# CHRISTIAN MEDICAL MISSIONS

## Principles and Practices in the Church's Role for Effective Community Outreach in the Philippines and Beyond

**By**

**Robert H. Munson**

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**Cover photo:** Medical Mission held on the river island of Pulo, in Macabebe, Pampanga (Philippines). Celia Munson (wife of the author) and others are serving at the Registration and Blood Pressure station. Held on April 11, 2010, as a social ministry of Bukal Life Care.

## ACKNOWLEDGEMENTS

Vital to this work is my wife, Celia. She is a nurse by profession and this has been important for understanding medical missions. She has organized and led numerous missions herself, and has been a valuable resource. Rev. Dan Carlton, encouraged a mechanical engineer and nurse in Virginia to go to the Philippines and see what God has for them. We are thankful for his support, and for our home church of Spring Hill Baptist (Charlottesville, VA).

Rev. Jun Vestidas of Calvary Baptist (Baguio City) and JR Andres of Dakilang Pag-Ibig DIADEM Ministries helped my wife and I get started in medical missions and inspired us to move forward in this work. Many of the people we worked with also helped with the interview research involved in this work. For them and others that shared their knowledge, I am extremely grateful.

Dr. Dan Russell, my advisor/supervisor at Asia Baptist Graduate Theological Seminary has helped me put together research to understand medical mission events better. Additionally, other members of the sfaff and faculty ot ABGTS reviewed and assisted in ensuring that the research was sound and could be turned into a meaningful dissertation. They were a great help, and this book would not have been much if there was not first a dissertation.

This is a short, and arguably completely inadequate list, but I hope others will understand my appreciation of their expertise and support. I hope they are satisfied with the results.

## FOREWARD

This short book is based on a dissertation for my doctorate of theology degree at Asia Baptist Graduate Theological Seminary. The dissertation is entitled, **"STRATEGIC USE OF MEDICAL MISSION EVENTS IN LONG-TERM LOCAL CHURCH OUTREACH: A CONSULTANT-STYLE FRAMEWORK FOR MEDICAL MISSION PRACTITIONERS IN THE ILOCOS REGION, PHILIPPINES."** This unjustifiably long title simply means that I researched and interviewed people who have been doing Christian medical missions events in the Ilocos Region (Northwest Luzon) of the Philippines. Based on the research and interviews, I developed a way to guide and troubleshoot medical missions so that they can be integrated into long-term ministry work, by a local church, in its community.

In addition to this, I have had a fair amount of experience in organizing and participating in medical mission events in the Northern Philippines. I assisted and later organized medical missions as Director of Missions at Calvary Baptist Church in Baguio City, Philippines (2004-2007). I also helped found and worked with Dakilang Pag-Ibig DIADEM Ministries, a medical mission organization also based in Baguio City. I was involved with them from 2005-2009. Then I was involved with (and helped found) Bukal Life Care & Training Center, a ministry focused on training and pastoral care, but also involved periodically with medical missions (2009-present).

It should be noted that while the research centered on Northern Philippines, I believe that the basic principles and methods will

work in much of the Philippines. However, some areas, such as heavily urbanized or Muslim tribal regions may prove to require modifications. Hopefully, some others could research this. The literary research also included ministry work in other countries. It is hoped that the principles may have value in other parts of the world as well.

A final note is that the findings support a broader understanding of how short-term missions activities can assist long-term church/mission work. The fact that it CAN suggests the other truth, that short-term missions activities often DOESN'T assist long-term church/mission work.

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## INTRODUCTION

Medical Mission Events are extremely common in Philippines. They are done by many groups-- government and non-government, religious and secular, national and international. However, there is a question as to whether they are effective. There are those who feel that medical missions are useless. Some go further and suggest that they have a negative effect on community health. These concerns need to be faced honestly. In the church setting, at least in the Philippines, medical missions appear to be less controversial. Churches generally seem very willing and happy to have a medical mission done with and through them as long as it doesn't tax their resources much. Yet there appears to be disagreement as to why medical missions should be done at church.

Consider, for a moment, three (of many) medical mission sites that our team has been involved with in the Ilocos Region of the Philippines. Site A is a small city. Our team was asked to partner with a foreign NGO (non-government organization), the local city government, and a small local church. Things rapidly spun out of control when the city government invited more people than had been agreed upon. Our own team was ill-prepared to deal with the government and the crowds. The local church chose to take a passive role in the event. Little to no tangible results were noted, of any sort, after the medical mission.

Site B is a fairly remote rural barangay. The team partnered with a local church-planter who had had difficulty being heard in the community. The medical mission was done with the church-planter as the only local partner, without the involvement of local

government or other civic organizations. There was no measurable change of the physical condition of the people. However, the event greatly helped the church planter, who was able to formally organize a vibrant local congregation within a year of the event.

Site C is a barangay on the edge of a large village. The team worked closely with an established church, as well as the local government. Several positive results occurred from the event. First, the local church was able to grow and expand ministries. Second, the church developed a healthy positive relationship with the local barangay government. Third, follow-up work led to a series of community development projects both within the church and with others in the community.

All three of these sites were in the same province and were, in fact, within a short drive of each other. The actual medical mission event for each was not all that different in its plan and execution. The differences in results were due to more subtle things. The three sites in no way show all of the possible results of a medical mission event, but suggest three common results. The first event is where considerable money, time, and labor is expended for little to no tangible results. The second event is where resources expended help lead to measurable spiritual fruit, but no direct impact in other aspects. The opposite can, of course, also occur, where physical or developmental fruit occurs with no associated spiritual impact. The third event is where tangible improvement happens in multiple facets within the community.

Assuming that the over-arching goal is that the community and its residents are helped long-term by the medical mission event on multiple levels, the question is how to ensure this happens. Medical missions that do not lead to long-term positive impact may be an unnecessary waste and perhaps should be replaced by more effective strategies. Since medical mission events are so popular both with those in the church and those outside the

church, especially in the Philippines, it is worth the effort to determine if medical missions can be done to make effectiveness likely.

There are several reasons why it is important to gain a clearer understanding of the how's and why's of medical missions. **First, it will help medical mission organizers work with local groups effectively for church planting and church growth.** Dr. Amadeo Laxamana (former Director of Medical and Social Ministry with the Luzon Convention of Southern Baptist Churches) stated this very fact: that there is a great need to understand better the role of medical mission events within the broader goals of church planting and church growth.[1]

Ignacio Andres Jr. also believes that additional research is needed to understand how to ensure that medical mission events support a long-term local church ministry. He is the president of Dakilang Pag-Ibig DIADEM Ministries (DPDM), a non-government group that organizes medical mission events. He notes that some medical missions appear to support lasting change in a church while others do not. Understanding the necessary components of sound strategy and planning should help ensure that medical mission events are used effectively.[2]

**Second, it will give insight on how to make medical mission events become part of the solution in meeting genuine long-term needs within a community.** Dr. Victor and Rhodora Mendoza, leaders of the Philippine-based Holistic Community Development and Initiatives Inc. noted that medical mission events, while popular with churches and other governmental and non-governmental groups throughout the Philippines, often have little long-term impact in the community. Medical mission events should generally be categorized as relief.[3] Relief work is ministry that seeks to meet one-time needs. It is short-term in nature and, commonly, in impact. Needs handled in relief work include food, temporary shelters, clothing or emergency financial assistance.[4]

Jerome Baggett laments the tendency of churches to minister to their communities in ways that are short-term without providing help with deep or long-term problems.[5] This challenges medical missions to be linked properly to longer-term strategies in the local church.

