of influence.

The program consists of small and large group sessions with an emphasis on problem-based learning and group activity. Included in the course work are field visits, participation in a mentorship program, written assignments and an oral class presentation.
Save the Mothers recently launched an international cohort of students in the MPHL program at UCU. It sought out students from other East African nations (including Tanzania, Rwanda, Southern Sudan, Kenya, Democratic Republic of Congo, etc.) to study in the MPHL program at the Save the Mothers’ training centre in Mukono, Uganda. The MPHL program now has two different groups of students—a Ugandan cohort and an East African cohort.

The graduates of this program, founded by Canadian obstetrician, Dr. Jean Chamberlain Froese, are advocating for systemic change across a variety of fields—health care, social work, business, media, government, and the faith community to name a few. To date, some two hundred and fifty East African professionals have studied in the MPHL program. Graduates are working towards needed societal change to reduce maternal deaths. Child educators are writing books and implementing programs (such as after school maternal health clubs and theatre groups that perform plays about maternal health) designed to inform children about the importance of good maternal health and to communicate these messages to family members at home. Journalists are raising public awareness of the factors that lead to maternal death and of the need to resolve maternal mortality’s causative issues. Policy makers are introducing legislation aimed at supporting maternal health initiatives. Lessons learned in the training of multidisciplinary leaders for health promotion in developing countries involve the choosing of the right champions (or students) and the flexibility of the program (Chamberlain and Watt, 2012:344-348).

The Mother Friendly Hospital Initiative (MFHI), developed by Save the Mothers (with support from Uganda’s Ministry of Health and the WHO office) is directly addressing the third delay—at the hospital. A team of Ugandan and Canadian experts in obstetric and health administration has developed a curriculum to train STM MPHL graduates at Uganda Christian University as Mother Friendly Hospital resource teams. Save the Mothers supports the teams, providing them with the skills to work with hospital administrators and staff in assessing, recommending and implementing changes, and monitoring the maternal and newborn services in their hospitals. These teams strive to provide needed life-saving equipment and to ensure safe environments for mothers to deliver their babies thus facilitating the
institutions becoming “Mother Friendly Hospitals.” The program also seeks to improve the knowledge and clinical skills of the hospital staff who care for mothers and their babies.

The problem is not just that more doctors, more medicine or more money are needed. A radical change in the way women and mothers are treated by societies in the developing world—Sub Saharan Africa, Afghanistan, Haiti, India, as examples—needs to occur. The solution requires ordinary people who want to make connections that create extraordinary outcomes (Westley, Zimmerman, Patton, 2006). It involves the recognition that much variation exists between cultures and that flexible, locally meaningful systems need to be established (Miller, McDaniel, Crabtree, Strange, 2001). “Successful practices...make good sense of what is happening, and effectively improvise to make good practice jazz.”¹⁰ Furthermore, given that there is a large and growing Christian population in Sub-Saharan Africa, and there are Western Christian missionaries involved in stemming the tide of maternal mortality and morbidity, a biblical and theological basis for maternal health needs to be articulated. Such a missiological framework can be derived by considering the stories of three biblical women (Eve, Rachel, and Mary) and one man (Boaz, the husband of Ruth). The following attempts to articulate such a biblical and theological foundation for maternal health as mission.

In some cases, asserting this theological framework must go up against patriarchal prejudices about the role of women. Indeed, asserting this biblical and theological foundation is vital in much of East Africa (and arguably worldwide) to correct anti-feminist interpretations of Scripture. There is a clear and important role for women in society, and this fact can be found in the biblical story. Too often, devaluing women—especially as the expendable property of a father/husband who can be discarded should they die or be maimed in childbirth—is justified on biblical misinterpretation. What is worse, many Christian organizations fail to correct this misogyny because of a fixation on other issues.

