



Christian Responses to Health and Development



Symposium at the
German Institute for Medical Mission (DIFAEM)

Tübingen, June 2014

Documentation

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Content

Preface 3

The Healing Ministry of the Churches Today 5

The Legacy of “Tübingen I” 12

The Declarations of Tübingen in the 21st Century: History or
Guiding Principles?..... 25

The Christian Contribution to Health Today – A Medical Perspective 45

Being Accountable for the Life of Religious Health Assets..... 53

Christian Responses to Health and Development: A Discussion Paper on
Significance, Practice and Future of Christian Health Services 62

A Call to Health and Healing – Declaration 93

Contributors..... 96

Impressum 98

Christian Responses to Health and Development

Preface

From June 26th to 29th, 2014, 60 participants of the international symposium on "Christian Responses to Health and Development" met at the German Institute for Medical Mission (DIFAEM) in Tübingen, Germany. They affirmed the Christian healing ministry and shared the conviction that Christian health services play an important role in the provision of health in the 21st century.

DIFAEM called for this symposium on the occasion of the 50th anniversary of the "Tübingen I" consultation. In 1964 medical mission was challenged and called to define its distinctiveness and its special role in the context of that particular time. The consultation "Tübingen I" clearly stated: "The Christian church has a specific task in the field of health and healing"¹, and developed a concept of wholeness and of the role of the congregation in health provision. 50 years later, the question of the proprium of Christian health services is again a very important one. At a time when governments, international non-governmental organizations and other philanthropic organizations participate in health care, the question has to be asked: What is the specific contribution of a Christian health service or ministry of healing? At a time when chronic disease challenges not only rich but now also poor countries, when infections like Ebola that for years were hidden in Africa pose a threat to the global situation, Christians have to reflect on the question of the proprium of Christian health care.

This publication comprises the main presentations held during the symposium and it gives an insight into the discussions on relevant health issues.

Representing the World Council of Churches (WCC), Isabel Phiri in her address *The Healing Ministry of the Churches Today* values the consultation "Tübingen I" as the starting point of the rich work of the WCC's Christian Medical Commission. Jim Cochrane's contribution *Being Accountable for the Life of Religious Health Assets* gives an insight into the concept of religious health assets and relates it to the Primary Health Care approach and the need to align Christian health services to governmental and private health providers. In *The Legacy of Tübingen I*, Christoffer Grundmann provides an overview on the process leading to that consultation and describes its theological statements as well as its reception and impact in the decades to follow, even until today. Steffen Flessa asks the question of *The Declarations of Tübingen in the 21st Century: History or Guiding Principles?* He points to the competitive position Christian health services face today and to the special contribution of Christian health services in this context. In his presentation *The Christian Contribution to Health Today – A Medical Perspective*, John Oommen discusses the characteristics and the specific contribution of Christian health services in our time from his Indian perspective.

¹ World Council of Churches: *The Healing Church* (World Council Studies No.3), Geneva 1965, 34f.

The chapter on *Christian Responses to Health and Development* was drafted prior to the symposium. The participants commented on particular topics of the paper and the main sections were discussed and amended in working sessions. Therefore, this document reflects the discussions during the symposium. At the same time it was the foundation for drafting the *Call to Health and Healing – Declaration Tübingen III* which the participants adopted and later on shared within their constituency.

DIFAEM would like to express a warm word of thanks to all those who prepared the symposium, to all presenters and to those who contributed to the fruitful discussions. We also very much appreciate the financial support from Bread for the World – Protestant Development Service and the Evangelical-Lutheran Church in Württemberg.

It is our hope that this conference documentation will transport the enthusiasm of the participants who affirmed their commitment to the Christian healing ministry. At the same time, we wish to join hands with you on a common journey towards more justice in health and towards transforming the lives of individuals and communities.

A handwritten signature in black ink, appearing to read 'G. Schneider'.

Dr. Gisela Schneider

DIFAEM Director

The Healing Ministry of the Churches Today

Isabel Apawo Phiri

The WCC congratulates DIFAEM for 50 years of Christian responses to global health and development. Let me take this opportunity to clearly state that the WCC is committed to the healing ministry of the churches today as it was 50 years ago when the WCC co-organized jointly with the Lutheran World Federation (LWF) and the German Institute for Medical Mission (DIFAEM) the Tübingen I and II Consultations in 1964 and 1967. The WCC traces the motivation and the creation of space for the birth of the Christian Medical Commission (CMC) of the World Council of Churches in 1968 to the Tübingen I and Tübingen II consultations. It is within this context and spirit that the invitation to the WCC to take part in this symposium was received. The invitation stated that ‘our invitation honours the significant role the WCC and its former Christian Medical Commission has played in promoting the implementation of the Christian healing ministry through its member churches.’² At the same time, the WCC honours the commitment of DIFAEM to keep the vision of Christian responses to global health and development alive and focused. It is therefore befitting that at an international symposium of this nature, the WCC acknowledges the significant role played by DIFAEM in keeping the torch burning on the discourse of Christian responses to global health and development.

Brief Background and Development of the WCC’s Work in Healing Ministry

In the WCC 2015 project plans for Health, Healing and Human Dignity,³ we remind ourselves of our roots, which connect us to Tübingen I and Tübingen II consultations, and how we have developed over the years in our health ministries with the churches. I take the liberty to quote substantial sections of the background information of the plans because it explains the WCC background and development of involvement in the healing ministry in a very concise way. It starts by acknowledging the engagement between the WCC and DIFAEM over a period of 50 years in the area of health, healing and wholeness.

The WCC (through Christian Medical Commission, CMC: Churches’ Action for Health) played a critical role in the 1960s and 1970s in facilitating data collection, research and evaluation into the most appropriate ways of delivering health services which could be relevant to local needs and the mission and resources of the churches. CMC was concerned with determining “what specific or unique contribution to health and medical services can be offered by the churches”. CMC also facilitated many conversations on theological roots of health, healing and wholeness, a task that is still going on today.

²Gisela Schneider, DIFAEM Director in a letter to Rev Dr Olav Fykse Tveit dated February 2014.

³The 2015 project plans were developed by Rev Dr Nyambura Njoroge and Dr Sue Parry, taking into account the outcomes of the ecumenical conversation EC 20 Ecumenical health and healing ministries, offered at the 10th Assembly of WCC.

CMC used *Contact Magazine* (first issue in 1970) to communicate its findings and articles on theological discourse. By 1973, one of the major outcomes of CMC's focus was to bring to the world's attention many projects that offered innovative ways to improve the health of populations in developing countries. Eventually the World Health Organization (WHO) paid attention and several meetings took place between the staff of CMC and WHO to explore "possible collaboration and the mechanisms of action". A joint working group was established which prepared a six-page statement that was subsequently approved by both organizations.

On May 27, 1974, the statement formed the "Memorandum of Understanding" between WCC (CMC) and WHO, which enabled a working relationship by "joint involvement in common endeavors on very practical level." WCC through CMC became the first Non-State faith-based-organization (FBO) through which churches' health workers could have a voice and a platform for advocacy on health policies at the annual WHO Assembly and the Executive Board. CMC was in fact instrumental in WHO's Primary Health Care Approach. Equally important, WHO was instrumental in WCC's ecumenical response to the AIDS crisis in 1986! Subsequently collaboration was established with UNAIDS (since 1996) but no formal memorandum of understanding exists with the WCC.

Sustaining the WHO-CMC collaboration is based on mutually agreed objectives and activities for a three year period, the results of which are reviewed by the WHO Executive Board every three years. The current agreement is due for review in 2015. This review is a very important milestone for WCC Health & Healing work in 2015 and beyond.⁴

So much has changed since the joint statement in 1974 – however, some important things remain, especially data collection, surveys, research and evaluation (evidence-based documentation) of how churches, as a key audience of the WCC Health & Healing work, have engaged and/or lack of engagement on the Millennium health related goals (2000-2015) and how they are preparing for the post 2015 global health agenda.

On the other hand, many of the UN bodies working on health-related issues (UNAIDS, UNFPA, Global Fund to fight Malaria, TB and AIDS – another WCC key audience for this project) have come a long way in acknowledging that religion and faith have a lot to do with people's health and the decisions they make about health and healing and that they have both positive and negative impact for various reasons. These UN secular bodies acknowledge the volume of health work carried out by religious institutions but inevitably require evidence-based documentation on the data and the impact.

⁴It is important to note that after the WCC Assembly in 2013, a decision was taken by the leadership to present the Health and Healing project to the WHO under the brand name of "WCC" rather than "CMC: Churches Action for Health". A letter dated May 4, 2014, was sent to Dr Margaret Chan, Director-General of WHO, to officially communicate this change and at the same time assuring her of the WCC's commitment to Health and Healing as well as specific engagement on the global HIV and AIDS response.

Invitation to Join a Pilgrimage of Justice and Peace

Through the theme of this symposium, the WCC is indeed grateful for the invitation to reflect on the healing ministry of the churches today. The resolutions of the WCC 10th Assembly to journey together on the pilgrimage of justice and peace from the 10th Assembly in Busan, Korea to the 11th Assembly in 2021 provides the first basis for this reflection. The assembly message stated:

We intend to move together. Challenged by our experiences in Busan, we challenge all people of good will to engage their God-given gifts in transforming actions. This Assembly calls you to join the pilgrimage! May the churches be communities of healing and compassion and may we seed the Good News so that justice will grow, and God's deep peace rest on the world.⁵

Through the ecumenical conversations, the 10th WCC assembly created spaces for detailed engagement on issues which are important in the ecumenical movement. Of particular significance to this symposium is "Ecumenical Conversation 20 on Health and Healing Ministries". This ecumenical conversation developed a road map to give direction to the healing ministries of the churches today and to identify challenges which need to be overcome. In the final report of this ecumenical conversation, it was stated that:

"The participants affirm that:

Churches, ecumenical partners and the WCC see health and healing as a primary area of mission to which we are called by God, that member churches offer a significant percentage of health services, particularly in the Global South, often going where governments and NGOs do not reach.

The WCC has a strong history of supporting Christian health associations and serving as a bridge to UN agencies and other similar agencies.

Since 1986 the WCC has engaged in HIV response, including the creation of the Ecumenical Advocacy Alliance and the work of Ecumenical HIV and AIDS Initiative in Africa (EHAIA).

The WCC has supported the "Healing of Memories" for dealing with trauma, especially in relation to atrocities, and addressing individual and collective wounds of the past.

The participants acknowledge the following challenges:

Christian health associations are facing difficulties in the areas of advocacy, resource mobilization and capacity building. There is the need for the WCC to continue to actively engage in support of Christian health associations and facilitate the sharing of best practices that promote health and healing, including contextual bible studies and, "Healing of Memories."

Despite medical advances, HIV continues to be a significant global health crisis. There is the need for the churches, ecumenical partners and the WCC to emphasize the responsibility

⁵Message of the 10th Assembly

and role of the Christian church in overcoming stigma, addressing social determinants, sharing effective practices among regions, and serving the needs of persons living with and affected by HIV for prevention, care and support.

There has not been collective ecumenical action in relation to addressing the health-related Millennium Development Goals (MDGs) and participants encourage the WCC to develop a collective strategy to address the Post MDGs 2015.

There are tensions in the church for addressing specific health-related concerns, such as human sexuality and gender-based violence. The WCC is encouraged to develop resources, including frameworks for creating safe spaces that can help Christian churches address these sensitive areas of concern affecting health and wholeness.¹⁶

These affirmations and challenges have informed the WCC strategic plans for 2014 to 2017⁷ and have been translated into the project plans for Health and Healing and for the Ecumenical HIV&AIDS Initiative and Advocacy.⁸ It is through these plans that one sees very clearly the WCC's commitment to the healing ministries of the churches as an indispensable part of our Christian calling. In the spirit of the pilgrimage of justice and peace, the WCC through the Health and Healing and Human Dignity and Ecumenical HIV &AIDS Initiatives and Advocacy (EHAIA) projects plan to be involved in the following activities: Advocacy in Health and Healing with WHO and UNAIDS; Strengthening global networks to promote a voice for health issues in all their fullness; Human sexuality, dignity and health; Increased capacity of churches to respond effectively and compassionately on HIV and AIDS; Transformed life-affirming theology; Integrate Comprehensive Sexuality & Reproductive Health Education and eMTCT (elimination of mother-to-child-HIV transmission) in HIV interventions; Theological literature production and documentation of ecumenical HIV response.⁹

Method of working

Of significance to mention here as one of the mandates of the 10th Assembly which has a bearing on the healing ministry of the churches today, is the WCC methodology of operations as reflected in the report of the Programme Guidelines Committee (PGC). The report stated that:

⁶EC 20 Ecumenical health and healing ministries. WCC Assembly, Busan, South Korea, 30th October - 8 November, 2013.

⁷In the WCC strategic plans for 2014 to 2017, it is stated that 2017 is the midpoint at which the plans of WCC will be evaluated. The results of the evaluation will form the basis in which further plans for the beyond 2017 will be structured.

⁸The last A for EHAIA has been changed from Africa to Advocacy by the WCC governance leadership to accommodate the expansion of the WCC HIV and AIDS work from Africa to Global starting with Jamaica, Philippines and Ukraine.

⁹2015 Project plans for Health, Healing and Human Dignity and EHAIA.

"At the 8th Assembly (Harare, 1998) the need to find a new balance between the WCC as a fellowship of churches and the WCC as an organisation was acknowledged (*Common Understanding and Vision*). Since the 9th Assembly (Porto Alegre, 2006) the WCC has been in a period of transition because of major financial challenges which necessitated restructuring. Subsequently, there is the likelihood that as an "organisation" we will keep facing the prospect of diminished financial resources. As a "fellowship" however, we have much greater potential, and this is an opportunity to actively reconsider how we want to engage with each other through the WCC.

A question that must be asked is, how does viewing ourselves as a fellowship of churches change the WCC's programmatic methodology? Can the WCC continue designing programmes from the Geneva offices, or has the time come that we plan and implement programmatic work more systematically together with the member churches? The PGC believes that our programmatic work has a strong relational dimension, and that relations with our member churches are a condition for effective programmatic work. With respect to the fellowship, the criteria should therefore be that programmes will be run only when they are undertaken in cooperation, at both planning and operational stages, with member churches."¹⁰

The 10th Assembly also decided that the work of WCC as an organization is to be done together with member churches and ecumenical partners. This is why at the 10th Assembly, in the ecumenical conversations it was an imperative to have both the member churches and ecumenical partners work together to shape the future programmatic work of the Council and the fellowship. In the context of this methodology of working, this symposium needs to reflect on how the healing ministry of the churches today is to be undertaken together in cooperation of planning, implementation, reporting and evaluation levels within the framework of the pilgrimage of justice and peace.

Engagement in the pilgrimage as a response to the *Missio Dei*

The framework in which the World Council of Churches as a fellowship of churches embarks on the pilgrimage of justice and peace and understands and reflects on the healing ministry of the churches today is well articulated in the document *Together Towards Life: Mission and Evangelism in Changing Landscapes*.¹¹ In the section entitled 'Mission as Healing and Wholeness' of this document, it is stated that:

"Actions towards healing and wholeness of life of persons and communities are an important expression of mission. Healing was not only a central feature of Jesus' ministry but also a feature of his call to his followers to continue his work (Matthew 10:1). Healing is also one of the gifts of the Holy Spirit (1 Corinthians 12:9; Acts 3). The Spirit empowers the

¹⁰10th Assembly report of the Programme Guidelines Committee page 3.

¹¹*Together Towards Life: Mission and Evangelism in Changing Landscapes*. (Geneva: WCC, 2013, 19-21). This WCC Publication 2013 was prepared by Commission on World Mission and Evangelism and approved by the WCC Central Committee in 2013.

church for a life-nurturing mission, which includes prayer, pastoral care, and professional health care on the one hand, and prophetic denunciation of the root causes of suffering, transforming structures that dispense injustice and the pursuit of scientific research on the other.

Health is more than physical and/or mental well-being, and healing is not primarily medical. This understanding of health coheres with the biblical-theological tradition of the church, which sees a human being as a multidimensional unity, and the body, soul and mind as interrelated and interdependent. It thus affirms the social, political and ecological dimensions of personhood and wholeness. Health, in the sense of wholeness, is a condition related to God's promise for the end of time, as well as a real possibility in the present.ⁱ¹² Wholeness is not a static balance of harmony but rather involves living-in-community with God, people and creation. Individualism and injustice are barriers to community building, and therefore to wholeness. Discrimination on grounds of medical conditions or disability – including HIV and AIDS – is contrary to the teaching of Jesus Christ. When all the parts of our individual and corporate lives that have been left out are included, and wherever the neglected or marginalized are brought together in love, such that wholeness is experienced, we may discern signs of God's reign on earth.

Societies have tended to see disability or illness as a manifestation of sin or a medical problem to be solved. The medical model has emphasized the correction or cure of what is assumed to be the "deficiency" in the individual. Many who are marginalized, however, do not see themselves as "deficient" or "sick". The Bible recounts many instances where Jesus healed people with various infirmities but, equally importantly, he restored people to their rightful places within the fabric of the community. Healing is more about the restoration of wholeness than about correcting something perceived as defective. To become whole, the parts that have become estranged need to be reclaimed. The fixation on cure is thus a perspective that must be overcome in order to promote the biblical focus. Mission should foster the full participation of people with disabilities and illness in the life of the church and society.

Christian medical mission aims at achieving health for all, in the sense that all people around the globe will have access to quality health care. There are many ways in which churches can be, and are, involved in health and healing in a comprehensive sense. They create or support clinics and mission hospitals; they offer counseling services, care groups and health programmes; local churches can create groups to visit sick congregation members. Healing processes could include praying with and for the sick, confession and forgiveness, the laying-on of hands, anointing with oil, and the use of charismatic spiritual gifts (1 Corinthians 12). But it must also be noted that inappropriate forms of Christian worship, including triumphal healing services in which the healer is glorified at the expense of God, and where false expectations are raised, can deeply harm people. This is not to deny God's miraculous intervention of healing in some cases.

¹²*Healing and Wholeness: The Churches' Role in Health*, Geneva, WCC, 1990, p.6.

As a community of imperfect people, and as part of a creation groaning in pain and longing for its liberation, the Christian community can be a sign of hope, and an expression of the Kingdom of God here on earth (Romans 8:22-24). The Holy Spirit works for justice and healing in many ways and is pleased to indwell the particular community which is called to embody Christ's mission."

Since the Assembly, the WCC leadership has been engaged in drafting the WCC strategic plans 2014 to 2017. This document was presented to the Central Committee in July 2014. In one section, the document explains further that:

"The pilgrimage is the overarching approach of the Council's work enabling the fellowship to move forward together. In the period between the 10th and the 11th assembly, the WCC will fulfil its purpose by supporting the member churches and ecumenical partners to journey together, promoting justice and peace in our world as an expression of faith in the Triune God'."¹³

Conclusion

This presentation has shown that the World Council of Churches is committed to health, healing and human dignity because it is core to the work of the churches. There is a very clear biblical mandate on health and healing. Over the years the WCC Assemblies and Central Committees have made clear statements and minutes that have shown its commitment to health healing and wholeness for all. As the World Council embarks on a pilgrimage of justice and peace, I quote again from the final recommendation of the report of the Programme Guidelines Committee:

"The assembly invites member churches and ecumenical partners to commit to working together as a fellowship in 'A Pilgrimage of Justice and Peace'."

Two questions for our discussions should be: How does the group present at this symposium intend to be engaged in the pilgrimage of justice and peace in the context of Christian response to global health and development? What do you see as the most important contribution from the WCC in the process of this engagement?

¹³WCC Strategic Plan 2014-2017, page 9.

The Legacy of “Tübingen I”

Christoffer H. Grundmann

People who do not remember are like trees with their roots cut and rivers with their feeders dried up. While there may still be water and foliage neither river nor tree can sustain life for much longer; soon both will be gone.

Humans need to remember—at least now and then—where they come from and what their calling is in order to be able to stay human and act accordingly. While the day-to-day demands tend to swallow us up until nothing distinctive is left, remembrance makes us reconnect with the roots of our being and with what we have set out to accomplish. Once we forget who we are and what we stand for we not only lose focus and orientation, we lose ourselves. Therefore, taking time out for remembrance and refocusing, as we do these couple of days, is vital for us personally as it is for the ministry to which we are committed.

Our symposium is occasioned —at least in part — by remembering the consultation known as “Tübingen I” held fifty years ago and hosted by this same institution. However, “Tübingen I” was neither the first nor the biggest get-together of people working in medical missions concerned about the future of such engagement; “Tübingen I”, rather, was a consultation of experts tasked to advise the Lutheran World Federation and the World Council of Churches of how to best grapple with the challenges faced by church-related hospitals and health care programmes notably in Africa, Asia, and Latin America. Yet, despite the secluded weeklong deliberations of nineteen¹⁴ consultants “Tübingen I” turned out to blaze the trail of a new understanding of the churches’ involvement in health care and healing leading over time to significant practical changes. While the then acting Secretary of the World Council’s Division of World Mission and Evangelism, Charles H. Germany, was confident that the “Statements of the Tübingen Consultation will surely find an echo in the thought of Christian medical people throughout the world,”¹⁵ to most of the other participants this came as a total surprise. As Lesslie Newbigin stated in the preface of the consultation report

"In the course of the week spent together, certain common convictions were given to the group, and they felt bound to express them in a statement. Although this statement was not immediately published, the offices in Geneva began to receive very large numbers of enquiries about it. Many thousands of copies have been distributed in response to requests. ... In a way which was not expected [the statement] seems to have spoken to the condition of

¹⁴James McGilvray in his account of the events (in: *The Quest for Health and Wholeness*, German Institute for Medical Missions, Tübingen 1981, pp. 9-17), speaks erroneously of “18 participants of Tübingen I” (p. 13) whereas the official documentation of the consultation lists 19 (see: *The Healing Church*, World Council of Churches Studies No. 3, World Council of Churches, Geneva 1965, p. 54-55, ‘List of Participants’). Charles H. Germany in his article ‘The Healing Ministry – Report on the Tübingen Consultation’ (in: *International Review of Missions*, 53, 212 [Oct. 1964], pp. 467-475) counted only 15 participants (p. 467) obviously discounting the four LWF and WCC staff members who were present, and some of whom contributed papers.

¹⁵ ‘The Healing Ministry’, p. 475.

many who were wrestling with the problems of medical missions, and ... with the healing ministry in one form or another."¹⁶

In order to better understand the impact of and the legacy left by that very event I will, first, situate “Tübingen I” within its historical and institutional context before analyzing in a second step its “Findings”. In the concluding section I will look at what happened to the insights gained in those days during the half a century which has since passed.

“Tübingen I” within the context of its time

As previously stated, “Tübingen I” was not the first nor was it the biggest consultation addressing the challenges faced by medical missions and church sponsored medical programmes in the middle of the twentieth century. Already in 1948, just three years after World War II, the Church Missionary Society in London (CMS) published an elaborate Statement on its medical policy¹⁷ calling for the realignment of medical missions:

"Realignment is designed to meet recurring need as circumstances alter. ... Realignment may involve the use of new methods and the abandonment or subordination of old ones."¹⁸

The new methods the Statement envisioned were recognized as being “of great simplicity and of outmost importance.”¹⁹ They anticipated nearly everything of what some thirty years later would become known as Primary Health Care (PHC), namely: to focus on preventive medicine, on proper ... sanitation, working, and housing conditions, on food supply²⁰, on child welfare²¹, on the training of nurses, midwives, and auxiliaries²², on refresher courses for lay workers²³, on intersectoral and interdenominational cooperation²⁴, on hospital outreach²⁵, and, last not least, on the compilation of regional statistics and reports.²⁶ What is even more striking than these recommendations *at that time* is the Statement’s sober realization of the basic “dilemma” as it was called of Christian medical work and how to face it. I quote from the respective paragraphs, because they express what later was also of concern for the Tübingen Consultation, but not yet clearly articulated.

Having analyzed the situation of Christian medical missions at that time the Statement asserts:

¹⁶*The Healing Church*, p. 5.

¹⁷*The Health of the Whole Man – A Statement on C.M.S. Medical Policy 1948*, Church Missionary Society, London 1948. This 24 page booklet deals with the subject matter in 107 numbered paragraphs.

¹⁸*Ibid.*, p. 23, para. 95.

¹⁹*Ibid.*, p. 12, para. 39.

²⁰*Ibid.*, p. 10, para. 30.

²¹*Ibid.*, p. 6, para 11.

²²*Ibid.*, p. 13, para. 40.

²³*Ibid.*, p. 13, para. 42.

²⁴*Ibid.*, p. 6f, para. 11; p. 16, para 59.

²⁵*Ibid.*, p. 13, para 42.

²⁶*Ibid.*, p. 18, para. 72.

(47) "We seem to be faced ... with the alternatives [!] of greatly increased support for the work in the field, or greatly reducing that work. If we let the situation go by default, then a quite disorderly closing down is likely to take place, altogether irrespective of strategy.

(48) We might attempt less, much less, and do this less much better. ... We may have to be prepared to scrap much and to start again."²⁷

The Statement, however, did not leave matters there. It went on to appeal to the faith dimension in declaring:

(54) "The rediscovery and restatement of the nature of medical evangelism [i.e. medical missions as an expression of the healing ministry of the Church], under the conditions we face in the world today, is the prime urgency, whether in the realignment of the work overseas or in the re-inspiration of its home support. To act whether by retreat or by advance, until that issue is clearly understood and faced by all concerned, is to act in the realm of superficial expediency. There is a new message for the new men of this new world; we shall fail both in faith and achievement if we do not acknowledge it."²⁸

Reaffirmed in a like statement by the same Society in 1956²⁹, this was said sixteen years *before* "Tübingen I"!

By far the largest conference to address issues of Christian medical missions in the post-World War II era was the International Convention on Missionary Medicine organised at Wheaton College, Wheaton, Il., in December 1959 by the Christian Medical Society, a North American association of Christian physicians and dentists.³⁰ "Far exceeding the expectations of the planners, this event brought together more than 750 furloughing missionary physicians, prospective medical missionaries, residents and interns, nurses ... executives and others ..." from 45 mission boards and 27 countries.³¹ Panels dealt with practical and technical questions of medical missions in the changing global environment, while plenary presentations were either of motivational character³² or addressed matters of principle like the responsibility of the medical missionary³³ and the challenges of raising nationalism in countries overseas breaking free of the fetters of colonialism.³⁴ Of special interest to us here is the presentation by Robert Cochrane on the "Changing functions of medical missions."³⁵

"Only too often is the ministry of healing equated with modern medical missions" Cochrane said and continued,

²⁷ *Ibid.*, p. 14.

