



Healthcare missions pre-congress ICMDA World Congress, Arusha, Tanzania

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Introduction

At the International Christian Medical and Dental Association 17th World Congress in Arusha, Tanzania, 1200 doctors from 107 countries gathered for a time of fellowship, training, and networking (Figure 1).¹ A pre-congress workshop was held on the topic of Healthcare Missions from 20-22 June 2023. Victor Fredlund led the three days of sessions with enthusiastic word and song with participants from many different countries.

Figure 1. 17th ICMDA World Congress Participants



Biblical Basis of Healthcare Missions

Mathew George started this first portion with a reading of 1 John 1:1-3 to introduce the grand narrative of God's mission into which our narratives become an integral part, sharing a common life (*koinōnian*) with God. God created the world and directed humans to steward the earth, but human (and angelic) rebellion affected all of creation. Therefore, God entered the world to redeem its broken state and calls and empowers his people to live out his reign until he completes the renewal of all things — from the pure garden to the purified city. The four parts of the metanarrative are the kingdom inaugurated (Gen 1-2), the kingdom abdicated (Gen 3-11), the kingdom restored (Gen 12 & Rev 2), and the kingdom consummated (Rev 21). Humans were created in God's image with relational, language, rational, and oversight abilities and intrinsic

dignity, no matter how impaired they may be. The goal of God for us is to serve our original intentions as vice reagents of the Lord as prophet, priest, and king. God provided the cultural/creation mandate which can be divided into governance, vocational, scientific, and relational mandates to humans. Our work is expressed in community, both “intertwined gifts from God,” turning our area of work or engagement into a showcase of the glory and beauty and majesty of God, bringing God's values and God's will to earth, including into areas of research, turning chaos into order, redeeming broken relationships, and turning injustice into justice. Health was an original “very good” gift of God and indicated His intentions for humans — shalom — multidimensional well-being, flourishing, wholeness, and delight — expressed in right relationships within ourselves, with others, with the rest of creation, and with God. But the kingdom was abdicated through moves toward autonomy, and shalom was lost, nature corrupted (cursed), stewardship impaired, the image of God marred, relationships broken, and behaviours degenerated toward a state of brokenness and disease processes that we experience today. Shalom begins to be restored as a sign of the kingdom being restored.

Daniel O'Neill then led the discussion on how the four-fold theological timeline of creation, fall, redemption, and consummation parallel the four-fold phenomena of shalom, dis-ease, healing, and mission — and the four-fold healthcare approach of physiology, pathology, practice, and purpose. Understanding salvation, healing, and mission starts with the Old Testament view that we dwell in enemy-occupied territory east of Eden, that the Covenants engaged the people of God to be “blessed to be a blessing,” that the Law (*torah*) protected from disease (Ex 19-20, Lev 11-26), and that God called himself Healer (*YHWH Rapha*, Ex 15:26). He calls his people to establish Bethel (house of God) amid Babel or Babylon, and at Shechem in the promised land to announce blessings and

curses with the call to “choose life, that you and your descendants may live” (Deut 30:19). The prophets warned of “sword, famine, and plague” as consequences of sin and injustice, and 1/3 of the Psalms were laments and calls for rescue. Justice toward the quartet of the vulnerable, the “widow, orphan, poor, and foreigner” were moral imperatives which express the heart of God for the marginalized. Salvation and healing are literary parallels linked with worship. “Heal me, Lord, and I will be healed רָפָא (*rapha*); Save me and I will be saved יָשָׁא (*yasha*), for you are the one I praise” (Jer 17:14). The grace of Hezekiah’s temporal healing was an occasion to worship in response to the living God. “Lord, by such things people live; and my spirit finds life in them too. You restored me to health and let me live . . . the living, the living praise you” (Isaiah 38:16 & 19). Healing is more than techniques. Wise speech and pleasant words bring healing (Pr 12:18), just as the Father’s word brings life and health (Pr 4:22). “Good news (*shâmuw`ah* שְׂמֵחָה—the gospel) is health to the bones” (Pr 15:30). Following God’s creation work, humans are called to bring order out of chaos and speak truth for life amid deception and death.