**Third, it will help the church have a vital role in the community.** Bryant Myers, of World Vision, notes that churches often narrow their concept of ministry and miss opportunities. Sometimes churches and parachurches coexist with a certain amount of uneasy hostility. At other times they divide up what ministries should be carried out by each. Myers sees this as a deeply flawed relationship.[6] Churches should be ministering in their communities broadly in viable and understandable ways. John R. Cheyne, a missionary with the International Mission Board, notes that the church's absence from community concerns raises a serious question. He says,

> One of the questions that is being asked and will be asked over and over again is that of the authenticity of the church. Nationalism, ethnicism, and political ideologies all rise up to ask the same question- "Is the church genuine?" In the context of real-life concerns, human suffering, isolation, hunger, displacement, loss of franchise and basic freedoms, they may also be asking, "Where is the church?"[7]

For the purpose of this book, the following words will be defined as seen below:

***Medical care.*** I am utilizing the broader definition sometimes used to describe primary health care. It includes, per the World Health Organization Symposium, 1982, *"health promotion, prevention of disease, nutrition, basic sanitation, health in the workplace, and first-line medical care."*[8] For medical mission

events, this could include general medical, dental, and surgical care. Additional services could include such things as diagnostic health screening, eye care, health training, acupuncture and clinical massage.

**Strategy.** The utilization of money, time, and personnel effectively and efficiently to allow a church to accomplish its God-given mission to be witnesses and instruments of God's love to its surrounding community.[9] The term "strategy" is important here, since a medical mission event is not simply about an event, but integrating it into a long-term church strategy.

***Medical mission event.*** A short-term activity organized to provide medical care for the inhabitants of one community. For the purposes of this book, the term is further limited to those that are organized by Christian churches or organizations as a part of Christian ministry.

With this in mind, the purpose of this book it to look at strategies and guidelines for the use of medical mission events in such a way that medical care is provided and local church outreach and impact is expanded within a community. The purpose is not the "nuts and bolts" of organizing a medical mission. There are considerable resources available for that already. Books by Steffes and Kuhn are good places to start (refer to the Bibliography for these and others).

# CHAPTER 1
# MEDICAL MINISTRY AND THE CHURCH: A SHORT HISTORY

I have come across those who feel that the church should have nothing to do with medical care. Some feel this way because they see the church as only involved in "spiritual" ministry. On the other hand, some see health ministry as being Christian only as part of miraculous or prayer-based work. These two extremes in no way describe all of the possible views that Christians may have about medical care. Missions is a practical theology (ideally) drawn from Biblical (and Systematic) Theology. As such, the Bible is vitally important in giving insight into the purposes and range of appropriate practices as seen through the Word of God, the life of Christ, and the practices of Hebrew and Christian faithful. Additionally, Christianity is not simply something done today based on a history that ended 2000 years ago. The history of the church is our history, the people in that history are our family, and we put ourselves at great risk to ignore that history. The review of Christian medical ministry from the 1st century to the 20th century gives insight into how the church interpreted its Biblical mandate at different times in history.

## Medical Ministry Before the Church

The Old Testament shows medical ministry in some diverse ways. A short list of references of medical ministry in the Old Testament include:

- Ezekiel 34
- Numbers 21:8-9
- Leviticus 13 & 14
- I Kings 17

**Ezekiel 34** is the parable of the bad shepherd. If you are not familiar with it, don't be afraid that it is in the challenging middle section of the Bible. Take time to read it. It refers to political and religious leaders in Israel. These leaders failed, in part, because they neither healed the sick nor bound the broken. Although this passage is written as a parable, it seems reasonable to assume that physical care is part of their responsibility. This point is supported with the other listed passages. Leaders (religious and political) were responsible for both the physical and overall well-being of their people. Numbers 21 describes Moses, a political leader, addressing the problem of people who have been bitten by poisonous snakes. The Leviticus passage describes the responsibility of priests to diagnose, quarantine, and evaluate the cure of various skin diseases. The passage in Kings is one of the passages where prophets do miraculous physical healing. Political and religious leaders in Israel were to be involved in addressing the medical concerns of the people.

The Old Testament references share a common concern for the well-being of the people. However, different methods are used. They include miraculous healing, common medical or first aid care, public health policy and quarantine. There appears to be no one single “blessed” form of medical care.

The Gospels refer to the life of Christ prior to the formation of the church. Since Jesus provides the basis for Christian faith and living, Jesus' relationship to medical/physical ministry (as well as that of his disciples) is highly relevant.

Jesus did healing as part of His ministry. Luke 4:18-19 gives Jesus' self-understanding of His ministry. He stated that among other things, He was to give healing and sight to the blind. This cannot simply be taken as figurative language since Jesus did in fact heal as part of His ministry. Additionally, Luke 7:20-23 states more explicitly that caring for the blind, deaf, lame, and leprous was part of His work. These passages show that healing was not a trivial part of His ministry. They also show that Jesus understood that healing was a sign of His being the fulfillment of prophecies since the two passages refer back to prophecies in Isaiah 61 and Isaiah 35 respectively.

One might still argue that medical ministry within a Christian context is not validated by Christ, if Jesus saw healing only as a sign of His divine role. Others might draw a strong separation between "miraculous healing" and "medical healing." I have come across some people who have argued that standard medical care is demonic, since it utilizes the modern equivalent of herbalism ("pharmacia"), which was commonly tied to pagan practices in the time of Christ. For them, one is from God and the other is not (or at least is less so). However, since medical healing utilizes what God has created and designed to aid in healing, it seems flawed to assume it as being of a lesser origin than "miracles." Nevertheless, it is wise to look for additional evidence as to whether medical ministry is Biblically sound.

An important passage that speaks of medical ministry is Luke 10:25-37. This passage involves the parable of the Good Samaritan. In this parable, a Samaritan discovers a man who had been robbed and brutalized by highwaymen. The Samaritan applied oil as a salve, wine as a disinfectant, and bandages to protect the wounds and promote healing. Then he transported the injured man to a place for healing, nursed him for one day, and paid the innkeeper money to continue nursing. The purpose and application of the parable demonstrate that this story describes a sound Christian ministry. The purpose of the parable was to

explain the meaning of the phrase, “and love your neighbor as yourself” as well as add insight to the question of who is one's neighbor. The application is, perhaps, even more direct since in verse 37 Jesus tells those listening that they are to “go and do likewise.” This passage demonstrates that non-miraculous healing care to minister to someone in need is good, consistent with, and, indeed, commanded by our call to love our neighbor.

Another important passage is Matthew 25:31-46. This passage contrasts those people that please God and those that displease Him at the final judgment. Those who please God and are welcomed by God include those who care for the sick, along with those who minister to other physical and social problems such as hunger, thirst, homelessness, exposure, and imprisonment. Jesus states, in verse 40 that,“inasmuch as you did it to one of the least of these My brethren, you did it to Me.”

The Luke 10 and Matthew 25 passages together close a logical loop. Matthew 25 states that loving God/Jesus compels one to care for the sick. The Luke 10 passage states that loving one’s neighbor also compels one to care for the sick. Therefore, while Luke 10:27, known as the Great Commandment, may have two components, they are inseparable. Medical care is a normal and necessary application of the Great Commandment.

**Medical Missions History in the Early Church**

The early church continued the role of Jesus as a healer. The twelve along with Paul and some others did miraculous healing. This was done commonly as a demonstration of their message, although certainly compassion must be part of it as well. As Paul said, the Greeks seek wisdom, while the Jews desire a sign. Medical care, especially miraculous cures, can serve as such a sign. An additional passage is James 5:14-15. This passage shows that caring for the sick is a normal ministry in the early church.

The sick were to come to the church elders for anointing with oil and prayer. Anointing with oil was a common part of medical treatment (such as in the Luke 10 passage); so the oil could suggest medical care, at least symbolically. However, the anointing with oil could suggest the Holy Spirit. It may be too limiting to be dogmatic as to whether this passage is about miraculous or non-miraculous healing. Paul healed miraculously, but also gave Timothy medical advice for a nervous stomach (I Timothy 5:23). Either way, caring for the sick was seen as an important part of the ministry of the church.