²⁸ *Ibid.*, p. 15f.

²⁹ *The New Phase in Medical Mission Strategy*, Church Missionary Society, London, 1956.

³⁰ See J. Raymond Knighton, 'The Christian Medical Society and Medical Missions', in: *International Convention on Missionary Medicine in Review*, Christian Medical Society, Oak Park, Il., 1960, p. 130-136. – The Convention took place on December 27-30, 1960; see *ibid.*, p. 2.

³¹ David B. Biebel, '70 Years of Changing Hearts', in: *Today's Christian Doctor*, 33, 2 (Summer 2002), p. 6.

³² So the three contributions by A. W. Tozer about "The man God uses", in: *International Convention*, pp. 53-75.

³³ L. Nelson Bell, "What is the responsibility of the medical missionary?", *ibid.*, pp. 28-36.

³⁴ C. Everett Koop, "Nationalism brings new challenges", *ibid.*, pp. 37-52.

³⁵ Robert C. Cochrane, *ibid.*, pp. 11-27.

"I suggest that *even without a mission hospital, the ministry of healing, in the New Testament sense, could still be used by the Church as a powerful factor in the restoration of health.* ... If ... the Christian Church is to make its full contribution toward the ministry of healing, there must be a much clearer understanding as to what the meaning of the ministry of healing is in relation to Scripture."³⁶

To achieve this, Cochrane was convinced,

"That it is urgently necessary to make an appraisal of ... medical missionary institutions along two lines: (a) their contribution to the upbuilding of Christ's Church, and the extension of His Kingdom, (b) their denominational allegiance, as to whether this is a weakening influence rather than a source of strength to the younger Churches."³⁷

We will hear something quite similar from "Tübingen I" five years later.

Dr. Cochrane also mentioned in his address the name of James McGilvray, with whom he got acquainted in the 1940s at the Christian Medical College and Hospital in Vellore, India.³⁸ He not only praised McGilvray's "original" and "eminently wise" approach to Christian leadership; he also cited McGilvray's reorganisation of medical mission work in the Philippines in 1957 as a shining example of what a new approach might look like, because instead of investing in "Christian medical teaching centers", McGilvray made the Philippine churches identify their medical students in the universities and nurture them spiritually throughout the course of their studies so that these did not get estranged from the Church and could perceive of their professional work as an act of Christian witness in the world.³⁹

The CMS Statement on medical policy as well as the convention at Wheaton clearly show, that "Tübingen I" was neither an isolated affair, nor that its findings were all that new nor that people did not know of one another.⁴⁰ "Tübingen I", rather, falls in line with similar events and did not come up with something entirely original; only the problems requiring a solution had aggravated. Yet, it was "Tübingen I" which made the impact; not Wheaton, nor was it the CMS Statement. Why? A closer look at how the consultation came about might give us a clue.

According to the published records it all began in 1962 when the Commission on World Mission of the Lutheran World Federation invited the newly established Division of World Mission and Evangelism of the World Council of Churches⁴¹ "to join ... in a study of medical missionary questions. As a first step", recalled Lesslie Newbigin, then director of the WCC

³⁶ *Ibid.*, p. 14; original emphasis.

³⁷ *Ibid.*, p. 17.

³⁸ *Ibid.*, pp. 20-21.

³⁹ *Ibid.*, p. 21.

⁴⁰ Actually, the CMS Statement of 1948 is listed in the 'Brief Bibliography' of the "Tübingen I" report, as is its sequel of 1956; see *The Healing Church*, pp. 50-51.

⁴¹ The Division of World Mission and Evangelism of the World Council of Churches came about at the WCC General Assembly held in New Delhi 1961, when the International Missionary Council (IMC) merged with the WCC; see Max Warren, 'The Fusion of IMC and WCC at New Delhi: Retrospective Thought after a Decade and a Half', in: *Occasional Bulletin of Missionary Research*, 3 (July 1979), pp. 104-108.

Division of World Mission and Evangelism, "it was decided to ask a small group, mainly of doctors, to advise about what were essential issues and what – if anything – the two world bodies could do about them."⁴² A former medical missionary of the Church of Norway, Dr. Erling Kayser, was hired as Organizing Secretary charged with the task to prepare such a consultation. During a six months period⁴³ Dr. Kayser surveyed existing documents on the topic⁴⁴, designed a respective questionnaire and did a lot of traveling and interviewing to collect background documentation "for the purpose of sharpening issues and calling attention to written materials and reports ... available."⁴⁵ Except for the four LWF and WCC staff members, participation was on an individual basis⁴⁶ of people with experience in the field across denominational divides; however, one notices with surprise the absence of someone from the Church Missionary Society, undeniably the most articulated and most active body in the field. Future studies will have to shed light on this strange phenomenon. – However, among those present eleven were or had been medical missionaries in Asia (7) or Africa (4), while two others had expertise in medical missions' administration; of the remaining two one was a professor of pastoral care from the United States, the other a physician from Tokyo, the chairman of the Japanese Christian Medical Association.⁴⁷ Some more theologians had been invited, but sickness prevented them from attending.⁴⁸

The overall frame of reference for the deliberations during the week of May 19th - 25th, 1964, was: "The Healing Ministry in the Mission of the Church."⁴⁹ This was also the theme of Lesslie Newbigin's opening keynote address, which set the stage for the subsequent discussions.⁵⁰ In the first part of his reflections, Newbigin articulated basic questions regarding the Christian witness in a secular society, especially in the medical profession, the relation between faith and healing, and "the relation of medical work to evangelism."⁵¹ In the second section he alerted to "matters on which" the LWF and the WCC sought "guidance"⁵² like: What is the place of healing in the mission of the church? What are the roles of congregations, institutions, and individuals in such a ministry? What is "the

⁴²*The Healing Church*, p. 5.

⁴³ This is according to L. Newbigin who reports, "The meeting was prepared by six months of visiting and correspondence by Dr. Erling Kayser of the Church of Norway" (*The Healing Church*, p. 5.) Charles H. Germany, however, contradicts this statement somewhat by telling that "Dr. Erling Kayser ... gave four months of full-time work as Organizing Secretary." ('The Healing Ministry', p. 469.)

⁴⁴ A sample list of the materials Dr. Kayser collected is documented in the 'Brief Bibliography' appended to the report of the consultation; see *The Healing Church*, pp. 50-53.

⁴⁵ Charles H. Germany, 'The Healing Ministry', p. 469.

⁴⁶ "The participants attend as individuals ... rather than as representatives of their churches, institutions or geographical areas." (Charles H. Germany, 'The Healing Ministry', p. 467).

⁴⁷*The Healing Church*, p. 54-55.

⁴⁸ "The Tübingen Consultation was weakened by the absence of the professional theologians who had taken part in the preparation and were scheduled to be present. Ironically, sickness kept them away." (Charles H. Germany, 'The Healing Ministry', p. 470.)

⁴⁹ See 'Editor's Notes' of Lessie Newbigin in *The International Review of Missions*, 53, 1964, p. 250; see also Charles H. Germany, 'The Healing Ministry', p. 467.

⁵⁰*The Healing Church*, pp. 8-15.

⁵¹*Ibid.*, p. 12.

⁵²*Ibid.*, p. 13.

relationship of Christian medical work to government”?⁵³ “What are the priorities with regard to medical work in each major region” [of the world]? Newbigin also asked boldly: “Do we include all non-Roman missions, or have we reached the point in history when we can include Roman missions in this kind of strategic thinking?” Then, further, “How are the churches ... to become fully involved in the healing ministry?” and “What kind of machinery do we need for joint planning and mutual aid on a national and international and interconfessional basis?”⁵⁴

In closing Newbigin plainly told his audience,

"This consultation is planned only as a first step towards getting into the issues. It is not a consultation which will produce a great statement of principles. We are not competent, we are not prepared, we are not sufficiently representative. ... [W]e ought to resist the temptation to produce a manifesto, for ... we are not ready for it. ... If we are led in the providence of God to strong convictions—which may well be—we should rather embody these in the form of a document which we would send to our sponsoring bodies under the general rubric of a question, ‘Does this statement help illuminate your problems?’ If we can raise the right questions we shall have done our job.”⁵⁵

All what was sought was, first, raising the right, that is, the truly relevant questions with regard to medical missions and its place in the healing ministry of the Church, and, second, to give guidance as how to best accomplish this, well knowing that it “will be most difficult to achieve in respect of medical missions a real deep full spiritual integration with the Church”⁵⁶, as Newbigin put it. And yet, against the explicit charge not to produce a document, the participants felt they should do just that. Above and beyond raising probing questions they—surprisingly—found some kind of an answer which they felt urged to publish. Newbigin described these dynamics as “something” that “happened ... beyond” the “plan”⁵⁷ and “the preparatory material”⁵⁸, while James McGilvray spoke of “the Holy Spirit’s guidance”⁵⁹ and Charles H. Germany in his ‘Closing Meditation’ described the experience with the phrase “We have been led ...”⁶⁰, noticing somewhere else that the “Findings” could not “have been written in advance.”⁶¹

Having thus sketched the historical and institutional context of “Tübingen I”, we now can identify at least three major elements contributing to the consultation’s impact. These

⁵³ Ibid.

⁵⁴ Ibid., p. 14.

⁵⁵ Ibid., pp. 14-15.

⁵⁶ Ibid., p. 14.

⁵⁷ Leslie Newbigin, *ibid.*, p. 5.

⁵⁸ Ibid., 6.

⁵⁹ *The Healing Church*, p. 49.

⁶⁰ Ibid., pp. 44-45.

⁶¹ H. Germany, ‘The Healing Ministry’, p. 471.

elements are (1) the convening bodies represented global denominational⁶² and interdenominational networks with a critical mass of “younger” churches making their concerns heard. This was not so the case in the Wheaton Convention of 1959, organised by an association of pious individuals working in medical missions, while the CMS Statement represented more or less unilateral considerations from the side of a sponsoring church body, albeit also a global one. (2) The topic of “Tübingen I” was not confined to medical missions only, as was the case in Wheaton and with the CMS Statement. “Tübingen I”, rather, addressed medical missions in the much the broader framework of their place in the healing ministry of the Church. (3) Relating practical and organizational issues faced by medical missions to basic questions of identity, calling, and witness as members of the Christian Church led to a unity of questioning and, consecutively, to surprising “Findings” which mark “Tübingen I” as unique. However, while giving us some clue, the three elements just mentioned do not fully explain why the “Findings” got the broad hearing they actually received by people not present at the consultation and working in very diverse situations and places. This, certainly, has to do with the content of the “Findings”, to which we now turn.

The “Findings” of the Tübingen Consultation of 1964

The unanimously adopted, unsought findings of the first Tübingen Consultation are documented in a ten page booklet. Preceded by a “Preamble” counted as section I, the “Findings” are hierarchically arranged in eight subsections, proceeding from basic theological statements in sections II-IV to technical and organisational issues in sections V-IX.

The Preamble documents the self-conscious certainty of its authors writing under the impression of having been led to the insights gained. They express the conviction that their “statement” is “revolutionary to much of the Church’s ... involvement in medical work.” How so? Here is their argument:

"Mission boards ... societies and national churches are ... promoting medical work in terms of meeting physical need or providing avenues for the preaching of the Word all within a varied understanding of Christian compassion and concern. Yet the valid criticism by younger churches that such institutions are a ‘burden’ to them, and the lack of intimate involvement in medical institutions in the West points up the absence of a sufficient distinction between much Christian medical work and the service of secular agencies. It is our earnest hope that these findings may lead to the criteria by which existing and projected Christian medical work can be evaluated."⁶³

⁶² What is of special interest here is the participation of Dr. W. F. Bulle, Executive Secretary for medical missions of the Lutheran Church Missouri Synod (LCMS), which is not a member church of the LWF (see *The Healing Church*, p. 54).

⁶³ *Ibid.*, p. 34.

This diagnosis is radical in so far as it not only declares that the conventional justifications for Christian involvement in medical care by individuals or institutions based on compassion and evangelism are insufficient to sustain such work.⁶⁴ Likewise radical is this diagnosis in identifying (a) the complaint by younger churches that running hospitals is a "burden" and (b) "the lack of intimate involvement in medical institutions in the West" as being due to the "absence" of a distinctive Christian perception of medical work, which the "Findings" attempt to remedy. How?

Instead of letting go off the Church's medical work, the consultants — to their own surprise — had to reaffirm such a commitment arguing first and foremost in section II that the "Christian Church has a specific task in the field of healing" which cannot be surrendered "to other agencies" because healing is "an integral part of its witness to the Gospel" and an expression of salvation.⁶⁵ The Church and the Christian congregation — explicitly defined in the document as "the corporate fellowship of the People of God wherever it manifests itself"⁶⁶ — is mandated by its Lord to "exercise the healing ministry," which "must be kept under constant review ... in each generation" to see if it lives up to its task.⁶⁷

Section III deals with "The Role of the Congregation in the Ministry of Healing."⁶⁸ It specifies particular responsibilities of local congregations such as realizing their belonging to a body called to bring about healing in one way or another through the ministry of the Word, the Sacraments and prayer, while other "healing services, laying on of hands, and anointing" may also play a part in it, provided that "proper medical means" are not discarded and that the patient is not exploited. However, the healing ministry extends beyond, that is, also to the care for those who work as physicians, nurses, ancillary medical staff, and it also includes the encouragement of others "to enter the healing professions."⁶⁹

The topic of section IV, the last of the non-technical subdivisions of the "Findings", addresses

"The Healing Ministry in Theological Education."⁷⁰ Stating that "A Christian understanding of healing is already implicit in theology" but absent from respective syllabi in theological

⁶⁴ "In our search for this distinctive character of [Christian] healing we have considered compassion in response to need; we know that compassion is a part of a Christian concept of healing, but it is not distinctive. - We have recognized in much medical work a motivating sense of the dignity of man. This too in a special sense is true of Christian healing, but even a particular sense of the dignity of man is not enough. - We have noted that the disciplined practice of the medical art is a part of responsible work, but this is also not distinctive to Christian healing. - We have seen a noble dimension of the willingness of those engaged in healing to suffer. This also is fundamentally a part of Christian healing, but this too is not entirely distinctive. - We have been led to hold our search against the background of the New Testament drama of salvation." (Charles H. Germany, 'Closing Meditation', in: *The Church and Healing*, p. 44.) - "So long as the basic motivation remains that of meeting physical need or of using medical practice as a means to another end, the historical pattern is likely to be repeated in the developing countries of the world." (James McGilvray, 'The Next Steps', *ibid.*, p. 46.)

⁶⁵ II - The Christian Concept of the Healing Ministry, *The Healing Church*, p. 34-36; quotes from pp. 34-35.

⁶⁶ *Ibid.*, p. 35, footnote 1.

⁶⁷ *Ibid.*, p. 36.

⁶⁸ *Ibid.*, pp. 36-37.

⁶⁹ *Ibid.*, p. 37.

⁷⁰ *Ibid.*, pp. 37-38.

training, the teaching of the Church's ministry of healing in colleges and seminaries is deemed to be "imperative" and probably "most effectively" carried out in the department of "practical theology."⁷¹ "The theological college and seminary" it is said, "should ... train ... students to be trainers of ... laity who as members of the congregation should carry on the essential ministry of healing."⁷²

The following sections, marked by a slightly different style than the preceding ones, deal with "The Training of Medical and Para-Medical Workers as a Task of the Church" (V)⁷³, "The Institutional Forms of a Healing Ministry" (VI)⁷⁴, the relationship of a Christian Healing Ministry to secular government initiatives (VII)⁷⁵, and the joint ecumenical that is — planning of healing ministries across denominational lines (VIII)⁷⁶. The last section contains recommendations as to how to continue the quest set in motion during the consultation (IX)⁷⁷. Besides "gathering, analyzing and making ... available ... the very large amount of work in survey and study" already existing, further studies and surveys of the healing ministry "at local, regional and international levels" are incited⁷⁸, as are "the carrying out of pilot and experimental projects in an integrated programme of healing."⁷⁹ Also, "particular attention [should] be given to ... the theology of health and healing", especially to the topic of "Health and Salvation," to "the relationship of Church and state in the area of healing and health", to "the Church's ministry of healing to private practice of medicine" and to "joint action by the churches in the ministry of healing, particularly in relation to medical missions."⁸⁰

Studying these "Findings" one is struck by their clear awareness of the Church's responsibility for medical pursuits of healing as an integral part of the healing ministry. To bring about healing the Church cannot ignore medicine; instead, the Church has to avail of it in such a way, that medical activities and institutions become genuine expressions of the healing ministry by their "complete integration ... into the life and witness of the Church." This "should not be taken simply as meaning that the administrative control" of hospitals and medical programmes is in the hands of a church body. It, rather, was to mean, that "the congregation ... recognize(s) itself as the healing community which knows the hospital to be an essential channel of its witness to the world."⁸¹ Thus, the

"Consultation discovered in a quite unplanned way that to ask whether or not the time has come for the Church to surrender its work in medicine ... is to ask a theological question. One has the feeling that before Tübingen ... consultation participants leaned in the direction of the Church withdrawing from areas of healing now strongly occupied by the state. ... Even so,

⁷¹ *Ibid.*, p. 38.

⁷² *Ibid.*

⁷³ *Ibid.*, pp. 38-39.

⁷⁴ *Ibid.*, pp. 39-40.

⁷⁵ 'The Relationship of a Christian Healing Ministry to Government', *ibid.*, p. 41.

⁷⁶ 'Joint Planning and Use of Resources for the Healing Ministry', *ibid.*, pp. 41-42.

⁷⁷ 'A Continuing Programme of Study and Work', *ibid.*, pp. 42-43.

⁷⁸ *Ibid.*, p. 42.

⁷⁹ *Ibid.*, p. 43.

⁸⁰ *Ibid.*

⁸¹ *Ibid.*, p. 40.

the Consultation was led to articulate the belief that ‘the Christian Church has a specific task in the field of healing’.”⁸²

And also,

“The Tübingen consultation did not find it possible to say that no more ... medical institutions should be built overseas. On the contrary, increased government services do not necessarily mean that the Church should withdraw.”⁸³

It is precisely this call to remain engaged in and recommit to medical expressions of the ministry of healing which has “spoken to the condition of many who were wrestling with the problems of medical missions, and ... with the healing ministry in one form or another” as Lesslie Newbigin remarked in the ‘Preface’ to the Consultation report.

What has become of these insights in the fifty years since?

“Tübingen I” fifty years later

Appraising the consultation one of those then present remarked shortly thereafter: “Sometimes a conference is timely enough and demanding enough in theme to serve as stimulus for a continuing programme. Tübingen was certainly of this character.”⁸⁴ He was right. “Tübingen I” had an impact not just on its participants, but on the global plane as well. To keep its momentum going “a small consultation of theologians ... to discuss the subject ‘Health and Salvation’” was called to meet “at an early date, perhaps in 1965.”⁸⁵ However, this sequel consultation — known as “Tübingen II” — came about only as late as September 1967.⁸⁶ It not only reaffirmed the findings of the previous one, but also expressed “the need for the creation of an ecumenical agency to assist the churches in their search for relevant styles of health care involvement.”⁸⁷ Similar concerns were raised in like events organised in other parts of the world that same year in Tanzania (Makumira, February), India (Coonoor, March), Ghana (Legon, April), and South Africa (Johannesburg, May; Mapumulo,

⁸² Charles H. Germany, ‘The Healing Ministry’, pp. 470-471.

⁸³ *Ibid.*, p. 473. The “assumption that the Church should now withdraw in those situations where her pioneer service in medical work has drawn a multiplicity of secular agencies simply denies any uniqueness of service which the Church by her very nature can render. ... We must ask why it is that the Church and its hospitals have developed too often into ‘separate’ entities.” (James McGilvray, ‘The Next Steps’, in: *The Healing Church*, p. 46.)

⁸⁴ Charles H. Germany, ‘The Healing Ministry’, p. 474.

⁸⁵ *The Healing Church*, p. 43.

⁸⁶ See James McGilvray, *The Quest for Health*, p. 28-31, with excerpts of presentations on pp. 111-115. The proceedings of this weeklong consultation (Sept. 1-8, 1967) have never been published but are available in archival copies by the title “Health – Medical – Theological Perspectives”, Tübingen 1967. For a report (in German) by one of the participants in that consultation see Gerhard Hoffmann, ‘Heilung und Heil’, in: *Ärztlicher Dienst weltweit: 25 Beiträge über Heil und Heilung in unserer Zeit*, W. Erk, M. Scheel, Hrsg., Stuttgart, J. F. Steinkopf Verlag 1974, pp. 144-152.

⁸⁷ ‘Preface’ in: *In Search of Wholeness ... Healing and Caring*, Contact – Special Series 2, June 1979, Geneva, WCC, unsigned, unpaginated.

September).⁸⁸ “Tübingen I”, further, gave rise to systematic surveys of churches’ involvement in medical and health care programmes in Africa (Cameroon, Zambia, Ghana), Indonesia, and India⁸⁹, and, led to establishing in June 1968 the Christian Medical Commission (CMC) as “an outspoken ecumenical programme”⁹⁰ with Roman Catholic participation from its very inception. James McGilvray tells why the CMC was called such:

“Some may wonder why it was called a ‘Medical’ Commission when its chief concern was to be with health. When the original proposal to create a Christian Health Commission was announced it attracted an immediate response from various spiritual and divine healing groups which felt that ... they were being provided a forum within a worldwide ecumenical body. Since the Commission was intended to assist the churches which were engaged in medical services around the world it was decided that it would be more appropriate to designate it as such.”⁹¹

The CMC was mandated to implement what was envisioned at Tübingen in 1964, namely to “promote ... joint planning and action (a) between ... churches ... and (b) between ... other voluntary agencies and the Government,” but also to “undertake and encourage the study of the nature of the Christian ministry of healing and the problems which confront it [i.e. the healing ministry] in a changing world.”⁹² The Commission existed until 1992 when in the restructuring process of the WCC the then so-called ‘CMC Churches’ Action for Health’ merged with the sub-units on Education and on World Mission and Evangelism to form Unit II labeled “Churches in Mission: Health, Education, and Witness.”⁹³ This, however, was bemoaned by the World Health Organization (WHO), with which the CMC had established a remarkable relationship of mutual respect that became instrumental in bringing about the ambitious 1978 Alma Ata Declaration pronouncing “Health for All by the Year 2000.”⁹⁴

⁸⁸ See James McGilvray, *The Quest for Health*, pp. 17-22.

⁸⁹ *Ibid.*, pp. 32-41. – Charles H. Germany mentions that “the Tübingen Consultation gave highest priority to survey and study.” (‘The Healing Ministry’, p. 474.)

⁹⁰ Ans J. van der Bent, *Vital Ecumenical Concerns: Sixteen Documentary Surveys*, Geneva, Switzerland, World Council of Churches 1986, p. 303.

⁹¹ James McGilvray, *The Quest for Health*, pp. 43-44.

⁹² From the CMC ‘Mandate’ as given in the recorded minutes: ‘Christian Medical Commission – First meeting’, Ecumenical Centre, Geneva, Switzerland, Sept. 2-6, 1968, p. 2. – McGilvray, however, later distorted this mandate somewhat when he writes that the CMC was “charged ... with responsibility to promote the national coordination of church-related medical programmes and to engage in study and research into the most appropriate ways by which the churches might express their *concern for total health care*.” (in: *The Quest for Health*, p. 41; emphasis mine) For an at least partial history of the work of the CMC see *ibid.*, pp. 42-101.

⁹³ See G. Paterson, ‘The CMC Story 1968-1998’, in *Contact*, 161-162, June-July/August 1998, pp. 3-48. See also ‘8th Assembly and 50th Anniversary Preparatory Materials: HEARING ON UNIT II: CHURCHES IN MISSION – HEALTH, EDUCATION, WITNESS, Annotated Agenda’, World Council of Churches, online database at www.wcc-coe.org/wcc/assembly/hu2wb-e.html (accessed May 27, 2014). The CMC presented its final ‘Report’ to the Central Committee at its meeting in Moscow in 1989 (David Hilton, Manoj Kurian, ‘Healing, Health, Health Care’, in: *Dictionary of the Ecumenical Movement*, Geneva, Switzerland, WCC Publications, 2nd ed., 2002, p. 511).

⁹⁴ See James McGilvray, *The Quest for Health*, pp. 70-80. – See also: G. Paterson, ‘The CMC Story 1968-1998’, pp. 13-14; J. H. Bryant, J. B. Richmond, ‘Alma Ata and Primary Health Care: An Evolving Story’, in: *Health Systems Policy, Finance, and Organization*, ed. by G. Carrin, K. Buse, K. Heggenhougen, and St. R. Quah, San Diego, CA, Academic Press 2009, pp. 59-81. On the reaffirmation of the PHC approach by the WHO, see: *The*

Writing about “The Christian Medical Commission and the Development of the World Health Organization’s Primary Health Care Approach” in 2004, a former WHO official made the distressing remark: “Sadly, however, the CMC will no longer be involved with whatever emerges [in WHO policies], as it was effectively disestablished in the 1990s.”⁹⁵

The latest reshuffle of the WCC has caused the concerns for which the CMC once stood to be further obscured by placing these under the heading “Health and Healing” in the Programme Area “Justice, Diakonia and Responsibility for Creation” with minimal staff support.⁹⁶ Except for the magazine ‘Contact’⁹⁷ nothing much is left of the CMC today. A lot, rather, has been lost, not only in regard to the terminology, the ecumenical, professional, and political cooperation.⁹⁸ Regrettably, what has also been lost is the great vision of “Tübingen I” that the Christian Church has a specific task in the field of healing which cannot be delegated to other agencies, since it is a genuine element of the proclamation of the Gospel.