The biblical story is clear about the importance of women, including to the messianic mission itself (and not simply as child-bearers). Eve, the first woman created, wife of Adam and mother of Cain, Abel and Seth (Genesis 4:1-2, 25)¹¹ is condemned to bear children in pain for eating the forbidden fruit. She and her husband are banished from the Garden of Eden and desperately wish to return. And yet, in
the first messianic prophecy—“and I will put enmity between you and the woman, and between your offspring and hers; he will crush your head, and you will strike his heel” (Genesis 3:15)—there is a sense that she and all humanity will be “saved through childbearing” (1 Timothy 2:15) as the Messiah crushes the serpent’s head. One commentator makes a compelling case that Eve (and Adam) thought that through their childbearing the Messiah would be born. This writer makes his case by considering the meaning of the names: Eve “life-giver;” Cain “acquired;” and Abel “breath.” That is, according to this commentator, Eve the mother of humanity announces at the birth of Cain “I have brought forth or acquired a man, even the deliverer” (Genesis 4:1). She, of course, is mistaken in thinking that her firstborn son, Cain, is the Messiah of all humanity and the means by which they might return to the Garden. Cain kills Abel and his short life is like a breath. Later, at the time of Seth’s birth, Eve makes the statement: “God has granted me another child in place of Abel, since Cain killed him” (Genesis 4:25). This time Eve acknowledges that God is the source of providing the son. “What she had to learn, and what God taught her through Cain’s ensuing sad history, is that the deliverer could never come by her or her husband’s own doing but would be God’s gift. So the second time around she says, “God has granted me another child in place of Abel.”” (Boice, 1982).

Although Adam and Eve do not directly bear the Messiah as they hope or think, through their offspring, Jesus the Messiah is eventually born. The Pauline phrase “woman will be saved through childbirth” often reads with great difficulty for interpreters, but the inevitable sense is that the salvation of woman—and indeed of humanity—comes from a woman, God in Christ.12 “One relatively common attempt to resolve the difficulties is to assume that the singular subject of “will be saved” is Eve and the “childbearing” is the birth of the Messiah Jesus, implying that Eve’s sin is reversed with the coming of the work of Christ” (Mickelson, 1986: 296).

The biblical character Eve suggests that the salvation of humanity is directly related to child bearing. If the stakes are so high, then maternal health ought to be a high priority. If the coming of the Messiah is to be through one woman, should not all women be equally valued?
Scripture repeatedly makes mention of the need to care for the fatherless and the orphan (for example, Exodus 22:22-24). Interestingly, it rarely, if ever, comments on those children who lose their mother. The exception is Rachel. She is an Aramaean woman and the second wife of Jacob, who, like many biblical women, has difficulty conceiving. She eventually does conceive and gives birth to Joseph, Jacob’s favourite son. The birth of Rachel’s second son Benjamin brings about her death through childbirth (Genesis 25:18-19). Jacob loves Rachel dearly, partly because of her great beauty and the many years he has to serve his father-in-law before they are married. When she dies he is filled with grief and erects a memorial pillar over her grave. The location of this pillar is known in Saul’s day, when it is described as being on the border of Benjamin and Zelzah (1 Sam 10:2). Ramah is thought to be the location of this grave marker and the place from which the voice of Rachel is heard weeping for her motherless children: “A voice is heard in Ramah, lamentation and bitter weeping. Rachel is weeping for her children; she refuses to be comforted...” (Jeremiah 31:15).

The reference to Rachel’s weeping occurs in Jeremiah’s Book of Consolation and in the midst of a beautiful, but difficult, poem (Jeremiah 31:15-22). The crucial verb in this initial part of Jeremiah’s poem is “heard.” In Jeremiah’s prophecy, God hears the weeping of Rachel. He is not completely detached from his people. God is able to hear the mourning from Ramah. Rachel’s children are his as well and thus God is also concerned about their plight. This concern is evidenced by God’s response to Rachel’s weeping. Furthermore, God hears the moaning of Rachel’s children, personified as “Ephraim.” The emphatic repetition of the verb “to hear” serves to enforce the fact that God has heard the grieving: “I have surely heard the moaning of Ephraim” (Jeremiah 31:16). The soliloquy in Jeremiah 31:20 reveals the heartfelt response of God not only to the moaning of Ephraim but also to the weeping of Rachel. God’s pathos ridden words to Ephraim are:

Is not Ephraim my dear son,
The child in whom I delight?
Though I often speak against him,
I still remember him.
Therefore my heart yearns for him;
I have great compassion for him.
Particularly poignant is the line “my heart yearns for him.” The response of God to the remembrance of God’s people (and hearing Rachel weep) is that God is filled with distress, agitation and grief. The best understanding of the phrase, it could be argued, would be “my heart grieves for him.”13 This is the sense that the Japanese theologian Kazoh Kitmori takes and uses as the basis for his *Theology of the Pain of God*.14