The early church took the role of caring for the sick and dying seriously. The early church fathers and missionaries provide insight as to the church's attitude and role in the area of medical care. Polycarp (69-155AD) stated that church leaders (presbyters) were to be compassionate and merciful. Part of this behavior involved visiting the sick.[1] Justin Martyr (103-165AD) noted that Christians of financial means were to give to the church money to help those who are in need. Among these who were to be helped financially were those who were sick.[2] Irenaeus (died circa 202AD) wrote that all Christians were to use the gifts given them by God for the good of others. One was the gift to heal the sick.[3] Eusebius of Caesarea (263-339AD) notes that Christian witness was often most clear to outsiders during times of plague or other emergencies.[4] Cyprian (died 258AD) saw the necessity to care for the sick and dead, both Christian and non-Christian alike, and encouraged his church members to have no fear of illness and death caused by providing such care.[5] Dionysius of Alexandria (died 265AD) reiterated Cyprian's call and more clearly noted the danger associated with providing such care.[6]

Over time, medical care in the early church became more sophisticated. During the first millenium of the church “Nestorian” missionaries were setting up hospitals along with educational and spiritual institutions throughout Central Asia to provide help for the local peoples as well as to propagate the

Gospel.[7] It is evident that medical care and other forms of social ministry were considered a vital part of Christian life and ministry.

**Modern Medical Missions History**

I am going to skip a few centuries, not because they are not important, but I believe that the pattern set in the New Testament church and the Church Fathers, is pretty clear. The role, however, of medical care within the context of missions in recent years is more immediately relevant to this book, so focus will be placed on the 20th century.

In the last two centuries, medical care as part of intentional missions strategy has grown in import. However, medical mission history has had limited coverage in academic studies. Despite recent works by Grundmann[8] and Hardiman,[9] there is a lack of research in many aspects of the medical missions throughout church history. This may be due to the secularist emphasis in colonial and medical historical research.[10] However, this book is not focused on history, but rather how medical mission events fit into the broader history and understanding of medical work in missions. Thus the focus here will be on major changes during the 20th century, and into the present.

Thomas Ayers, a medical missionary working in Asia in the early part of the 20th century wrote, in 1930, about medical ministry, and discussed what defined successful medical ministry work. He focused on the role of foreign missionaries in full-time medical service. He felt that evidence of success of medical mission work was seen in the increase of medical missionaries, mission hospitals, medical colleges, scientific research, and quarantine policies in the field.[11]

David Seel, a medical missionary working in Asia wrote, in 1979, with a decidedly different perspective on medical missions.

Although, his work focused on mission hospitals, he noted problems with this traditional form of medical ministry. He said that the traditional emphasis on medical training centers, clinical excellence, disease-orientation, and focus on medical science was a problem.[12] He believed that medical missions must be more people-centered where compassionate care takes priority, and more focused on promoting healthy lifestyle and providing pastoral care.[13]

Robert Wenninger, nearly ten years after Seel, noted that growth of primary health care eroded faith in the mission hospital. He noted that many at that time felt that primary health should replace medical hospitals. Others felt that the two complement each other. He noted that few are going into full-time medical mission work because of the sense that it is a dying ministry.[14]

Grundmann, writing in 2008, shows a continuation in the trend noted before. He tracked medical ministry back to the compassion work of the early church. He also reported that medical missions has moved beyond narrow definitions of medical doctors healing diseases in hospitals, to a full range of promoting well-being in a community.[15] Mission medical care needs to move beyond the mission hospital to meeting specific needs that the local health infrastructure cannot, or does not, handle. This may include serving the poor in urban areas and those with HIV and AIDS.[16]

This survey of medical missions shows a gradual, yet radical, transformation. Medical missions, over time, have moved from a focus of medical doctors treating diseases in hospitals and clinics to a decentralized health care utilizing a mixture of professional and non-professional healthcare workers. Also there has been a movement from focus on curative treatment toward preventive treatment and an associated broadening of definition of wellness.

**Conclusion**

Medical care is clearly part of the role of the church as can be seen within Biblical History and Church History. Different methods of medical care have been used and it seems as if no particular form of medical care is deemed as blessed or superior over another. This book does not strictly define what forms of medical care can be used. Curative medicine, preventative medicine, and hygiene training are certainly aspects appropriate to medical mission events. That doesn't deny prayer, psycho-emotional counseling, alternative medicine, and so forth as possibly having some relevance within such a ministry.

## CHAPTER 2
## PURPOSES AND PROBLEMS IN MEDICAL MISSIONS

One cannot know what one should do unless there is first an understanding of what the goal is that needs to be hit and what problems must be avoided. A solid understanding of problems and purposes is foundational for determining appropriate practices.

### Purposes

Since Christian medical missions is supposed to be... well... Christian, theology must be considered. A key set of theological purposes relate to the nature of Christ or to the nature of missions. Both Fountain[1] and the Dohns[2] note that medical missions are consistent with following Christ's example**.** As described earlier, Jesus' expression of His mission to the world given in Luke 4:18-19, notes healing to the brokenhearted and restoring sight to the blind as among these. Stott views John 20:21 as suggesting that our mission must be modeled after Christ's. Therefore, healing is a necessary part of missions.[3] Further; Christians are called upon to help the sick and needy.[4]

Matthew 25:34ff shows the depth of Christ's desire that His disciples care for the sick and needy. Stott concluded that we are not to limit ourselves to the "spiritual" aspects of missions only.[5] Spiritual and social ministries should not be thought of as independent, but interdependent, like two blades of a pair of scissors or two wings on a bird.[6] Heldt takes the point further. As a medical doctor and missiologist, he believes that any biblical understanding of mission must integrate spiritual and social aspects.[7] Medical missions have purpose if they are consistent with Christ's nature and mission.

While the theological purposes for medical missions are deontological, the second category is distinctly teleological. This category is "benefits to role players." Some role players include senders, goers, hosts, and recipients. Bridges notes that central aspects of medical missions involves providing various forms of needed physical care, spiritual care, and resources to those in need.[8] Nelham repeats a similar set of priorities, noting that recipients are the most obvious beneficiaries.[9] However, hosts and locals working with the medical mission team, should also benefit.[10] Likewise, the goers and senders should gain experience[11] and vision[12] from the mission event as well.

Medical mission practitioners give a similar list of purposes. These were grouped into several categories. When asked about purposes of medical mission events, the first reason given by most of the interviewees was **evangelism**. This seemed to suggest that this was their primary motivation. It should be noted that the interviewees were leaders of evangelical churches or involved in evangelical mission groups, so it is not surprising that evangelism was given priority. A second reason listed was to **meet the physical needs of people** in the community. A third reason was **addressing social problems or needs within the community**. Some emphasized that these various community needs should be thought of together as the **wholistic needs of the community**. A fourth area was the **needs of the church**. These could be sub-

divided into two categories. One of them was the caring for those within the church, while the other was making the church more effective in working within the community. The final area had to do with Christ. This was expressed different ways. Some spoke of expressing **Christian love to the community**, while others spoke of **following the example of Christ**. A statement that encapsulated the interviewees understanding of the purpose of medical mission events was a statement by one who said,

> "The church should understand that Jesus is the healer. He appointed and anointed the church to bring a holistic healing to the world – and not just limited to the spiritual aspect although this is their topmost priority. I believe that the gift of healing may also be entrusted to Christians who are doing medical practice. Thus, medical mission is a tool in bringing spiritual healing using the felt need as a stepping stone."