What happens to medical concerns within the WCC now? Do these still find a hearing? It seems that the supporting churches have recoiled from challenging scientific medicine by the distinctive Christian understanding of health and healing as envisioned in Tübingen 1964. True, the CMC did conduct several regional consultations to identify a ‘Christian Understanding of Health, Healing, and Wholeness’ during the years 1979 to 1987.⁹⁹ But this initiative hardly led to anything more than the reaffirmation of what churches were already doing in PHC¹⁰⁰ and community-based HIV&AIDS programmes. These consultations did not realise that such activities represent the Christian healing ministry only in part. Focusing on care for marginalized populations, these consultations sidetracked proper attention to medical concerns by broadening essential terms to such an extent that those lost their distinctive meaning and became trivialized and, thus, unsuitable for the qualified discourse with the scientific community. The terminology of health, healing, and wholeness might fit nicely into overall WCC concepts and concerns, but it has become irrelevant for the discourse with the medical profession in the real world.

So, what about the legacy of “Tübingen I”?

World Health Report 2008 – Primary Health Care Now More Than Ever, World Health Organization, Geneva, Switzerland 2008.

⁹⁵ American Journal of Public Health, vol. 94, 11 (Nov. 2004), p. 1892.

⁹⁶ See “World Council of Churches – What we do” at <http://www.oikoumene.org/en/waht-we-do> (accessed May 27, 2014).

⁹⁷ The first issue of ‘Contact’ appeared November 1970, counting till date 195 issues. For a complete listing of these see <http://www.oikoumene.org/en/what-we-do/health-and-healing/contact-magazine> (accessed May 27, 2014). For a history of this publication see G. Paterson, ‘The CMC Story 1968-1998’, pp. 12, 44-45.

⁹⁸ On the CMC cooperation with secular agencies see Hakan Hellberg, ‘The CMC and its Impact on Secular Organizations/Agencies’, in: *The Vision and the Future: 25 Years of CMC*, CMC – Churches’ Action for Health, World Council of Churches, Geneva, Switzerland 1995, pp. 42-44.

⁹⁹ These consultations are documented in *The Search for a Christian Understanding of Health, Healing and Wholeness. A Summary Report on the Study Programme of the Christian Medical Commission of the World Council of Churches 1976-1982*, Geneva, WCC 1982, and *Healing and Wholeness. The Churches’ Role in Health. The Report of a Study by the Christian Medical Commission. World Council of Churches*, Geneva, WCC 1990.

¹⁰⁰ For an early and highly instructive criticism of PHC within the CMC see Charles Elliot, ‘Is Primary Health Care the New Priority? Yes, but ...’, *Contact*, no. 28, August 1975.

What about the legacy?

Those gathered here fifty years ago were convinced that *if it is true that all healing is from God* and related to *salvation*, then the Church is tasked with making this explicit to medicine as the professional agency of healing, too. Such discourse might prove to be complex and difficult, but this does not exculpate the Church from *not* engaging in it, even though some fundamentalist Christians regard engaging with the world in this way as an indication of “the diabolical tenor of the Tübingen consultation.”¹⁰¹ The Church is not indemnified from articulating the unique contribution of her healing ministry to medicine and the health care professions. Not that the Church knows more about healing than medicine; she certainly does not. But the Church knows — thanks to the Gospel — something that is essential for putting medical and therapeutic efforts into proper perspective. What such discourse might look like has been demonstrated in an exemplary fashion by the dialogues between John Bryant and David Jenkins on “Moral Issues and Healthcare” and on “Health Care and Justice” during the annual CMC meetings 1971-1973.¹⁰² Never again was such depth of argument and understanding reached in the attempt “to bridge the gaps between ... Church and Medicine [!]”¹⁰³ and, actually, to learn what healing has to do with salvation.¹⁰⁴

Furthermore, “Tübingen I” defined the Church as an agency of healing in “God’s plan of salvation for mankind.”¹⁰⁵ Christians have to bear witness to this. They do so *all the time* and *everywhere* through their *living, speaking, and acting*, not just in medical or ecclesiastical environments or on topics of healing.¹⁰⁶ When referring to *this way* of authentically living the Gospel — and *to this way only* — it is appropriate to speak of the Christian congregation as a “healing community” and of the Christian Church as a “Healing Church,” phrases, which drew appropriate criticisms from early on.¹⁰⁷ However, the vision of the Church as a healing

¹⁰¹ So Pamela E. Klassen in her book *Spirits of Protestantism: Medicine, Healing, and Liberal Christianity*, Berkeley / Los Angeles, University of California Press 2011, p. 53. Here is the quote in full: “Together, they [i.e. the people at Tübingen] emphasized the need to work with scientific medicine and to be suspicious of sensational faith healing, while they also repeatedly asserted that all healing came from God and was a ‘dethroning of the powers of evil.’ Deployed in tandem with psychological concepts such as anxiety (‘a red light testifying to the abyss’) and medical approaches such as psychosomatic medicine, the diabolical tenor of the Tübingen consultation’s definition of healing grew from the discourses of both spiritual equilibrium and spiritual intervention.” While the book is presented as an anthropological study of “liberal Protestantism” (Preface, pp. xviii-xxi), its language gives it away.

¹⁰² Documented in *In Search of Wholeness*, pp. 17-51.

¹⁰³ James McGilvray, *The Quest for Health*, p. 31.

¹⁰⁴ For further reflections on the issue of health see David Jenkins, ‘Foreword on being concerned both about medicine and about something more’, in: McGilvray, *The Quest for Health*, pp. IX-XIII.

¹⁰⁵ *The Healing Church*, p. 35.

¹⁰⁶ Very instructive in this regard is McGilvray, *The Quest for Health*, chapter 10: ‘The Way Ahead’ (pp. 102-110).

¹⁰⁷ “The Tübingen I concept of ‘The healing Church’ too positively – perhaps too magically – equated the values of Health and Salvation without sufficiently accounting for the very empirical phenomena of suffering and death. This shortcoming, acknowledged by all who participated, however had directly led to further theological reflection at Tübingen II.” (Hans Florin, ‘The Role of the Church in Health and Medical Services’, in: *Christian Medical Commission – First Meeting Ecumenical Centre, Geneva, Switzerland, Sept. 2-6, 1968*, archival typescript, p. 30); see also Stanley G. Browne, *The Healing Church, an ambiguous and misleading concept*, London, Christian Medical Fellowship 1970. In German: Ulrich Bach, *Heilende Gemeinde? Versuch einen Trend zu korrigieren*, Neukirchen, Neukirchener Verlag 1988.

community is not a matter of semantics. It, rather, is a call to live up to in whatever our pursuits are. That, too, is left to us as legacy from “Tübingen I.”

The Declarations of Tübingen in the 21st Century: History or Guiding Principles?

Steffen Flessa

In May 1964 representatives of Protestant mission societies gathered in the little town of Tübingen (Germany) to discuss the „Healing Ministry in the Mission of the Church“¹⁰⁸. The results of this “Tübingen I” (May 19th – 24th, 1964) and of the subsequent “Tübingen II” (September 1st-8th, 1967) conferences had a major impact on the self-perception and the strategies of Christian health work.¹⁰⁹ Although the majority of ideas formulated in the statements presented at this conferences were not completely new¹¹⁰, the declarations of Tübingen gained an unprecedented momentum and led to the foundation of the Christian Medical Commission (CMC) which had a strong impact on the development of the Primary Health Care paradigm of the World Health Organization.¹¹¹

Recently the World Health Organization (WHO) titled its World Health Report as „Primary Health Care – Now more than ever“.¹¹² With this, the WHO clearly underlines that the principles of Primary Health Care (PHC) stipulated in Alma Ata are increasingly relevant, even in the 21st century. While some concepts of PHC have to be adopted to the „challenges of a changing world“¹¹³, the main paradigms and objectives remain unchanged. This reconfirmation of PHC by the WHO strongly contradicts the poor perception of the declarations of Tübingen by the world-wide churches and the mission societies in the 21st century where the knowledge of “Tübingen” has almost been lost. The CMC of the World Council of Churches was replaced by a small health desk and lost almost all relevance for the medical field. Consequently, one has to ask whether the declarations of Tübingen are merely historic events without any relevance for the future of Christian health care services in the 21st century. Under which conditions could we state “50 years of Tübingen I – now more than ever”? And what has to change in Christian health care services (not only in resource-poor countries) so that they can continue fulfilling their call in the future?

This paper argues that church-based health care services still matter in modern societies but that there is a strong need to reflect on their proprium and to strengthen the spiritual dimension of Christian health care services. As this is the core of the declarations of Tübingen, the paper argues that "Tübingen I" and "Tübingen II" are not only historical events

¹⁰⁸Newbiggin, L., 'Editor's Note', *The International Review of Missions* 53 (1964), p. 250.

¹⁰⁹McGilvray, J. C., *The quest for health and wholeness*, Tübingen, German Institute for Medical Missions, 1981.

¹¹⁰Church Mission Society (1948). *The Health of the Whole Man - A Statement on C.M.S. Medical Policy*, Church Mission Society, London, 1948.

¹¹¹Diesfeld, H. J., G. Talkenhorst and O. Razum, *Gesundheitsversorgung in Entwicklungsländern. Medizinisches Handeln aus bevölkerungsbezogener Perspektive*, Berlin et al., Springer 2001.

¹¹²WHO, *World Health Report 2008: Primary health care: now more than ever*, Weltgesundheitsorganisation, Genf, 2008.

¹¹³Ibd.

but of high relevance for the future of Christian health care services if they are transferred to the 21st century and adapted to the new conditions.

In the next section I will analyse some of the changes that challenge Christian health care institutions. Then I will demonstrate why these services still have a unique role in the society and discuss the preconditions of relevance. The paper will end with some conclusions.

Economic history of Christian health care services

The healing ministry of the church relates to all dimensions of human life: body, soul and spirit. Thus, Christians are called to holistic health care as an essential dimension of their faith.¹¹⁴ Consequently, Christians have (almost) always been engaged in healing, caring for the sick and establishing institutions of charity for the poor and needy. In the late 19th and early 20th century many church-based hospitals were founded all over the world. They frequently grew to major institutions with thousands of employees.¹¹⁵ For many people Christianity and hospitals became almost identical, in particular in the former colonies where mission hospitals used to form the backbone of the new churches.¹¹⁶ Although mission hospitals could never cover the entire population¹¹⁷ they were an essential element of the health care sector in most regions of the world, in particular in Sub-Saharan Africa and Asia.

The majority of Christian health care institutions in these regions were built in rural areas whereas the colonial powers frequently concentrated on towns of strategic importance. In most rural places churches had a natural monopoly for “modern” health care as the next provider was so far away that the catchment population of the health care provider had actually no chance to reach an alternative provider. The maximum distance of travel was lower than the distance between the institutions.

As a consequence, Christian health care providers did not have to justify their existence by any other characteristic than by their presence. Christian health care services in Sub-Saharan Africa and Asia were “good” simply because they were there. Had they not existed, nobody else would have been there. In case of a monopoly the provider does not have to be better than others. And the provider does not have to find reasons why the services are provided as there is plainly no alternative.

The declarations of Tübingen were formulated at a time when the contribution of Christian health care to the health of the population was not being challenged. During the

¹¹⁴EKD, *Texte zum Schwerpunktthema: Diakonie, 3. Tagung der 9. Synode der EKD* (1.-6. November 1998, Münster), Evangelische Kirche in Deutschland, Hannover, 1998.

¹¹⁵Städtler-Mach, B., *Das evangelische Krankenhaus: Entwicklungen-Erwartungen-Entwürfe*, Hamburg, Verlag an der Lottbek Jensen, 1993.

¹¹⁶Grundmann, C. H., *Gesandt zu heilen*, Gütersloh, Gütersloher Verlagshaus, 1992.

¹¹⁷Schweikart, J., *Räumliche und soziale Faktoren bei der Annahme von Impfungen in der Nord-West Provinz Kameruns*, Geographisches Institut, Universität Heidelberg, Heidelberg, 1992.

conferences, nobody questioned whether there was a need for Christian health care services in these areas as they were natural monopolist. The delegates to the conferences knew that the newly independent states and their governments were about to start building-up a „safety net for the poor“¹¹⁸ but at the time of Tübingen I and II there was hardly any competition in the health care field. The economic problems which they saw, such as increasing costs of medical equipment and drugs, were strong forces behind the declarations of Tübingen, but they had nothing to do with local competition for patients.

Fifty years later the situation in almost all parts of the world has changed. Figure 1 shows the development of public health facilities in Kenya between 1959 and 2002. In 2002, there are still some areas where a health care facility has a natural monopoly based on distance. However, these are sparsely populated regions. The vast majority of Kenyans has a choice of provider. Christian health care providers have lost their monopolies almost everywhere. The government facilities cover nearly the entire country and in many cases Christian and government facilities are within walking distance.

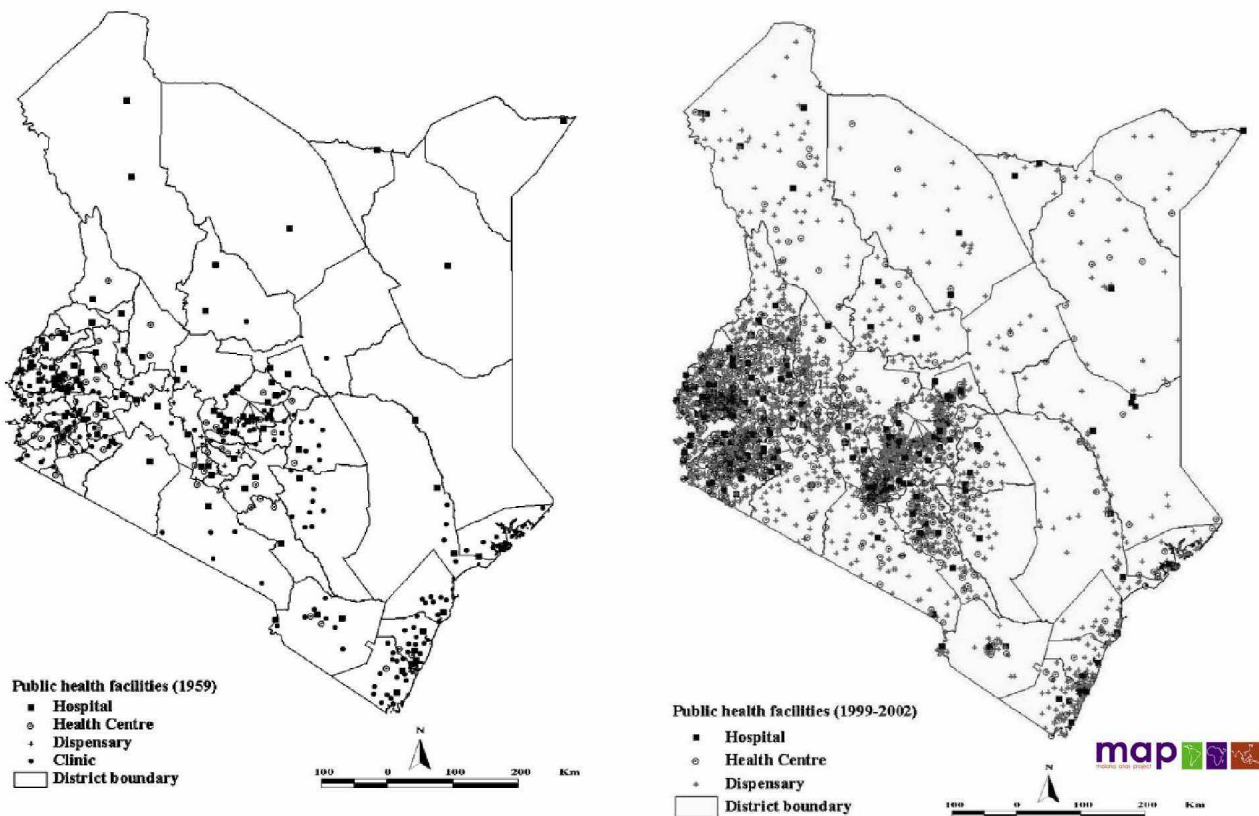


Figure 1: Public health facilities in Kenya (1959 and 2002)
Source: Public health facilities map. Nairobi, map international

¹¹⁸Brugha, R., 'The private sector: friend or foe of the poor?', *Africa Health*, Jan. 1998, pp. 16-18.

Figure 1 does not include private for-profit health care providers. The 1990s and the new millennium have seen a strong rise of these institutions. As an example, figure 2 shows that governmental, Christian and private for-profit providers are strongly competing in Thika District, Kenya. For a long time a few private providers had offered their services to the rich minorities in major towns. They did not compete with Christian service providers as they had completely different target groups. However, the situation has changed dramatically. For example, more and more poor no longer use Christian services as they cannot afford them. As Flessa has shown, church-based health care providers in Tanzania¹¹⁹ frequently have to charge higher fees than government institutions to recover their costs so that the poorest tend to avoid Christian institutions. At the same time, private providers have discovered the poorer strata (most likely not the poorest of the poor, but in particular the “working poor”) as their clients. Since the World Bank has promoted the “Business of Health in Africa”¹²⁰ many private for-profit health care providers that have opened their dispensaries, pharmacies and hospitals even in rural places are directly competing with Christian health care services. The time of monopolies for the majority of Christian institutions is over.

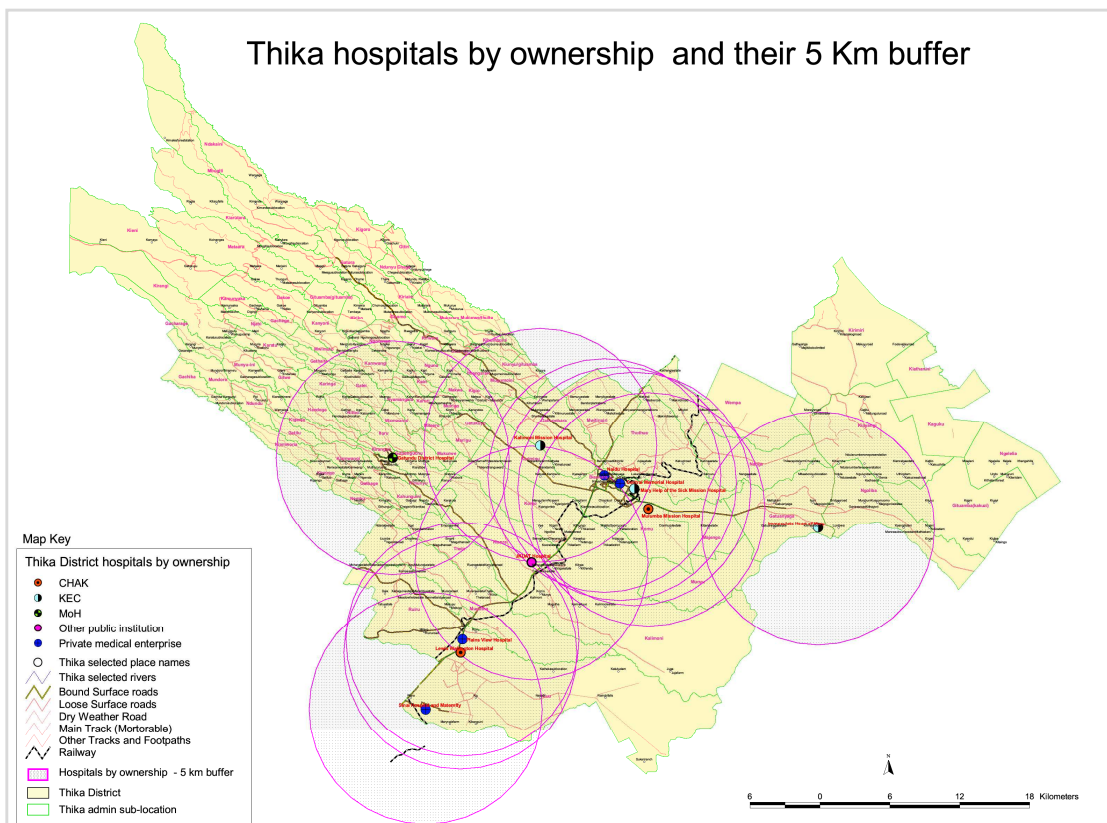


Figure 2: Hospitals in Thika District, Kenya (2008).
Source: Ministry of Health (2008). Mapping Study, Thika District. D. o. Planning. Nairobi, Ministry of Health.

¹¹⁹Flessa, S., *Gesundheitsreformen in Entwicklungsländern. Eine kritische Analyse aus Sicht der kirchlichen Entwicklungshilfe*, Frankfurt a.M., Lembeck, 2002.

¹²⁰The World Bank, *World Development Report: Investing in Health*, The World Bank Group, Washington D.C., 1993; Weltbank, *Weltentwicklungsbericht: Investitionen in die Gesundheit*, Weltbank, Washington D.C., 1993.

The loss of their monopoly challenges the economic foundation of many Christian health care providers. Already in the 1990s several of them were underused¹²¹ as patients moved to the improved governmental providers or to the user-friendly private providers. In many African and Asian countries Christian institutions retained a monopoly of quality for some time as they had access to international drug markets through their international connections. However, in the new millennium, through liberalization and economic growth in several of these countries, governments and private for-profit providers could offer the same quality of services and thus took away the last visible reason of exceptionality of Christian health care providers.

The loss of the monopoly position had not only economic impacts. As its most crucial impact Christian health care providers had to justify their existence. Simple presence does not justify existence anymore as it did 50 years ago. Today the governments, national and local societies as well as the international (donor) community no longer take the existence of these Christian institutions for granted. In a market economy – and most countries have moved in that direction even in the health care system – any market element must have a comparative advantage to survive. It can be cheaper, have a higher quality or provide a rare utility component. Christian health care institutions are no exemption. They are asked to justify their existence by lower fees, better quality or a dimension of services that cannot be offered by other institutions.

Another important change happened in the international policy arena. The “natural” partner of the Christian Medical Commission (CMC) was the World Health Organization (WHO) - both were located in Geneva. Indeed, CMC gained quite some influence on the WHO. However, at the beginning of the 1980s other important players entered the discussion room and gained a much stronger influence on the international agenda than the WHO and CMC. Already a few years after Alma Ata, UNICEF came up with the concept of “selective primary health care” degrading the original concept of “comprehensive primary health care” to a few target groups and diseases. Only a couple of years later a major player entered the arena: the World Bank. The 1993 World Development Report “Investing in Health”¹²² became a milestone in the international health policy. This report did not only call for more cost-effectiveness in health care, but it moved the “philosophical” and value-based discussion towards a technical dimension displayed in the concept of disability adjusted life years (DALYs).¹²³ The DALY reduces human health purely to its physical dimension – miles away from the concept of wholeness of the Tübingen consultations. The World Bank became the prime mover of global health – and neither the WHO nor mission societies nor Christian health care services had a major influence on them. The WHO reacted with accusations – but finally accepted and adopted the World Bank concepts.

¹²¹Flessa, S., 'The costs of hospital services: a case study of Evangelical Lutheran Church hospitals in Tanzania', *Health Policy Plan* 13 (4, 1998), pp. 397-407.

¹²²The World Bank, *ibid.*

¹²³Murray, C. J., 'Quantifying the burden of disease: the technical basis for disability-adjusted life years', *Bull World Health Organ* 72 (3, 1994), p. 429.

Although the World Health Organization came back to the international policy arena in the late 1990s (under its director Gro Harlem Brundland), the Christian community had very little influence on the subsequent developments. Neither the “Joint Commission on Macroeconomics and Health”¹²⁴ nor the development of the “Millennium Development Goals” was systematically influenced by churches or church-related institutions. It is a matter of fact that individual Christians were in the relevant committees, but they did not bring the value-based discussions of Tübingen into these discussions. In particular the MDGs clearly focused on the physical dimension of life without any reference to social or spiritual existence.

As a next step, the concept of “Universal Health Coverage” (UHC) came up. The concept itself is not new but it gained political relevance in the new millennium. The World Health Report 2010 was titled “Health Systems Financing: The Path to Universal Coverage”.¹²⁵ Following this report a number of conferences on UHC were held (e.g. Mexico City: Political Declaration on Universal Health Coverage 2012, Bangkok Statement on Universal Health Coverage 2012, Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector 2012). The UN-resolution “Transition of National Health Care Systems towards Universal Coverage” (2012) accepted UHC as a major target of all health care systems.

The WHO defines UHC as „Ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship”.¹²⁶ Evans, Hsu & Boerma (2013) express it in other words: “Universal health coverage is the obtainment of good health services de facto without fear of financial hardship”.¹²⁷ Consequently, UHC is not a revival of „Health for All by the Year 2000” but a strong concentration on health care provision and social security at the same time.

Figure 3 shows the dimensions of UHC. The concept implies that all members of the society should have a right to receive a comprehensive package of health care services at affordable prices. It is generally accepted that UHC will only be achieved through the establishment of some form of social health insurance. Local and small-scale initiatives such as the community-based health insurances frequently supported by churches will not suffice.

¹²⁴WHO, *Report of the Commission on Macroeconomics and Health*, World Health Organisation, Geneva, 2001.

¹²⁵WHO, *Weltgesundheitsbericht 2008*, Genf, Weltgesundheitsorganisation, Genf, 2010.

¹²⁶WHO, *Universal Health Coverage*, from http://www.who.int/health_financing/en/.

¹²⁷Evans, D. B., J. Hsu and T. Boerma (2013), 'Universal health coverage and universal access', *Bull World Health Organ* 91, p. 546-546A.

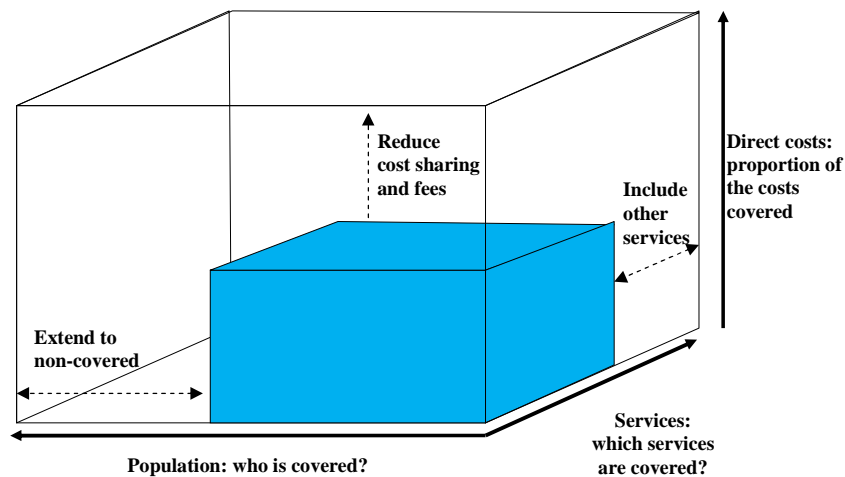


Figure 3: UHC-cube.