When Jesus Christ was incarnated, peace (*eirene* -ie., *shalom*) on earth was announced. At the beginning of his earthly ministry, he proclaimed that healing and sharing good news with the poor was a prophetic sign of the anticipated Messiah (Lk 4:14-27), and he healed, saved, and proclaimed that the kingdom of God had come (Mt 11:5). He healed with compassion and cared deeply about human affliction, expressing indignation against those who obstructed healing. He then sent the disciples to do likewise — to preach and heal and proclaim the kingdom — first the 12, then the 72 as a witness to God’s power to bring life. Healing was often the first act, provoking questions to which the gospel was the answer — the second act. Only 10% of lepers healed (*katharizo* — cleansed) returned to give praise and thanks to Jesus and be completely healed (*sozo* — made whole, rescued, saved) (Lk 17:11-19), and he was a Samaritan! Healing was extended to Greeks, Romans, and Canaanites who expressed faith, showing justification through faith, reconciling broken relationships, and God’s heart for the nations. “Daughter, your faith has healed you [*sesoken*] Go in peace [*eirene*].” (Lk 8:48)

This healing grace is more than *shalom* (*eirene*) in the bible but also salvation (*yasha/rapha, sozo* - Jer 17:14), liberation (*eleutheria* - Gal 5:1, Acts 26:18), wholeness

(*holokleros* - 1 Thes 5:23, James 1:4), blessedness (*beatitudo* - Mt 5:2-12), and flourishing (*eudaimonia*). It means restoration (of structure, function, purpose, meaning), redemption (that humans are never beyond repair and are of infinite worth), reconciliation of “all things in heaven and on earth” (2 Cor 5), and renewal of “all things” in the end of days (Rev 21:5), including the redemption of our bodies (Rom 8:23). Healing requires a few things. Following Jesus’ example, it requires sacrifice, touch, talk and tokens (instruments of healing), compassion (*splanchnos*), the Word of God (*logos*), repentance (*metanoia*), purification (*kathairo*), holiness (*hagnizo*) — being set apart for noble purposes, and acquiring virtue — that is the cardinal virtues of temperance, fortitude, prudence, and justice — along with the theological virtues of faith, hope, and love. It also requires rejecting vice — an ecology of sin, the cause of much disease.² All this work aligns with God’s ultimate intentions for all of creation. “And the leaves of the tree are for the healing (*therapeia*) of the nations (*ethnos*)” (Rev 22:2).

History of Healthcare Missions

It is important to review history, to highlight the “golden thread” of how the healing metanarrative expressed itself in “fits and starts” throughout history since the Apostles, and to recapture and enhance a biblical and global perspective. In the first few centuries of Church history, Tertullian (ca. 160-220) wrote that “the body is the pivot of salvation,” alerted already in the third century to this lingering danger of gnostic dualism which devalued the human body. Gregory of Nazianzus wrote, “As far as you can, support nature, honour the original freedom, respect yourself, cover the shame of our race, assist those with sickness, and aid those in need.” Augustine encouraged the pursuit of the highest good through “this veil of tears” while manifesting a “certain form of life.” Another North African, Shanuda of Atrrea (upper Egypt) wrote “have you visited the sick person, have you visited the prisoner? Then you have visited the Lord and welcomed him.” He saw illness as an indication of spiritual need, establishing the White Monasteries which included healthcare centres for healing, encouraging women leaders — for care and prayer, especially among the Nubian refugees. In Ethiopia, in the 17th C, Walata Petros was a female leader who prayed for and healed a key leader, Sila, and resisted the spirit-body

dualism the Eastern church saw rising on the West. One of several Ethiopian participants noted that the Ahmaric word for the Savior of the World is *medihaniyalem* (medicine to the world). In Asia, the Syriac Christian community developed with a common theme of health and healing. Ephrem the Syrian was the most influential, associating sickness with sinfulness and healing with sanctification. “It is a suitable help to heal you and be healed ourselves.” Ephrem was appointed as hospitaller and utilized empirical treatments to the sick, but he died caring for plague victims in Odessa in late 4th C (unlike others who fled). This set a trajectory for healthcare within Syriac Christianity which spread across Asia up to 1000 CE. Jesus was called the “Sam-Hi-Aye” (great Healer) in the School of Nisibus (in Turkey) which taught theology, philosophy, and medicine founded by Persian Christians in 350 CE. In the West, by the 6th C, St. Benedict included caring for the sick in the monastic rules, and a series of religious orders developed which focussed on healthcare from 1095 (St Anthony) through the Camillians in 1582.