Purpose Summary

Firstly, physical, spiritual, social, and wholistic needs together as **"Needs of the Community."** Secondly, love and Christ's Example for grouped level one categories were grouped together as **"Christian Love."** Finally, the two remaining items were combined as **"Empower the Church for Impact"** in the community. Therefore, there are three major purposes for doing medical missions. The first purpose in medical mission events is to provide for the various types of needs of the community. The second is a practical demonstration of Christian love. The third is to empower the church to impact its community. These purposes are very much related. In fact, these purposes could be synthesized into a common statement of purpose. Such a statement could be as follows: ***Medical Missions is one form of a practical expression of Christian love that empowers the church to impact and address the various local needs of the surrounding community.*** Based on the interviews done, medical missions that are inconsistent with the above statement must be

considered suspect (at least within the context of evangelical medical mission events).

**Problems**

There are three major areas of problems in medical mission events were noted by the writers. The areas are strategic, medical, and attitudinal. Generally, these problem areas were not considered insurmountable, but must be addressed to ensure mission events achieve their intended purposes.

There are potential **strategic problems** in medical mission events. The problems centered on efficiency and effectiveness. In the area of efficiency, Adeney, among others, noted that medical mission events tend to be an inefficient use of money. This is especially true when a medical mission team flies from overseas. The cost of the airline tickets alone makes many medical mission events an expensive proposition.[13] Inseparable from inefficiency is effectiveness. Efficiency, after all, is the ratio of effectiveness to cost. Bezruchka is quite outspoken in his belief that medical missions tend to be relief-oriented and likely to have little positive long-term impact.[14] DeCamp goes further in suggesting that medical missions not only often do not have long-term benefit, but may undermine long-term development work.[15] A further problem that is particular to the Philippines is the role politics plays in medical missions. Elected officials often use medical missions as a way of promoting themselves before elections. The problem is that medical missions commonly are not the most effective use of resources for regional health.[16]

Of equal concern are **medical problems**. The concerns here are that the medical care provided is inappropriate or inadequate. The medical care can be inappropriate since it relies on resources that are not available in the community.[17] In fact, the medical care given may harm local health care systems.[18] Lack of knowledge of local problems, local laws, procedures, and standards for health

can hurt the effectiveness of teams.[19] Additionally, medical care utilized tends to follow a more "Western" model of care, rather than wholistic model, and more curative than preventive.[20] Therefore, the broader underlying problems may not be dealt with, but simply be masked. Even if the medical care is appropriate, it may be inadequate. Inability to do follow-up hampers any long-term effectiveness. In fact, the ability of medical missions to, alone, provide long-term improvements is questionable.[21] The sum of this is that locals may be placing false hope in the medical care that is being provided to them.

A third area is **attitudinal problems**. Many medical mission teams come into a community with a paternalistic mindset.[22] The teams go in as teachers, but are unwilling to learn[23] and share ownership of the mission with the host community.[24] The problem often goes deeper into motive. Often the greater focus on medical mission teams (even by proponents of medical mission events) is the benefit to the goer, rather than the presumed recipient.[25] Medical Mission events often appear to be designed to meet team members' emotional need for self-fulfillment rather than the community's need for transformation.[26] A review of the problems associated with medical mission events shows that there are many good reasons for rejecting this ministry. These must be faced realistically. However, few, if any, of the problems are insurmountable. Any model for effective medical mission events must minimize these problems, while achieving the purposes for which it was done.

Medical mission practitioners have a fairly similar set of problems noted. A common, and key, problem noted was the difficulty of overcoming the **short-term nature** of this form of ministry. Some interviewees seemed to hold the lack of long-term impact as acceptable. They felt that other ministries are meant to have long-term impact, but medical mission events are supposed to be short-term. Others felt that it is a problem that needs to be overcome. A second, and related, problem was the

tendency to **create dependency** because the solution to felt needs comes from outside of the community. Another problem was the **high investment of money, time, and human resources** needed compared to many other ministries. Additionally, there were **concerns about the quality of care**, both in the short-term and in the long-term. Several more problems spring from the roles and interactions of various groups. **Lack of understanding and willingness to invest in team-building** can greatly harm medical missions. Medical missions can be used as an **attempt to gain political prominence**. This does not have to be local politicians. It can also be other insider or outsider groups as well. Further, medical missions can be done in a manner that is **not focused on service to God**. Finally, medical missions may be **done where there is no need for it or desire for it**. In this case, the mission is done because the local church or the NGO "wants to do something." Again, these problems must be faced honestly and addressed.

Problem Summary

Unlike Purposes, it is not evident that one could create a synthesis of the problems into one statement. However, problems appear to fit into four basic categories. Problems occur when medical missions are done with **wrong motives**. Problems also occur when **relationships are not properly established** between different parties based on cultural sensitivity and sound understanding of roles. Failure in this leads to alienation and mission break-down. Additionally, problems occur when s**ervices are not provided that meet the felt needs of the community**. Finally, problems occur when medical missions **create, or at least do not alleviate, community dependency**. It is worth noting another relationship. There is a huge amount of overlap between the Wrong Motives in Problems and the Purposes. The oppositive of the purposes are to act with the wrong motives in mind. In other words, the corrective to having wrong motives, is, quite obviously, to have correct purposes.

**Conclusions**

The results of the purposes for medical missions, as well as problems is a sound foundation for determining appropriate practices. Additionally, the provide insight for troubleshooting and evaluating medical mission events. These problems and purposes provide insight into the models that will be presented in the next three chapters. These are:

- Structural Model (in Chapter 3)
- Content Model (In Chapter 4)
- Process Model (in Chapter 5)

# CHAPTER 3
# A STRUCTURAL MODEL FOR MEDICAL MISSIONS

I am using the term "Structural Model for Medical Missions" for this chapter and figure. Perhaps it is better to say "foundational model" since the idea is that underlying purposes and philosophies will provide a sound foundation from which the structure of the medical mission event may develop. In the end, I prefer the term "structural" since the model should go further than simply provide a foundation, but should integrate with all aspects of the organizing structure of the work. Either way, this model can be used along with the Process Model and Content Model (in subsequent chapters) to guide and troubleshoot medical mission events. The models are built on an organic metaphor. Hopefully, the correlation between plants and medical missions will aid in memory and understanding of medical mission events.

Figure 1 and Table 1 show the structure of medical missions in terms of a flower. The image of a flower for ministry is used because ministry is meant to be growing, and should be adorning (Titus 2:10) the Gospel.

The goal in medical missions is that it is “REAL”. So what are the characteristics of “REAL” medical missions?

**R**ight Motives

**E**ffective Partnering (Outsiders)

**A**ctive Community Participation (Insiders)

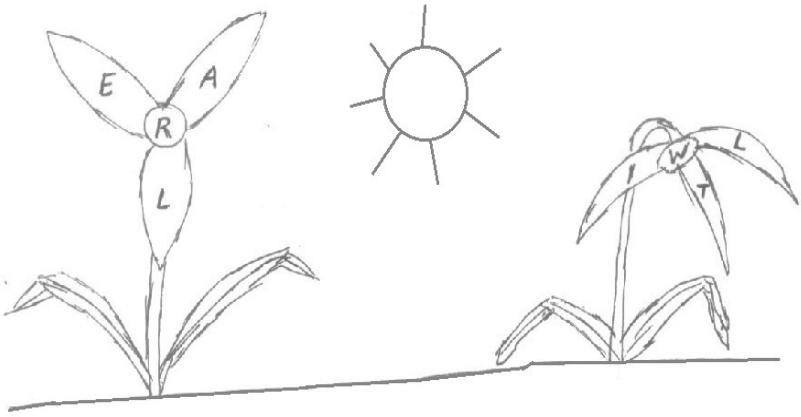
**L**ong-term Strategy and Planning

The visualization of this model came quite naturally for the four qualities in REAL. Giving Right Motives a central place in the figure resulted in a trillium (or any flower with three petals). Right Motives is where the petals meet. Figure 1 shows this form. The triangular region that forms from the combination of Right Motives, Effective Partnering, and Active Community Participation is the Relational Component. All parties must come together effectively with the right motives to develop an effective medical mission. The region formed by Effective Partnering (of outside entities), Right Motives, and Long-term Strategy and Planning is similar to half of Figure 4. This is the Relief Cycle Component. Outsiders work together with right motives in a long-term plan to meet specific needs in the community. The final region, Active Community Participation, Right Motives, and Long-term Strategy and Planning is similar to the other half of Figure 4. This is the development cycle component. The community effective works together with right motives in a long-term strategy to improve itself.