Source: WHO, Weltgesundheitsbericht 2008, Weltgesundheitsorganisation, Genf, 2010.

The concept of UHC is about to become explicitly or implicitly a backbone of the post-MDG period. Obviously, Christian health care services have hardly had any influence on this development. This is particularly regrettable as UHC is definitely a short-fall of the holistic concept of health stipulated in Tübingen. UHC could require a stronger focus on health instead of health care – but Christian institutions have lost their influence on health care policy-making.

In addition, in a number of developing countries the consequences of social security as an element of UHC can be observed already. Potential patients are covered by a health insurance system. They become clients and customers, not just beneficiaries of good Christians. And they receive a right to choose between different providers. Even the poor – as the target group of a number of health insurance projects in developing countries – suddenly have the right to decide where they will go for services. Consequently, the future will bring a situation to Sub-Saharan Africa and Asia which is similar to the one that already exists in Europe and Northern America today: Christian health care services are normal market partners. From a pure economical perspective they have lost all exceptionality. They compete with other providers – other churches, government and scores of private for-profit enterprises. And some of them will suffer the same fate as many church-based health care institutions all over the world; after a century of great history they will go bankrupt and have to be closed down. Many of the remaining Christian health care providers cannot be distinguished from their private or governmental competitors.¹²⁸ UHC and social protection lead to free choice of providers – and it is not yet determined whether people will always continue choosing the Christian provider.

¹²⁸Flessa, S., *Arme habt ihr allezeit! Ein Plädoyer für eine armutsorientierte Diakonie*, Göttingen, Vandenhoeck und Ruprecht, 2003.

Consequently, 50 years after the declaration of Tübingen, Christian health care services are called anew to define their purpose, their distinctiveness and their proprium. However, today it is not only a question of defining “a better way to serve the Lord” but it is also a question of life or death – the existence of our institutions must be justified to save their existence.

Unconditional reliability in modern society

A market justifies and supports the existence of a market element if it produces a value for the entire population. Consequently, we have to ask which of the values produced by Christian health care services is unique or at least more likely to be efficiently produced by these providers than by any other. In order to determine the relevant value of Christian health care providers for the society and economy we have to reflect on the characteristics of modern societies.

Modern societies and the lives of individuals are characterized by continuous changes.

Figure 4 shows old system regimes are disturbed by perturbations and become unstable. These perturbations can be internal or external, technical, organizational or societal innovations. If the perturbation is strong enough the system falls into a crisis until it reaches a “point of no return”, the bifurcation point. Here it is obvious that nothing will remain as it was, but it is not clear what the new system regime will look like. Ideally, the system reaches a new steady state at a higher energy level.

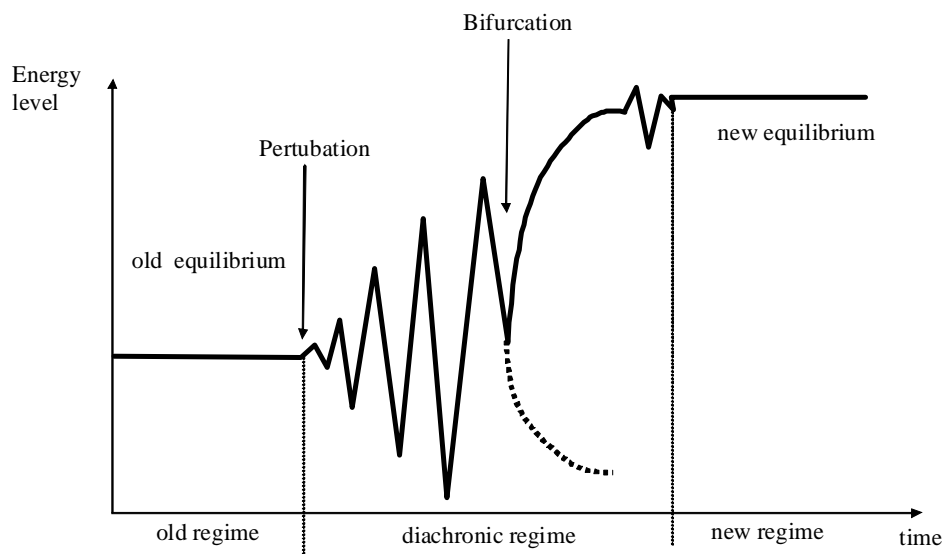


Figure 4: System regimes

Source: Ritter, W., Allgemeine Wirtschaftsgeographie. Eine systemtheoretisch orientierte Einführung. München, Oldenburg, 2001.

The length of the stable steady-state equilibrium between two diachronic regimes determines the stress on society and individuals.

As figure 5 indicates the time can be very long (zone I). In the Middle Ages, for instance, rules, technologies and social strata sometimes remained constant for generations.

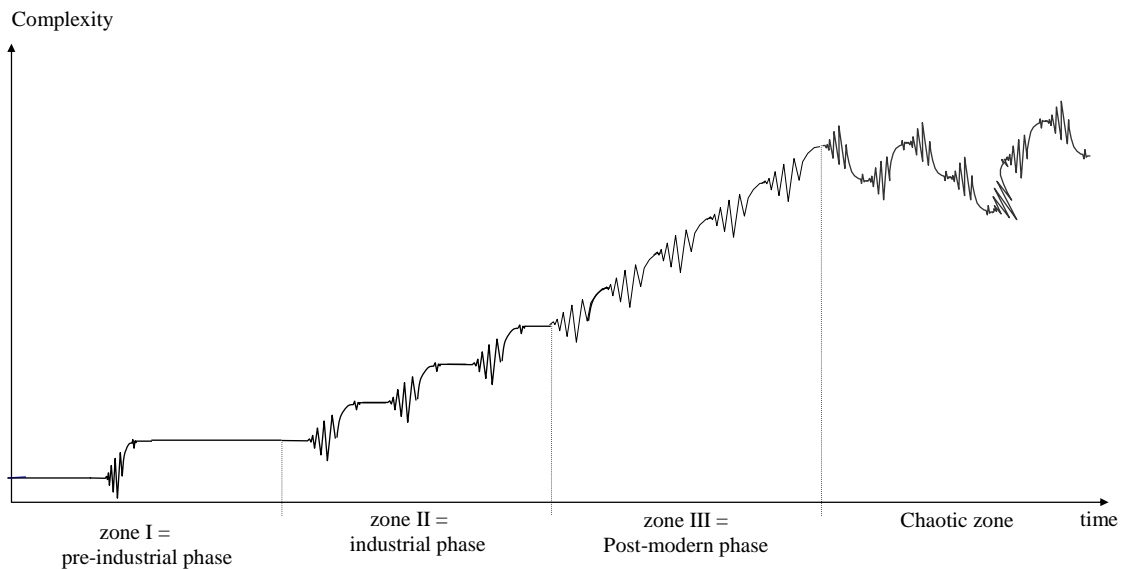


Figure 5: Dynaxity

Source: Flessa, S., *Grundzüge der Krankenhaussteuerung*, München, Oldenburg, 2008.

During the industrial era (zone II) the number of changes and crises strongly increased. However, the synchronic phases remained long enough so that a complete stabilization („freezing“) of organizations, societies and individual lives became possible. Consequently, stable meta-structures such as strong organizations, rules and hierarchies were possible and required. However, if the frequency of changes and crises increases even more the synchronic phases will become so short that no steady state will be possible. As soon as a system comes out of a crisis, the next perturbation is waiting. Thus, no fixed rules are possible, instead ad-hoc-decisions and -structures are required. Decisions have to be made in the micro-structure (on the basis), but need multiple information so that networks become extremely important (zone III). Finally, this might lead to a situation where phases and directions cannot be distinguished (zone IV). New major perturbations appear before a new macro-structure can be established and the system falls into destructive chaos.

In the course of the last fifty years the number of perturbations, changes and crises has steadily increased. Rieckmann analyses these developments and points out that modern societies are characterized by these three features which are summarized in the term “dynaxity”: complexity, dynamics and uncertainty.¹²⁹

¹²⁹ Rieckmann, H., *Führungs-Kraft und Management Development*, München, Zürich, Gerling, 2000;

Complexity means that the number of elements in a system, the number of relevant environmental systems and the number of existing relations between elements in the system and between system and the environment are increasing. In the 1960s, for instance, most markets were local. Providers were mainly “stand-alone” institutions connected primarily with their catchment population and the local government. Modern business units and individuals today, however, have a tremendous number of interdependencies with highly mobile clients, globalized suppliers, civil society, worldwide competitors, customer rights organisations, lawyers, tax consultants, international NGOs etc... Definitely, the complexity has definitely increased.

Dynamics is expressed by the speed of the development of new elements and new relations of a system. A system is dynamic if it does not only develop new relationships with other organizations but if the interval between the creation of new interrelations becomes shorter and shorter. At the same time old foundations deteriorate and there seem to be no more safe harbors on which society and individuals can rely. Regulations, customers, supplier relationships and traditions change as rapidly as knowledge.

The consequence of this is that the predictability of changes in time becomes more difficult, i.e., uncertainty increases. This either means that possible conditions of the environment are completely unknown or that their realization can only be assessed by likelihood. Nothing is certain any more, stochastics is the art of the future and decision-theory is mainly dealing with uncertainty. Enterprises, other organisations, societies and the individuals are left with a high risk of all activities and of life.

Dynaxity zone III as the description of a post-modern society and economy¹³⁰ requires a lot from individuals.¹³¹ They must be able and willing to understand highly complex systems, to accommodate rapid changes and to take risks under extreme uncertainty. As the 21st century puts a high demand on people's personality, the individual and the society will need a resource that gives them the capability of dealing with this complexity, dynamics and uncertainty. What kind of resource could equip them to take the risks of modern life and prevent them from drifting towards destructive chaos in the presence of complexity, dynamics and uncertainty? It is obvious that this is only possible if central areas of human lives are protected by unconditional reliability.¹³² Thus, modern society and economy call for unconditional reliability as a resource of modern life.

This unconditional reliability has different dimensions. The physical dimension requires an unconditional protection of the human body through reliable health care services. Only if people can be sure that their physical needs will be attended to under all conditions of life,

Rieckmann, H., *Management und Führen am Rande des 3. Jahrtausends*, Frankfurt a.M., Lang, 2005.

¹³⁰Koslowski, P., *Wirtschaft als Kultur. Wirtschaftsethik und Wirtschaftskultur in der Postmoderne*, Wien, Passagen Verlag, 1989.

¹³¹Karst, K. and T. Segler, 'Postmoderne - eine Standortbestimmung', *Management jenseits der Postmoderne*, Heidelberg et al., Springer, 1996, pp. 11-25.

¹³²Schweer, M. K. and B. Thies, *Vertrauen als Organisationsprinzip*, Bern, Huber, 2003.

will they be able to take the risks of life. A young man willing to become an entrepreneur must know that there will be a comprehensive basic health care package available for him even if risks materialize and he goes bankrupt with a pile of debts. Consequently, reliable health care services for every member of the society as the core of universal health coverage are not a luxury but a resource of unconditional reliability in a modern world. Christian health care services contribute to this unconditional reliability as the world can be sure they will care regardless of whatever happens.

Unconditional reliability also has a social dimension. Dynaxity zone III is full of networks and relationships – but people have the desire to be more than a business partner in a network. They want to be loved and respected irrespective of their personal success. Nobody can “survive” and invest himself fully into a network economy or society unless he can fully trust that there are some sources of respect of his dignity and love for him as an individual even if he fails in life. Consequently, reliable health care services which respect the dignity of human beings under all conditions are not a luxury but a resource of unconditional reliability. Christian health care services have the unique calling to make this respect and love perceivable for their clients irrespective of their success in life, their ability to pay, or their failure.

Finally, unconditional reliability also has a spiritual dimension. Human beings are essentially seeking for meaning¹³³, also and even especially in phases of sickness and of dying. This means that every human needs time and space to find this meaning of suffering and dying without fear, accompanied by relatives and friends and without terrible pain. People cannot dare to invest their lives into modern economy and face all the risks of Dynaxity zone III unless they can rely on knowing that there will be spiritual support in the crucial situations of life. Christian health care services have the unique chance to provide exactly this support, help the seeker and provide answers that offer reliability beyond this life.

In a nutshell, we can conclude that individuals, the economy and the society have to be assured that they can rely on functional, humanitarian and “warm” health care services. Otherwise they cannot dare full dedication of their lives and work in zone III in a post-modern society. Thus, Christian health care produces a value which is crucial in Dynaxity zone III: unconditional reliability in all dimensions of life. The consequence is trust as the “moral capital”¹³⁴ of human life, economics and societal development. It is the trust in one’s capability, in others, in the social system and in God that is so crucial for our future. Without trust society and economy will collapse.¹³⁵ But the economy cannot produce this trust. Instead, trustworthiness must be experienced in families, friendship, churches and health

¹³³Graf, H., *Mit Sinn und Werten führen: was Viktor E. Frankl Managern zu sagen hat*, Münster u. a. O., LIT Verlag, 2005.

¹³⁴Lachmann, W., *Ausweg aus der Krise: Fragen eines Christen an Marktwirtschaft und Sozialstaat*, Witten, R. Brockhaus, 1984.

¹³⁵Albach, H., 'Vertrauen in der ökonomischen Theorie', *Zeitschrift für die gesamte Staatswissenschaft/Journal of Institutional and Theoretical Economics*, 1980, pp. 2-11.

care services.¹³⁶ An economy and society in Dynaxity zone III induces stress¹³⁷ on the „flexible man“¹³⁸ which he can only cope with if he based on a strong foundation of unconditional reliability. Unless we want to risk a trust crisis in the modern society¹³⁹ we need this firm foundation. Christian health care services can produce this utmost important value: Trust based on unconditional reliability.

However, the production of trust based on unconditional reliability in Christian health care organizations is not by default. In other words: We must make wise decisions on our portfolios and processes in order to guarantee that Christian services can meet this requirement. In the next section, I will analyse the conditions of this function of Christian health care providers for the society.

Portfolio and process management

Obviously, the physical dimension of unconditional reliability does not necessarily have to be provided by Christian services. Government and private for-profit enterprises are capable of performing this function as well. Only if the supply of services provided by these competitors is insufficient, will Christian health care services provide a value that would not exist without them. The social dimension is frequently addressed by professional quality management. Respect for the dignity of human beings is not a unique feature of Christian services.

Consequently, we have to analyse the portfolio of Christian health care services to determine where they should be engaged to have a unique value for the society. Figure 6 displays a decision-chart of the portfolio analysis. In a first step we analyse the competitiveness, i.e., we ask whether Christian health care providers are monopolists or if there is total or partial competition. If no other provider offers the services (such as it was for generations in rural Sub-Saharan Africa), the Christian provider must give a high priority to this service. If there is competition, we have to analyse whether the alternative supply is sufficient in quantity and quality to satisfy the needs of the population. It can be shown¹⁴⁰ that non-profit organizations will have – ceteris paribus – a tendency to produce a higher quantity of services as they try to achieve their output maximum which still re-covers their costs while a for-profit provider would maximize its profit margin. Under the condition of an S-shaped production function this is less than the quantity of a not-profit organizations.

¹³⁶Röpke, W., 'Ethik und Wirtschaftsleben', *Grundtexte zur Sozialen Marktwirtschaft*, W. H. Stützel. Stuttgart, New York, Gustav Fischer, 1981, pp. 49-62.

¹³⁷Habermas, J., *Hat die Demokratie noch eine epistemische Dimension? Empirische Forschung und normative Theorie*, Berlin, Suhrkamp, 2008.

¹³⁸Sennett, R., *Der flexible Mensch. Die Kultur des neuen Kapitalismus*, Berlin, Bt Bloomsbury, 1998.

¹³⁹Siegenthaler, H., *Regelvertrauen, Prosperität und Krisen. Die Ungleichmäßigkeit wirtschaftliche und sozialer Entwicklung als Ergebnis individuellen Handelns und sozialen Lernens*, Tübingen, Mohr, 1993.

¹⁴⁰Flessa, S., 'Betriebswirtschaftslehre der Nonprofit-Organisationen', *Betriebswirtschaftliche Forschung und Praxis* 61 (1, 2009), pp. 1-21.

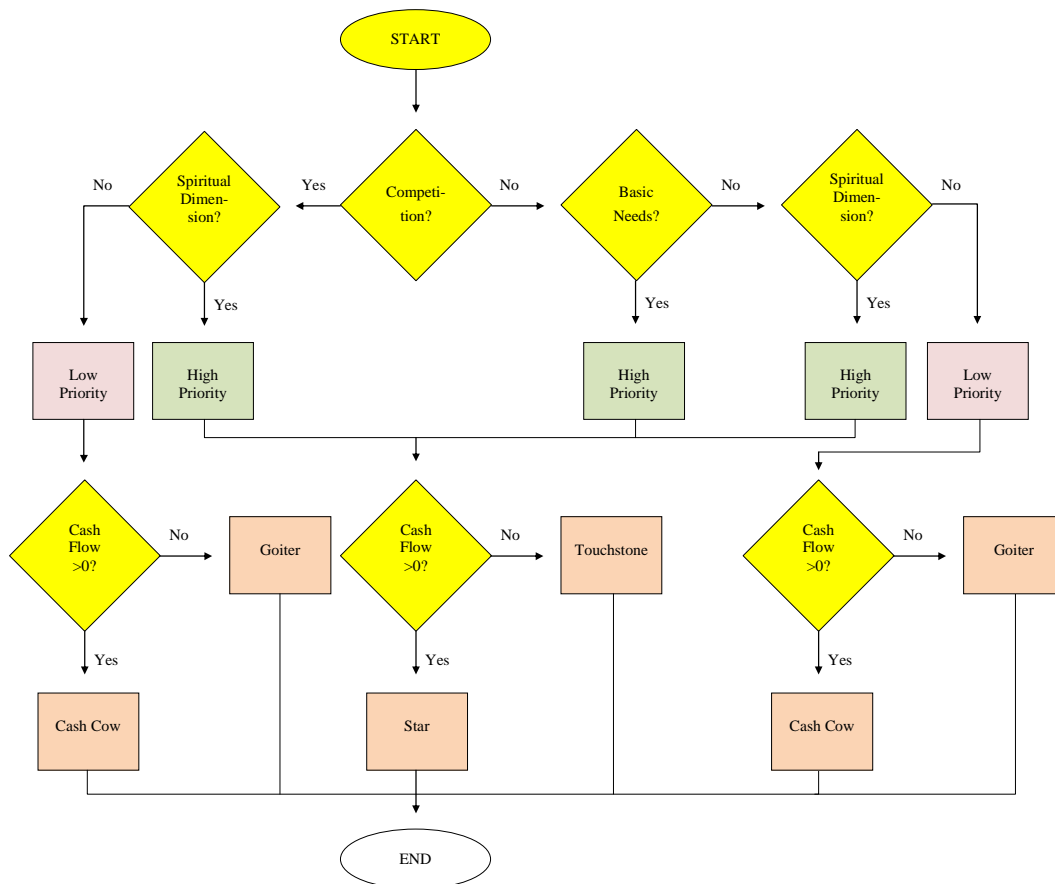


Figure 6: Portfolio Analysis

Source: Flessa, S., Prozess- und Ergebnisprofilierung diakonischer Sozialleistungsunternehmen, Verkündigung und Forschung 59 (1, 2014), pp. 38-50.

On health care markets with structural imperfectness a free market does not necessarily guarantee that the produced quantity is sufficient to satisfy all basic needs including basic health care. Supply provided by government and for-profit organizations can be insufficient so that Christian services should consider supporting the population with additional supplies. Here Christian services are competitors on the market but their existence is crucial.

However, even if the supply is insufficient there might be no need for Christian providers to fill the gap. Instead, we have to make a second step of analysis and appraise whether the needs justify a Christian engagement. For instance, there might be a tremendous demand for jewelry, but this does not call for Christian provision. Only if the physical existence or the dignity of human beings is threatened, will Christians be urged to intervene. In all other cases, we can leave the satisfaction of needs to the free market or just accept that not all needs on this earth have to be satisfied.

Nevertheless, the situation is different if the spiritual dimension is considered as decision-relevant. Generally, all services and commodities have different utility dimensions. If we can separate these dimensions (e.g. physical and spiritual dimension) different providers can provide the services. For instance, a private for-profit hospital can do the operation and the

spiritual care can be taken on by a pastor from an outside Christian institution. However, if the spiritual dimension cannot be separated from the physical, Christian health care providers have a high incentive to fulfill the physical needs of their clients. In this case it makes sense to have a Christian health care provider and not only Christians “visiting” other providers for spiritual care. This requires that the personnel is capable and willing to perform not only technical-functional tasks but also to offer spiritual services (e.g. prayer with the patient) *una persona*.

Based on figure 6 we can distinguish categories of Christian health care services.¹⁴¹ Services that address existential needs and that are not sufficiently provided by the competitors have a high priority. Services where spiritual and physical dimensions cannot be separated also have a high priority even if other competitors suffice to satisfy the physical needs. All services that can be provided by others in the very same way should have a low priority.

At the same time we have to see that Christian health care providers could have elements in their portfolio that have a low priority but produce cash flows to subsidize high-priority fields. These “Cash Cows” are necessary to finance “Touchstones” with high priority but low financing. Services which produce neither a positive cash flow nor have a high priority are as useless as a “Goiter” and should be taken out of the portfolio at once. Services that can be fully re-financed and have a high priority are “Stars”.

Figure 7 shows the respective portfolio matrix.¹⁴² Christian health care providers are asked to analyze their portfolios to realize whether they produce the value of unconditional reliability in each quadrant of the matrix. Without doubt the ideal producer of trust is the touchstone. People realize that Christians are aware of the current (health) problems and provide solutions irrespective of finances. Christians take their own funds – cash flow from cash cows or donations – to offer services regarded as relevant and needed. Almost all Christian health care services were touchstones at the time of their inauguration. And until today many Christian institutions are touchstones, in particular in rural Sub-Saharan African and Asia. Here it is to be decided whether Christian love and solidarity is really more than just a tradition. And here it is to be determined whether the world perceives that it can rely on Christianity.

¹⁴¹Flessa, S., 'Prozess- und Ergebnisprofilierung diakonischer Sozialleistungsunternehmen', *Verkündigung und Forschung* 59 (1, 2014), pp. 38-50.

¹⁴²Flessa, S. and J. Westphal, 'Leistungsprogrammplanung karitativer Non-Profit-Organisationen als Instrument des Ethik-Controlling', *Zeitschrift für Wirtschafts- und Unternehmensethik* 9 (3, 2008), pp. 345-362.

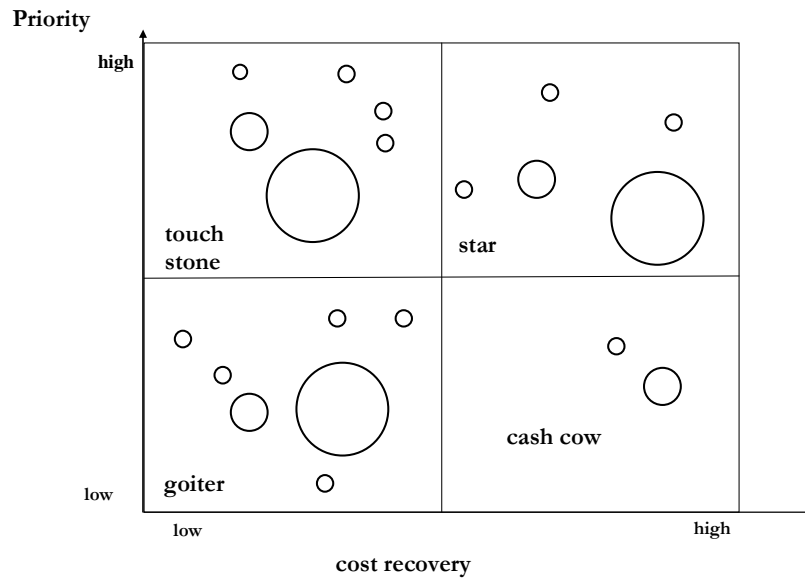


Figure 7 Portfolio Matrix. Source: Schellberg, K., Betriebswirtschaftslehre für Sozialunternehmen, Augsburg, Ziel Verlag, 2004.

The development of social security frequently makes stars (which are of high priority and are fully financed) out of touchstones. However, full financing calls for competition. The Christian provider will lose its monopoly and unless he manages to stress the spiritual component the original touchstone will soon become a cash cow. The amalgamation of physical and spiritual dimension will produce the unconditional reliability for the society. Every human being can be sure that Christian health care services will not treat only his or her body but will also support him or her on his or her journey of finding meaningful answers for the important questions of life. The search for meaning in life, suffering and dying are not only luxuries for the rich and successful minorities but are integrated into Christian health care services at their best.

In the worst case, the cash cow cannot compete with private for-profit providers and run again into the loss-zone. At the end of the cycle a service remains that has neither a Christian priority nor does it produce cash flow for re-financing touchstones.

In other words: Christian health care services must “live above the line” by focusing on services with a high priority, either by providing services in places where nobody else wants to work or by closely linking the spiritual and the physical dimension of health. The latter is definitely an issue of process management. Therefore the future of Christian health care services and their role in producing ultimate reliability as a source of trust for the society and economy will depend on the dedication of the Christian health care staff.

Conclusions

I have shown that the economic conditions of Christian health care services at the time of the declarations of Tübingen were quite different from today. Church-related health care providers were monopolists without competition providing existential services for their catchment population within rather simple systems. Today the situation is already different for the majority of Christian services worldwide. Technical-functional services for the physical dimension of life are provided by many competent competitors. In many locations the pure presence is no longer the rational for their existence.

