Holistic Mission: The Church and Health
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Of all areas of great human need, health is possibly the most profoundly compelling. Dry skin forms a puckered tent on the abdomen of a dehydrated child carried into a mission clinic. A cry of grief from a young Thai woman reverberates in the counseling center as she learns that her new husband is HIV positive. The hand and umbilical cord of a child protrude from the womb of a village woman, carried in too late to a maternity center. The chasm between the rich and poor grows with 1.3 billion people living on less than one dollar per day. Today's six billion people may be ten billion in 2100 with most in crowded urban centers, lacking the resources and knowledge to deal with inadequate food, unsafe water, and disease. [1] What, then is the response of the church? On what foundations and understandings, under what mandate and in what manner, can its people—who worship and serve the God of hope—be effective light and salt with regard to holistic healthcare in this generation?

Biblical Foundations Regarding Health
Scripture has much to say about health: God's vision for the health of humankind, what health and healing are, and the root causes of ill health. Also given in scripture is a mandate for health ministries.

God's Vision for Health
It is perhaps passages in Isaiah that most clearly set forth God's vision for the health of humankind. "The blind will be able to see and the deaf will hear. The lame will leap and dance, and those who cannot speak will shout for joy" (Isaiah 35:5-6a). "There will be no weeping there, no calling for help. Babies will no longer die in infancy, and all people will live out their life span" (Isaiah 65:19-20).[2] Daniel Fountain pointed out in *Health, the Bible and the Church* that this refers to the time of God's sovereign rule and humankind's obedience to his patterns for living, rather than to heaven in which there is no death. Our part, he advocated, is to work toward God's vision now.[3]

In Western thought the word health "conjures up the vision of a robust physical stature" while the far broader biblical perspective concerns wholeness or harmony "between body, mind and spirit, between the individual and others, and between the individual, nature and God."[4] E. Anthony Allen, a psychiatrist and theologian who worked in Kingston, Jamaica with the community whole-person health program of Bethel Baptist Church, told of the confusion he experienced as a medical intern when "health" applied to the clinical setting and "salvation" belonged only in "church." He argued that health is not simply the absence of disease but "a maximum quality of life called wellness." Wholeness does not come by treating (i.e. acting upon an organism but rather by healing in which relationships are made whole with self, God, community, and nature.[5] In Western Christianity, salvation has been spiritualized and llimited to repentance, forgiveness, accepting Christ's sacrifice for our sins, moral transformation, and striving toward moral perfection. As a result, "The body is left to the doctor; the mind, to the psychologist; the soul to the church' and the socioeconomic to the social scientists and politicians."[6] Allen concluded his argument by saying that salvation refers to total transformation and since healing is total transformation they are then one and the same, or two sides of the same coin.[7]

Health in the Old Testament

In scripture health is a condition in which the components of the body-mind complex are both free from disease and function to promote the well being of a person. Thus a person can be described as healthy with minor pathological conditions or when experiencing the degenerative processes of normal aging. Healing , prominent in scripture as well, is a process that commonly involves treatment of a pathological condition that results in the functional repair (and sometimes the actual regeneration) of the damaged or diseased portion of the mind or body.[8] In numerous ways God's laws promoted the health of the Israelites. Sabbath rest provided recuperation and guarded against disease. Circumcision promoted physical hygiene. Laws regarding sexual relationships, such as the prohibition of adultery, homosexuality, lust, and bestiality had both biological and social benefits. Dietary and sanitary restrictions, as well as instructions on personal hygiene, prevented a variety of maladies: tapeworm, cholera, plague, and many others transmitted through biting insect and polluted water.[9]

Biblical Terms Related to Health

Health and salvation have the same root word in the Hebrew *yeshuwah,* meaning "something saved, deliverance, aid, victory, health, help, salvation, saving (health), welfare,"[10] In Greek the words *soteria* and *sozo*, used for healing, also mean salvation.[11]

In addition to *yeshuwah*, the other Hebrew word that references physical health is *shalom,* commonly translated as "peace," but with a meaning broader than that word has in English. In Malachi 2:5 God's covenant is described as one of "life and *shalom*."[12] Shalom is the wellbeing that results when people are in right relationship both with each other and with God, and it includes social justice. Health, for the Jews, was a positive quality present when people had harmony personally, with other people, and with God. Jeremiah indicated that shalom is dependent on moral righteousness and described as false prophets those who say: "Peace, peace [shalom, health] …when there is no peace." (Jeremiah 6:14b. Indeed, the Messiah is the Prince of Shalom. Importantly, because shalom included physical, social, and spiritual wholeness, Tony Atkins stated that the pursuit of health in a society without Christ is futile.[13] Beyond survival and rehabilitation, as vital as those are, shalom/salvation embraces "the totality of human life,"[14] While shalom will only be perfectly fulfilled in the Kingdom of God at the end of the age, Christians involved in healthcare nevertheless live and work in the light of that vision. Further, in societies impacted by the physical/spiritual dichotomy of the Enlightenment, shalom is both the bridge that communicates the connections between evangelism and development and the key to understanding holism.[15]

There are two pitfalls to avoid when discussing health. The first is *mediocentrism*, the belief that Western scientific medicine has the only truth with regard to health and illness questions. One examples of mediocentrism is the doubt that any authentic cures can take place outside of the Western scientific framework.[16] The second pitfall is unreflectively adopting non-Christina values in health ministries. Health ministries need to be grounded in biblical values: viewing humans as made in the image of God, understanding that wholeness in life is communal—as modeled in the church, and seeking the Kingdom of God and its justice by treating all with dignity "as image bearers of God."[17]