Is it too much to suggest that in light of the pain God experiences at the death of the mother Rachel and the effects of her death upon her children, the heart of God must be distressed and agitated by the deaths of mothers in our day? World Health Organization statistics reveal that every other minute a woman dies from preventable complications from pregnancy or childbirth (WHO 2012). The unfortunate consequence is that this high rate of maternal mortality leaves over one million orphans behind. Without a mother to care for their needs, these little ones are ten times more likely to die within two years of their mother’s death (UNICEF 2005). Sarah Brown, wife of the former British Prime Minister Gordon Brown, made the following statement in a speech given to the African First Ladies Summit in Los Angeles, organized by USDFA and African Synergy:

I don’t believe that we will make the progress on HIV/AIDS without addressing maternal mortality. We will not make the progress we want on malaria without addressing maternal mortality. We will not make progress on getting more children to school without reducing maternal mortality.

But we will make progress on all these things and on nutrition, on empowerment and education, on health care, on immunization, even—I believe—on the environment, if we make progress to reduce the number of mothers dying needlessly in childbirth. When one mother survives, a lot survives with her.15

The efforts of most relief and development organizations, Christian ones included, focus on care of the orphan. While the care of orphans is vital and necessary, greater attention must be given to the roots of the problem, that is, saving the lives of mothers. Cutting
down the weed without dealing with the root will not bring about the desired result. If God grieves at the death of Rachel, then surely attention to mothers should be a high priority.

The final lines of Jeremiah’s poem in the midst of the Book of Consolation portraying the grief God experiences have been a topic of considerable debate. Here at the end of the poem (Jeremiah 31:22), the statement is made that Yahweh will create a new thing on the earth—a woman will encompass a man. The Septuagint provides no clue, it simply translates “men will go about in safety.” The oldest interpretation is that of Jerome’s in his translation based on the Hebrew text and his commentary. He postulates that the phrase was a prophecy about the Virgin Mary’s protecting embrace of the Christ in her womb. In his commentary, Jerome states “The Lord has created a new thing on earth; without seed of man without carnal union and conception, ‘a woman will encompass a man’ within her womb—One who, though He will later appear to advance through the stages of infancy and childhood, yet, while confined for the usual months in his mother’s womb, will already be perfect man.”

The information about the mother of Jesus and the one who ‘encompasses a man’ is largely confined to the infancy narratives in Matthew and Luke. Herein we learn that when the angelic announcement of the birth of Jesus occurs, Mary is living in Nazareth, in Galilee, and is engaged to a carpenter named Joseph. The conception of Jesus is described as ‘of the Holy Spirit’ (Matthew 1:18; Luke 1:35), and his birth as taking place in Bethlehem (Matthew 2:1; Luke 1:5; 2:4). It is recorded that after the birth the holy family lived at Nazareth. Matthew alone records the flight into Egypt, where Joseph and Mary and the child Jesus take refuge from the jealous anger of Herod. At the end of Jesus’ life, Mary is at the foot of the cross (John 19:25), when she, and the beloved disciple, are entrusted by Jesus to each other’s care (vv. 26-27). Even in his death Jesus keeps the commandment to “honour your father and mother.” Following the example of our Lord, there ought to be care for mothers, our own, and by synecdoche, all mothers. It is interesting to note that while tradition tells us that Joseph likely died early in Jesus’ life (the last time Scripture mentions him is in the anecdote about Jesus as a boy with the teachers in the temple) God in His providence saw fit to ensure that his son had a mother throughout the duration of his life.
When Christians stand to confess their faith in the words of the creed—“I believe...in Jesus Christ...our Lord, born of the Virgin Mary”—they acknowledge that God has created something new. Mary, the Mother of God, has a special place in the minds of Christians because she gave birth to Jesus Christ, the promised and longed-for Messiah. Through a difficult labour, encountering the same delays that cause mothers to die in childbirth today, her womb surrounded and protected the baby Jesus. Indeed, the salvation of the world was entrusted to her. Using Paul’s language from Galatians, “when the fullness of time had come, God sent forth his Son, born of a woman, born under the law, to redeem those who were under the law, so that we might receive adoption...”

So far, the biblical and theological basis for maternal health has focused on women—Eve, Rachel and Mary. Now, we turn to a man. Boaz, a man of standing, saves the lives of two mothers—Ruth and her mother-in-law Naomi. When their husbands die, they are destitute. Naomi returns to her people and Ruth, an outsider, a foreigner, follows her.