In Sub-Saharan Africa and in Asia there are still Christian health care providers with limited or no competition. However, this situation will change as soon as these countries are successful in their strife towards Universal Health Coverage and the establishment of social security systems. In particular, as the poorest of the poor are covered by subsidized insurance schemes they become customers with rights of their own, with purchasing power and with a right to choose. All of these expected developments are positive and have to be welcomed – but they challenge the self-perception of Christian health care services. We have to ask anew whether we should be distinguishable from all other providers, what criteria could make us special and how we can find our place in the market of health care. The old search for the “*proprium*” of Christian health care as it was stipulated in the declarations of Tübingen is relevant “now more than ever”. If we do not find contemporary answers to the “quest for health and wholeness”¹⁴³ Christian health care services can neither survive nor produce the unique value of unconditional reliability to which they are called.

Based on this analysis we can conclude that Christian health care services can only be different and fulfill their function of producing unconditional reliability if the spiritual dimension of healing is strengthened. Therefore, we have to ask whether the reality of Christian health care institutions globally reflects the reality of the “congregation as the healing body of Christ” instead of reducing spirituality to an ethics committee – just as it exists in all governmental and private for-profit hospitals.

Finally, the fulfillment of the original function of Christian health care providers requires a spirituality that is interwoven in daily processes within these institutions. This is primarily not a question of quality management but of staff that is personally deeply grounded in the truth of the Gospel and a relationship with the living God. The spiritual dimension of health care requires spiritual co-workers. Their love, dedication, faith and trust determine whether Christian health care providers really make a difference. This also requires spiritual leaders. Their spiritual life, motivation, ability to develop visions and to motivate as well as their trust determine whether co-workers can make Christian health care services distinguishable and whether there is still a need for Christian health care services in future.

¹⁴³ McGilvray, J., *The Quest for Health and Wholeness*, Tübingen, German Institute for Medical Missions, 1981.

Consequently, there is a great need for a new vision of proprium, leadership and spirituality of Christian health care services. The findings from 1964 are guiding principles for the future of Christian health care services so that we can indeed state "50 years of Tübingen – now more than ever"! Christians have a unique contribution to give – grounded in the theology of health and healing as well as in the reality of competitive health care markets.

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The Christian Contribution To Health Today – A Medical Perspective

John Oommen

I grew up hearing the word Tübingen around my childhood home in Vellore in south India. My father, now 93 years old and a pastor of the Church of South India, was then the Chaplain of the Christian Medical College and Hospital (CMCH), Vellore, and was the lone delegate from India in the 2nd Tübingen consultation of September 1967. He came home with a lot of ideas and thoughts. These ideas were then developed over group discussions with medical and chaplaincy colleagues, leading to the evolution of a unique philosophy and thinking at CMCH, Vellore and later at the Christian Medical Association of India (CMAI). When many years later, as a medical student and a young doctor, and then as editor of the journal of the CMAI, I was searching for the rationale behind the healing ministry and the work we do in a mission hospital, I returned to the feet of the guru, to learn the meaning of suffering and pain, the theology of the healing ministry and a logic for my own life. So for me, “Tübingen” means many things, and I feel humbled and inadequate for the task asked of me. I therefore went back to my father two months ago, and spent three days discussing and debating the thoughts I now share, based on his insights from a lifetime in the healing ministry, and my own spiritual and professional journey as a community health physician for over two decades. We are all prisoners of our view-points, and however global we think we are, there is so much more that we cannot see. And so I speak with the humility of partial ignorance.

My brief is to speak on the Christian contribution to health today, from a medical perspective; juxtaposed between the more scholarly theological and economic perspectives. Given my limitations, may I take what in my country would be called anticipatory bail: I am neither a scholar nor a global thinker. I am a medical doctor working in a small hospital in a small place in a relatively unknown part of India. And I apologise in advance for the limitations of my viewing point. But I hope that even if the answers I suggest are not relevant all over the world, at least my questions may be.

What has been the Christian contribution to health and health care ?

The answers to this question are myriad, and I wouldn't dare attempt to be comprehensive in responding. But if I cherry-pick some that stand out to my mind, they would be :

- Pioneering concepts in health and medicine through monasteries and healing centres, through hospitals and discoveries
- Reaching the unreached. This means reaching the geographically unreached regions of the globe, through medical missionaries who served the under-served. It also means taking on the unpopular and unfashionable issues and diseases, like leprosy, tuberculosis and HIV&AIDS, when those afflicted had nobody else to care for them

- Propelling paradigm shifts in global thinking. The best example being the role of Tübingen I and II and the Christian Medical Commission in evolving the idea of Community-Based Health Care, that later changed the direction of health care through the WHO, Alma Ata and Health For All.
- Training competent and caring health care professionals, defining and developing the fields of nursing and allied health sciences, for holistic care
- Being a prophetic voice on ethics in medicine in the increasingly complicated matrix of decision-making in health

There is no doubt that the Christian contribution to health and health care has been significant and critical at different points in history. The proportionate role today varies from country to country and region to region. In many developing countries, it is still significant and critical to the health especially of the poor; it is visible and starkly different from other health care options. In some other settings, the Christian tag in health care is not more than a name with historical relevance. With secularization of the value systems originally associated with the Judeo-Christian faiths, the distinctive nature may no longer be apparent in many western countries. But it is clearly visible in many other settings where this is not the norm.

The context of Tübingen-I and II

Tübingen I was convened because of changes in the global environment that raised pertinent questions on the medical work churches and Christian agencies were doing. It was a time of change. Medical missions were spread out in the developing countries. Most of these countries were declaring independence, moving from colonialism to self-rule. Expatriate missionaries who had manned the mission hospitals were returning home. Young churches with shrinking budgets were “saddled” with expensive hospitals to maintain, and the lack of trained people to run them. Church attendance “back home” in the post-war period was decreasing, and with it the resources and motivation for long-term financial commitments far away. And there were also questions if the mission hospital model was actually making a difference to the health of the poor or the population. And of course, there were those in the Church who wondered why health care was their mandate anyway.

Bishop Leslie Newbegin, formerly Bishop of the Madras Diocese of the Church of South India, was the chairperson of that consultation. In his opening paper, he delineated the questions around which the consultation was called together; questions being asked by different stakeholders in Christian health care.

- Medical professionals were asking, “What is the meaning of my work? Am I just repairing bodies that will break down again? Is there a greater meaning to what we do?”

- The question from the point of view of the patients was, “What is the meaning of my illness? My heart is sick or my leg is sick. But when am I sick? And what then is healing?”
- The question from the Church was, “What is the connection between Jesus’ healing ministry and his command to 'Go – preach, teach and heal' on the one hand, and the medical work we are undertaking on the other.”

Tübingen I and II brought about a new understanding of the healing ministry of the Church. It said healing is not just cure, but restoration to the purpose of God; that healing is best understood in the context of the people, in the congregations and communities ; that the Church is in the healing ministry because that is our reason for existence; every church must be a hospital, every hospital must be a church. These were revolutionary ideas and they led to the formation of the Christian Medical Commission and its path-breaking work on Primary Health Care, forcing the World Health Organization to sit up and take notice, and then work together on a journey that led to Alma Ata and the Health For All declaration.

Changing trends and key events in health and health care globally (1964 – 2014)

In the 50 years since Tübingen I, the context has changed completely once again. And yet some questions are still just as relevant. Re-reading Bishop Newbegin’s paper today, I dare say it could pass off as a contemporary comment on Christian health care in India today.

But there are major changes and events in the history of health and disease, health care and medicine that must inform our discussion today. Some of them are :

- The high points of public health history: Alma Ata and the Millennium Development Goals; the two mountain-tops when we saw whole and not fragmented, and defined destinations rather than vehicles.
- Decreasing child and maternal mortality and increasing life expectancy.
- The success of survival strategies, Primary Health Care and focused interventions.
- The newer challenges in increasing geriatric care.
- Changing disease epidemiology.
- We eradicated small pox, and will hopefully eradicate polio and maybe, measles.
- Age-old diseases like malaria and tuberculosis continue to rage unconquered.
- HIV arrived with a bang and elicited unprecedented responses.
- Newer, emerging and re-emerging diseases like SARS, swine flu, dengue, chikungunya and ebola keep us guessing.

- The rise and rise of non-communicable diseases like diabetes, hypertension, ischemic heart disease and chronic kidney disease threaten the over-burdened health systems of poorer countries and the lives and household budgets of the poor.
- Mental health and illness, suicide and depression remind us of the need to think of the whole person.
- Changing patterns in health care provision:
- Moving from charity/voluntary/service mode to government provision and rights-based approaches; but also rising commercialization of health care provision through private/for-profit/business models, where health care is an industry driven by market forces
- Evidence emerges that out-of-pocket-spending for costs of hospitalisation is one of the leading causes of rural indebtedness and even farmers suicides in countries like India
- A range of models of national health care provision emerge, some ancient, some modern, some just, some unjust, some inclusive, some excluding many.
- Globalisation of disease and health care raises interesting and difficult challenges.
- The increasing role of technology in health care, that sharpens and speeds up diagnosis and makes previously unimagined treatments possible; there is hope for those with conditions previously considered incurable. This also raises the costs of health care, and broadens the health care team needed to run a hospital today. Increasing specialisation fragments patient care, enhancing the de-personalization process.

One could of course go on with an endless description of a constantly changing environment. But I must turn to the specific question I am called to address in this situation.

What is the contribution of Christian health care today?

The answer necessarily varies based on country and region. The change in the proportionate share of Christian health care in the national picture depends on the quality and range of government provision and the level of privatization of health care. In some countries, without Christian hospitals and health care agencies, much of health and health care would collapse; in others, maybe there would be a mild blip and then the world would go on. We do not really know.

In India, we have recently formed a new network of networks – the Christian Coalition for Health, bringing together the Catholic and Protestant health care agencies. Together, we have over 70,000 hospital beds, 2,290 health care institutions including about 10 medical colleges. The government health provision has improved and increased significantly in the last 10 years through innovative initiatives and greatly enhanced financing. The private/for-

profit sector is mushrooming with attractive infrastructure and back-breaking bills. The Christian health care network and other likeminded not-for-profit agencies are the sandwich class – squeezed between two huge sectors. What is our role? Will we survive? Should we? Quo Vadis?

May I suggest that Christian health care in India (and I assume in other countries too) face many operational challenges. These include

- The question of scarce human resources: Caring and competent health care professionals are hard to get and hard to retain in a globalised market
- The question of resources and funding: Financial sustainability through user fees can be achieved, but there is a cost to the vision and mission of the organization. Insurance programmes are presented as a potential alternative, from the micro form to the large, commercial models. The evidence is still evolving.
- The conceptual crisis of vision, of theology, of guiding philosophy.

I suggest there are three critical questions we in Christian health care need to face:

1. What is our role? What are we called to be and to do ?
2. What is our distinctiveness? What is that extra we bring to the table? What is different about Christian health care? What is Christian in a Christian hospital?
3. Why do we exist? Why is the Church in health care? What is our theological basis? How does that fit with what we are doing today?

I suggest that question 3 holds the key to the other two. And so, though I am not a theologian, I would like to share my thoughts on this issue that I see as critical to the future of Christian health care.

We are operating in a theological vacuum. The last time we faced this question honestly and squarely was in 1964 and 1967; and it led to a paradigm shift in Christian and global thinking. The road from Tübingen led to Geneva and Alma Ata. But in the subsequent years after Alma Ata, the global Church abdicated its role in health and health care. Maybe we felt robbed of our issue once the World Health Organisation (WHO) took up Primary Health Care in all earnestness. But they wanted the flame and not the fire; and it gradually burnt out. In the meantime, the global Church seems to have felt the field was becoming very technical and that this was not our role as a church. We obfuscated the objective issues by widening the concept of healing to include everything from ecology to economics to politics to eternity – but excluding medicine and health care, thereby justifying the side-stepping of issues of physical pain, disease, medicine and healing.

And today Christian health care, which is often the acceptable face of Christianity in hostile settings, doesn't know why it exists. For some, it is a purely professional, scientific enterprise

undertaken by some people whose names just happen to be John or Peter or Moses or Elijah; an identity issue. Some others are accused of seeing health care as a fishing net; a ruse to get unsuspecting public into their firing range; a pretext for evangelisation or proselytisation. To some others, it is a business opportunity, baptised with the name of some saint, to give it an aura that sets us apart at the bank counter. For some, it is a justice issue; for others, it is an avenue for believing Christians to practise ethical medicine, which should anyway have been done in all hospitals ideally. In some churches, it is seen as social service, the kind of thing good Christians do, but without a clear biblical basis. So the question remains: What is Christian about a Christian Hospital?

Six years ago, when faced with anti-Christian riots in the part of India where I live and work, we in the Christian Medical Association of our state were forced to re-examine our basis and mission. We prayed and searched and studied and talked, and the understanding that emerged helped us re-define our mission. This could be summarized in the following points:

- The Mission is God's – *Missio Dei*: It is not yours or mine, or of this church or that. Mission is what God is doing in the world. He calls us to listen to His music and to dance to his tune; to discern what He is doing and to join Him as co-workers with God.
- The pattern for mission is from Jesus Himself – the original missionary: Sent by God. He did not consider equality with God something to be held on to, but emptied Himself, became a servant, and was obedient even unto death on a cross. So the pattern for mission is incarnational. We are called to empty ourselves, identify with and become part of God's mission; in humility and brokenness.
- God is a healing God: Jesus communicates for us the nature of God, through His life and His death; expressing the spiritual in the only language we understand – the human form. The word became flesh. Though born in a carpenter family and familiar with agriculture, Jesus chooses the ministry of healing to show us what God is like: our God is a healing God.
- His method of healing is not a one-point, blitz-the-disease, hands-off approach. He is moved with compassion; or He "suffers with". He shares the pain. He heals. He restores to purpose. For Him, as we stated in Tübingen I, healing is restoration to the purpose for which God created us. Healing is a sign ; a proclamation of the Kingdom of God.
- Jesus' method is seen in all its fullness in the cross of Calvary, where God shares the pain of humanity, and it kills Him. God's way of healing is not a remote-controlled, distant way – but one of involvement, of cost, of taking the pain on oneself. And by His stripes, we are healed.

How does this connect with what we do in our daily lives as doctors and nurses in Christian health care ?

I suggest that we Christians are in health care, because that is where God is. Wherever there is pain and brokenness, God is there, sharing that pain, crying with that patient, mourning with the bereaved. We are called to join Him. When we touch their pain, we touch God. That is the foot of the cross.

Mother Teresa told the story of a young sister in her congregation who was nursing a homeless man on the streets of Calcutta, and removing maggots from his body. The man died while she was caring for him. The Mother asked the sister : “What did you feel during this time?” The sister replied : “I felt I was touching the body of Christ”.

Health care for Christians and the Church cannot be just a scientific exercise or social work or a fishing-net or a business venture. It is sacramental. It is holy ground. We must take off our footwear. God is here.

Practical Implications for Christian Health Care

I suggest that in all societies and in all ages, there will always be a role and relevance for Christian Involvement in health care. The specific modalities, issues and channels will necessarily change – but the mission goes on. It may be through institutions or through movements; through congregations and through health professionals. But when the Church withdraws from this engagement with people in pain and objective suffering, the Church loses itself. The Church needs to be in health care for it to remain the Church. Health care needs the Church in it to retain its soul.

Using the present context of India as a reference, I suggest three key roles for Christian Health Care:

1. Standing in the gaps: Identify the pain in society that is un-addressed, the gap areas. These may be geographical gaps or gap issues that nobody else wants to respond to. Share the pain. Let transformation and healing occur, inside us, around us, through us or in spite of us.
2. Creating models : Show how things can be done differently; building perspectives. This includes a commitment to relevant research and running some hospitals. We need to hold together the seemingly disparate objectives of situational excellence and social relevance, remembering that our God is the crucified Christ – a man who comes on a donkey and not on a horse or an elephant.
3. Training and mentoring people: Creating value-based, competent and caring health care professionals. We have something extra to offer in our building of people, that purely professional training does not have. We must train our students to not hang on to their side of the clinic table, but to cross over to the patient side, to share his or her pain, and to face the disease or problem together.

May I end by reminding ourselves of the Christian Medical Commission's definition of health: "Health is a dynamic state of wellbeing of the individual and the society – of physical, mental, spiritual, economic, political and social well being; of being in harmony with each other, with the material environment and with God." – This is Shalom. This is what we dream of and work towards.

And may God the Creator, Sustainer and Healer, give us the courage to shake the ground we stand on, and if needed to fall to the ground and die, so that new life may come.

Being Accountable for the Life of Religious Health Assets

James R. Cochrane

Like all concepts, the idea of *religious health assets* is an invention, intended to describe and order appearances in the world. What appearances are we trying to order and understand? Responding to this question, I want to place it in a longer history of Christian concerns about health in our time, and then talk about our *deep accountability* for the religious health assets that we hold and leverage.

Religious Health Assets

The notion of 'religious health assets' was introduced about a decade ago in forming the international collaboration known as the African (now International) Religious Health Assets Programme,¹⁴⁴ or ARHAP/IRHAP.¹⁴⁵ ARHAP's specific goals were: a) to identify and define religious health assets, b) to explore their claimed 'religious' uniqueness or added value over the 'secular' or non-religious equivalents, and c) to address their alignment (or lack of it) with other private or formal state health facilities and systems. What have we achieved?

Identifying and defining religious health assets

When ARHAP began to speak of 'religious health assets', many rightly asked, "What on earth is a RHA?" An unusual blend of words, it functioned as a heuristic tool – a provocation to learn something. It was meant to push us to think again about what was either invisible to most public health systems and agencies, or visible but not taken seriously enough to count.

The work ARHAP did for the World Health Organization in Lesotho and Zambia from 2005 to 2006 aimed at going beyond anecdotal accounts of religious health assets and their existence. Using a carefully chosen set of integrated GIS (Geographic Information Systems) and participatory tools, it established the existing definition of 'religious health assets,'¹⁴⁶ identifying both tangible and intangible assets of relevance to population scale health that

¹⁴⁴ See www.irhap.uct.ac.za/, accessed 20 June 2014.

¹⁴⁵ ARHAP was co-founded by myself at the University of Cape Town, Gary Gunderson, then Director of the Interfaith Health Program at the Rollins School of Public Health, Emory University, and Deborah McFarland, a public health economist, also at Rollins. See James R. Cochrane, Deborah A. McFarland, and Gary R. Gunderson, "Mapping Religious Resources for Health: The African Religious Health Assets Programme", *Religion as a Social Determinant of Public Health: Interdisciplinary Inquiries*, ed. Ellen L. Idler, New York, Oxford University Press, 2014.

¹⁴⁶ African Religious Health Assets Programme, "Appreciating Assets: The Contribution of Religion to Universal Access in Africa", (ARHAP, Report for the World Health Organization, Cape Town 2006). See also Cochrane, McFarland, and Gunderson, "Mapping Religious Resources for Health: The African Religious Health Assets Programme."

were either directly linked to faith-based or faith-inspired organisations, or were part of the faith and activity of people in communities. It did this theoretically, but also empirically.

ARHAP showed, for example, that intangible assets – like trust, compassion, accompaniment, mentoring or credibility – were as critical to health care as are facilities and other material resources. Also, besides formal facilities (hospitals, clinics, dispensaries), we identified tangible entities with durable presence and significant levels of engagement in health promotion, prevention, treatment and care that were far more widespread than any official acknowledgement, either by state health systems or even religious denominations. Of 434 entities we mapped in the two countries, all of 432 were not present on the WHO's Healthmapper system or any official country map; as one example, in the Chipata area of Zambia, official maps showed two health facilities while we were able to point out another six that were, in effect, invisible to the authorities. In short, not counted, they did not count – a major error, as we were also able to demonstrate.

In principle at least, we now knew better what to look for, and how to look for it. In practice, despite our work and that of others, the picture is less satisfactory. Partly, this is because of a general confusion around terminology that still affects everyone about how to define religious entities (FBO, FIO, FBNP, etc.),¹⁴⁷ or what phenomena are to be included. Equally unsatisfactory has been the laxity of many claims about religious entities engaged in health; they often lack precision, and they are frequently weighted with self-interest.

The uniqueness of 'value-added' of religious health assets

One view on 'religious entities active in caring for health' (REACH) is that they provide unique or qualitatively different care and services than those which are 'not religious' or 'secular'. Even if one can support this claim in local, topical ways, it cannot be generalized. Of course, the papers or publications that have tried to show their value, including ARHAP's first study on the Masangane comprehensive, integrated HIV and AIDS programme in the Eastern Cape of South Africa,¹⁴⁸ are not wrong.¹⁴⁹

¹⁴⁷Jill Olivier, "'An Fb-Oh?': Mapping the Etymology of the Religious Entity Engaged in Health," *When Religion and Health Align: Mobilizing Religious Health Assets for Transformation*, ed. James Cochrane, Barbara Schmid, and Teresa Cutts, Pietermaritzburg, Cluster Publications, 2011.

¹⁴⁸Liz Thomas et al., "'Let Us Embrace': Role and Significance of an Integrated Faith-Based Initiative for Hiv and Aids: Masangane Case Study," (Cape Town: African Religious Health Assets Programme, University of Cape Town, 2006).

¹⁴⁹Most recently, Ellen Idler has suggested that religious institutions, on the positive side, affect health status by providing social support and intimacy with others; by establishing norms and controlling behavior, especially health-related behaviours; and by creating institutional social capital in communities. See Ellen L. Idler, ed., *Religion as a Social Determinant of Public Health: Interdisciplinary Inquiries*, New York, Oxford University Press, 2014. The most important collection assessing the 'evidence' for the contribution of religious health assets is contained in three volumes that have come out of the World Bank: Jill Olivier and Quentin Wodon, eds., *The Role of Faith-Inspired Health Care Providers in Sub-Saharan Africa and Public-Private Partnerships*, vol. 1, *Strengthening the Evidence for Faith-Inspired Health Engagement in Africa* (Washington D.C.: World Bank,

But they are also only partial, for virtually all the same claims for ‘value added’ care or services can be upheld by other studies that concern entities with no religious faith dimension at all. Compassion, sustainability, accompaniment, spiritual care, and many other elements often treated as special to religious entities are, it turns out, characteristics that arise wherever any aware, reflective and morally responsible human beings come together to care for the health of others or for the health of all.

In short, when it comes to health, none of the core values of the Christian faith are necessarily unique, including those most pertinent to the poor or vulnerable. Even a basic import of the incarnation, even if expressed uniquely in the story of Jesus of Nazareth, can be found elsewhere. The critical realization in the doctrine of the incarnation of God in Christ is that we, as human beings, are the heirs of God’s intention for a whole, healed, and flourishing life and world. We *are* God’s responsible stewards of that intention. We are so because we are created free, that is, with the intrinsic and defining capacity to add something to nature and the world that is not there in itself. With that capacity we can build a new world – or destroy the one we live in.

For that reason, our capacity also confronts us with the demand to take responsibility for the world and for life full and abundant in it. This is a realization to which others can and do come to, along different paths, some of which we would not even call ‘religious’.

Aligning religious health assets

The most recent collection of essays produced by ARHAP, from participants in its last international colloquium, focused on the question of aligning religion and health.¹⁵⁰ The alignment (or lack of it) of faith-led or faith-inspired health facilities and programmes with state or other private facilities and programmes is often a critical element in health delivery and population health. Such alignment cannot at all be taken for granted, or is so easy to achieve.

One of the most encouraging examples of a concerted attempt to establish such an alignment in the postcolonial period, beginning with efforts in Malawi and Ghana and then spreading, was the establishment in Africa of the Christian Health Associations that arose with the wave of innovations in global health of that time. What can we say about such alignment in our time and with what we know of religious health assets?

2012); *The Comparative Nature of Faith-Inspired Health Care Provision in Sub-Saharan Africa*, vol. 2, Strengthening the Evidence for Faith-Inspired Health Engagement in Africa (Washington D.C.: World Bank, 2012); *Mapping, Cost, and Reach to the Poor of Faith-Inspired Health Care Providers in Sub-Saharan Africa*, vol. 3, Strengthening the Evidence for Faith-Inspired Health Engagement in Africa (Washington D.C.: World Bank, 2012). See also Katherine Marshall, *Global Institutions of Religion: Ancient Movers, Modern Shakers*, New York, Routledge, 2013.

¹⁵⁰James R. Cochrane, Barbara Schmid, and Teresa Cutts, eds., *When Religion and Health Align: Mobilising Religious Health Assets for Transformation*, Pietermaritzburg, Cluster Publications, 2011.

First, in many respects it is uneven, fragmentary and partial even if one focuses only on formal medical facilities and health services. Increased costs, competition with state and private for-profit facilities and services, poaching of well-trained personnel, political dynamics and other factors have increased the difficulty of achieving optimal alignment.¹⁵¹ But at least one can work more intentionally towards alignment among faith-based or denominational bodies and programmes, and this has yet to be done adequately. The ACT Alliance,¹⁵² though not specifically about health, is an example of one model for pursuing this; and an interesting example in the context of health reform in the USA is Stakeholder Health, previously known as the Health Systems Learning Group.¹⁵³

Second, however, this is still alignment across facilities and formal services. The larger question, one that in fact drove Tübingen I & II, and the Christian Medical Commission (CMC) that flowed from it,¹⁵⁴ is about all the assets that lie beyond and outside of the facility walls and services. Primary health care was meant not just as another addition to existing services. It was meant fundamentally to restructure the way one thought about health care and acted as a consequence. The results I mentioned from ARHAP's work in Lesotho and Zambia make the point starkly – even the hospital and clinics that have a religious base or inspiration are poorly aligned with, or even aware of, the many other faith-inspired health work going on around them. From one point of view, the CMC's vision of primary health care is largely or wholly unmet in this regard. Most often, it has been dumbed down to become a model of community health workers – but by and large, they too are merely extensions of and hierarchically accountable to the formal services and facilities that employ them, and do not represent any deep partnership of practice with others in the community.

An asset-based approach to health helps, and like others,¹⁵⁵ ARHAP drew upon it. ARHAP also incorporated a multiplicity of valuable tools from appreciative inquiry, participatory appraisal, action research and liberative pedagogy. None of this, however, necessarily escapes its instrumentalization. Like the idea of primary health care, the idea of religious health assets is easily co-opted into a fairly functionalist, instrumental approach¹⁵⁶: Let's

¹⁵¹ See, for example, Steffen Fleßa, *Gesundheitsreformen in Entwicklungsländern: Eine Kritische Analyse Aus Sicht Der Kirchlichen Entwicklungshilfe*, Frankfurt am Main, Verlag Otto Lembeck, 2002.