Principles that form the foundation for health and medical practice, and which have been widely accepted in Christian circles, include: 1) All healing is of God and is the expression of the Creator's redemptive energy. 2) Faith is at the center of health, and health involves the whole body, mind, spirit, and personality in purposeful living. 3) Health can only be

experienced in fullness through community and the corporate fellowship of Christians. 5) A commitment to promoting world health is mandatory for Christians and this includes a just distribution of resources.[18]

Root Causes of Health Problems

The causes of ill health are a complex of problems. Dr. N. R. E. Fendall, a tenacious gruff British physician who served twenty years with Her Majesty's Overseas Medical Services in Asia and Africa, was a memorable professor of Tropical Community Health at the Liverpool School of Tropical Medicine. He spoke and wrote with passion about health issues: the septic fringes resulting from urban migration and misguided efforts to *improve* slums rather than *prevent* them. He grieved over inadequate understandings of environmental biology and vector- and arthopod-born diseases, such as trypanosomiasis, onchocerciasis, schistosomiasis, and malaria that are commonly exacerbated by indiscriminate clearing of land, dam construction, and land use affected by human resettlement. He emphasized the interrelationship of epidemics, illiteracy, wasteful fertility patterns, paucity of financial resources, and scarcity of trained personnel.[19] With regard to the root causes of health problems he would forcefully emphasize, "It's poverty, prejudice, ignorance, fecundity, and disease."[20]

E. Anthony Allen cautioned to not overlook, as causes of health problems, an individual's sins of lust, envy, avarice, hatred, deceit, and idolatry of materialism; nor to overlook the evils in the socio-political systems of the world. Racism, unbridled capitalism, and rightist fascism impact health as well.[21] Contrasting the impact on health of the fruit of the Spirit versus the acts of the sinful nature (Galatians 5:19-23) is one of many scriptural eye-openers on the root causes of ill health, both personal and societal.

The Biblical Mandate for Health Ministries

In Luke 9:1-2 Jesus called the twelve disciples together, gave them power and authority to drive out demons and cure diseases, and then sent them out to preach the kingdom of God and to heal the sick. The integration of proclamation and healing is a mandate from Christ to be obeyed. "Thus Jesus empowers and sends his disciples and ourselves both to preach the kingdom and to heal the sick."[22] Indeed, in Jesus' own ministry, healing was preceded by proclamation of the kingdom.[23]

Because "reflection on medical mission followed rather than preceded the establishment of medical missions" and "all participants in the discussion sought either to impede or advance what was already in place" it is not surprising that agreement on a mandate for health ministries has been elusive.[24] The most compelling motif, however, may be the "imitation Christi" (I Corinthians 11:1, and I Thessalonians 1:6) in which Paul advised others to imitate him as he imitated Christ. Underlying this, and not to be divorced from it, is the way in which healing correlates with redemption. In the Judeo-Christian tradition healing is the "personal and bodily expression of God's ongoing creation (creation continua) …and a token of God's desire to restore humans to what they ought to be."[25] Thus, healing as "a potential encounter with redemption/creation" requires that the gospel be proclaimed. Christoffer Grundmann argued that, "Proclaiming the gospel by healing the sick distinguishes the unique ministry of Jesus Christ. Proclaiming the gospel in imitation of him is the ongoing challenge for genuine Christian mission."[26] In God's economy loving our neighbor is coupled with the greatest commandment of loving God himself (Matthew 22:37-39).

Healing in the New Testament

The four gospels describe twenty-six occasions of healing and refer to many additional ones. Significantly, the focus is not simply on the curing of a specific disease but rather on a restoration "to wholeness of health in body, mind and spirit in an ongoing social context."[27] Jesus healed in many different ways, whether placing mud on the eyes or asking a caring question that touched on the hopelessness of the helpless. "Do you want to get well?" was the question he asked of the man at the pool of Bethesda who had been infirm thirty-eight years (John 5:5-7).[28] It was, as well, the weak and socially marginal that Jesus commonly healed: the blind beggar, a prostitute, the slave of a Roman soldier, and an older bent over women. Lepers were healed and the lame walked. Because Jesus saw death not as the end of life but rather "a door into a different dimension of existence with God" his followers have "a particular ministry of comfort and hope to the dying."[29]

The commission of Jesus to the disciples in Mark 16:15-20 included laying hands on the sick who then recovered. In the first apostolic miracle Peter healed a man over forty years old who had been lame from birth (Acts 3:1-11). Such events brought a multitude of people who were afflicted or tormented by evil spirits "and all of them were healed" (Acts 5:16 NIV).

Historic Ministry Models

It is instructive, with regard to health ministries, to look back in time prior to considering the future. There are lessons to be learned from the early church, through the Reformation, and on into the more recent centuries of medical missions.

The Early Church

In his *History of the Expansion of Christianity* Kenneth Latourette described the impact the early Christians had on their society. Eager to share the gospel and expecting the imminent return of Christ, they were nevertheless fully engaged in serving those around them. The church in Rome supported 1,500 widows, prisoners, and the poor while the church in Antioch supported 3,000.[30] Latourette credited Christians with improving the status of women and children, ending prostitution in pagan temples and gladiatorial contests, and protesting against both infanticide and abortion, as well as improving the "lot of slaves."[31] This was particularly remarkable as the Christians were a minority population and experienced ten major persecutions in their first three hundred years.[32] Authorities observed the care that early Christians took of the poor. The emperor Julian, seeking to restore confidence in Athene, Hermes, Helios, and Zeus, said of the Christians,

Why do we not observe that it is their benevolence to strangers, their care for the graves of the dead and the pretended holiness of their lives, that have done most to increase atheism? (He often refers to Christians as Atheists.) I believe that we ought really and truly to practice every one of these virtues….For it is disgraceful that, when no Jew ever has to beg, and the impious Galileans support not only their own poor but our [*sic*] as well, all men see that our people lack aid from us. Teach those of the Hellenic faith to contribute to public service of this sort.[33]