Just as it is possible to show a visual model of a good (REAL) medical mission structure, it is possible to show the opposite. Right motives becomes Wrong Motives. Effective Partnering becomes Ineffective Partnering. Active Community Participation becomes Lack of Community Participation. Long-term Strategy and Planning becomes Temporary (or short-term) Planning. These

four characteristics form an acronym as well-- WILT. Therefore, one can have REAL medical missions or medical missions that WILT. The related visual framework is also in Figure 1 .

**Figure 1 . "REAL" Medical Missions Model**




## "REAL" Medical Missions

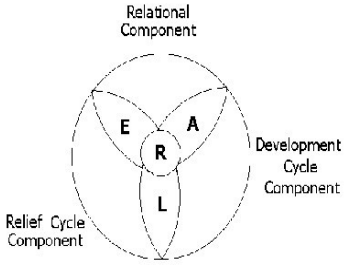
**Medical Missions that have:**

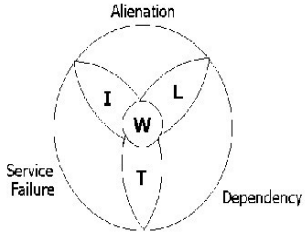
**R ight motives**
**E ffective partnering**
**A ctive community participation**
**L ong-term strategy and Planning**

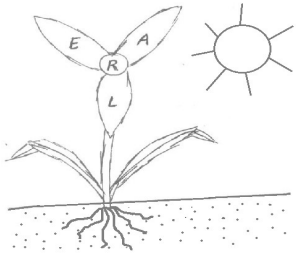
## Medical Mission that "WILT"

**Medical that have:**

**W rong motives**
**I neffective partnering**
**L ack of community participation**
**T emporary planning**

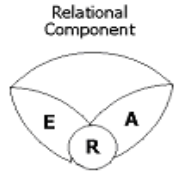
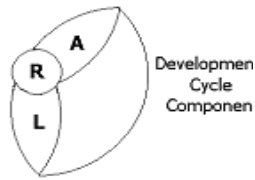
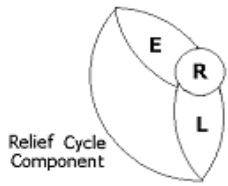


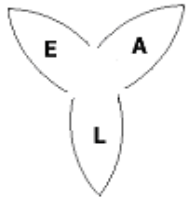
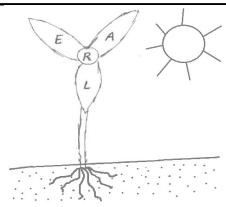
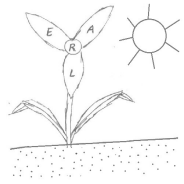



Plant showing roots (grounded in the human element) and leaves (empowered by the sun or spiritual element)

**Table 1. Structure Consultation Guide**

| Component Missing | Graphic | Result |
|---|---|---|
| **Long-term Strategy and Planning** |  | Good teams and relationships without a long-term plan will result in no long-term ministry (neither relief nor development cycles). Expect service failure and dependency. |
| **Effective Partnering** |  | A break-down of outside support and teams removes the ability to build relationships with the community and provide aid, skills transfer, and materials transfer. What is left is development, the community trying to help itself the best it can. Expect alienation and service failure. |
| **Active Community Participation** |  | If the community is not part of the team, the result is simply a continuing cycle of relief, without a good relationship between the outsiders and insiders and without skills and |

| | | |
|---|---|---|
| | | material transfer to lead to development. Expect alienation and dependency. |
| **Right Motives** |  | Without right motives, the heart of the mission has been removed. One should not expect that the medical work should function as a Christian ministry at any level. |
| **Spiritual Methodology (Leaves)** |  | Mission work carried out without spiritual methodology/strategy is like a plant with no leaves. It is deprived of the needed energy that comes from the sun. |
| **'Secular' Methdology (Roots)** |  | Mission work carried out without "secular" methodology/strategy is like a plant with no roots. It lacks the proper grounding to stand and to absorb nutrients. |

Just as the REAL "flower" forms three smaller regions, so does the WILT "flower". If there is lack of community participation, wrong motives, and ineffective partnering, there is alienation of all players in the work. If there is ineffective partnering of outside groups, wrong motives, and temporary planning, there is a failure to provide adequate services to the community. If there is lack of community participation, wrong motives, and temporary

planning, there is a tendency towards creation of a sense of dependency.

**Structural Framework as a Consultation Tool**

The purpose of developing this visual framework was for consultation. Therefore, the test of the framework is in how well it explains problems and solutions in medical missions. If the visual framework is unclear or misleading, then its purpose negated regardless of its aesthetic qualities. The following shows the visual role of the framework.

The four qualities (REAL— Right Motives, Effective Partnering, Active Community Participation, and Long-term Strategy and Planning) are important for a medical mission that results in community wholistic change and growth. Refer to Table 1. If medical missions events are done with bad motives, all three regions disappear. One does not have good relationships between different players in the work, one does not have good development or relief. Right motives are critical. On the other hand if one has ineffective partnering of outsiders, the problem is serious but not as dire. The development cycle region still remains. The local community can work together to improve itself. However, the relationship between insiders and outsiders is hurt; as is the relief cycle work… helping the community meet its immediate needs. If there is a lack of community participation, relief can still occur, but a healthy relationship between insiders and outsiders cannot result. Likewise, development will not occur. Finally, if there is no long-term strategy or plan, sustainable relief and development cannot occur. However, one can have a healthy relationship between all parties.

**Explanation of Terms**

Although the visual framework appears to show the relationships in a way that could be valuable in consultation, without explanation of terms, it still does not say much. A term in need of explanation is **"Right Motives."** What are the right motives for

medical missions? According to the interviewees there are three major or common right motives:

1. **The example of Christ to love others and to express that love in tangible ways.**
2. **Concern for the varied needs of the community**
3. **The desire to empower the church to impact its community**

Additionally, there were three major or common areas described as **wrong motives**:

1. **Focus on anything other than God/Christ's Example/Love.**
2. **Prioritization on strategy or ministry (rather than the community)**
3. **Accumulation of power (rather than empowering others)**

It is evident that the wrong motives are essentially the negation of the right motives listed previously. Examples given by the interviewees were enlightening. Several interviewees noted that medical missions are often done where they are not needed or wanted. The implication is that the ministry is focused on itself, not the needs of the community. It was also noted that medical missions are often done by government groups for self-promotion. However, it was also related that churches can also be guilty of using medical missions as a form of advertisement rather than as a service to the community.