By the protestant reformation there was a turn away for care for the body possibly because of an emphasis on original sin, and it took a while to recover this. Catholic missions, particularly the Jesuits in Japan and Taiwan and Latin America in the 16th C had significant impact on healthcare and mission. The Great Awakenings (revivals) gave significant impetus for healthcare missions. Dr. John Thomas was instrumental in inspiring William Carey to go to India in 1750. Dr. John Scudder served in India starting in 1819, whose granddaughter Ida founded CMC Vellore and educated women to address health needs — leaving a lasting legacy. Carl Gutzlaff in the 1820s turned his attention to medicine as a key inroad into the heart of the people, influencing David Livingstone and Hudson Taylor. Starting in 1834, Peter Parker, as an ordained minister and physician, opened China, and the same year Dan Beach Bradley introduced modern medicine and opened doors in Thailand. The modern nursing profession had its origin around that time in 1836 when Theodor Fliedner, a Lutheran Pastor, rediscovered the diaconate ministry in Kaisersworth, Germany, which Florence Nightingale visited to acquire concepts of antisepsis and other aspects of effective nursing care.

The Student Volunteer Movement in 1887 with the vision for “The evangelization of the world in this

generation!” hailed medical missions as the most suitable means to achieve that goal. Their call for medical missions gives an idea of the power ascribed to this venture: “We believe that the means must largely consist in reaching the soul through the healing of the body” noting that it was Christ’s method, commanded of his disciples, and that it was an efficient and effective means to accomplish this vision. Much of the interest in medical missions during this era was because of the success of emerging scientific advances. John R. Mott saluted “medical missionary work” as “the climax of the integrity of [the] all-inclusive gospel” because “it gives us the most vivid apprehension of the real meaning of the incarnation and likewise the life of our Lord and Savior.”³

Colin Phaff then led the discussion about the turn of the 20th C when there were significant changes through political movements for independence from colonial powers, the increasing expense of developing technologies, hospital mismanagement, loss of a biblical view of health, excessive trust in science, and privatized health systems. WHO was founded in 1948 and the Tubingen I & II conferences in the 1960s met to reevaluate the role of healthcare outreaches, and they concluded that the church retained a calling to health care, but emphasized the widespread responsibility for all Christians, and this at the community level. This led to the Christian Medical Commission which influenced the WHO decision to adopt Primary Health Care at the 1974 Alma Ata conference with a goal of “health for all”. MDGs in 2000 and SDGs in 2015 were developed as well as the goal for universal health coverage but not with full consideration for the whole person or every distinct ethnolinguistic people group. Christians may have lost this voice at the international level. Tubingen III occurred in 2016 to ask the question, “Does the church still have healing responsibility?” and the answer was “Now more than ever!”⁴ PHC was still declared in the Atsana conference in 2018 as the key approach to health for all (though Christian leaders were not invited). Learning history is more that learning from our mistakes, but adapting the heart of the call of God to be influential in evolving circumstances and in every nation in changing times.

Understanding the World Around Us

Anil Cherian presented the most urgent global health challenges of today: Fragile states (conflict), health disparities, the social (including spiritual) and economic determinants of ill health, communicable diseases (malaria, TB, HIV), mental illness, lifestyle disorders, climate change-related disorders, etc. Tribalism is universal, and “brain drain” is a major phenomenon, along with government corruption and dependency on foreign aid. Pockets of fragility are evident and changing often, with the top 10 fragile states mainly located in Africa, but also Syria, Afghanistan, Haiti, and Yemen. The goal is to build resilience and work with governments (though often corrupt) or other non-governmental organizations (NGOs). Health disparities are geographic between and within countries — unequal access to skilled health workers and medicines especially among marginalized groups — migrant workers, displaced populations, people with disabilities, undocumented workers, stigmatizing diseases, childhood stunting, sexual disorientation, and gender-based violence. Structural causes include inordinate military defence spending, privatization of healthcare, food, and water insecurity. World Bank looks at income per person, but a better index is the Multi-Dimensional Poverty Index (MDPI) and the Global Health Security Index (GHSI), showing that even upper middle-income countries can have a low index.