In 256 A.D., when there was an epidemic of bubonic plague in Alexandria, Christians stayed behind to care for the sick and dying rather than fleeing from the city. Many lost their own lives in doing so.[34] The majority of missionaries from the fourth century until the Reformation were Benedictines, Celts, Dominicans, Franciscans, Jesuits, Nestorians, and Orthodox monks. Translation of scripture resulted in the development of alphabets, written languages, and literacy work. The Cistercians cultivated land, developed methods of agricultural administration and became significant wool produces in Europe.[35] In relation to

health, confraternities affiliated with churches provided hospital, burial, and insurance services for members and many monasteries had affiliated leper asylums and hospitals.[36] According to the Benedictine Rule the sick were to receive attention. Xenodochia, for example, were accommodations that bishops were directed to provide for the destitute. Basil the Great established one such facility in 372 A.D., though the majority of them provided only shelter, food, and some amenities. In the sixth and seventh centuries a small number of xenodochia had trained physicians who cared for the sick.[37] Various religious orders were later established specifically to care for the ill: the Order of St. John of Jerusalem (1113 A.D.), the Hospitaller of St. John of God (Do Good Brothers, 1540 A.D.), and the Bethlehemites in Mexico (1667 A.D.).[38] During those centuries documents indicate there were at least 326 homes for those with leprosy in Britain and 2,000 in France, with nearly all supported by Christians.[39]

The Era of the Reformation

Martin Luther felt that life should not be separated into the sacred and secular but that Christians, as both children of God and citizens of this world, should live "life in this world in order to show forth the love of the kingdom of God."[40]

At that time in Europe some thought social needs should be dealt with through ideal societies, which "drew their inspiration largely or in part from Christianity."[41] John Calvin felt the state should be "dominated by the religious idea" and Oliver Cromwell "strove to constrain the realm to conform to Christian ideas"[42] though neither Luther nor Calvin felt that the previous system of almsgiving, which had been extensive, was adequate to address the complex social problems of their day.[43] Partnership of word and deed was modeled by the Puritans, Pietists, Moravians, and Wesleyans. Puritan missionary John Eliot served the Algonquin Native Americans by helping them secure land use, taking cases to court on their behalf, establishing schools, and translating books. Pietist A. H. Francke established an orphanage and schools for the poor that uniquely welcomed girls as well as boys. The Moravians, both highly evangelistic and skillful farmers, worked in Greenland, the West Indies, Europe, and on the western frontier of North America. In England John and Charles Wesley worked tirelessly to abolish slavery in the British Empire.[44] The eighteenth century evangelical revival resulted in increased care for the poor. John Wesley set up loan funds and established medical clinics to aid the poor. He opened a free dispensary in 1745 for the poor, the first of its kind, and the following year published *Primitive Physic* which gave health advice to those who could not pay to see a doctor. Between 1700 and 1825 there were 145 new hospitals established from individual and coordinated voluntary efforts.[45]

While living in India from 1793 to 1834, William Carey campaigned 25 years against the practice of *sati* or widow burning until its abolition, advocated human treatment for people with leprosy, initiated savings banks to combat usury, established the Agri-Horticultural Society, and began the first college in Asia at Serampore.[46] Between 1867 and 1893 China Inland Mission (CIM) was involved in both church planting and social services. CIM had 28 shelters for the cure of opium addicts, 16 dispensaries, and 7 hospitals, as well as 29 day schools and 11 boarding schools.[47]

The Centuries of Medical Missions

In the nineteenth century "medical missions" referred primarily to overseas Protestant missions, although the term originally referred to a medical post supported by a Christian congregation that might be a clinic or dispensary for the poor.[48] The Danish-Halle or Tranquebar Mission commissioned the first physician to work overseas in 1730. Dr. John

Thomas, who served with William Carey in 1773, was one of the earliest missionary physicians in India, followed by Dr. John Scudder, the first American sent in 1819. Scudder was both a minister and physician. Over a span of four generations, 42 members of this family contributed over 1,100 years of missionary service. Best known was Dr. Ida Scudder, daughter of John Scudder. As a young woman she was resistant to serving in that "horrible country, with its heat, dust, noise, and smells," until a traumatic night when three women—Brahmin, Hindu, and Muslim—died in childbirth because there was no female physician to attend them. She went on to found Vellore Medical College and saw—in her over 50 years of service—her ten by twelve room become a modern 1,700-bed medical complex. She was so well known that a letter addressed only "Dr. Ida, India" reached her without delay at Vellore.[49] In that same era Dr. Edith Brown from England laid the foundations for the Ludhiana Medical College in India.

Between 1850 and 1950 Britain alone sent more than 1,500 medical missionaries to the developing world. The Salvation Army Nurses' Fellowship, which originated in the London blitz of the Second World War, grew rapidly into an international organization. Its midwives, who traveled by foot, paddleboat, and bicycle were paid with "a love-gift of an egg, or a posy of wild flowers, or maybe a handful of grain."[50] Dr. Carl Becker spent 50 years in the Congo and was revered for his compassionate treatment of residents at a 1,100-acre leprosy village. Dr. Stanley Brown, a young man from a modest south London home with an encyclopedic memory, became renown for his work in leprosy prevention and control. During the civil war in Congo, Dr. Helen Roseveare suffered physical assault from Simba Rebels at the Nebobongo mission where she worked and Dr. Paul Carlson at the Wasolo mission station in the Ubangi Province of Congo was captured, tortured, and finally killed in the streets of Stanleyville.[51]