"Effective Partnering" focuses on the relationship between the outsider elements of the NGO and Sponsor, and their integrating of planning with the community. Effective partnering involves a clear understanding of the roles of each group. The sponsor clearly has a powerful role in the mission event, but must not take control since the NGO, typically, is the expert in doing the mission (the "How"), while the community is the expert on what is needed (the "What"). The NGO brings the expertise, but must also actively run the mission. It must be a pawn to no one, but

humbly seek to learn from other groups, especially the insiders. The local government and church must learn to work with the outside groups in a manner that is equal, based on mutual respect, and supported with good communication and commonly agreed-upon goals. An interview quote sums up, in many ways, this relationship between the NGO, local church, and LGU:

> *Before a medical mission – The relationship between these three identities should be one of partnership and equal, meaning that each organization shares the same goals and aspirations for the target community. The three identities come together to plan, strategize and map out what needs be done before, during and after the medical mission and what roles and responsibilities each identity will take on.*

**"Active Community Participation"** is another major component of successful medical missions. It is generally recognized that a medical mission event will fail if the community is not involved, or if it takes on a passive role, in medical missions. The local community must desire the medical mission and believe that it meets a felt need. The local church, local health practitioners, the LGU, and the community in general must overcome their tendency not to work together. They must find common purpose, and be willing take on their part of the role of the medical mission. They must take on the long-term role of care for the community since the NGO and other outside groups have only a short-term or periodic presence.

**"Long-term Strategy"** refers to the intention of making the medical mission event part of a long-term process for community improvement. Whether this strategy involves outsiders working within the community long-term, returning periodically, or empowering the community toward self-improvement, the plan must be researched, agreed upon, and periodically evaluated. Long-term strategy does not happen by accident, and medical

missions that are not intentionally integrated into a long-term plan will rarely produce long-term results.

An additional component to this plant analogy might be described as the "balanced strategy factor." **"Balanced Strategy"** was part of the Structural Category for Medical Mission Best Practices. The findings were consistent with the findings of Christian Schwartz in Natural Church Development and could have been shown in a similar manner where spiritual and mechanistic methodologies support and build off of each other.[1] However, it seemed best to incorporate this finding with the plant motif of Figure 1 .

The interviewees noted that one needs effective organizing, strong leadership, good communication, shared strategy, common philosophy, careful research, and full evaluation. These are grouped under mechanistic or human-centered (or "secular") methods. They are necessary for a successful medical mission. The interviewees also noted that methods are not enough. Medical missions need God's activity and leading. This requires prayer, seeking God's will, and spiritual maturity of the local church and other Christian members. The understanding is that Christian medical missions is a spiritual enterprise, not merely a secular enterprise with a spiritual ministry content.

The plant model shows the ministry as it relates to both secular and spiritual methods. The human or secular methods can be seen as the soil... a material foundation for the plant. A healthy ministry, like a healthy plant needs strong roots anchored in the soil, needs to be grounded in proven human-centered methods and drawing nutrients from it. Spiritual or divine methods can be seen as the sun, empowering the plant to function. A healthy plant must also have healthy leaves placed to benefit from sunlight, empowering it to grow, produce flowers and fruit. The relationship between sound "secular" and "spiritual" methods is not antagonistic or even neutral. Rather, the two empower each

other. Strong medical missions involves the effective and intentional integration of these methods. This is shown and described at the bottom of Figure 1 and Table 1.

**Summary**

The organic structure of a flowering plan provides the motif or model for a medical mission. The flower (in this case a three-petal one) in a healthy plant suggested the structure of a good medical mission, while the flower of a wilted plant provides its opposite with an idea of the results. However, tied to the plant motif is the idea that the roots and leaves are needed to sustain the plant and allow it to thrive. “Secular” methods (so called) provide organization and planning that is needed to make the mission flow. However, there is a divine aspect to Christian ministry to cannot (or at least should not) be overlooked.

One can continue the plant analogy with the fruit. A flower is never (at least from the plant's point of view) the end product. The fruit is the end product. With this analogy, the Content Model is a fruit and is the fruit of the medical mission. This is covered in the next chapter. But plants are not static, they are planted, they grow, and they reproduce. This process provides guidance for the Process model in chapter 5.

## CHAPTER 4
## A CONTENT MODEL FOR MEDICAL MISSIONS

The structure and process of medical mission ministries are important, but without the content of the ministry, it accomplishes nothing. It is the fruit of the ministry in that is the goal, so for the

model, it is shown as the fruit produced by the plant in Figure 1 . Figure 2 shows the Content Model with Table 2 providing additional insight.

There are three major areas of care provided in a healthy medical mission event (as integrated into a broader ministry program). One of these is **Physical care**. A medical mission, by definition, must be concerned with the physical health of the people. Generally, this is done utilizing medicines, diagnostic equipment, vitamins, surgical and dental procedures, and utilizing the human resources of medical and dental professionals. While there can be different forms of physical care provided, there is essential agreement in this area.

There was also generally an agreement regarding **Spiritual care**. Within the confines of a medical mission event this was typically limited to presentation of the gospel, seeking a spiritual conversion response, and providing prayer support. This is what most clearly separates Christian medical missions from other forms.

The third area is **Long-term presence**. The act of being available in a continuous or continuing manner is, in itself, a form of ministry. This is where differences really begin to show themselves among the interviewees. Some see long-term presence as a periodic activity. With this, the outside organization (mission team) returns on a periodic basis to provide care for the community. On the other hand, some described long-term presence in the form of modeling and empowering local groups to take on the long-term care in the community. A third option is to create new organizations within the community to provide a long-term presence. A final option involves a long-term partnership between outside and inside organizations.

The three areas were combined in the form of a fruit in Figure 2. The character of the relationship between these areas is also noted

in Table 2. The skin can be thought of as the long-term presence. The skin of a fruit protects the rest of the fruit from pests, disease, and decay. Likewise, the long-term presence in ministry is needed to ensure that the other ministries are not wasted or destroyed. The flesh of the fruit can be compared to physical care ministry. It supports the seed and nurtures it. The seed can be thought of as spiritual ministry. The seed is the reason for the existence of the fruit. It is the enduring part of the fruit and results in renewal and reproduction of the plant. Likewise, the spiritual ministry provides the enduring portion of the overall ministry, providing the component of individual and community ministry that creates renewal and transformation.

Table 2 describes the importance of the three areas of ministry. A fruit lacking skin is prone to being attacked by pests and disease. In like manner, physical and spiritual care without a long-term presence is likely to wither and fail with time. Fruit without flesh (in addition to being less appealing) fails to provide the seed with a structure and nutrient base to promote germination and growth of the seedling. Likewise, long-term ministry with spiritual care that ignores physical concerns in a community is inhibited in its long-term growth and transformation. Finally, a fruit without seed may taste good and look good, but is sterile. It will not produce seedlings for reproduction and future growth. Likewise, long-term physical care that does not address spiritual needs in individuals and the community will fail long-term to engender renewal and transformation.

There is a strong consensus as to what the end-result of ministry should be. This is a long-term improvement in the spiritual and physical health of the community. This is the full fruit-- protected by the “skin” of long-term presence, supported and nurtured by the “flesh” of physical care, and enlivened by the transformed and renewed life found in the “seed” of spiritual care. The exact methodology should depend on the needs and capacities of the community.

The analogy of the fruit can be taken further. The shape and characteristics of the fruit are different for different plants to ensure the plant's long-term viability in its particular environment. In some plants, the flesh is predominant in the fruit to support and nurture the (smaller) seed. In such a case, the supporting nutrients of the flesh may be needed to ensure germination and growth of the seed. In other cases, the dominant feature may be the protective skin. An example of this is the coconut where the thick protective, and buoyant, husk allows the seed to survive and be transported by ocean currents. The point is that in long-term Christian ministry, the relationship and relative "sizes" of long-term presence, physical care, and spiritual care may vary, but it is important that these three contents exist and cooperate in the overall work.