¹⁵² See www.actalliance.org/, accessed 23/6/2014.

¹⁵³ Health Systems Learning Group, "Strategic Investment in Shared Outcomes: Transformative Partnerships between Health Systems and Communities," (Washington D.C.: Health and Human Services and Robert Wood Johnson Foundation Leadership Summit, 2013). See stakeholderhealth.org/wp-content/uploads/2013/09/HSLG-V11.pdf, accessed 23/6/2014.

¹⁵⁴ See James C. McGilvray, *The Quest for Health and Wholeness* (Tübingen: German Institute for Medical Mission, 1981).

¹⁵⁵ See, for example, Jane Foot and Trevor Hopkins, "A Glass Half-Full: How an Asset Approach Can Improve Community Health and Well-Being," in *Health Communities Programme*, London: Improvement and Development Agency (IDeA), UK, 2009; Glasgow Centre for Population Health, "Asset Based Approaches for Health Improvement: Redressing the Balance", in *Concepts Series* (Glasgow2011); Antony Morgan and Erio Ziglio, "Revitalising the Evidence Base for Public Health: An Assets Model", *Promotion & Education (now Global Health Promotion)* 14, no. 17 (2007).

¹⁵⁶ On the reductionist adoption of primary health care, see Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care", *American Journal of Public Health* 94, no. 11 (2004); John J. Hall and

map them, get people talking, make some connections, report some positive indicators, and hope something fundamental has happened.

The work has not been in vain; but it still falls far short of the challenge that others before us had in fact already taken up, and that we felt ourselves to be part of when we began. The question really is why we bother to map, assess or work with religious health assets? What are we really trying to reach for ultimately?

We have to locate any talk of RHAs within a much larger framework of passion and commitment. They have to help us shift the paradigms within which 'normal' work goes on if we are to really deal with the great challenges that still sit before us in working for the health of the people, the health of all. It cannot simply be another instrumental means of tinkering with a system that is in need of new thought and practice. It has to be a way of opening up new possibilities for breakthrough responses to the great challenges.

Revisiting the key questions: An historical legacy

It is highly appropriate then to recall the *Tübingen I and II* meetings held at Difäm in 1964 and 1967, as well as the Christian Medical Commission that played such a key role in what became the mandate for primary health care of the World Health Organization in its Alma Ata Declaration in 1978. This was a time of great vision and passion, taken very seriously and played out on a wide international scale.¹⁵⁷ When one reads the CMC's magazine, *Contact*, one sees how complex, inspiring and profound its vision was. It was a vision that extended well beyond what was achieved with the WHO in the end, and it has yet to be fulfilled. That's the point I now want to take up.

In *Contact*, James McGilvray had already long ago clearly identified several still relevant and mostly unanswered core questions: "About the nature of [faith-inspired initiatives] engagement in health, their role in facilities-based versus primary or preventative care, what it means to be a faith-inspired or Christian provider, whether it is possible to bear the costs of a 'pro-poor' mission, whether FIIs can continue to be sustainable, given new financial contexts and constraints, and queries about the value-added of FIIs."¹⁵⁸ Although unaware of

Richard Taylor, "Health for All Beyond 2000: The Demise of the Alma-Ata Declaration and Primary Health Care in Developing Countries", *Medical Journal of Australia* 178 (2003).

¹⁵⁷Only later did we in ARHAP/IRHAP realise how much we are indirectly indebted to that history. In fact, we are *directly* indebted too. Particular individuals closely related to the history of the CMC directly and personally inspired our work, including the Rev. Tom Droege and Dr. Bill Foege at the Interfaith Health Program in the first instance, and Dr. Rainward Bastian and Dr. Christoph Benn at Difäm later on. In the 1970s in South Africa, the powerful witness about the damages to the health of Black South Africans caused by Apartheid that came from doctors at Charles Johnson Memorial Hospital in Nqutu in KwaZulu made an impression on me too.

¹⁵⁸Cited in Jill Olivier and Quentin Wodon, "Faith-Inspired Health Care in Sub-Saharan Africa: An Introduction to the Spring, 2014 Issue", *The Review of Faith & International Affairs* 12, no. 1 (2014): 2. See also Olivier and Wodon, *The Role of Faith-Inspired Health Care Providers in Sub-Saharan Africa and Public-Private Partnerships*, 2.

McGilvray's list at the time when ARHAP began, it sought to address some of these same questions.

Identifying and working with religious health assets, as useful as this is in shifting a negatively oriented paradigm dominated by notions of needs, liabilities or deficits, is not enough. It cannot carry the full load of a necessary paradigm shift. What else needs to be added? I am going to sum that up by speaking of being deeply accountable for life.

Being Deeply Accountable for Life

The Christian faith is expressed in the body of Christ, the *ecclesia*, the public gathering of believers. As the body of Christ, the *ecclesia* exists not for itself but for the sake of the world. An historical, existential expression of the call to life and the demand to take responsibility for life, it is the place of formation and encouragement that enables one to do so. Leaving aside all accoutrements and encrustments, those who identify themselves with the Christian community and its traditions are thus accountable for a faith that claims to find its life in giving its life away.

Asset-based language helps not only because it points us in the direction of what people or communities have with which they and others can work and upon which one can build. More deeply, it points to capabilities and capacities embodied in human persons that are directly related to health or, more generally, to life – not just a life of surviving, but a flourishing life, not just individually, but in relation to others and to the earth itself.

This is what we are ultimately accountable for. This was already clear in the issue that shaped the purpose of the second meeting in Tübingen in 1967: the question of the intrinsic and intimate link between health and salvation or redemption. The secular version of an answer to that question came in the WHO's language arising from that consultation and the work of the CMC: health by the people,¹⁵⁹ health for all.¹⁶⁰ A theological perspective rests on the root meaning of the Latin word *salus*, the 'health and welfare of the people', from which, of course, we have the term salvation, and the equivalent Greek word *soteria*, from which we take the term soteriology. But it places it within the whole of life and the unity of life. To take responsibility for that is the call to deep accountability; it locates any particular responsibilities – for a health facility or a particular programme, for example, or for a specific task or role within such institutions or activities – within that wholeness and unity. It is, in the deepest sense, a moral responsibility and not just a technical, managerial or institutional responsibility. It is the responsibility for the fullness of life.

How shall we think of this now? While huge strides have been made in the last century to understand and combat the various pathologies that threaten human health and life, we

¹⁵⁹World Health Organization, *Health by the People*, Geneva, World Health Organization, 1975.

¹⁶⁰Halfdan Mahler, "The Meaning of 'Health for All by the Year 2000'", *World Health Forum* 2, no. 1 (1981).

have hardly begun to understand and encourage the processes that enable, sustain and enhance that life and its quality in the first place. Taking a cue from public health discourse and reversing its language, just as we did with a focus on assets prior to needs or deficits, we have begun to speak of 'the leading causes of life'.¹⁶¹ Within this framework, we theorize five 'leading', interrelated causes of life that provide a concise yet robust enough language to grasp the appearances of life, order them meaningfully and act accordingly. They are: coherence, connection, agency, hope and intergenerational blessing.

One can work powerfully with these 'causes of life' in several ways, including at least the following: 1) as a prognostic means of assessing where life is breaking forth that needs to be acknowledged and supported; 2) as a diagnostic lens on where connection, coherence, agency, hope and blessing are damaged or broken; 3) as a strategic intervention where working on one cause of life impacts upon and strengthens another; 4) as a research programme to better understand that which is generative of life and how to work with it; and 5) as an organizational approach that seeks to enhance the life of institutions and of those who live and work within them.

I cannot do justice here to the fullness of this thinking given the time we have together. For that reason, I have asked that everyone receive a two-page Briefing Note that explains a little more of this approach. Some copies are also available of a background paper to that Briefing, originally given as a keynote address to an international symposium meeting in Bayreuth, Germany, on priorities in medicine in the 21st Century. And lastly, I would like to refer you to an online publication, free to download, published in accessible but not dumbed down language and richly illustrated, easily used in groups of any size or and at any level, called the 'Barefoot Guide to Mobilizing Religious Health Assets for Transformation'.¹⁶²

Perhaps it is fitting to end with a quotation from physician and theological thinker Robert (Bob) Lambourne, a key figure in the Tübingen meetings of 1963 and 1967 and in the Christian Medical Commission that grew out of them. Already then passionate about shifting the emphasis from curative medicine and health services to healthy communities, which must include a link to justice and to right relationships among people within societies, he was clear about what deep accountability means in the Christian proclamation of life, of life abundant and of life for all: "... it is not a matter of taking the Gospel to heal the world, but being graced with the Gospel and gracing the world with the Gospel in the act of healing the world."¹⁶³

The task has not changed. It is about doing the right thing because it is right and not for any ecclesial or theological self-interest, and about doing it for the sake of the world, God

¹⁶¹Gary R. Gunderson and James R. Cochrane, *Religion and the Health of the Public: Shifting the Paradigm*, New York, Palgrave MacMillan, 2012; Gary R. Gunderson and Larry Pray, *Leading Causes of Life*, Memphis, TN: The Center of Excellence in Faith and Health, Methodist Le Bonheur Healthcare, 2006. See also: www.leading-causes.com, accessed 8 June 2014.

¹⁶² See www.barefootguide.org/barefoot-guide-3.html, accessed 25/6/2014.

¹⁶³Peter Bellamy, "The Significance of Bob Lambourne's Writing Today", *Contact* 81 (1985): 13.

incarnate. Deep accountability for the health of all, including the health of the world that sustains us, is the legacy of Tübingen I and II and of the Christian Medical Commission. It is a legacy that lies not in the past, but ahead of us, for it remains to be fulfilled. We have vastly more knowledge and considerably more resources than were available then to take up that task now. The will to do so is the key.

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Christian Responses to Health and Development: A Discussion Paper on Significance, Practice and Future of Christian Health Services

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On the occasion of the 50th anniversary of a consultation held at the German Institute for Medical Mission (DIFAEM) in Tübingen, DIFAEM hosts the international symposium on "Christian Responses to Health and Healing" on June 27th to 28th, 2014.

The aims of this symposium and of this paper are to:

- Reflect on the added value of Christian health services.
- Reaffirm the call to compassion and justice as part of the Christian healing ministry and the call for churches, church organizations and Christians worldwide to fulfill their responsibility to health and development.
- Create a new vision for the opportunities Christian health services provide in the new millennium.

The participants come from Africa, Asia, the USA, and Europe. They include health professionals and representatives of churches, mission societies, church-based and secular organisations, academics in medicine, public health, health economics and theology with an interest in global health.

The Christian healing ministry and the development of medical mission – a brief history

Healing the sick was central in Jesus' ministry and Jesus commissioned his followers to preach and to heal (Matt. 10,7f; Luke 9,2; cf. Mk 16,5-20). The early Church took Jesus' healing ministry very seriously and experiences of healing were prominent among Christian communities. Later, the churches interpreted their healing ministry more in the sense of caring for the sick and needy according to the example of the Good Samaritan (Luke 10:25-37) and the works of mercy (Matthew 25:31-46).

While ancient societies often marginalised and neglected sick and weak people, Christians turned to them and took care of them. Since the first centuries of Christianity, Christians have founded hospices (literally "inns" or "guesthouses") for the sick and dying as well as hospitals where the poor and underprivileged have been attended with compassion.

Therefore, from very early days of the Christian church, compassionate and healing ministries were a sign of God's Kingdom in this world.

In the Middle Ages monasteries started to run hospitals. These Christian health institutions focused on care and compassion, as well as healing, and care for the disabled and the dying.

The onset of scientific medicine in the Middle Ages and after the Reformation brought about the secularisation of church hospitals. Medicine became more and more independent from the churches. This was even more significant after the Age of Enlightenment when medicine and theology were regarded as separate entities.

With the beginning of the Mission Movement in the 18th century healing ministries were integral parts of missionary services. In the 19th and early 20th century mission societies founded Christian hospitals and other health facilities in the countries where they were operating. It was the time of the pioneers who even during the times of the World Wars and the Great Depression served in far to reach places. Names such as Dr. Albert Schweitzer in Gabun, Dr. Ida Scudder in India and many others stand for this time of pioneer medical missionary service.

In the middle of the 20th century, however, the engagement of the churches in providing medical services was fundamentally put into question, mainly for two reasons. Firstly, in some of the newly independent nations the governments were ready to take over church health services, and, secondly, the question was raised of whether church health services that were mainly facility based and curative really benefitted the poor and tackled the root causes of diseases in resource limited settings.¹⁶⁴

The Tübingen consultations and the work of the Christian Medical Commission: A Christian understanding of health and healing

In a time when churches and mission societies were insecure about the reason for and practice of Christian health services, two consultations in Tübingen in 1964 ("Tübingen I") and in 1967 ("Tübingen II") deepened the understanding of the churches' engagement in health.

The Tübingen consultation in 1964 reaffirmed the Christian healing ministry by stating that

¹⁶⁴A comprehensive history of medical mission is compiled in: Grundmann, C.H.: *Sent to heal! - Emergence and Development of Medical Missions*, 2nd, revised and slightly expanded edition, Missiological Classic Series 12, Centre for Contemporary Christianity (cfcc), Bangalore, India, 2014; cf. also Beal-Preston, R.: 'The Christian Contribution to Medicine', in *Triple Helix* 9, pp 9-14 (publication of the Christian Medical Fellowship, CMF), online: <http://admin.cmf.org.uk/pdf/helix/spr00/11history.pdf>

“The Christian Church has a specific task in the field of healing ... There are insights concerning the nature of health which are available only in the context of Christian faith. The Church cannot surrender its responsibility in the field of healing to other agencies.”¹⁶⁵

In particular, the consultation emphasised the role of the Christian community in healthcare:

“The Christian healing ministry belongs primarily to the congregation as a whole, and only in that context to those who are specially trained.”¹⁶⁶

Following this conference, the World Council of Churches (WCC) realised that the questions regarding the healing mission of the church in general and medical mission in particular needed more attention. This resulted in the formation of the WCC’s Christian Medical Commission (CMC) as its health desk in 1968. The CMC was mandated to develop a Christian understanding of health and healing, and to search for new ways of practicing the healing ministry.

In the 1970s and 1980s, the CMC called for a worldwide study process on the Christian understanding of health, healing and wholeness and the role of the healing community. The main insights were summarised in the statement:

“Health is not primarily medical ... The churches are called to recognize that the causes of disease in the world are social, economic and spiritual, as well as bio-medical. Health is most often an issue of justice, of peace, of integrity of creation, and of spirituality.”¹⁶⁷

As a kind of summary of these worldwide findings the CMC offered a definition of health which was adopted by the WCC in 1990, which says:

“Health is a dynamic state of wellbeing of the individual and the society; of the physical, mental, spiritual, economic, political and social wellbeing; of being in harmony with each other, with the material environment and with God.”¹⁶⁸

This definition builds on the well-known definition of health given by the World Health Organization (WHO)¹⁶⁹, but it introduces some new elements.

In particular, the CMC definition states that,

¹⁶⁵ World Council of Churches: *The Healing Church* (World Council Studies No.3), Geneva 1965, 34f.

¹⁶⁶ *Ibid.*

¹⁶⁷ World Council of Churches: *Healing and wholeness. The churches’ role in health*, The report of a study by the Christian Medical Commission of the World Council of Churches, Geneva 1990, p. 1.

¹⁶⁸ *Ibid* p 6.

¹⁶⁹ "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Source: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

- Health concerns not only individuals but also the local community and the society as a whole.
- Health is a dynamic state – nobody is completely healthy or sick at any time.
- The political and economic situation affects health of societies and of individuals.
- Spirituality has an important impact on health.
- Health is seen as a relational issue, and, therefore, each individual and each community can contribute to health and wellbeing of others and thus to the transformation of the world.

The CMC definition of health provides a concept of wholeness that reflects the biblical vision of shalom, which characterises the Kingdom of God. Shalom comprises not only peace in the sense of the absence of war but also means a state of justice and equity, of wholeness at individual and social level. Shalom relates to individuals and communities and includes harmonious relationships between God and humans (Ps 85,8), between individuals (Gen 34,21), with and among creation (Ps 72, Jes 35), and includes also a harmonious state of one's soul and mind externally and internally (Ps 4,8).

Health, in the sense of wholeness, is a condition related to God's promise for the end of time. However, as Christians, we believe that with the coming of Christ God's Kingdom on earth has begun, and is visible now. Whenever and wherever dimensions of good health become a reality, we may discern signs of God's Kingdom on earth.

Reaffirming the finding of the CMC that health is not primarily medical, this definition of health clearly shows that churches, congregations and Christians can contribute to health in an essential way.

Such a multidimensional and dynamic understanding of health and healing resulted from worldwide discussions that had taken place in the decades before 1990. In retrospect, this view of health had prophetic character as its core elements have been affirmed by scientific research in the years to follow. In particular, a huge number of studies have demonstrated the positive effect of spiritual and social factors to health of individuals and communities.¹⁷⁰

Developments in global health following the Tübingen consultations

In the 1970s there was a fruitful exchange of thoughts and ideas among CMC and WHO staff members in Geneva. Members of the CMC shared the insights of the ecumenical discussions on health and healing and the contribution of congregations/communities to health and thus contributed to the development of the Primary Health Care (PHC) approach promoted by

¹⁷⁰Cf. for example H. G. Koenig, H.G., D. E. King, D.E., V. B. Carson, D.E.: *Handbook of Religion and Health*, New York, 2nd edition, 2012.

the World Health Organization in Alma Ata in 1978. The concept of PHC was based on equity, social justice, universal access and solidarity and called for a people-centred and intersectorial comprehensive approach to health. The PHC approach to health was expected to pave the way towards reaching the ambitious goal of "Health for All by the Year 2000".

Albeit many were enthusiastic about the PHC approach, it has never been implemented on a large scale. The structural adjustment programme of the World Bank in the 1980s and 1990s led to a significant reduction of resources in the health sector. This led to an introduction of user fees in many church-related facilities and built a barrier to the poor and marginalised accessing care.

Alongside these developments, selective PHC was introduced as an "interim strategy".¹⁷¹ Programmes such as the Safe Motherhood Programme of WHO in the 1980s, the ORS (Oral Rehydration Solution) campaigns or the EPI (Expanded Programme on Immunisation) initiatives yielded great results but took the decisions out of the hands of communities.

The spread of HIV and the onset of the AIDS crisis since the early 1980s hit the health systems in many countries and revealed their weakness in an unprecedented way. Gains in health development over many years were reversed with a significant drop in life expectancy especially in sub-Saharan Africa.

Instead of reaching the goal of "Health for All", at the beginning of the 3rd millennium, the gap in health even had widened – between North and South and within countries between urban and rural societies. Growing populations and an increasing divide between poor and rich had led to a large number of people left behind with little access to health care even in areas where churches have medical work because they cannot afford the treatment costs.

With the beginning of the 3rd millennium the pressure mounted on the international community, governments and donors, to address the great need for treatment for millions of people affected by HIV and AIDS. The important step was the UNGASS¹⁷² meeting 2001 in New York that started to focus on poverty and made HIV and health an important part of the Millennium Development Goals (MDGs). In addition, the UN created new opportunities for funding through new entities such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria. This opened up new opportunities and made it possible that not only HIV could be addressed but also other priorities such as maternal health, child health, malaria and many other infectious diseases.

¹⁷¹Cf. Walsh, J.A., Warren, K.S.: 'Selective primary health care: an interim strategy for disease control in developing countries', in: *New England Journal of Medicine* 1979 Nov 1;301(18),967-74

¹⁷² UNGASS: UN General Assembly Special Session.

Christian health services today: What makes them specific?**4.1 Health service provision**

The Christian ministry of compassion and healing has an important contribution to make to health service delivery at all levels. Curative services at facility or community level, preventive and palliative services, home-based care, training of health professionals, and advocacy for improvement of health and justice in health are core Christian contributions.

Over the last 15 years, there have been efforts towards documenting the contribution of Christian health services. A lot has been done by organisations like Christian Connections for International Health (CCIH)¹⁷³, Christian Medical Fellowship (CMF)¹⁷⁴, the Joint Learning Initiative on Faith and Local Communities (JLIFLC)¹⁷⁵, the International/African Religious Health Assets Programme (IRHAP)¹⁷⁶, and the Ecumenical Advocacy Alliance¹⁷⁷ (EAA)

Publications and presentations often refer to the quantitative contribution of Christian health services to healthcare in particular countries, e.g. by stating that churches provide between 20% and 70% of the health services in sub-Saharan African countries, especially in rural and isolated areas where government health services often enough do not reach. It is very important to draw attention to the huge share of Christian health services in the health systems of many countries though we know that these figures are estimates and the data behind them often difficult to trace. According to recent publications, estimates based on household surveys usually come up with lower shares of church-related health services.¹⁷⁸

These observations show that there is a need for strong, evidence-based data on the contribution of church health services to the provision of health in African countries.¹⁷⁹ Often, Christian health services are fully occupied with their day-to-day business so that they neither have the time nor the capacity for providing proper documentation of their work.

In addition to data referring to the market share of church health services we will also need research on the performance, the added value of services offered by church facilities (see next paragraph), their availability to those people most in need, and also about health seeking behaviour of patients and the reasons for lack of access of care. So far, systems of

¹⁷³ www.ccih.org

¹⁷⁴ www.cmf.org.uk/

¹⁷⁵ www.jliflc.com/

¹⁷⁶ www.irhap.uct.ac.za/

¹⁷⁷ www.e-alliance.ch/en/m/about-us/

¹⁷⁸ Cf. Kagawa, R.C., Anglemeyer, A., Montagu, D.: 'The Scale of Faith Based Organizing Participation in Health Service Delivery in Developing Countries: Systemic Review and Meta-Anlysis', *PLOS ONE Vol 7*, Issue 11 (November 2012); Olivier, J., Wodon, Q.: 'Market Share of Faith-inspired Health Care Providers in Africa: Comparing Facilities and Multi-purpose Integrated Household Survey Data', *MPRA Paper No. 45365*, <http://mpra.ub.uni-muenchen.de/45365/> <http://mpra.ub.uni-muenchen.de/45365/>

¹⁷⁹ There is a special edition of the *Lancet* coming out in September 2014, and one of the papers seeks a meta-analysis of existing research on impact of faith based health interventions.

monitoring and evaluation of church health services are often not there or of minor quality due to lack capacity.¹⁸⁰

4.2 Beyond numbers: The added value of the Christian involvement in health

The assumption of a value added of Christian healthcare refers (a) to the Christian ethos of justice and solidarity, (b) to the particular significance of religion and churches to human beings, and (c) to the so-called intangible religious health assets found with church communities and faith based organisations.

- a. Christians are dedicated to justice and solidarity. To take sides for the poor and most vulnerable, to advocate for their rights, to live in solidarity with them, and to take care of them is at the core of the Christian ethos. Therefore, churches and faith-based organisations commit themselves to promote access to health for all people as a basic human right. Church leaders are the prophetic and critical voice to governments to advocate for the needs of marginalised, economically poor and underprivileged people.
- b. Churches and church leaders most often enjoy confidence of people. Churches offer a wide and sustainable network plus human capacities for integrating health issues in the lives of congregations. They have the potential of mobilising people to take social action. Sunday services, prayer meetings, cell groups and other church structures offer opportunities of conveying health messages. Lives of individuals and communities can be transformed through changing unhealthy lifestyles.
- c. Church communities have the resource of committed people to be engaged in community-based health services. Moreover, in areas of conflict and in times of political or humanitarian crises, often only churches keep up a sustainable infrastructure that can offer basic health services. They provide safe and sacred spaces in times of turmoil and afterwards for reconciliation and healing of memories.¹⁸¹

So far, the contribution of Christian health services mostly has been estimated in only quantitative terms (see above). But there are also intangible health assets that cannot be assessed as easily as tangible health assets. Intangible health assets can be social (relationships, sense of belonging, motivation/engagement of people) and spiritual

¹⁸⁰ cf. Olivier, J., Wodon, Q.: 'Research on African church health services: Where do we stand 30 years on?', in: *Contact*. A publication of the World Council of Churches, No. 193 (September 2011) 10-12; Dimmock, F., Olivier, J., Wodon, Q., 'Half a Century Young: The Christian Health Associations in Africa', *MPRA Paper* No. 45369, online available: <http://mpra.ub.uni-muenchen.de/45369/>; To the provision of HIV&AIDS related health care in Kenya see: Blevins, J.; Griswold, E.: *Essential Partners. The Scope of the Contributions of Faith-Based Health Systems to HIV Prevention, Treatment, and Support in Kenya*, Emory University, Atlanta, August 2014, online available: <http://ihpemory.org/2014/07/02/essential-partners-2/>

¹⁸¹ cf. Widmer, M.; Betran, A., Merialdi, M., Requejo, J, Karpf, T.: 'The role of faith-based organisations in maternal and newborn healthcare in Africa', in: *International Journal of Gynecology and obstetrics* 114 (2011) 218-222; Wilkinson, B.: 'Faith Works for Millennium Development Goals (MDGs) 4,5, and 6', in: *GHDN News Summer 2013*, 76-78, online: www.cmmb.org/sites/default/files/pdfs/GHD%20Article.pdf

(compassion, prayer, hope, trust, meaning). Intangible health assets make a difference in health institutions and in communities. Compassionate care has significant influence on healing processes. Therefore, it is important "how" patients in hospital are attended to. In communities, caring relationships can promote healing.¹⁸² It is mainly due to these intangible factors that church-related health work yields high percentages of adherence and can have a considerable influence on health seeking behaviors of people. This concept of intangible health asset is in line with the CMC definition of health as it offers a multidimensional understanding of health including the social and spiritual dimension of health as part of its broad view of health and healing accordingly.

4.3. A holistic approach to health

The expanded approach to health promoted by the WHO since 1948 has been confirmed by medical and social sciences over the years. Public health as well as individual health call for intersectorial approaches and include participation of people and of communities. In terms of individual health, we all know that a person is part of systems like society, family, neighborhood, and environment affecting health positively or negatively. This is of special importance with regard to the current shift from acute to chronic and from communicable to non-communicable diseases.