Nineteenth century missionary societies formed in Europe and Great Britain held evangelism and indigenous education as their highest priorities and advocated that medical missionaries were "to be first preachers, then medical men, if time remained for that."[52] Rev. Peter Parker, a Yale College graduate, also completed studies for his medical degree before going to China. His charge on departure in 1834, from the American Board of Commissioners for Foreign Mission (ABCFM) was to use his skills as a physician "only as they can be made handmaids to the gospel."[53] Parker opened an "Ophthalmic Hospital" and later helped organize the first Medical Missionary Society. Displeased at such a full engagement in the medical work, the ABCFM discontinued Parker's financial support in 1845. Parker worked on independently. After his retirement the ABCFM made amends by making Parker a corporate member of the board. Ultimately, at the World Missionary Conference at Jerusalem in 1928, a statement of "The Place of Medical Missions in the Work of the Church" was adopted, stating that "in the missionary enterprise the medical work should be regarded as, in itself, an expression of the spirit of the Master, and should not be thought of as only a pioneer of evangelism or as merely a philanthropic agency."[54]

In the nineteenth century, Protestant missionaries were commonly evangelists or church planters who secondarily engaged in social ministries. In the twentieth century, however, technological and scientific advances increasingly resulted in specialization in mission, including linguistics and translations, aviation, radio broadcasting, and medical missions.[55]

Specialists engaged in missions have commonly plunged directly into their tasks on arrival without adequate time for study of the language and culture, often rendering them ineffective in areas other than professional tasks. Further, in cases where preparatory

biblical and theological training have not been required, there have often been lesser skills for nurturing new believers and establishing them in fellowships.

In the last decades of the twentieth century, maintenance of institutions constructed in the pioneering phase of medical missions has been complex. National churches that have fallen heir to mission hospitals have struggled to pay staff salaries and purchase medicines. Overcrowding, lack of adequately trained staff, restrictions placed on spiritual ministry when government subsidies are accepted, lack of time for personal rejuvenation, and political instability have all contributed to frustration and burnout. Irregular power supplies have frequently caused problems with sophisticated medical equipment and staff have recognized they are repeatedly dealing with problems that could more appropriately be dealt with through adequate housing, sanitation, nutrition, and clean water.[56]

The 1978 International Conference on Primary Health Care, held in Alma-Ata (now Almaty, Kazakhstan), turned the attention of the global health community to healthcare at the community level. Primary health care was defined as accessible, acceptable, affordable care linked to community initiatives. Recognition was given to the need for prevention and control of endemic diseases, maternal/child healthcare, adequate nutrition and sanitation, and appropriate rehabilitative services, as well as health promotion and curative services. Importantly, an emphasis was placed on inter-sectoral coordination with departments of agriculture, housing, communication, and public works. Subsequent to the conference, the Christian relief and development agency MAP International and the Christian Medical Society facilitated the development of a declaration by mission and medical ministries policy-makers to shift attention from hospital-based to community-based ministries.[57] In *Mission and Ministry: Christian Medical Practice in Today's Changing World Cultures*, David Van Reken said that medical missions had passed from the pioneering phase of *doing* through an era of *teaching*—marked by the founding of training schools—to a period of *enabling,* characterized by national leadership and ownership and focusing on community development and sustainable indigenous growth.[58]

In the 1990s three key publications highlighted cases of holistic health ministries, reflecting on them from theological, social, and management perspectives, and then identifying trends and considerations for the future. The first was D. Merrill Ewert's *A New Agenda for Medical Missions* (1990), the second Eric Ram's *Transforming Health: Christian Approaches to Healing and Wholeness* (1995), and the third the *Serving with the Poor* (Asia, 1995; Africa, 1996; Latin America, 1997; Urban, 1998) series coordinated by Tetsunao Yamamori. Common themes in the very diverse initiatives described included a focus on community-based health that gives people the power to address their own problems, partnering with the church, an emphasis on sustainable transformation, facilitators who excel both in professional skills and Christian character, the necessity of practitioners living incarnationally, and the imperative of a biblical worldview with regard to health and God's vision of the future.

Contemporary Health Ministries

As the second half of the first decade in the new millennium rapidly approaches, it is encouraging to note the way in which contemporary holistic health ministries have built on lessons learned in the 1990s. A forum for observing this was the *Health and Wholeness for the 21st Century* conference in Chiang Mai, Thailand held in October 2003. Members of more than 50 indigenous Christian health ministries and mission agencies interacted on issues of contemporary best practice. Vignettes highlighting various elements of best practice follow.

Church-based Health Care

In the Democratic Republic of Congo, the Vanga Evangelical Hospital—under the leadership of Dr. Daniel Fountain—developed in 30 years from a rural hospital with two dispensaries to a 400-bed referral hospital with 13 physicians including 6 residents and 50 primary health care centers in partnership with the Baptist Church of Western Zaire. In 1975, following a presentation of the Vanga community health program at an annual meeting of regional doctors from all over the country, the Minister of Health stated that there would be cooperation between private and government health services. Rural Health Zones were formed and Vanga Evangelical Hospital became responsible for both government and church-related health facilities in its zone.[59] In 2003 the Democratic Republic of Congo had over 360 health zones of which approximately two-thirds were co-managed by Catholic and Protestant partners (Baptist, Methodist, Presbyterian, Mennonite, etc.). Under the umbrella of SANRU III (Sante Rurale or Rural Health) the U.S. government (via USAID) committed exceeding US$25 million over five years to redevelop 60 of these church-managed health zones, including refurbishing and equipping of 60 regional hospitals, over 12 secondary hospitals, more than 50 nursing schools and in excess of 1,200 health centers which together serve over 10 million people. Thus, with government funding and faith-based management, healing, relief, and holistic health are being brought to thousands of communities affiliated with the Church of Congo and mission organizations during a time of difficulty and despair; a true "Joseph in Egypt" story.[60]