There is a call to affect health systems and power structures, the principalities, and powers as Christian engagement. Malaria is the greatest threat in many areas, and a persistent problem, especially for infants and children, which has increased since the COVID-19 pandemic. Tuberculosis and HIV are ongoing additional burdens, as well as neglected tropical diseases. Programs are siloed due to funding streams, but the Christian approach is more wholistic and comprehensive. Fifteen percent of the population in LMICs are functionally disabled, with barely any access to healthcare. 970 million people live with mental illness, much with its origin in prior traumatic experiences, and these effect the health of the whole body and impair the development of nations. Lausanne’s recent publication on “The Sahel” notes that it is the most challenging region for global mission as it is ripe with the “perfect storm” of war, climate change, nomads, high population growth,

terrorism, displacement, and a 70% Muslim population.⁵

Dr. Cherian shared about the situation in South Sudan where he and his wife work, where there are 0.16 health workers per 1000 population. To achieve SDGs, 4.5 workers per 100,000 are needed, but most SSA countries have 1.6/100,000 and some of these are poorly trained, so the call is to capacity building, training — including allied health workers — 6.5 million by 2030 (54,000 in South Sudan alone). There is a mushrooming of private training enterprises which are exploitative and lead to limited skills development.

Figure 2. A session on work, vocation, and the heart of God.



Work, Vocation, and the Heart of God

Santhosh Mathew led a discussion of the value of work because God works (Figure 2). Participants shared that we work to see the kingdom extended, to make money, to stay well, to worship, to love, to serve, to have identity, to eat, for meaning and purpose, including unpaid domestic work, and with dignity. God worked by creating before the fall and it was good — manual work was given, along with governance (stewardship), scientific endeavours (naming), and relational development (connecting) in community. God worked and continues to work. “He will not allow your foot to slip; He who keeps you will not slumber. Behold, He who keeps Israel will neither slumber nor sleep. The Lord is your keeper” (Ps 121: 3-5). Jesus answered them, “To this very day My Father is at His work, and I too am working” (John 5:17). Work was ordained by God and was not a curse, and yet sabbath rest was also ordained for our own sake. What is needed is to breakdown dominance and increase affirmation of others, empowering them. The Greek mythology of the rock of Sisyphus shows that unrested work is onerous — work requires rest in cycles to restore and be “re-storied.” It is vital to remember to stop in order to remember all that God is doing, trusting God with the consummation. The work that we now do will be

perfected, completed, transfigured by God, and integrated into the new heaven and new earth, when the saints will continue to work, rule, live, and enjoy each other, nature, and God for all eternity. In other words, our work has eternal significance. Sharing life and reflecting God's character is an intrinsic good, and a demonstration of the gospel, and at times the word of the gospel can be shared, even before world leaders.

Rest is needed daily, weekly, and even every few years for the land (sabbatical), as we take His yoke upon us, so that there is no dichotomy between sacred and secular work. As the Benedictines taught, *Ora et labora* — pray and work, even between patients in order to fight the sacred-secular divide. Martin Luther noted that we are the masks of God, behind which he wants to remain concealed and do all things. Brother Lawrence was practicing the presence of God by peeling potatoes to perfection for God and to be united with God even in the most mundane of labour. We are about *meaning-making* for ourselves and our patients, as co-laborers. Fulfilment is at times elusive in missional healthcare, and there can always be improvement in doing God's work. We are doing the work for God in all things, measured by the obedience index, which is a source of joy, a gift which God shares with us — either now or ultimately in the various seasons of life. Godly goals are the measure of success and lead to true fulfilment, but if our own personal desires are the only goal, it will fall short of the greater good. A sound theology of suffering will help us carry the work load, longing for the consummation, and to reduce the suffering of others in the meantime. This requires going back to Jesus to know him better, to represent him better to others, and to be sent out as he was. It was recognized that there is an undue burden of labour on women globally. Our professions are to derive “bread, house, and clothes,” and the excess can be used for the “vineyard labour” to derive meaning for the kingdom.