However, the Christian Medical Commission's introduction of the spiritual dimension of health and healing still lacks general consent – despite considerable scientific evidence that spirituality and faith can have a positive impact on health. With regard to health, there is a persistent divide between the sacred and the secular; health and healing still seem to be secular issues. Accordingly, up to today the spiritual dimension of health has not been included in the WHO definition of health.

Based on the work and the findings of the CMC, Christians advocate the recognition of the spiritual dimension of health and affirm the following specifics of health, healing and of suffering to be taken into account:

- Health in the Christian understanding is linked to salvation. The relation to God is constitutive for humans and for their health. In this understanding, a person whose disease is not cured physically still can be healed and restored to community. Accordingly, a person who is cured physically can still be alienated from the community and so not be really healed/healthy. In some of the healing miracles there is also the aspect of restoration to communion with God through the forgiveness of sin(e.g. Luke 5: 17-26) – healing here means restoration of one's relation to God.

¹⁸² The concept of Religious Health Assets was developed by the International Religious Health Assets Programme (IRHAP, formerly the African Religious Health Assets Programme, ARHAP), based at the University of Cape Town, South Africa: www.arhap.uct.ac.za

- A Christian understanding of health is not compatible with an often expressed search for wellness or even an idolatry of physical and mental health and a consequent tabooing of suffering, ageing and death. These phenomena are prevalent in many affluent societies. The Christian understanding of health gives room for the chronically ill and disabled. It bestows dignity and worth to the weak and the suffering.
- Suffering and states of terminal illnesses are not regarded as conditions of deficit only nor as a consequence of personal failure. Suffering is not a state of God's absence but a condition where the suffering Christ is present and sympathetic. Therefore, suffering and death can offer a deep meaning to patients and their relatives. Also, the "why me" question is central and should not be put down, but has to be explored for each person and each period of time. Such dimensions of health and of suffering have been newly discovered through experiences During the height of the HIV and Aids epidemic when many individuals, families and communities were and still are faced with suffering, death and increased poverty.

Based on this understanding of health, Christian health services are not disease- focused but person-centered. People searching for health and healing are longing for more than just the bio-medical approach. They seek compassionate care. Moreover, many patients are very open to address existential questions like meaning of life, of suffering and death in times of severe or "non-curable" diseases. Christian communities can contribute to such a holistic approach to health by offering accompaniment, prayer and through healing rituals.

4.4. Christian health networks

Developments in health and healing have usually emerged at the local level, and there remains today only minimal strategic and operational oversight of health services by denominational or ecumenical structures. Though the missionary movements of the nineteenth and twentieth centuries spawned an extensive distribution of medical institutions, these largely remain locally owned and managed. As such they depend on multiple links across many networks to support their work.

As mission agencies and Christian development agencies have withdrawn from direct support for hospitals, they have instead focused on disease specific programmes in line with global health priorities. These have created a wide spread of new community based programmes with their local forms of governance and operation, yet still dependent on external financing. In addition, these agencies have recognised the value of joining global advocacy initiatives, and expended more of their resources in influencing the investment of public funds in health development.

It is not possible to describe a pattern of organisation amongst Christian health services, except perhaps for the Roman Catholic Church, the Adventist Church and the Salvation Army. The remaining pattern might be best characterised as 'unorganised'. This does not

imply an ineffective service at local level, but it does leave Christian health services without adequate processes of strategic and operational support at national and international levels.

Given the sheer scale of global Christianity and the diverse flows of energies within and between churches and agencies, it would be unrealistic to envisage a process of effective global coordination. So far, a considerable number of global, regional and professional networks have emerged to fill the vacuum. If the larger questions of financing and reforming medical mission remain critical, then it may be important for networking to expand, and for the resulting process of information gathering and analysis/reflection to be pooled as widely as possible.

In the following, only a few of the very many Christian health networks will be mentioned.

Global Networks

The **Ecumenical Advocacy Alliance (EAA)**¹⁸³ is a network of churches and faith-based organisations committed to justice through campaigns – currently for HIV&AIDS and food. Through the synergy of its members EAA lobbies to governments and international organisations and thus forms a strong voice for more justice. The Inter-Faith Preconference that they organise at the World AIDS Conference has been a key bridge builder between secular and faith based health responses.

The **Ecumenical Pharmaceutical Network (EPN)**¹⁸⁴ is based in Nairobi, Kenya. EPN is dedicated to the provision of quality pharmaceutical services mainly in Africa but also in other continents. In 2006, the WHO in cooperation with EPN published a multi-country study on the work of 16 EPN members' drug supply organisations (DSOs) and their contribution to the total medicines supply systems in particular countries. The report says that, "Among the major findings was that the proportion of the population served by 15 faith-based DSOs in 10 countries ranged from 25-60%, with an average of 43%."¹⁸⁵

The WCC's **Ecumenical Disability Advocates Network (EDAN)**¹⁸⁶ is a network of people with disabilities that has its office in Nairobi. EDAN advocates for the "inclusion, participation and active involvement of persons with disabilities in the spiritual, social, and development life of church and society."¹⁸⁷

¹⁸³ www.e-alliance.ch/en/m/about-us/

¹⁸⁴ www.epnetwork.org/

¹⁸⁵ World Health Organisation, *Ecumenical Pharmaceutical Network: Multi-Country Study of Medicine Supply and Distribution Activities of Faith-Based Organisations in Sub-Saharan African Countries*, Geneva and Nairobi 2005. p. XII.

¹⁸⁶ www.oikoumene.org/en/what-we-do/people-with-disabilities-edan

¹⁸⁷ *Ibid.*

Professional Christian Health Networks

International Christian Medical and Dental Association (ICMDA)¹⁸⁸ is an interdenominational and global movement uniting national Christian medical and dental organisations in over 60 countries, and is developing and supporting new movements in other places. It connects Christians in medicine and dentistry all around the world, equipping them to live out their faith at work through:

- Four yearly regional and global conferences
- Leadership training for ICMDA member movements
- Setting up national medical officer training institutions
- Supporting the emergence of new Christian medical movements through sharing their resources and experience through supporting leaders, sending teams and translating Christian medical literature.

Nurses Christian Fellowship International (NCFI)¹⁸⁹ is a network of national Christian nurses movements in over thirty countries, and aims to equip and encourage Christian nurses to integrate Biblical principles and Christ-centered values within clinical practice, leadership, education and research. It runs cascade training programmes in spiritual care and Christian leadership in nursing practice, four yearly regional and global conferences.

Regional and national networks

It is more than 50 years ago since the World Council of Churches supported the development of **Christian Health Organisations/Associations**. These most substantial and successful structures work as national umbrella networks of church-based health providers. They coordinate and support the work of their members (health providers and facilities, and training institutes) through capacity building, advocating for a proper recognition of Christian health services, and negotiating with governments. Countries that have a CHA usually provide better data about the market share of Christian health work than countries without such an umbrella organisation. In 2007, the African CHAs decided to form the Africa Christian Health Association Platform (ACHAP)¹⁹⁰ as a coordinating hub. ACHAP represents the CHAs, fosters capacity building, joint learning and exchange of knowledge among its members.¹⁹¹

¹⁸⁸ www.icmda.net/

¹⁸⁹ www.ncfi.org/

¹⁹⁰ www.africachap.org/x5/

¹⁹¹ Overview on history, members and main activities of the Christian Health Associations: Dimmock, F. Olivier, J., Wodon, Q.: 'Half a Century Young: The Christian Health Associations in Africa', in: *MPRA Paper* No. 45369, March 2013, online: <http://mpr.aub.uni-muenchen.de/45369/>

The **Ecumenical HIV&AIDS Initiative in Africa (EHAIA)**¹⁹², an initiative of the WCC, enables the churches to access information, training, resources related to HIV&AIDS and to help them deal with AIDS in their communities.

Christian Medical Association of India (CMAI) and other networks in India and Indonesia

CMAI¹⁹³ and its network of hospitals along with **Catholic Health Association of India (CHAI)** have more than 1000 institutions and more than 2500 primary level facilities. Besides these, there are several nursing and allied health sciences schools. The network has the largest presence across India and has the mandate to deliver services at affordable cost. This mandate has been threatened in recent times as the policies favour pro-profit making institutions and the private sector, imported from models of high income economies. CMAI's experience in delivering affordable cost healthcare, training human resources and innovations are worthy of replication by the government. This requires documentation and presentation to planners and policy-makers.

Emmanuel Hospitals Association (EHA)¹⁹⁴ is a major Indian medical mission organisation. EHA is the umbrella organisation of 20 hospitals and 30 community based health and development projects located in North and North-East India. EHA integrates clinical services with community-based approaches to health and thus improves the health of poor and marginalised people.

In **Indonesia**, the **Christian Foundation for Public Health (YAKKUM)**¹⁹⁵ implements public health services regardless the ethnic, nationality, religion, and socio-economic background. YAKKUM aims at providing access to compassionate healthcare through connecting community-based approaches to health with hospital-based healthcare.

Christian health services today: Areas of engagement and critical issues

5.1. Lessons learnt from HIV&AIDS

Over the years of pursuing the MDGs considerable achievements in improving the global health situation have been attained. Much progress was made in terms of malaria, HIV or tuberculosis. Also, mortality rates for mothers were reduced, child mortality fell and millions of people have gained access to complex treatment schemes such as treatment for HIV even in rural and hard to reach areas. There is still much to be done, but there are important

¹⁹²www.oikoumene.org/en/what-we-do/hivaids-initiative-in-africa

¹⁹³<http://cmai.org/>

¹⁹⁴www.eha-health.org/

¹⁹⁵www.yeu.or.id/

lessons learnt of what can be done if global and national resources are put together and the community is involved in improving health and health services.

Church health services have been part of the process during this period but in other areas they were side lined and lost staff from church facilities to government and international NGOs. In fact, the last 15 years have definitely changed the health environment in many resource limited settings and so it is important that church health services clearly define their role and contribution in terms of their healing ministry afresh.

The global response to HIV and AIDS has been one of the most significant and effective mobilisations of global resources for a single health condition ever. It has had a wider impact on health systems, and many see the way the response was initiated, coordinated and sustained as a model for addressing other global health needs.¹⁹⁶

The global church and Christian faith-based organisations (FBOs) have been a significant part of this response. Yet in the nineties and early noughties, many believed that Christian faith leaders and organisations not only had little to contribute, but were actively harming the response¹⁹⁷.

The example of Uganda and the comprehensive prevention response of the previous two decades (often using the acronym 'ABC' for Abstain, Be faithful, use Condoms) challenged this view. In Uganda, the government, NGOs, FBOs, churches and wider civil society worked together to galvanise a massive change in sexual behavior, attitudes to stigma, accessing treatment and testing, etc. It showed that the church and FBOs were in fact a critical component in responding to HIV¹⁹⁸. The Ugandan situation was not unique, and not without its problems, but others have learnt from its mistakes and built on its lessons.¹⁹⁹

Since then the work of FBOs like AFFIRM²⁰⁰, ACET²⁰¹, INERELA²⁰², PACANet²⁰³, etc. have shown that churches and FBOs continue to tackle HIV stigma, engaging actively in treatment, prevention, care and support. Alongside with the reduction of stigma and the availability of treatment, people living with HIV and AIDS were encouraged to disclose their status and to live openly with HIV. These men and women have become instrumental in further reducing stigma and addressing HIV and AIDS in church and society.

¹⁹⁶Positive gains: promoting greater impact on health through HIV and AIDS programming, UK Consortium on AIDS and Development policy briefing, October 2012, online available: <http://stopaids.org/wp-content/uploads/2013/08/Policy-briefing-Positive-Gains-01.10.2012-pmsmall.pdf>

¹⁹⁷Pisani, E., *Acting early to prevent AIDS: the case of Senegal*, UNAIDS/99.34E, p12 Best Practice Collection, Geneva 1999, Switzerland

¹⁹⁸Green, E. C., *Rethinking AIDS Prevention: Learning from successes in developing countries*, p285-297 PRAEGER, Westpoint, Connecticut, London 2003.

¹⁹⁹Byamugisha, G.B. et al, *Church Communities Confronting HIV & AIDS*, SPCK 2010.

²⁰⁰AFFIRM, Facilitation Associates Responding to HIV, <http://affirmfacilitators.org/>

²⁰¹AIDS Care, Education & Training www.acet-international.org/

²⁰²Network of Religious Leaders living with or Personally affected by HIV., www.inerela.org/

²⁰³Pan African Christian AIDS Network, <http://pacanet.net/>

Often the church has been the most significant source of community assets to mobilise local responses, build resilience, change attitudes and address the deep spiritual hurts that affect individuals, families and local communities affected by HIV and AIDS. It is also the most widely distributed, sustained and respected institution in many countries.

The global and national health and development institutions and funders woke to the role and potential of faith groups in responding to HIV and AIDS, and thence to wider health and development issues.

The lessons learnt through addressing HIV and AIDS can be summarised as follows:

- Involvement of people affected by the diseases is crucial in finding appropriate solutions.
- Devolving healthcare into the community is possible and strengthens the health systems.
- Home-based care and palliative care are essential and can be delivered in a comprehensive manner even in resource limited settings.
- Access to treatment is possible if there is international pressure on the pharmaceutical industry.
- Patent laws, world trade laws, TRIPS flexibilities and a free generic market are essential in creating access to all.
- Political will is necessary to facilitate legislation that will not discriminate but open the way to treatment and care.
- An intersectorial approach leads to successful strategies that involve people and can effect change.

5.2. A human rights based approach to health from a Christian point of view

In 1948 the World Health Organisation declared health to be a fundamental human right "without distinction of race, religion, and political belief, economic or social condition."²⁰⁴ The International Covenant on Economic, Social and Cultural Rights (1966) stated that, "Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."

The declaration of human rights in general and of the right to health in particular is in complete accord with the Biblical view of the dignity of human beings as they are created in the image of God (Genesis 1:27), and also with the Biblical concept of justice and the values of love and solidarity. However, the Biblical view goes much further.

²⁰⁴www.who.int/governance/eb/who_constitution_en.pdf

Human beings are made in the image of God (Gen 1,16) –but while the image is marred by the Fall, it still persists. Any violation by the state (Caesar) of this divine image (e.g. torture, denial of human dignity, denial of justice, denial of life) is in effect rendering to Caesar what is God's (Matt 22,15-22). All of us stand equal before God in this respect (e.g. Gal 3,28).

A Christian understanding of our 'rights' is based around the Law, which restrains evil, promotes the good, and gives us recourse to justice (Romans 13,1-7) and the Gospel which gives us freedom (e.g. Gal 5,13-14), not for license but to serve one another. Thus freedom of association, worship, to family life, to property, recourse to justice and to life itself are all found in the Mosaic law as equally balanced obligations to ensure that we each protect our neighbour's freedoms (Ex 20,1-17). And Jesus makes clear that our neighbour is not just the one like us or near us, but any fellow human (Luke 10,25-37) - crossing ethnic, religious, political and class boundaries (and geographical ones too!).

Taking the right to health in the Universal Declaration of Human Rights as an example²⁰⁵, the right is to access to the necessary resources (income, food, housing, medical care) to maintain good health. We cannot say we have a right to good health per se, nor are we obliged within the declaration to use our resources to maintain our good health and that of our neighbour. In Mosaic Law by contrast, elaborate rules for managing different illnesses (e.g. Lev 14), environmental contaminations (e.g. mildew, rotten food, etc.) were there to ensure good health (physical, spiritual, environmental and social), in the family and wider community. The Jubilee and Sabbath Year laws (Lev 25) were there to ensure all had adequate access to the means of production of food and wealth (i.e. land) to maintain health. But the obligation remained to use these resources and follow these laws to maintain the health and well-being of all (e.g. Deut. 6,1-4).

Therefore, if as Christians we stand up for the human right to health, we are not saying human beings have a right to health with respect to God our creator. Health, is first of all a gift of God we never can claim. However, we are saying that human beings are obliged to do everything that is in our power to save lives and maintain health and well-being. It is the responsibility of government to take the leading role in coordinating all that is needed to maintain economic and public well-being, including access to healthcare. Therefore it is appropriate that we demand that government makes available the resources needed to maintain and promote health. However, we also accept our individual and community obligations to maintain these rights and freedoms.

Taking on a human rights perspective impacts the strategies one chooses towards implementing health goals and reaching universal health coverage. In the 1980s we failed to implement Primary Health Care in its full meaning and reduced it to simple vertical

²⁰⁵Article 25, Universal Declaration of Human Rights accessed at www.un.org/en/documents/udhr/

interventions. And in the 1990s similar decisions were taken in terms of reducing maternal mortality:²⁰⁶

- Scientifically it was clear that in order to reduce maternal and neonatal mortality, it emergency obstetric care has to be made available at all levels, a demand well placed for a human rights perspective on health.
- Public health experts argued that as long as financial resources are limited, one has to choose the most efficient way to improve health. While admitting that the above mentioned measure might be the most effective way to improve maternal and neonatal health, they stressed that there are not enough resources for such interventions on a global scale. Therefore they recommended a community-based strategy as the most efficient, cost effective way to save lives of mothers and children.

This example demonstrates the sometimes conflicting argumentation of the human rights based contra the public health based approach. The reason why public health experts often recommend health strategies that they know are suboptimal is that they are used to making their decisions on the grounds of the actual available financial resource.

However, in the case of HIV and Aids it was possible to gather enough political will to actually implement a human rights approach: Once highly active antiretroviral therapy was available, everyone knew that only a comprehensive response including prevention plus treatment was able to turn the tide in the fight against HIV and AIDS. But there were voices that recommended to go for prevention only because resources didn't allow for both. The political will on international level, the availability of funds through global resource mobilization such as through the Global Fund against AIDS, Malaria and Tuberculosis allowed all Sub-Saharan African countries to make treatment available even to the poor at no cost and revert the HIV epidemic and reduce transmission rates drastically and therefore have a massive public health impact. Through not being threatened by a potential lack of funding this comprehensive approach saved the lives of millions of people who are under antiretroviral treatment today.

The lessons learnt through the fight against HIV&AIDS over the past decade should encourage the world community to scale up a comprehensive approaches in tackling other health problems instead of choosing suboptimal strategies according to limited funds.

Today, the world community has to make decisions on how to make health available to all people. Taking a human rights approach to health, we have to choose the best strategy to let everyone find access to health and mobilise financial resources accordingly. From a human rights perspective it should not just be a recommendation but an obligation that low-income countries allocate 15% of their budget to health, and that high-income countries contribute 0,7% of their Gross Domestic Product (GDP) to international assistance. Combining local and

²⁰⁶Cf. to the following: Ooms, G., Hammonds, R., "Right to health and global public health research: from tension to synergy?", in: *Tropical Medicine and International Health* Vol. 19 No. 6 (June 2014), 620-624

global resources government will be able to ensure that the per capita expenditure for health per person will reach \$50 per year (compared to \$10 in 2010).

As all human beings are created in the image of God and as humans have the Biblical mandate to take care for each other, from a Christian perspective we support the human rights based approach to health.

5.3. Justice issues in healthcare – how can we reach those who are marginalized and economically poor?

Justice in the Bible means living in right relationships so that the community/society as a whole and each individual can lead a life in dignity. Jesus stood primarily with those on the margins. Those who were healed by Jesus were often poor or outside the accepted circle. Jesus' healings brought people back into the community and thus reconciled/healed broken relationships.

"Healing" through improving access, affordability, and quality of healthcare for all human beings is a Christian contribution to justice in the Biblical sense. Christians are committed to reduce the burden of disease and to improve the quality of life for all people.

In the light of justice, Christian health services have specific commitments:

- On the individual level Christians promote equity and equality in healthcare by being obedient to Proverbs 31,8: "Speak up for those who cannot speak for themselves, for the rights of all who are destitute." We commit ourselves to ensure that all people, especially the economically poor and marginalized or those who are vulnerable because of their age, gender or health condition can access health services according to his/her needs and not according to merits or financial means. As an example, we cannot accept that user fees prevent economically poor people from accessing lifesaving treatments. We advocate for a just allocation of resources covering services for people in rural areas and allowing, e.g., quality care and drug research for treating neglected diseases.

To advocate justice in health does not deny personal responsibility of individuals for their own health. Therefore Christian healthcare is committed to health education like empowering people to pursue a healthy lifestyle and to avoid harmful practices. In a participatory process, the strengths and potentials of people and of communities are made visible and are developed.

- Besides meeting personal needs, unjust structures have to be challenged. We identify harmful structures and address the social determinants of health such as social, economic, political, environmental conditions at national and global level. We address the root causes of injustice by reducing poverty, improving education, and on protection from violence and discrimination.

- Christians address the root causes of lack of access to healthcare by strengthening health systems so that these can serve more people with better quality of services.
- People have to be protected from the exploitation by commercialised medicine.
- Christian health services must contribute to training and capacity building using the enormous resources available with young people wanting to serve in health.

5.4. Advocacy in health

Advocacy needs to be based on the situations and circumstances that people go through and experience. Based on what we see, there needs to be an appropriate response. In the realm where faith and health interact both at institutional and personal levels, there is a clear mandate for advocacy. Advocacy is also about asking oneself 'why', 'what' and 'how' in situations and we need to not only respond but reflect and ask oneself 'where are we?' We need to be co-workers in the process and dynamics of advocacy. We also need to be assertive in our advocacy without being overly aggressive. This is especially important as in the field of health and faith as we seek to heal in the spirit of compassion.

Though advocacy is often broad, it also needs to be based on specifics. In other words, it should be global, but contextual. For advocacy to be truly effective, we need to focus our collective energies on various players such as the governments, inter-governmental organizations, industry, church as well as individuals. Advocacy should be part of a Christian's innate nature as evidenced in the Bible, and free of vested interests.

The perspective of the Christian Medical Association of India (CMAI)

We have very often seen that ethics, democratic values and accountability are ignored in policy formulation and delivery of healthcare to the poor, women and the marginalized. Maintenance of equity in delivering health services is often neglected as a result of various factors. In the planning process, planners ignore evidence of inequity and unjust practices that affect the poor and marginalized unless confronted with such shortcomings.

In this context it is necessary that Christian groups engage with the Government in policy formulation and healthcare delivery at multiple levels. While these engagements are very much required, it is essential and appropriate that we consider the following issues while advocating for change.

- The Government is the largest healthcare provider and generally the most organized system available for the poor and marginalized. It is important that civil society organisations including Christian churches and church-owned healthcare institutions recognize the need for the presence of the government at multiple levels.

In India, we have central and state governments responsible for policy formulation and the primary responsibility for services being with the states. The delivery, regulation and monitoring of healthcare happen at the sub-district, district and state levels for primary, secondary and tertiary levels of care. It is necessary that Christian healthcare institutions are aware of all levels of care and administration processes which are accountable at these levels. Therefore, we have to work with administrators and bureaucrats at multiple levels to address issues related to inequity, poor practices and neglect of the poor, women and the marginalized groups. It is also important to use the levels of hierarchy for communication and for interventions.

- It is necessary to gather evidence and be well informed while advocating for any issue with the government, media or other civil society partners. There are several efficient administrators in the government who would like to have strong evidence base for addressing our request.

It is important that Christian agencies communicate with focus and clarity in the shortest possible time if they are to be listened to, although we do experience much goodwill and are known for our high quality work. If we do not communicate our thoughts and requirements clearly to the government, our messages will not be heard and acted upon.

- Christian agencies also do not operate in a vacuum. It is wise to understand the context and local environment while advocating for change. Advocacy is a continuous process and it is necessary that changing political and economic alignments, interest of community and religious groups offer scope for change in advocacy approaches.

5.5. Human resources in health

In search for a better life, millions of health workers decide where to work and for whom. Highly skilled health workers are shifting from poorer to richer regions and from the public to the private sector. In general, migration happens from inferior to superior work and to more stable political and economically rewarding situations. Poor management and unsatisfactory working conditions are other drivers for leaving the workplace. There is a considerable movement of the workforce from southern to northern countries, but still most migration of health workers is within countries as health workers are moving from rural areas to urban centers, and also from church facilities to practicing in private practices or in government institutions.

Faith Based Organisations (FBOs) have always provided a significant number of training institutions with a focus of training nurses and midwives according to high standards of education. Christian health workers are usually very committed to their job and practice medicine and care with compassion. But they, too, are leaving their institutions for different reasons including issues related to wages, working conditions, housing, access to schooling, etc.

Christian health care institutions need to adapt human resource management proactively and according to Christian principles. Some options are:

- Leaders should sensitize all staff members to the vision of the healing ministry, and enable them to see their work as a calling and vocation, and to sustain that sense of calling through their lives.
- Christian health care management should value each staff member as precious and created in the Image of God, and therefore treat them with care and respect.
- Christian health care management needs to continuously strive to provide all staff the working conditions, wages and accommodation that enable them to live a life in dignity.
- Church health services must develop career options and professional development that will create a motivated workforce for their facilities that can be part of the healing ministry.
- Leaders of Christian health care institutions should consider establishing a kind of "People Development Program" in their institutions so that even if people move on they will carry on the ethos of the healing ministry.
- With regard to the long-term perspective, Christian health care institutions have to work with young people. Churches have to encourage vocations and facilitate the training of committed Christian health care professionals through support and facilitation of sponsorships.
- In general, professional management of church health services and the creation of sustainable financing will create a new perspective and will contribute to the retention of staff.

In many countries it is the Christian health organizations/associations that develop and coordinate retention schemes. As a main approach, they try to integrate FBOs into ministry of health policies and programmes through public private partnerships. To be effective, retention schemes should aim to include financial incentives as well as non-financial factors like further training and improved working conditions.²⁰⁷ As one example, the Christian Health Association of Zambia (CHAZ) has implemented staff retention schemes in partnership with the Ministry of Health. However, so far there is no evidence that FBOs were able to retain their health workers through such schemes.

²⁰⁷Cf.: USAID, *CapacityPlus: The key role of Faith-Based Organisations in Strengthening Human Resources for Health*, online: www.capacityplus.org/sites/intrah.civicaactions.net/files/resources/FBO_overview.pdf

5.6. Financing Christian health services

Since their inception in the 18th century, church health services in the global South have counted on significant financial support from organisations and religious groups in the North. Over a long period of time they were financially independent so that most governments did not feel the need for including church health services in their planning, budgeting and deployment of staff. As a result, church health services mostly operated parallel to the ministry of health.