An Emphasis on Capacity Building

The Ballia Rural Integrated Child Survival (BRICS) Project, a cooperative project between World Vision US and USAID, was implemented 1998-2002 in Uttar Pradesh, India for the block of Beruarbari with a population of 151,804. The core organizing principle was capacity building with partners that included both public and private health care providers, NGOs (nongovernment organizations), and local government. The BRICS objective was to assist the Ballia Chief Medical Office, staffed by unmotivated and weak personnel at the inception of the project. The project dealt with immunization coverage, maternal/child care, family planning, and prevention of malnutrition. Traditional birth attendants, who oversaw home deliveries (85% of all deliveries) were trained, 6 local NGOs learned program monitoring, 7 module communication materials in the local dialect were produced, and local women with minimal education were empowered as community change agents. Goals for each intervention were met or surpassed. Intentional Christian witness without proselytism was integrated in this 98% Hindu area. A participatory evaluation, conducted with a staff member from Johns Hopkins School of Public Health, demonstrated that it was a very successful program.[61] Next steps include documenting and disseminating program methods and tools, as well as taking the program to a population of 4.7 million.

Training in Context

Independence for Kyrgyzstan in 1991 resulted in an economic crisis that impacted the socialized health care system. In 1995, needing to strengthen primary health care, the Ministry of Health sought help in introducing Family Medicine and requested assistance in retraining physicians and nurses for that discipline. The Scientific Technology and Language Institute (STLI), a newly formed Christian NGO, responded by providing volunteer physicians and nurses from many countries and different mission organizations. In partnership with USAID, the World Bank, the Kyrgyz State Institute for Continuing Medical Education, Abt Associates, and the Kyrgyz State Medical Academy, an eight-year project got underway in 1997. A one-year Training of Trainers curriculum (1997-2004) was established. Some 72 physicians and 66 nurses graduated by October 2003. A four-month

retraining program for 2,500 doctors and a two-month retraining program for 3,500 nurses, enabling them to work in "family group practices" (FGPs) resulted in 1,787 FGP doctors and 2,259 FGP nurses being trained by October 2003. In 2001, a national Family Medicine postgraduate two-year residency program was started to train some 50 Family Medicine specialists. Plans are underway for a new continuing education system that would build on foundations laid in the retraining program. In addition to occasional office hour discussions on ethical or spiritual issues and mentoring local colleagues, outside of office hours STLI staff members have been free to talk openly of spiritual matters. STLI volunteers have also been involved in local churches and helped to establish fellowship groups for indigenous medical workers who have become believers. Evaluation results of the program are still preliminary but there is evidence of gain in demonstrated clinical skills and also in theoretical knowledge as shown in written examinations. Hard data regarding impact on the population is yet to come but there is some evidence of a decreased infant mortality rate in an area where those already trained were practicing.[62]

Self-supporting Initiatives

Litein Hospital was started as a dispensary in 1924 by African Inland Mission. Managed and staffed by 262 Kenyans, in 2002 the hospital had a budget of US$1.2 million and was 100% self-reliant for monthly operating expenses, with money coming primarily from patient fees and small income generating projects related to the work of the hospital. As an example of the latter, in 1997 there were pieces of several community health initiatives that had languished. After assessing local needs, the community health program initiated a mosquito net program for the reduction of malaria. With the selling of 1,651 mosquito nets and 1,401 doses of treatment, Litein saw a 15% decrease in cases of malaria. Another initiative involved de-worming 56,063 people for US$.05-20 per person (depending on age), resulting in an associated change of 25% reduction in cases of intestinal parasites. This program generated US$5,479 net income and reduced those coming to the hospital with intestinal parasites by 25%. Profits have been used to pay the costs of other programs.[63]

Recruiting Christian Doctors for Mission Work

In India only three or four of the one thousand Christian doctors who graduate each year join medical missionary work. In nine states of North and North-East India the Emmanuel Hospital Association (EHA) and the Evangelical Medical Fellowship of India (EMFI) partnered in a project to remedy this attrition. Staff workers were recruited to work among medical and dental students. Mission Interest Groups (MIGS) were started in a number of medical colleges. Local prayer groups and leadership seminars were held. Annual state level meetings brought students and doctors together for intensive Bible study and a missions challenge. Limitations have included getting quality staff for a modest wage, difficulty in getting student contact, and inadequate reporting because of an intermediate partner. Nevertheless, over thirty-five medical and dental graduates responded and by 2003 EHA had, for the first time in many years, the optimum number of junior physicians.[64]

Integrated Health and Development Programs

The Health Environmental Learning Program (HELP) in Nepal is an example of a church-based program that has included—in addition to community health initiatives—literacy training, instruction in animal husbandry, and the promotion of smokeless stoves (chimneys).[65] Half a world away, Kenyan physician Florence Muindi learned while working in Addis Ababa, Ethiopia, that ministry can include a Vacation Bible School of 400 children, vocational training in carpentry and tailoring, a sports ministry, a church-based kindergarten, church-based library and tutorial services, and an HIV/AIDS ministry in addition to health screening by the church. Other health promotion activities included

cleaning public toilets, repairing the houses of those with leprosy, clearing drainage areas, and dealing with trash.[66] In integrated health and development programs around the world there is an increased emphasis on transformation of communities as well as an acknowledgement that such transformation takes time.

Issues Confronting the Church

Both recurrent and new challenges face the church with regard to global health. Injustice, armed conflict, recurrent as well as emerging health threats, and the enormous problem of HIV/AIDS all require a response.