Cross Cultural Communication

Colin Pfaff led a time of sharing how our cultural adaptation must start with an attitude of learning and humility, but this is challenging when we bring our own unexamined cultural values and are stretched to follow Jesus' example of incarnation. Cultural differences are often a source of conflict on teams through stereotypes and groupings. All models are incomplete, but a model is used to represent many cultural values, which are neither right

nor wrong, just different. We looked at 6 ways of looking at the world: time vs. event orientation, dichotomist vs. wholistic way of judging things, crisis vs. non-crisis orientation, task vs. personal orientation, status vs. achievement orientation, concealment of vulnerability vs. willingness to expose vulnerability. A scoring tool can be used to assess cultural orientation.

Supporting Cross Cultural Workers

Dave Moore led us in considering challenges healthcare workers face, sharing from his experiences in Papua New Guinea. He did a tropical medicine diploma and other mission training before serving in a team working among 40 of the 850 people groups, some still unreached. Some of the highs were to see how the Gospel is transforming lives and to participate in the team work involved in mission. Challenges included confronting weakness, vulnerability, and burnout. James wrote of endurance, and considering it joy (James 1:2), but this was not easy to apply. He is now Associate Head of Christian Medical Fellowship Global for training. About 1/3 of long-term cross-cultural workers come home due to non-preventable factors (e.g., retirement, to support children or ageing parents, health issues, transition to another ministry role) and preventable factors (e.g., lack of support [including financial], relationship breakdown with colleagues or leaders, inadequate training, poor cultural adaptation). Adjusting to culture shocks can be mitigated by someone coming alongside for ongoing support. Reverse culture shock can be just as challenging when returning to the home culture. Top reasons were burnout and lack of support. Other challenges are the pressure of limited resources, overwork, high levels of exposure to death and disease, moral injury, unexpected administrative and leadership burden, and the allurements of well-paid jobs elsewhere. Rick Allen from MedSend shared about the challenges of longevity for cross-cultural workers, the debt load of health professionals (in the USA), which they seek to repay. Medsend is coming alongside physicians with grants in Africa and Asia and have started the Longevity Project to address the preventable issues which lead to attrition, due to mismatch of training and clinical skills needed on the field, the high rates of death experienced, spiritual life challenges, and mis-met expectations. They offer a menu of interventions with resources for grant recipients to spend on 12 types of support services (e.g.,

counselling, mission training, mentoring, etc.) with a vision to extend services beyond US missionaries after the first few pilot years.

Inspired by Neal Pirollo's book, *Serving as Senders*, we considered different ways to support cross-cultural mission workers throughout their lifelong journeys through prayer, friendship, and giving.⁶ Biblical examples of financial support in ministry included: the Levites (Deut 14:22-23, 14:28-29), Jesus and the twelve (Luke 8:1-3; Paul – Acts 18:1-4, Phil 4:15-19), and the travelling teachers (3 John 5-8). *Interdependence* in the body of Christ is possible, but it requires work! It gives opportunities for others to participate in mission and to bless each other. Other types of support included pastoral/encouragement/visiting, practical/logistical, hospitality, supporting missionary children, clinical (eg., tele-radiology, specialist advice), sending equipment, re-entry/debriefing, and training. The real foundation is about finding our identity in Christ and the development of Christ-like character, especially cultural humility. *Xplore* is a resource utilized by many for preparation looking at the Biblical basis for mission and the 5 habits of a world Christian — praying, sending, going, welcoming, and mobilising.⁷ The *Momentum Yes* course covers similar themes in a video & discussion format.⁸ Other training approaches are through church-based discipleship, mentoring, small groups, training programs (e.g., ICMDA tracks, courses like *Christian Global Health in Perspective*⁹), reading, podcasts/webinars, conferences, and experiential learning. Recommended resources are Hawker & Horsfall's *Resilience in Life & Faith* (including a self-rating questionnaire)¹⁰, *Working Your Way to the Nations* (including a readiness for cross cultural mission questionnaire)¹¹, and *Missionary Care*.¹²

The Call to God's Mission

A panel discussion addressed the call to participate in the unchanging mission of God in healthcare and global health and how the actualization of that call varies and may change over time. The facilitators each shared their unique influences, inspiration, calling, conviction, equipping, steps of faith, challenges, and evolving opportunities. Many were drawn to areas of great human health needs, to least-reached areas, or into academics or the secular global health sector.