Fortunately, Naomi has a relative on her husband’s side—Boaz. The systems are in place to help him help them. The family system works. Naomi cares for Ruth. Ruth cares for Naomi. Naomi uses her family connections on her husband’s side to receive support. The social welfare system works. Widows are allowed to glean in the fields during harvest time to obtain the food they need for survival. The legal and financial systems work. Boaz goes to the city gate (where business is conducted) and finds a quorum of ten men required for a legal transaction. He negotiates with another relative of Ruth for some property and, with the purchase of the property, the opportunity comes to marry Ruth. He seals the deal with an ancient custom of taking off his sandal and giving it to the other. As a result, he marries Ruth and promises to take care of her.

In Ruth’s situation the systems functioned as they were meant to, to protect the weak and vulnerable. But systems break down. And in many places in our world today, when they break down, mothers die in staggering numbers. Their deaths are entirely preventable. Something has to be done. The cry of the psalmist, “Hear, O Lord, my righteous plea; listen to my cry. Give ear to my prayer...keep me as the apple of your eye; hide me in the shadow of your wings,” is the cry of
many women in our day. They could easily be saying the same things the psalmist said, “Rise up, O Lord...rescue me...O Lord, by your hand save me.”

Boaz is the means God uses to answer this prayer from the lips of Ruth. And by saving her from destitution, others are also saved. Later in the book of Ruth we read that Ruth and Boaz have a child named Obed. The women of the city say to Naomi (in what was to be a positive prophecy), “Bless the Lord who has given you this grandson. May he be famous in Israel. May he restore your youth and take care of you in your old age, for he is the son of your daughter-in-law who loves you so much, who has been kinder to you than seven sons.” Boaz and Ruth’s son Obed has a son named Jesse who has a son named David, the King of Israel. Through David’s line comes Jesus of Nazareth.

In the gospel of John, Jesus the distant descendant of Ruth, the mother saved by Boaz, has upset the religious establishment in Jerusalem. There is a plot to kill him. The High Priest suggests “it is better for you that one man die for the people than the whole nation perish.” John, the gospel writer interprets “He, the High Priest, did not say this on his own, but as high priest he prophesied that Jesus would die for the Jewish nation, and not only for that nation but also for the scattered children of God.”

And so, you see the effects of saving one mother. Boaz saves Ruth. Ruth becomes the great, great, great, great, great, grandmother of Jesus. Jesus becomes the Saviour of the world. Save the mother and you save others. To illustrate this further, permit a personal example. I booked a hair appointment not so long ago. I called the barber using the Save the Mothers’ cell phone. While sitting in the chair, the woman cutting my hair asked about the name that came up on the call display. Was it, “Save the Mothers’ or was it ‘Save Them Others’? she asked. You see the letters are the same and without spaces on her call display it is easy to see how she could mistake ‘Save the Mothers’ with ‘Save them Others.’ Yet, that is the point, isn’t it? If you save the mothers, you save them others. When a child looses his mother in the developing world, he receives the inheritance of poverty and disease.

Dr. Eve Nakabembi, the first academic director of the Save the Mothers’ Master in Public Health Leadership program and Dr. Jean Chamberlain Froese, the founder of Save the Mothers, know all about this. They know if you save the mothers, you save the child. If you
save the mother and child, the society is better off. Save the mothers and you really do save them others. Boaz was a mother saver. The Twenty First Century needs more men (and women) like Boaz who bring about systemic change so that mothers like Eve, Rachel and Mary survive childbirth. The Canadian NGO Save the Mothers is attempting to do its part to train cross-disciplinary professionals to provide the climate and conditions for mothers to live.
Notes

1. Indeed, even at the outset of the MDGs, there was concern at the overly ambitious nature of the goal. See a piece from September 2006, A. Rosenfield, D. Maine, L. Freedman, “Meeting MDG-5: an impossible dream?” The Lancet Volume 368, Issue 9542:1133-1135.

2. The maternal health issue that receives the most attention within the Christian community is usually abortion, perhaps followed closely by issues related to family planning. As a result, Save the Mothers has adopted a value statement that allows them to maintain their convictions and yet function in a pluralistic society. The statement reads: “The lives of mothers, their babies, (both born and preborn) are worth saving. We promote their well-being through strategies that support healthy pregnancies. Abortion should be avoided through family planning and abstinence (as appropriate). Save the Mothers does not provide termination of pregnancy, but encourages women who have suffered complications of abortion (whether spontaneous or induced) to seek medical care.”