**Figure 2. Ministry Content Model**[1]

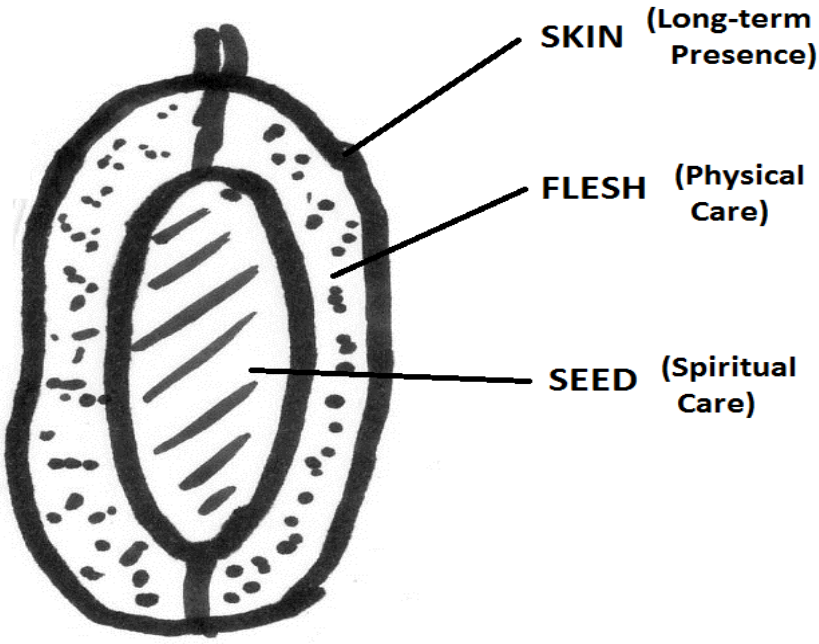
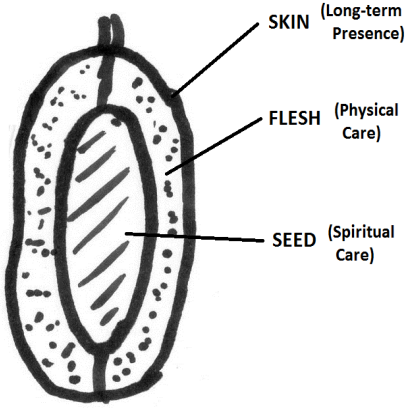



**Table 2. Content Consultation Guide**

| Graphic | Description |
|---|---|

| | |
|---|---|
|  | **Skin:** Protects the flesh and seed from outside harm. Ensures the viability of the seed for reproduction. Long-term presence in ministry likewise helps ensure that physical and spiritual care is protected, sustained, and propogated. |
| | **Flesh:** Protects the seed and gives sustenance to the seedling. Physical care nurtures the individuals and community to aid spiritual growth and community transformation. |
| | **Seed:** The "eternal" component of the fruit. It is transformed into new plants to produce new fruit. Spiritual care is a renewal process for creating new lives and transformed communities. |
| Fruit with only Flesh and Seed (no Skin) | **Wholistic Care (short-term).** Physical and Spiritual Care without Long-term Presence. Without protection of the skin, likely to die away. |
| Fruit with Skin and Seed (no Flesh) | **Long-term Spiritual Care.** Evangelism with discipleship and church development. Lacks the nurturing supportive environment that the flesh of the fruit provides. |
| Fruit with Skin and Flesh | **Long-term Physical Care.** |

| | |
|---|---|
| (no Seed) | Recurrent medical missions, or primary health program. Lacks the seed that can reproduce, grow, and renew. |
| Full Fruit (lacking nothing) | **Wholistic Care with long-term community transformation.** The full fruit-- able to renew, reproduce, transform. |

The Content Model describes what is sought to be accomplished in a community--- its fruit. The Structural Model describes the characteristics of the mission that can produce that fruit. The Process Model (in the next chapter) describes how all of this works within the time frame (process) of community and outsider interaction.

## CHAPTER 5
## A PROCESS MODEL FOR MEDICAL MISSIONS

The visual representation of the process is shown in Figure 6 with associated Figures 3, 4, and 5. The three rectangles in Figure 3, describe the three primary role players: the host, the goer/sender, and the recipient. The goal is for the hosts to come together with the goers/senders to minister to the recipients. The process based on figure 1 suggests a movement of the two upper rectangles towards each other and down towards the recipients. The preparation for the coming together of hosts and senders/goers is pre-field time, the time when these two join with the recipients for ministry is field time, and afterwards is the post-field time. After the medical mission event occurs the hosts return to their former position and the goers/senders return to their former position. This suggests two vortices.

One could focus on the vortex on the right as shown in Figure 4. This is the one on the right where an outsider comes to a community to minister and then leaves, with the help of hosts. The mission in this form is short-term in nature, meeting a specific short-term need. This is often described as relief ministry.[1] On the other hand, one can focus on the left vortex as shown in Figure 5. This one describes an insider who works within his/her community to build it up, with the help, of some sort, from outsiders. This is normally a long-term process and describes a development ministry.[2] In medical mission events, these two ministry cycles are meant to work together. This is to compensate for the weaknesses of the hosts and the goer/senders. Hosts have a cultural awareness and a long-term presence in the community. However, they lack certain skills and resources.[3] Goer/senders have the opposite situation. They have specific skills and resources needed for ministry, but lack cultural

awareness of the community they are to work in, and lack a long-term presence there.[4] Success in medical mission events depends on the two groups working together, compensating for each other's weaknesses.[5]

**Plant Metaphor**

Let's bring in the plant metaphor for the process model. If medical mission work is seen in terms of a plant, the process can be seen in terms of two types of farming practice. One type of farming practice focuses on external sources and one type focuses on internal sources.

A. External Source Farming. If one wishes to grow plants in a garden, one can go to the garden center and buy seeds, fertilizer, weed killer, and so forth. Then one sows the seeds, and uses the fertilizer and perhaps a little weed killer to help the plants grow big and strong. Later in the season, one gathers the fruits of the planting. The following year, one may decide to plant again, so one goes again to the garden center and buys seeds, and so forth. This creates a cycle of gardening that focuses on an external source (the garden center) to grow plants. This is similar to the relief cycle where external sources dominate the work.

B. Internal Source Farming. If one wishes to grow plants in a garden, one can focus on the sources one already has. If one has seeds, and waste organic materials for compost, and such, one can plant based on what one has. At the end of the season, one can gather the fruits and separate out the seeds for the following year, and plow under the plant materials to provide a portion of the nutrients for the following year (along with other composting that can be produced). The next year the cycle may begin again, utilizing materials one already has from the previous year. Relatively little is required from the Garden Center. This is similar to the development cycle where local resources dominate the work.

With gardening, it may be desirable to do Internal Source Farming. However, if one is just beginning to farm, one has few resources with which to do gardening. As such, one is quite dependent on external sources. However, proper management of resources (a long with increase in agricultural knowledge) one should become less dependent on Garden Center the second year, and each subsequent year, one should become more and more internally sourced. The same idea exists with Figure 6 for the overall Process Model. It is normal that both vortices (relief and development) exist, but over time the initial dominance of the relief cycle should be replaced with dominance of the development cycle.

**Further Notes on the Process Model**

The most important part of the pre-field time is the development of a successful partnership between the host and the goer/sender. The initiator of a medical needs to be based on a common philosophy of mission and long-term strategy. This is an area that is especially noted in the United States Standards of Excellence in Short-Term Mission.[6] Differences in attitudes and beliefs in these areas will lead to conflict in goal-setting and planning.

As noted above, Figure 6 can be broken down into three main components. Reviewing, the first of these is role players, as shown in Figure 3. Hosts are the people who are local and prepared to partner with the the outside team. They have provide cultural sensitivity and a long-term presence in the community. Goers/Senders are outsiders who have skills and resources to provide care for the community. Recipients are locals who have needs (both felt needs and real needs) that need to be met, and who, will gradually be brought into the development/ transformation process in the community.