For various reasons, the funds from the North have been reduced considerably since some decades. Moreover, block grants are being continuously replaced by targeted project funds not allowing the recipients to do long term strategic planning. In some countries, alongside with the decrease in external funds, governments further reduced their already limited support for church health services as a result of health sector reforms in African countries.

In addition, since the 1990s HIV&AIDS initiatives and programs/projects and other single disease approaches have attracted attention and funding of donors and development organisations so that other areas of health have been side-lined to some degree.

These developments make it difficult for Church health providers and Christian Health Organisations to guarantee sustainable provision of services. Church health services often substantially rely on user fees thus often excluding the economically poor from accessing their services instead of keeping up the Christian value of benefitting the poor. These “out of pocket” payments are still among the main causes that drive people into poverty.²⁰⁸

Instead of relying on external funding or on user fees, church health services are called to strive for becoming financially independent through self-financing, reorganization of their services, and explicit prioritization.

In general, church health services have to partner with the Ministry of Health and have to be included in the government health budget through service level agreements and sector wide approaches. In this regard, the Christian Health Organisations/Associations have a key role in negotiating with governments and foreign donors.

Cooperation with the government is also needed in the area of searching for new ways in health financing. In this regard, the WHO has identified the following four key actions:

- Reduce “out-of-pocket” payments.
- Maximize pre-payment
- Establish large risk pools

²⁰⁸ Cf. Okech, T., “Empirical Assessment of the Various Sustainable Financing Mechanisms for Healthcare Services in Kenya”, in: *International Journal of Academic Research in Economics and Management Sciences*, June 2012, Vol.1, No. 3, 58-79

- Use general government revenue, e.g. dedicated tax funds, to fund those who cannot afford to contribute.²⁰⁹

From the perspective of the churches, health financing mechanisms have to meet the criterion of benefitting the poor and vulnerable people and reducing “out of pocket” payments. Therefore, churches are hesitant to promote forms of voluntary private and community-based health insurances that are difficult to administer and impose premiums to poor people. Instead, churches support the creation of national risk pools that combine payroll contributions, tax revenues, and development aid. Such national risk pools will continuously increase insurance coverage and thus benefit a growing share of the population.

5.7. Ethical issues

The main focus of Christian medical ethical concerns has historically been around the divisive issues of abortion and euthanasia, but with advances in medical technologies, demographic, sociological and cultural changes, globalisation and communications technologies, the arena of medical ethics has become vastly more complicated and complex in the last two decades.

Issues that need a careful, theologically and scientifically grounded consideration by Christians include embryo research, human cloning, compassionate care for the elderly (especially in the ‘ageing societies’ of the West and Japan), assisted suicide, care of premature babies, healthcare resource allocation, ‘lifestyle diseases’ etc. We also need to bring the Christian understanding of human personhood and dignity into debates about personal autonomy, identity, professional conscience, the ‘medicalisation’ of human experience, etc.²¹⁰

These are all hugely complex issues, and the debates have largely been dominated by secular Western thinking. However, there is a strong Christian body of thought that is engaging with all of these issues, and needs to be heard. How can we encourage Christian health ministries and practitioners to engage constructively in these issues?

Another set of ethical questions arise around the status of Christian health professionals in non-Christian and secular societies. Expressions and discussions about faith may be difficult or even dangerous with colleagues and patients in some settings, and holding to Christian ethical standards may run contrary to their employer’s or profession’s guidelines, or even national legislation. At the very least, their stance may run contrary to workplace culture, and bring censure from professional peers and superiors. The function of Christian

²⁰⁹Oxfam: *Universal Health Coverage. Why health insurance schemes are leaving the poor behind*, 176 Oxfam Briefing Paper, October 2013, online: www.oxfam.org/sites/ and www.oxfam.org/files/bp176-universal-health-coverage-091013-en_.pdf

²¹⁰See www.cmf.org.uk/publicpolicy/clinical-practice/ and www.cmf.org.uk/publications/cmf-files/ for articles and discussions around these and related issues

healthcare professional associations at national and international level is key to helping Christians to deal with these challenges, but so is the engagement of churches in connecting people around workplaces and the need for spiritual, professional and theological reflection and support at church association levels.

Christian health professionals today face many challenges and questions to their faith as they practice medicine, nursing and other professions. Ongoing opportunities to support one another in prayer, professional practice, scriptural, theological reflection and Christian fellowship are vital.

5.8. The ministry of reconciliation – Christian health services and Christian communities in conflict areas

Deaths due to armed conflicts and other forms of political violence continue to be a reality for many. For thousands in the world, state terrorism through low-intensity conflict, torture, imprisonment and other forms of human rights violations has made the well-being of mind, body and spirit, i.e. wholeness, impossible.²¹¹

In areas of conflict and in post-conflict situations, very often the provision of health services is severely affected or even collapses because the health infrastructure is destroyed and/or staff cannot keep up their services under difficult or even life threatening conditions. In some areas where government health services are no longer available the churches with their wide network remain the only healthcare providers. Provision of health to people in insecure situations is a pathway for reconciliation.

In conflict areas, the Christian ministry of reconciliation is particularly important but at the same time difficult to implement. In many countries, there is so much suffering from political and economic violence that the traditional means of reconciliation are not practiced any more or are not sufficient. In the past traditional societies, the family or a community mediator, such as a village elder, listened to both sides in order to foster reconciliation and help heal broken relationships. Traditional concepts of health and sickness support the view that disharmony in relationships between individuals or within families leads to alienation, separation and brokenness, and may provoke the onset of mental and physical disease.²¹²

Today, in some areas violence has reached a point where traditional values are not respected anymore and where communities are no longer a social network but are disrupted.

Reconciliation in the true Biblical sense and also literally, means the healing of relationships – among human beings, between humans and God, between humans and creation and the

²¹¹Cf. World Council of Churches (WCC), the German Institute for Medical Mission (DIFAEM), *Witnessing to Christ today, Promoting health and wholeness for all*, Tübingen 2010, p. 25.

²¹²Ibid.

relationship to oneself. Thus reconciliation comprises "the efforts towards and engagement for mending broken and distorted and building up community and relationships afresh."²¹³

For example, healing of relationships is of utmost importance in the Democratic Republic of Congo where fights and riots prevail though the war officially ended many years ago. Rape has become a weapon of war destroying the lives of individuals and of communities. Often the state is absent and the civil society is dominated by political and economic corruption. Immunity has invaded all the levels of the judicial proceedings. To some degree even the churches feel powerless in such a disastrous situation.

Nevertheless, Christian communities, especially at the grass-root level, can offer an immense and specific support for the reconciliation of relationships at all levels. Healing concerns individuals, families, communities, culture, religion, social classes, ethnic groups –the whole society including the church. Through prayer, rituals and through mutual support Christian communities can be like safe spaces in midst of conflicts and can be cells where transformation happens and where transformation of individuals and the society can have its origin.

Seeking for justice for the victims has to be part of the process of reconciliation as true healing and peace is not possible without justice for the victims. In the sense of restorative justice, what has been taken from victims has to be restored while in the sense of retributive justice, wrongdoers are to be held responsible for what they did.²¹⁴

The ministry of reconciliation is the responsibility of all members of the Church not only of activists of justice and peace. It is the fruit of love and compassion that are gifts of the Holy Spirit offered to all baptised. It is also a dimension of the diaconal ministry (diaconia) of the church.

5.9. Exploring the Christian contribution in revitalisation of Primary Health Care (PHC)

Primary Health Care (PHC) is recognized by Christians as a relationship driven movement. Jesus Christ himself modeled PHC as he demonstrated and stimulated the response characterized by health and faith.

In 2008, 30 years after Alma Ata, there was a call for revitalizing PHC recommending a concept of integrated Primary Health Care, sometimes also called Diagonal Primary Health Care²¹⁵. It is proposed that horizontal and vertical interventions are not regarded as mutually exclusive, but vertical programmes are effectively integrated into comprehensive and

²¹³World Council of Churches, *"You are the Light of the World". Statements on Mission by the World Council of Churches 1980-2005*, Geneva 2005, p. 98.

²¹⁴Ibd. 109.

²¹⁵Walley, J., Lawn, J.E., Tinker, A., de Francisco, A., Chopra, M., Rudan I., Bhutta, Z.A., Black, R.E., and the Lancet Alma-Ata Working Group (2008) Alma-Ata: "Rebirth and Revision 8: primary health care: making Alma-Ata a reality", in: *The Lancet*, Vol. 372, Number 9642:1001.

horizontal approach. Links are created between different service levels such as community, primary and referral level.

The Christian faith has demonstrated its contribution to health and healing through tangible and intangible assets in the networks and pertinent, non-redundant relationships.

Revitalization of PHC means rediscovering the foundation of PHC. Although at the Alma Ata declaration community participation is considered a key component, it is one of the weakest strands of PHC²¹⁶. Community participation requires a definition since it has been used to indicate active and passive community involvement; it can be top down or bottom up as well as contributive, consultative and collaborative²¹⁷. Participation considering a utilitarian perspective means donors and governments (including church health service providers) to use community resources to offset costs of providing services. From an empowerment perspective, participation can be defined as “people-centered development” in which local communities take responsibilities and an active role for diagnosing and working to solve their own health and development issues²¹⁸.

As Christians we consider communities as local people of neighborhoods in which everyone counts and no one is left behind including the poor and marginalized. Local people are the authors of their own future and stimulate their own response. Building local people’s capacity and learning from their response is fundamental in PHC, which goes beyond primary service provision.

In the past, health workers considered community participation and mobilization as communities, or target groups responding to what they, the health professionals, instructed in order to improve the health of the target groups. In recent years, health workers have started to change their roles and act as facilitators focusing on both the processes and outcomes of health improvements²¹⁹.

Traditionally, health projects apply a deficit model focusing on the problems, needs and deficiencies of communities and designing services to address these problems. This deficit model disregards what is positive and what works in communities terming communities and individuals in negative terms²²⁰.

²¹⁶ Lawn, J.E., Rohde, J., Rifkin, S., Were, M., Paul, V.K., Chopra, M.: “Alma-Ata: Rebirth and Revision 1: Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise.”, in: *The Lancet*, vol. 372 (2008), Number 9642:921.

²¹⁷ Rifkin, S. B., Community Participation in Health: An Overview. Workshop “Assessing Participation: an overview”. Netzwerk Partizipative Gesundheitsforschung, Katholische Hochschule für Sozialwesen Berlin (KHSB); 02 December 2011.

²¹⁸ Morgan, L.M., “Community participation in health: perpetual allure, persistent challenge”, in: *Health Policy and Planning*; 16(3):221-230.

²¹⁹ Rosato, M., Laverack, G., Grabman L.H., et.al (2008) Alma-Ata: Rebirth and Revision 5; Community participation: lessons for maternal, newborn and child health. *The Lancet*, Vol. 372, Number 9642:962.

²²⁰ Morgan, A. and Ziglio, E., Revitalizing the evidence base for public health: an assets model. *Promotion & Education*, Supplement 2 (2007):17-22.

Participatory and appreciative methodologies propose ways of working with communities starting with a clear commitment to discovering and mobilizing existing community capacities²²¹ and often dormant assets including Christian health assets. This approach looks at what is working in communities, what is successful and life-giving, even if limited, appreciating the best of what is, thinking about what should be and might be, and a shared commitment to a vision and how to achieve it²²². By recognizing that God has created a good and life-giving social world, in whatever good is found in our world, we see God's work and gifts in it. This appreciative perspective encourages transformational health development to finding God's redemptive work within oneself, in the life of communities and to become more intentionally part of it²²³.

The SALT practice²²⁴ can be considered an example of the participative and appreciative methodology, that is a way of thinking and relating ourselves to a situation. SALT stand for: S - Support, Stimulate, Share, A - Appreciate, Analyze, L - Listen, Learn, and Link, T - Transfer and Team. Home visits and neighborhood interactions become the place of private sharing, where concerns, loss, grief and hope are expressed. These key practices, although simple are a necessary foundation for building relationship and a sustained health response within a community. It needs to be framed within an approach of community conversation, local relationships, mutual learning, reflection and personal faith.

These local movements in health demonstrate how the activation and partnership of available resources and assets for health, demonstration of agency, initiation, and transfer of health action across boundaries, and the turning of information into knowledge can be used by people in their families and neighborhoods for their own well-being.

5.10. Christian responses in middle and high income countries

In the countries of the North the majority of the people regard religion as a private issue in the sense of "me and my God". Religion has moved out of the public sphere and does not impact social relationships in neighborhoods for example. There is little understanding of "diakonia" to be lived out through hospitality and visitations. Instead of regarding neighborhood as a blessing, some see it as a burden.

To a large extent the Christian task to heal has been handed over to Christian professionals. Congregation usually are not aware to be possible partners of the formal health system. At the same time, Christian health institutions are struggling to keep up their identity. They are

²²¹ John P. Kretzmann and John L. McKnight (1993) *Building Communities from the Inside out: a path towards finding and mobilizing a community's assets*. Institute for Policy Research, Illinois.

²²² Hammond, S.A (1996) *The Thin Book of Appreciative Inquiry*. Thin Book Publishing Co. Plano, TX.

²²³ Myers, B.L. (1999) *Development Practice: The Tool Kit*. In: *Walking With The Poor: Principles and Practices of Transformational Development*. World Vision; Orbis Books, New York, USA. pp168-203.

²²⁴ Cf. AFFIRM, Facilitation Associates Responding to HIV, <http://affirmfacilitators.org/>

part of a medical system that to some degree puts efficiency and effectivity above love and compassion. At the same time, patients feel the deficiency of a purely medical approach to health and long for compassionate care. Many patients are open for the spiritual dimension of health and healing.

In this context, the healing ministry of the churches needs renewal. Here are some reflections from India, Norway, and England.

The example of India

As public health and medical services grow and take responsibility for the health of India's people, and high technology services become increasingly available and accessible to many through the large private networks, is there a role for Christian medical work in India? What can churches and Christian hospitals (many of which are struggling to exist) do for health?

As we live in times when many people feel hopeless, one of the crucial roles for churches and Christian institutions is to bring hope.

In particular, the following areas of engagement are suggested:

1. Set standards for compassionate and competent care;
2. Set high ethical standards for medical care;
3. Work with people at the margins economically as well as socially, as well as in the areas of medicine that are not glamorous like leprosy, HIV&AIDS, mental health, and disability;
4. Set standards for research that are locally relevant and ethically sound;
5. Pioneer low cost approaches to providing care;
6. Value-based education of medical professionals that produce committed, caring and competent individuals;
7. Set up models of care where these principles are worked out in different places in the country;
8. Work with others including the government to influence policy;
9. Engage in ecumenical initiatives for health.

A Norwegian perspective

The existing Norwegian welfare model has been built on three basic principles:

1. Universality. All Norwegian citizens have equal rights to benefit from health and social services.
2. Public funding. The costs for maintaining health and social services are covered by public budgets, and not by individual health insurances.
3. Public services. Most health and social institutions and services are owned and run by the government, at national or local level.

This model has limited the role of the church as provider of health and social services to a large degree. Until the 1980s many parish nurses were employed, but then the municipalities were required to set up home-based nursing, with the consequences that the work organised by local congregations was dismantled. On the other hand, quite a number of diaconal institutions managed to survive; today they number around 150 and represent together some 8 % of the total capacity of health and social services in Norway. In addition to three local hospitals, most of these institutions work within the area of care for elderly people and for persons suffering from different kinds of addiction.

Over the last years this situation has been changing, presenting new opportunities for the church and its ministry of health and healing. One factor has been the introduction of "New Public Management" that on the one hand is open for private initiatives and thus in a way has legitimised the role of diaconal institutions as actors within Civil Society. On the other hand, it has also introduced strict management requirements that make it difficult for diaconal actors to uphold their standard of quality and holistic care.

Presently, some important reforms are about to be implemented by the government. One, "Samhandlingsreformen", focuses on cooperation between providers that deliver health and social services, and for the first time church-based actors are fully recognised as partners. Another, "Omsorgsreformen", deals with the need of restructuring the care services, and it invites Civil Society and private actors to assume new tasks, for instance by organising volunteers in care services. It is indicated that up to 25 % of the care services could be provided by non-governmental organisations.

As already indicated above, this development presents new opportunities for the church to practice the ministry of health and healing. In the changing context of post-secular society, the church can offer services that express its distinct values, which include attending the spiritual needs of people. Among the assets that the church possesses is also the potential of mobilising local congregations, thus connecting diaconia "from above" with diaconia "from below".

An observation from England

Whereas most European and North American nations have retained some Christian led health services and institutions, but see them dwindling, in the UK we lost all church health institutions in the 1950ies with the advent of the National Health Service (NHS), but with the

increasing de-regulation and de-centralisation of the NHS we are now seeing doorways opening for the return of new church health responses – hence the massive growth of initiatives like Parish Nursing²²⁵ and Christian General Practice.

The future context: Global health in the post-MDG era

6.1. Transition in health

Demographic changes such as ageing and urbanisation will pose challenges to healthcare. Though the world population will increase at a slower pace, it is expected that the population will still reach 9 billion people by 2050 before a global decline in population will begin. The world will look different in the future: As life expectancy is about to be improved all over the world, people will be older in industrialised countries but also in developing countries. Many countries that are experiencing rapid growth are not able to meet basic human need for water, food, education and healthcare.

According to the WHO, by 2050, 70% of the world's population will be living in towns and cities. Determinants of health and disease patterns of urban populations are different from rural populations. Lack of physical exercise, air pollution, unhealthy diets are among the factors affecting health of people living in the cities.²²⁶

Epidemiologic transition. Alongside the continuing challenge to reduce infectious disease, burdens and poor maternal/new born health in many low income countries, there is a growing convergence between societies in the rise of non-communicable diseases (NCDs). Many less economically developed countries are faced with the double burden as persistently high rates of communicable diseases are combined with rapidly rising rates of chronic disorders. These so-called "diseases of affluence" impact health of societies across all countries. Growing demand for health services to combat cancer, cardio-vascular diseases, diabetes and a spectrum of mental health problems is threatening the viability of

all health systems.²²⁷ Furthermore, traumatic injuries, violence and road traffic accidents will further strain health systems and result in a triple burden. This challenge presents a new and disconcerting problem for public authorities. To what extent can they address the lifestyle influences that make people more susceptible to these diseases of affluence?

Climate change will impact on health in the future. Warmer global temperatures will increase the risk of heat-related illnesses and will further deteriorate air quality. An increase in extreme events such as floods and droughts will threaten health and human lives. Environmental foundations of population health like food and water supplies will be

²²⁵<http://parishnursing.org.uk/>

²²⁶www.who.int/bulletin/volumes/88/4/10-010410/en/

²²⁷Cf. e.g. WHO, National Institute on Aging, National Institutes of Health, U.S. Department of Health and Human Services: Global Health and Aging (NIH Publication no. 11-7737, October 2011), online: www.who.int/ageing/publications/global_health.pdf

weakened. Moreover, climate change will allow some diseases to spread more easily. But while urban societies in the North may not be heavily affected by these changes, many poor and vulnerable populations are already experiencing the health impacts of human induced climate change, be it through under-nutrition, diarrheal disease, extreme weather events, or sea level rise.

6.2. Health and global strategies in the post MDG era

In 2015 the achievements of the Millennium Development Goals (MDGs) will be measured against the targets set by the global community in 2001. The questions are: What has been achieved and what comes after 2015? How can Sustainable Development Goals (SDGs) be defined?

The health-related MDGs are still "unfinished business". Consultations with stakeholders, especially those in developing countries, are consistently ranking health among the top five goal areas to be addressed, while the development agencies are putting it lower down the priority list.

At its 67th World Health Assembly in May 2014, the WHO proposed the following overarching health goal to be addressed in the period 2015 – 2030:

Ensure healthy lives and universal health coverage at all ages,

and identified four sub-goals:

- Achieve the health-related Millennium Development Goals (MDGs)
- Address the burden of non-communicable diseases, injuries and mental disorders
- Achieve Universal Health Coverage including financial risk protection
- Address the social and environmental determinants of health.

Healthy Life Expectancy (HALE) is a measurement developed by the WHO that attempts "to capture a more complete estimate of health than standard life expectancy rates. HALE estimates the number of healthy years an individual is expected to live at birth by subtracting the years of ill health – weighted according to severity – from overall life expectancy."²²⁸

The WHO defines **Universal Health Coverage (UHC)** as "ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient

²²⁸www.who.int/healthinfo/statistics/indhale/en/

quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services."²²⁹

²²⁹www.who.int/healthsystems/universal_health_coverage/en/

A call to health and healing – Declaration

A call to health and healing – Declaration

Drafted by the participants of the symposium

We, the participants of the Symposium “Christian Responses to Health and Development” held at the German Institute for Medical Mission (DIFAEM), Tübingen, Germany, from 26 – 28 June 2014, are Christians in Health from Africa, India, Korea, Europe and the USA, from different denominational and professional backgrounds, different cultures, yet part of the Body of Christ, His Church in the world.

We affirm that

1. The Christian Church continues to have a unique, relevant and specific role to play in Health, Health Care, Healing and Wholeness, in changing contexts and in all regions of the world.
2. Every human being is made in the image of God²³⁰, created with dignity in diversity irrespective of any personal circumstances, and this is equally true in suffering, disability or when living with chronic disease.
3. God wishes that all may have life; and life in all its fullness²³¹; through living relationships with God, each other, themselves and the world²³².
4. Part of God's call to the Church is a ministry of healing and transformation, with compassion and unconditional love, in the spirit of Jesus Christ²³³, the servant healer and author of peace, justice and reconciliation.²³⁴
5. The WHO Constitution states that “*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being*”²³⁵ – This calls for participation of all in prevention, promotion, treatment, care and rehabilitation, as well as the engagement for justice, peace and reconciliation, taking responsibility individually and collectively.

We want to see

- A world where everyone is participating in the health and healing experience and no neighbourhood is left behind based on the Primary Health Care approach that puts

²³⁰ Gen 1:27

²³¹ John 10:10; 2 Peter 3:9

²³² E.g. Deut 6

²³³ Phil 2:5-11

²³⁴ E.g. Rev 22,1-5

²³⁵ WHO Constitution, www.who.int

A call to health and healing – Declaration

communities at the centre. It is a cornerstone for any health system and can strengthen the key determinants of health.

- Reconciling and healing communities and congregations participating in social transformation.
- Universal health coverage and the protection of individuals and families from falling into poverty through unaffordable health care.
- New financing mechanisms creating equity in health care.
- Health Systems strengthened with equitable access to care taking into account local patterns of disease and evidence-based treatment and care irrespective of whether a person is poor or rich and irrespective of religion, ethnicity, gender or political standing.
- Churches, Christian organisations and networks working together with civil society including people affected by disability or disease to mobilise governments, international agencies and the corporate world for more justice in health and access to medicines and quality health care.
- Opportunities used to develop health care to its highest possible standards in the local context, creating access for those who are poor, marginalised and vulnerable.
- Christian health care that reflects Christ's love, at all levels, for all people in all parts of the world.

We call on Churches to

- Create healing and reconciling communities and congregations that are open for those who are marginalised, poor and vulnerable, restoring their dignity, protecting their rights and nurturing their agency through active participation.
- Accept God's given calling to be hospitable communities of health and healing.
- Support all Christian health professionals and those working within church health systems through training, support, the creation of conducive working environments and the development of career paths, thus enabling a motivated and committed workforce.
- Lift their voice with those who are poor, marginalised and vulnerable for justice, reconciliation and access to quality health care.
- Help in the setting of standards for compassionate and competent care.
- Contribute to the elimination of financial barriers to health care for those who are poor and marginalised.
- Play an active part in developing and maintaining national health systems with the Ministry of Health in collaboration with all stakeholders.
- Participate in the development of local answers to health challenges and share these through their global networks.
- Equip church leaders with sufficient knowledge of health that allows them to be involved in partnership in helping to provide adequate pastoral care and support health workers and communities.

A call to health and healing – Declaration

Governments to

- Ensure that adequate resources are allocated to health to allow everyone access to health care.
- Affirm the local responses as critical foundation for effective Primary Health Care.
- Protect all persons from stigma and discrimination irrespective of ethnicity, disease, religion, gender, sexual orientation or economic status.
- Respect faith based health services as an important part of the public health system and actively engage them as part of civil society to contribute to policy making and accessing respective resources.
- Ensure legislation that fully supports access to quality medicines at affordable prices irrespective of international trade laws.
- Ensure that adequate resources are allocated to fund research into proving better healthcare for those who are poor, marginalised or otherwise disadvantaged.
- Further promote new drug development for diseases affecting those with Neglected Tropical Diseases and other illnesses especially impacting those in the developing world through the use of regulatory incentives and other active measures.

International Corporations, global donors and the private sector to

- Invest in research and development addressing global health needs.
- Provide affordable access to essential medicine and other supplies, especially for those who are poor and marginalised.

We commit ourselves to

- A healing and reconciling ministry that puts people at the centre and allows for a wholistic approach in health care.
- The pursuit of professional excellence and relevance in our health care service and our willingness to learn and share.
- Ethical health care specifically in view of those at the beginning and the end of life or otherwise vulnerable to exploitation and abuse.
- Work with people who are marginalized and to advocate for their health.
- Flexible and adaptive responses to the dynamics of global and local health situations.
- Contribute to research and development in health that is locally relevant, evidence-based, ethically sound and globally accepted.

Network and support each other in mutual respect, demonstrated by an approach of love, justice and compassion willing to learn, share and being a caring, appreciative global Christian community.

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The Institution

DIFAEM – German Institute for Medical Mission is a Christian NGO offering technical expertise and financial support for health services in resource-limited settings. Its special emphasis is on Primary Health Care and access to good health services even for poor and marginalized communities. DIFAEM works in partnership with churches, mission and development agencies and other non-government organizations. Its work is based on and motivated by our Christian faith and seeks to address health issues in a holistic manner. Through its international work, DIFAEM provides support for about 80 health projects mainly in Africa, but also in Asia and to a lesser extent in Latin America. The countries of focus are the DR Congo, Chad, Sudan, Malawi and the Great Lakes Region (Uganda, Tanzania, Kenya), as well as India and Papua New Guinea.

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