Global health research and publishing give influence and a voice in academics, and to show the work of Christ in the world through his followers. Christians tend not to measure their results, trusting God with the outcomes, but the world is clamouring for evidence from FBOs, even participating in localization of funding through collaborations with FBOs. The *Christian Journal for Global Health* (cjgh.org) is one such venue to integrate scientific evidence with Christian faith in mission. Mission agencies do not have lots of resources (or interest) for research, but examples of partnerships with Western secular academic centres exist, serving as an expanded witness and contributing to global health knowledge, especially in neglected areas, and applying God-given wisdom for innovations. Many breakthroughs in innovative solutions to global health problems were initiated by Christian missionaries. Global marketplace workers ("tentmakers") are given opportunity with research projects and the public sector, approached as an integrated ministry even in creative access (closed) countries. For every one formal healthcare missionary, there may be ten with deep Christian faith integrated creatively within the marketplace (but this has never been measured). The biblical vision and the fulness of the gospel need to be owned and applied to unique localized contexts, even contexts hostile to the gospel. This begins to fulfil the prayer "your kingdom come, your will be done," throughout the earth. The key is the centrality of Christ, confidence in the power of the gospel, and creative application in every context where they are sent.

The panel noted the danger of "lone ranger" efforts to be self-supported marketplace workers, due to the lack of structures of accountability and organizational support. Being "on mission" is for everyone, professional and non-professional, local and global, but there is a need to prioritize the least reached, and to sense a specific call and follow that call to be sent. The church needs to be mobilized to support and send to these areas most needed and least-reached.

Tools for Decision Making

Santosh Mathew led small groups which were formed to discuss the call of Moses to lead Israel and the need to learn how to make life choices wisely, especially for the emerging generations. God is a God on mission. Our lives must align with his mission in the world where we find

meaning and fulfilment. Our skills, talents, and professions are given to us to align our lives to God's greater mission. "It is not about what I can do for God, but how can I be part of what He is doing . . . It is not that God has a mission for His church, but that He has a church through whom He accomplishes His mission" (Christopher Wright). It is a privilege to be part of what God is doing and healing ministry is a way for Christ to heal through His people — "Christ in you, the hope of glory" (Col 1:27). It was noted that one might think there is only one singular plan of God for your life and that you might miss it, when, in fact, God gives a series of life choices to navigate on the journey. Some are led by their proclivities and personalities, but being led by these may not be optimal if it leads to not being open for new directions. Some start with listening to one's heart and reflecting where God can begin to lead. If you are not clear (God has not put any specific desire in your heart) — develop a "spirit of indifference" — for example, praying the Ignatian Prayer of Indifference which calls us to set aside "disordered attachments" and embrace what things help us love God and love others more. If there is some nudge in your heart — listen and see if it is from God or from self, if you sense it might be from God nurture it. Understand what the skills and talents God might have given you — but do not be limited by them! Listen to your heart when you see people brought to you with a need — is God bringing these people into your life to challenge you? We are called to be true about ourselves in knowledge and skills in the comparison of competence and self-awareness.

Sometimes the heart is the wellspring of life (Prov 4:23), but it also can be subject to corruption (Jer 17:9). Times of retreat and reflection and engaging with people or "sauntering" instead of hiking, and some get refreshed in the act of labour in the vineyard. The heart can develop fear of missing out, even to the point of paralysis. We must be open to uncertainty, and embrace the mystery of God, while holding loosely to some lesser things. We must practice "double listening" to the Word and the world — looking at health and gospel gaps and seeking to fill them. Listening to the world includes looking at which communities, people groups, nations, or tribes have the greatest need for health care — for the area you think you can best contribute. Understanding which communities do not have a Kingdom presence and lack health care access and seeing if there are communities where both these needs are urgent and critical. Expose your self to these possibilities — take time and visit some of the communities

and see if God is nudging you through what you've experienced. It is important to engage the heart, brain, and soul in deciding where and how to serve as a disciple who makes disciples — being careful not to frame goals as "finishable" with clear metrics or using dichotomies of "dark" and "light" places to serve. Even the rich and educated are desperately in need of God's love. "Who is my neighbour? The neighbour is not he whom I find on my path, but rather he in whose path I place myself, he whom I approach and actively seek" (Gustavo Gutierrez). We often do things based on what we think is best, without listening well-enough to the past. Listening to the Word means in your times of quietness with God and studying the written word will give needed direction, but also listening to the Word through friends, mentors, and communities of which you are a part. Listening to what others have done earlier — listening to stories of people who have walked these paths of decisions and engagement before. We step out in faith with the little clarity we have, step by little step. "The place God calls you to is the place where your deep gladness and the world's hunger meet" (Frederick Buechner). Understanding the bible in its entirety, in context, helps to follow God's direction for our lives and those around us now in our own contexts, holding the stories of the past with our own futures.