3. The purpose of Save the Mothers is to promote the education of professionals and societal leaders on the causes of high maternal and infant morbidity and mortality within their communities, including the development and delivery of local post-secondary education programs to support the growth of indigenous expertise in addressing these problems.

4. See “The Enhancement of East African Universities’ Contribution towards the Attainment of Millennium Development Goal 5—Improving Maternal Health,” sponsored by Mobilizing Regional Capacity Initiative (MRCI) of the Association of African Universities (AAU), a DFID Sponsored Initiative. Also, Dr. Archna Gupta a MD who is completing her Master in Public Health at the University of Toronto carried out an evaluation of the “continuum of change” that is generated by the STM program—whether the program is training local leaders with a multidisciplinary approach. Outcomes assessed as part of her Master’s thesis fall into two categories: 1. The impact of the program on the individual learner; 2. And the impact of the program on the broader community.


A ten-step approach has been articulated by the Save the Mothers team to measure the standard of care: 1. Respectful and dignified maternity care; 2. Complies and maintains the MFHI Emergency neonatal and obstetrical care checklist; 3. Effective communication to community about availability of quality maternal and newborn care; 4. Ensure appropriate documentation of levels of care; 5. Protocol establishment and reinforcement; 6. Nurture friendly and well motivated health care professionals; 7. Mother centred care with feedback system; 8. Functional referral network (inter-hospital/health unit communication); 9. Adheres to Baby Friendly hospital initiative; and, 10. Commitment to on-going certification by the Mother Friendly Hospital Initiative.


Most Biblical quotations are from the New International Version.

The verb hamah is used figuratively of the soul and is often translated “murmur.” It can describe a soul in distressful prayer (Psalm 55:17 (18); 77:3 (4)) or in deep discouragement (Psalm 42:5 (6)). As the subject of the noun meyeh, hamah refers to the thrill of deep-felt compassion or sympathy. The thrill of loving concern is seen in the excited exclamation of the beloved, “My feelings (literally, bowels) were aroused for him.” The phrase in Jeremiah 31:20 is the most definitive statement of the concept of the suffering of God in the book of Jeremiah. God is so intensely involved with Rachel and Ephraim that he grieves.

Kazoh Kitamori, The Theology of the Pain of God. Richmond: John Knox Press, 1965. Although Kitamori does provide a fairly extensive exposition of his exegetical findings in Jeremiah 31:20, these are only an appendix to his writing. The majority of his work revolves around a philosophical and theological explanation of what Kitamori refers to as “the heart of the gospel”—“the pain of God.” Using Hegelian logic, the love of God and the wrath of God which oppose each other, in Kitamori’s view, are encompassed in the pain of God.


The Jewish wedding ceremony is thought to bear witness to this interpretation. The last part of the wedding processional at a traditional Jewish wedding involves the bride’s encirclement of the groom. When the bride reaches the marriage canopy, she walks around the groom seven times, with her mother and mother-in-law following her. By drawing a circle with her own body she creates an invisible wall and then steps inside. This signifies togetherness and distinctiveness from the rest of society. The tradition is thought to be based on the messianic understanding of Jeremiah 31:22. Blu Greenberg, “Marriage in the Jewish Tradition,” Journal of Ecumenical Studies 22:(1985) 3-20.
Works Cited

Boice, James Montgomery

Brown, Sarah

Chamberlain Froese, Jean
2004 *Where have all the mothers gone?* Bellville, ON: Epic Press.

Chamberlain, Jean, and Watt, Susan

Cohen, Deborah J., et al

Conn, Harvie M. and Ortiz, Manuel

Hiersberger, Jean Marie, ed.

Kleinman, A., Eisenberg, L, and Good, B.
Kroeger, Catherine Clark  

Miller, William L., et al.  

Rosenfield, Allan, Maine, Deborah, and Freedman, Lynn  

Scholar, David M.  

Scott, Daniel D.  

Thaddeus, S. and Maine, D.  

UNICEF  

Westley, Frances, Zimmerman, Brenda, and Patton, Michael Quinn  
Wolterstorff, Nicholas

World Health Organization