Injustice and Inequality of Opportunity

Of the longstanding, recurrent, and new issues that confront the church with regard to global health, perhaps the most painful realities are the injustice and inequality of opportunity facing those born today. A girl born in this decade in Japan has a life expectancy of 85 years and will likely receive a good education, vaccinations, and have adequate nutrition. While she may develop chronic diseases in old age she will have access to treatment, rehabilitation services and US$550 annually in medications if needed. By contrast, a girl born Sierra Leone is likely to be underweight during childhood, not have access to immunizations, marry while an adolescent, bear six or more children, and anticipate a life span of 36 years. If ill, she is likely to receive US$3 per year of medicines and if she survives middle age and develops chronic disease she is likely to die prematurely due to lack of sufficient treatment.[67] In 2002, fully 98% of children less than five years of age who died were from developing countries. In 14 African countries child mortality rates are higher now than in 1900.[68] Anthony Allen of Jamaica lamented that while developing world health professionals are lured away to the West "we look to foreign First World doctors to run 'band-aid, two-week clinics' for our poor."[69]

Armed Conflict

The world continues to be at war with millions living in the daily reality of it: Chechnya, India, Iraq, Sudan, Condo, Nepal, and the list goes on, both of new conflicts and of those ongoing for years. Angola and Myanmar provide two representative examples of the impact on health.

Having experienced almost four decades of armed conflict, Angola is now experiencing large population migrations. Some 450,000 refugees are returning, with many coming from areas with high prevalence rates of HIV. Prevention initiatives and voluntary testing centers are scarce and knowledge of HIV/AIDS transmission is limited.[70] Myanmar, in the grip of a civil war since the end of World War II, has a battered public health system and a piecemeal response to AIDS.[71] Ethnic minorities, such as the Kachin, Chin, Karenni, and Karen, have been regularly terrorized by the brutal Burmese State Peace and Development Council (SPDC). Houses, schools, churches, and clinics have been routinely burned. Rape has been a weapon of war, with 625 documented in Shan state alone between 1996 and 2001. Of those, 61 percent were gang rapes and 83% were carried out in front of their troops by army officers. The Sa Sa Sa terror squad of the Burma Army has beheaded villagers and then displayed the heads.[72]

All wars leave orphans, widows, refugees, and the disabled. Following relief efforts, enormous tasks remain for those concerned with the long-term impact on health.

Recurrent and Emerging Health Threats

In addition to injustice and armed conflict, the centuries-old problems of malaria, tuberculosis, cholera, hepatitis, diarrhea and dehydration, and other chronic, infectious, and preventable conditions continue to require a vigilant response. The final eradication of smallpox in 1980 led to an optimistic but ultimately false forecast by the World Health Organization (WHO) that tuberculosis, polio, measles, tetanus, diphtheria, and whooping cough would similarly be eradicated through the Expanded Program on Immunization. Drug resistance has emerged in the agents causing tuberculosis. Deforestation has given pathogens causing yellow fever new access to human host populations. Water pooling in the piles of rubber tires outside cities host the *Aedes aegypti* mosquitoes that serve as a vector for dengue fever. Sewage and fertilizer pouring into rivers and lakes in partnership with climate changes have occasioned algal blooms that result in more toxic forms of pathogens such as *V. Cholerae 0139.*[73] For the past twenty years, new diseases have appeared at the rate of one each year, with SARS causing global alarm in 2003.[74] With 8,000 cases resulting in 900 deaths in 30 countries, SARS has posed a new challenge to the public health community.[75]

Equally ominous in the developing world are the rapidly growing epidemics of injury and death from road traffic accidents, cardiovascular disease, and the use of tobacco products. The five million who died in 2003 as part of the tobacco epidemic were largely the poor in poor countries.[76] No single problem, however, has equaled the massive devastation caused by HIV/AIDS.

HIV/AIDS

In the panorama of the world's health history, AIDS has joined the medieval "Black Death" plague and the influenza pandemic of 1918 as one of the greatest pandemics of all time. In 2003 three million more people died of AIDS and an additional five million became infected; bringing the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimate to 40 million people living today with the virus.[77]

Sub-Saharan Africa

The epidemic in sub-Saharan Africa has had stable prevalence rates for several years because high mortality rates are matching the significant rate of new infections. In Swaziland, Zimbabwe, Botswana, and Lesotho the life expectancy of both men and women has plummeted more than twenty years.[78] Health care workers in Africa are painfully aware of "children with matchstick arms and vacant eyes who lie in beds all day awaiting the next seizure" and towns that have moved from averaging two to seventy-five funerals each week.[79] Welcomed efforts regarding antiretroviral treatment in Uganda, Nigeria, Cameroon, and Bostwana have been overshadowed by the reality that only 1% of pregnant women in countries that are heavily affected have access to services that could prevent mother-to-child transmission.[80]

Women in Africa are 1.2 times more likely to be HIV-positive than men because the virus is more easily transmitted male to female, women become sexually active earlier than men, and they are more likely to have older partners.[81] With less than 2% of the world's population, Southern Africa has 30% of the world's population living with AIDS.[82] Prevalence of HIV is relatively low in North Africa and the Middle East, with the exception of Southern Sudan, which has a heterosexual epidemic.[83]

Asia and Eastern Europe
The AIDS epidemic has spread rapidly in Central Asia and Eastern Europe, primarily fueled by shared equipment for IV drug use and unsafe sex among young adults, particularly men. More than 80% of persons HIV-positive in the Russian Federation are under 30, in contrast with the United States and Western Europe where only 30% of cases are among persons less than 29.[84]