Mobilisation toward Healthcare Missions

Anil Cherian led the discussion on mobilisation and discerning where to serve. The top 10 concentrations of Protestant Christians are in the US (160M), Nigeria (60M), China (58M), Brazil (41M), South Africa (37M), UK (34M), DRC (32M), Kenya (24M), Germany (20M), Indonesia (20M), and India (11M), with significant change over past 100 years. South Korea started with a handful of converts in the late 19th C to almost 10M (20% of the population) today, and is commissioning the second largest number of missionaries in the world. The African Continent has the largest number of protestants. The number of commissioned missionaries from 1900 to 2020 increased from 62,000 to 425,000, but the ratio of missionaries to Christian population decreased from 1/1220 to 1/6000, suggesting a decline in missional thinking and engagement. In 2021, 53% were from the global North, down from 88% in 1970's. There is a notable increase in sending missionaries from Brazil, South Korea, Philippines, and China. There are more Christians but

relatively less sent from the global south – 66% in the global south, but they send <1/2 of missionaries (this may not include those not in full-time Christian work with a mission agency).

We noted 15-20 medical colleges were established by Christian missionaries which are still in operation with 1500-2000 graduates every year. There has been a global shift in Christianity to the South and East, the rise of Pentecostalism, globalisation, migration, multiculturalism, travel, tele/electronic communications, old evils not resolved (slavery, trafficking). The barriers are theological (a need for greater convergence of word and deed, mind and body), addressing dualism (either-or, sacred-secular), and a misalignment of historical paradigm with original commission. The term “medical” assumes a professional biomedicine enterprise, typically curative care, but “healthcare” is a broader term. Mission requires considerable finances and challenges, especially challenging for low resource countries. The Lausanne movement was established to develop global alignment, integration of faith and deeds, and the people-group concept. They only just recently added the *Health for All Nations* issue network (2014). They are challenged with holding conferences in English (language hegemony), and in what new ways do we need to view missions? How can the local church and the leadership structures be engaged? How can we meaningfully partner and communicate between agencies and various countries facing global challenges, and how do we engage with new and emerging churches? How do we follow effective and proven models but remain open to innovation and to broaden healthcare from physicians and nurses to allied health professionals, public health workers, community health workers, and broader development workers. We must see where God is working, and join in envisioning mission and building capacity.

Wei-Leong (William) Goh, Family Physician from Singapore and general secretary for ICMDA in Southeast Asia, shared about the 2017 first conference in Bali. He asked what healthy thriving communities would look like (10 countries) in the ecosystem in that region. Several groups formed — focussed on UPGs, public health, creation care, and diverse generations. They invited all mission agencies, then developed WhatsApp groups for communication. Friendships formed, being less about presentations and more about conversations. There are engagements like environmental activism for health

(“Saving the Rainforest with a Stethoscope”), advanced degrees in public health, and other young doctors doing very creative missional engagement in Asia.

Anne Bodilsen, an abdominal surgeon from Denmark, board member from CMF, noted there has been a trend toward short-term missions for various reasons in Europe, which undermines effectiveness due to lack of acculturation, etc. For some, it is working locally, or short-term projects, teaching other health workers. She noted a growing immigrant population, some undocumented, and human trafficking as issues to address. In Germany, another participant working with Frontiers in Chad noted the importance of the local church to foster good sending relationships among younger people with mission interest. Another from Sweden noted a lack of training for cross-cultural healthcare missionaries.