Commercial sex and injecting drug use have spurred the epidemic in Asia and the Pacific. Thailand, Cambodia, and Myanmar currently have serious epidemics. In Myanmar migrant workers, particularly loggers and gem miners, have spread the virus in the larger population.[85] India's National AIDS Control Organization reports that AIDS is spreading from urban and vulnerable populations to the rural areas and larger population. Injecting drug use has been the chief propellant in Indonesia's epidemic and in Thailand and Cambodia, countries with older epidemics, there is now significant new spread of HIV from those with high-risk behaviors to their sexual partners.[86] In China three provinces have had whole villages infected with AIDS as a result of serving as registered stations for the selling of blood in the 1990s.[87]

Latin America and the Caribbean
Twelve countries in the Caribbean Basin, where commercial heterosexual sex is a key factor, have a national HIV prevalence of at least 1%. Other countries in that region, such as Brazil, have very concentrated epidemics. Transmission in South American countries is primarily through injecting drug use and men having sex with men who subsequently infect heterosexual partners.[88]

Europe
In high-income countries access to antiretroviral drugs has resulted in an increasing total number of people living with AIDS.[89] In the Netherlands, Germany, and Greece men having sex with men is the most common mode of transmission. In the United States men having sex with men accounted for 42% of new cases and in Australia in 2001 it accounted for 86% of new cases.[90] In Sweden, Norway, and the Netherlands significant numbers of new cases of HIV were acquired while living in other countries. In England this rate was 70%.[91]

Responses to HIV/AIDS
The challenge HIV/AIDS has presented to both health agencies and the church is staggering. In the 2001 United Nations General Assembly Special Session on HIV/AIDS a Declaration of Commitment to respond was endorsed by member nations. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has provided leadership for the global health community. In addition to promoting cooperation among the eight United Nations agencies that comprise UNAIDS, the organization has worked with many partners in governments, the business sector, and civil society including Christian NGOs. Efforts have focused on increasing resources to fight AIDS, expanding prevention programs, strengthening human rights protection for people with HIV/AIDS, and making both treatment and care available.[92]

On many fronts the church has played a significant role in response to AIDS. One of the early initiatives was a 1994 All Africa Church and AIDS Consultation held in Kampala, Uganda. Representatives of twenty-eight African countries and delegates from Asia, Europe, and the Americas attended. From that came a declaration regarding the role of the church and an articulation of its mission in response to HIV/AIDS. Importantly, it saw HIV/AIDS as an opportunity for the church: to share the message of repentance that leads to forgiveness, to respond to the call to sacrifice, and to be involved in prophetic, priestly,

and pastoral roles.[93] The Ethiopian Evangelical Church Mekana Yesus has had HIV/AIDS prevention and control programs for more than a decade, with such elements as creatively hosting song and poem competitions as well as dramatic performances in churches.[94] Judah Trust in the United Kingdom has promoted a network of prayer support for grass-roots Christian organizations responding to HIV/AIDS through its monthly *AIDS Intercessors Newsletter*. International NGOs such as the Salvation Army, World Vision, World Relief, and World Hope have variously partnered with local churches in home care, AIDS Orphan Trusts, income generation for families with HIV/AIDS, pastoral counseling, support of institutions caring for the sick, and prevention initiatives. Grounded in communities and bearing a message of hope, churches are eminently suited to respond to HIV/AIDS. The comprehensive *Life at the Crossroads* materials, birthed out of the "Why Wait?" materials and Campus Crusade for Christ in Malawi, have been effectively used in numerous countries.

Yet those engaged with the church in response to HIV/AIDS are invariably the first to say that Christians and the church have not done enough. The church has been silent about sexuality and AIDS, extended judgment rather than compassion to those affected, and done little to care for widows, orphans, and those who die. Beyond an opportunity, AIDS is a crucible for the church, revealing the extent of commitment and care for which Christians will one day be accountable. The hungry, thirsty, alien, those lacking clothing, and prisoners of Matthew 25 are the stigmatized, homeless, orphaned, widowed, and impoverished of the HIV/AIDS pandemic[95] and Christians stand in judgment if we do not respond to the least of these.

But in the darkest places there are still lights of hope. An aging grandmother in Zambia, who had lost her four children and their spouses to AIDS, cared for their eight orphans. A falling tree had crushed her kitchen shelter, she walked two kilometers for water, and her latrine had collapsed. Then the Women of the Mukinge Orphan Support Group came to her aid. They cleaned her compound and paid someone to dig a new latrine. They provided blankets, clothing, and transportation for the family and encouraged other church members and neighbors to help as well. In 1998 the ten Mukinge women organized knitting groups to make blankets for orphans. They later engaged in income generating projects to develop a source of revenue and by 2002 were supporting 90 orphans in five communities with school fees and uniforms. They have also sought to know each child personally and share the love of Christ with "orphans and widows in their distress" (James 1:27).[96]

The church has responded in both the past and present to injustice, the consequences of armed conflict, and diseases both historic and emerging. Much more, however, remains to be undertaken.

Action Plan for the Church

The assigned task for the health sector members of the 2004 Forum Holistic Mission Issue Group is to articulate a plan that "the Church can implement through denominations, local churches, and focused ministries"[97] that will stimulate action with regard to health, especially for the poor and marginalized. Several areas have been identified for discussion and planning. Issues and questions raised by sector group members have also been incorporated.

Promote a Comprehensive Biblical Understanding of Holistic Health

The Church needs language in common use that reflects a comprehensive biblical understanding of health and wholeness. It needs to be gripped by both the Isaiah vision for

health and an understanding of the Kingdom of God as both now and not yet. This must include a grasp both of the root causes of ill health, including sin, avarice, idolatry of materialism, and evils in socio-political systems as well as the redemptive work of Christ and the opportunity to share the good news of salvation. Finally, there needs to be an understanding of the mandate for reaching out in ministries of health and healing.