David Moore, head of mission for CMF (UK), noted that of the 4000 members, 105 are serving overseas, missionaries and non-traditional marketplace workers. Trying to help workers see themselves as part of the larger mission where ever they work. They run the *Developing Health* course and have a Global Track with mentoring, webinars, and training.¹³ “Medicine, Mission and Me” is a residential retreat.¹⁴ “Momentum, Yes” is a video-based small group program to enhance Church engagement. Pull factors and push factors for engaging in mission are unreached people groups (UPGs), and global needs/disparities. During the past 5 years, there were disruptors to mission engagement: COVID-restricted travel, cultural movements which emphasize decolonization, white saviourism, and intersectionality, the environmental concerns affecting willingness to contribute to emissions via air travel, and the need to work in home country to keep licence, navigate visas, etc.

Daniel O'Neill noted the 350-year-old Christian mission heritage of his own ancestors from colonial America, and the migration of the centres of mission drive from the north in his own country (New England) to the south (which has become the “Bible Belt”) and now missionaries are being sent back to the secularized north and throughout the world. In the Southern U.S., a yearly mobilising conference in Louisville, KY attended by thousands of students, and health professionals get equipped and connected with sending and training agencies, along with several other regional conferences.¹⁵ CMDA (USA) has a Center for Advancing Healthcare Missions with equipping resources.¹⁶ There is also a

whole-person care movement (Global CHE Network) and increasing numbers of faith-based Family Medicine residency training programs. While the US still sends the most missionaries (130,000 currently, possibly 13,000 healthcare-related), there has been a history of “mission drift” of Christ-based academic centres and hospitals and reduced willingness to serve long-term cross-culturally, as well as diversion to short-term mission experiences. The organisation *Health for All Nation* at Frontier Ventures was created to address upstream causes of human disease and strategic, innovative approaches to promote global health — a touchpoint for Christian witness.¹⁷ The Lausanne movement accepted *Health for All Nations* as an issue network in 2014, producing a Global Classroom¹⁸, published a special issue on healthcare missions on the frontiers¹⁹ and acquired a track in the mission network, *Missio Nexus*, publishing a special EMQ issue on healthcare missions in October 2023.²⁰

Osemven Asemoto, former head of CMDA Nigeria, noted Nigerians are the most persecuted Christians in the world (70% of all martyrs), and they are also dealing with fragmentation of denominations with various approaches. But due to the “brain drain,” they have sent missionaries involuntarily throughout the world. They started the Institute of Medical Missions (IMM) to train young doctors and nurses to be deeply mission-minded.²¹ They collaborate with churches and foreign partners for synergy doing medical outreaches, noting that medical outreaches have been very good inroads into non-Christian regions for both churches and partners. Also, due to corruption in the government, they do advocacy for just policies and encourage academics to reach the academic community, including Professor Chima Ariel Onoka, current CEO of CMDA Nigeria — producing “Gamaliels” who can speak to the “Sanhedrin” of our day. 80% of doctors emigrate from Nigeria, and they equip them early to use the stethoscope like the rod of Moses to liberate others from the kingdom of darkness wherever they go.

Varghese Phillip from Mission Aviation shared a vision for a young doctor sensing a call but with many obstacles. He discussed the three categories of nations: 1. Countries with desperate need but visa and access restrictions. 2. Countries with human resources but churches not willing to support doctors, not considering it proper mission work. And 3. Countries with resources but unwillingness to go (long term). He suggested coming together for networking and to develop a platform needed

to mobilize resources in synergy together through shared training programs, funding, etc. The key problem is motivation. A key question to ask: “To whom does my life belong?” Even one week of training can be instrumental, exposing young professionals through small group training, information-sharing, mentoring, and modelling.

Alan Gijbers shared about Australia — the secularization and increasing irrelevancy of the Christian faith in the West, regarding God as an “optional extra.” He enters into discussions in the academy — about humanity, spirituality, and flourishing. The older paradigm of sending missionaries has not resolved, but there are alternatives to be on mission.

Conclusion and Call to Action

Victor Fredlund concluded the sessions noting that the world is in decay, but God is healing in all the earth through his emissaries, but how can they go unless they are sent (Rom 10:15)? The facilitators recognized the significant contributions shared from the culturally and geographically diverse participants, and an invitation was extended to continue the conversation. Together we can further share and grow in our application of the learning. Our strength is in our diversity, and God has crafted each for a unique contribution to the healing of nations. To apply what we have learned from one another to care enough to speak of God’s glory across the world, the synergy to build capacity, and the willingness to do the healing work of God to the ends of the earth

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