How can we promote a biblical understanding of holistic health and the mandate for health ministries?

Some suggestions for maximizing the impact of holistic mission on the body of Christ include:

1. Promote the development of modules on holistic mission for Bible schools/theological faculties/distance education.
2. Introduce an understanding of holistic mission into church-planting circles.
3. Promote synergy regarding holistic mission between local churches, Christian (mission) hospitals, and other healthcare institutions/organizations.
4. Integrate holistic mission teaching in Christian medical, nursing, and other healthcare schools.
5. Utilize models of good practice to inspire those training next generation leaders in and for holistic mission. (Chris Steyn, Hope for Europe, Netherland)

Focus on Transformation

Churches should not simply respond to social and physical needs in their communities as tasks secondary to evangelism but rather envision the transformation of their communities in all aspects of life: spiritual, economic, and social. Social action is not sufficient to effect justice but instead "the guilt, power and consequence of sin" need to be dealt with through the gospel of Christ.[98] Transformation is not achieved by a strategy but is rather God's work. It is his will reflected in human society and his love "experienced by all communities, especially the poor."[99] It is a vision that sees all people at the table of life with "enough to eat, decent work and wages, education for their children, adequate healthcare and housing, and most of all, hope for the future."[100]

What needs to be done to create a vision for transformation in communities?

Emphasize Primary Care and Strengthen Health Systems

As local and self-sustaining entities, with members or pastors that are ethical and commonly literate, churches are uniquely suited to both promote health and partner in strengthening health systems. The Vanga Evangelical Hospital provided an example of the church playing a major role in a public-private partnership while the Ballia Rural Integrated Church Child Survival Project demonstrated what a small Christian minority can accomplish working through a Christian NGO.

In what ways and to what extent can the church partner with other entities to strengthen primary care and health systems?

Develop Practitioners Who Are Committed Disciples of Christ

Practitioners must be committed disciples of Christ who manifest the fruits of the spirit, model professional excellence, have a clear grasp of the theology in which their ministries are grounded, empower others, and serve with humility.

1. How do we reach, disciple, and mobilize healthcare workers who are Christians in order to expand the number of them who are active in the Great Commission?
2. How do we respond to humanistic and increasingly pluralistic healthcare systems that exist in most countries, or the healthcare and government systems that are aggressively antagonistic to Christianity in some countries?
3. How can we leverage the influence that healthcare workers who are Christians have with their patients and colleagues, while maintaining Peter's exhortation in 1 Peter 3:15 that we give an account of our faith "with gentleness and reverence"?
4. How do we help health workers who are downtrodden, overworked, and utterly stressed beyond reason? They need the healing touch of the Great Physician, and Christians who are their healthcare peers are ideally situated to convey this message.
5. What should be done about physical danger and threat to staff and volunteers in settings where the work places staff in harm's way?
6. What does a Christian lifestyle look like for different backgrounds and how can it be transported to church members?
7. How far should Christian healthcare workers get involved in politics? What is helpful and where are limits?
8. What does it mean to take seriously the call to suffer with those who suffer? How can churches in the West be engaged in this kind of suffering? (Jeff Russell The Kardia Foundation, USA)

Work Together as the Body of Christ

"Partnership" is a common term in professional health and development circles but believers have a far more powerful and organically reality as the Body of Christ.

How do we join efforts, as the body of Christ, in fighting against the major world killers: famine, hunger, malnutrition, malaria, tuberculosis, HIV/AIDS, and disparity in access to health care? (Oscar Chicas, World Vision International, Honduras)

Strengthen our Response to HIV/AIDS

The church is confronted by multiple issues related to HIV/AIDS: church-based ministry to families affected by AIDS; the need for effective use of Christian global interaction and ministry in HIV/AIDS; the obligation to fulfill scripture's mandate to care for orphans; the misinterpretation of scripture in HIV/AIDS discussions, training, personal reflections, and beliefs; the slow, stigmatizing, self-righteous responses from within the church and the failure of Christians as models of faithfulness; and the opportunity HIV/AIDS provides for evangelism at all levels, from government policy levels to grassroots family levels.

1. What unique contributions can the local church give to the community AIDS crisis and how can this role be appropriately encouraged and supported by church leadership, church members, and the international body of Christ?
2. How can we maximize understanding and application of Scripture so that misinterpretations are addressed at all levels of Christendom? Some areas needing serious discussion, reflection, and biblical clarification in layman's terms include: AIDS as a curse; questions surrounding the theology of healing and AIDS; some cultural practices common to Old Testament times and practiced today in an age of AIDS including culturally-defined roles of women, care of women, and polygamy.
3. What is the role of the church in sex education?
4. How can sustainable church-based care of orphans be established? How is the church preparing for the impact of AIDS in areas of high prevalence?

5. How can we be better light and salt and prevent the spread of AIDS through sexual immorality among our own members, including clergy? (Debbie Dortzbach, World Relief, Kenya)

Engage in Research and Advocacy

We must encourage ongoing research in the field of health, assure continuing education, advocate on behalf of health programs, and identify both private and public funds for health programs.

In what ways, and to what extent, can the church be encouraged to engage in research and advocacy with regard to health?

Undertaking Our Assignment…

Acknowledging our weakness and dependence on the Holy Spirit, we prayerfully look to God, asking that his power work through us as we fully commit ourselves to the task of articulating a plan "the Church can implement through denominations, local churches, and focused ministries"[101] that will stimulate action with regard to health, especially for the poor and marginalized. As members of the Holistic Mission Issue Group, your responses are now invited.

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