A second component is the relief cycle as shown in Figure 4. The relief cycle focuses on outsider intervention. While partnership with local hosts is still needed, the primary activity is short-term

transfer of resources and skills to the community. This can happen as a one-time thing or as a cycle outsider involvement. The third component is the development cycle as indicated in Figure 5. In this the work of committed local hosts dominates. As shown in Figure 6, in a healthy work cycle, ministry may start more as relief, but with transfer of material resources and skills, outside help should lessen and become more like technical support as internal assets dominates.

The above describes the process of medical missions as part of the long-term process of local church outreach in a community. I have intentionally looked at it backwards. That is, I have started from the process, working backwards to structure and then to content. The reason is that the long-term process of relief and development gives the goal of community transformation. With this in mind, one can work backwards to what one needs to carry out the process, and from that one can see what content is needed.

**Figure 3. Role Players**

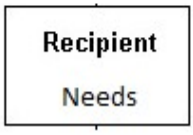




**Figure 4. Relief Cycle**

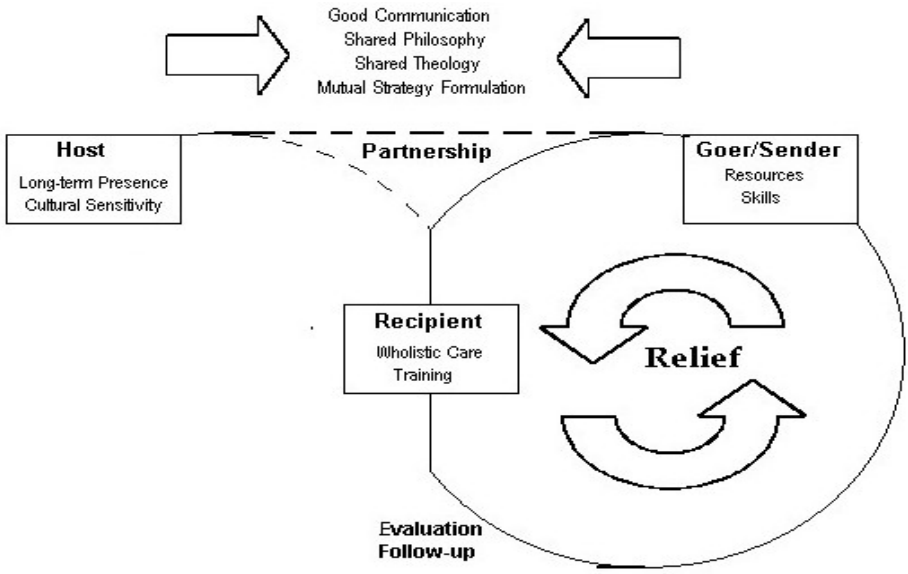



**Figure 5. Development Cycle**

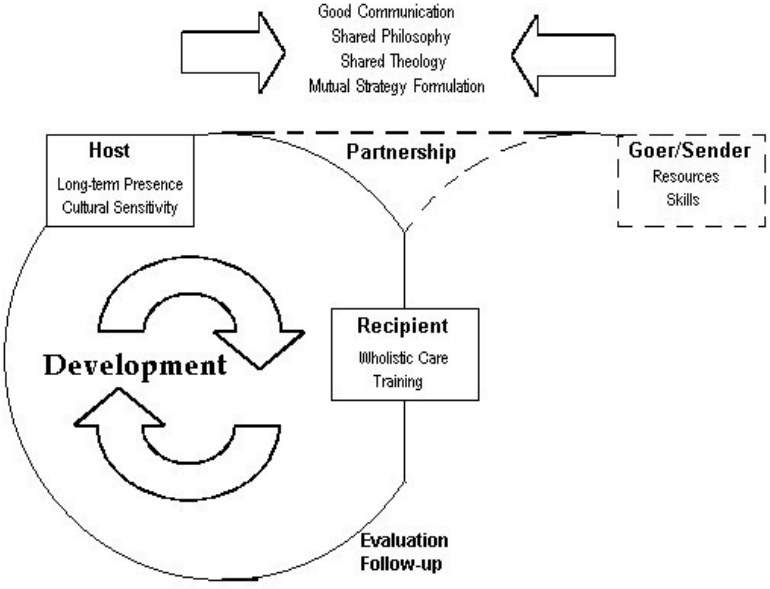
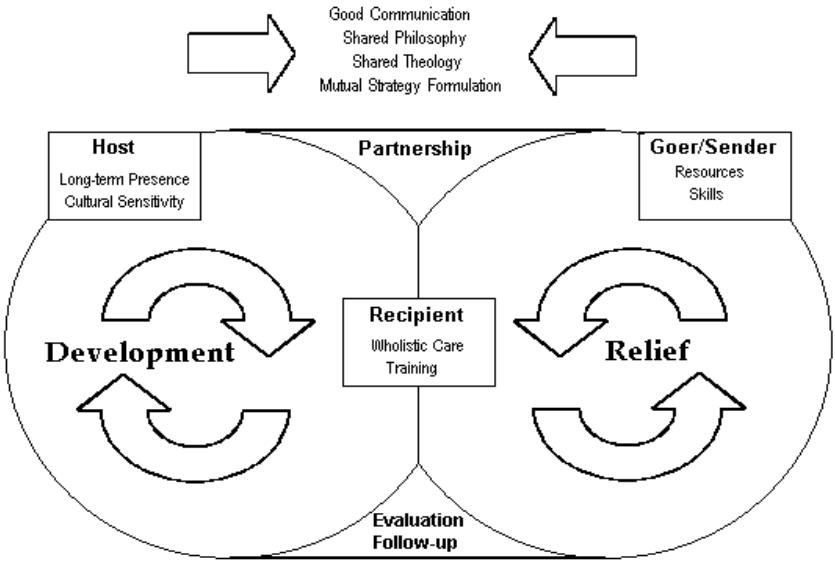


**Figure 6. Diagram of Medical Mission Event Process**




**Summary**

Curiously, that means that

**Purpose → Content → Structure → Process**

or

**Why? → What? → How to Design? → How to Do?**

That which was seen in the last chapter can be reversed. If you know the process you want to have carried out (How to do) it guides the structure (How to design), which in turn guides the content (What). It is my opinion that a sound process is one that works in both directions (from Structure and from Purpose). Even if you don't agree, I hope the logic of Process, Structure, and Content, will come together in dealing with Purpose (and Problems as well).

You have probably noted that there is little specific information on the nuts and bolts of medical missions. That is intentional here. However, more details are provided in Appendix C.

## CHAPTER 6
## OVERALL FINDINGS

The following are findings that are in word form rather than visual form. Visuals often hit us on a different and deeper level than words... but often the combination is better still.

**Importance of Partnership**
A key component in effective use of medical missions for long-term local church outreach is partnership. Partnership involves the intentional process of building teamwork between insider (community) groups and those outside of the community. Such teamwork requires mutual respect, common philosophy, good communication, and mutuality in roles and planning. Failure to build sound partnership can lead to dependency or failure to give good service within the community.

Partnership is necessary, albeit unpleasant at times. Churches often do not desire to work with local government because of mistrust. NGOs often feel the same way about churches. These feelings are, sadly, often justified. Creation of solid partnerships is done because it is necessary, not because it is easy or enjoyable.

**Why, Not Just What**
In medical missions, it is not simply what one does, but why one does it. This is because why one does it affects what one does. Good motives lead to good ministry, while unsound motives lead to failure.

Good motives in medical missions should have at least three characteristics. First, the medical team should be centered on Christ. Medical mission teams should use Christ as their example for ministry, and should seek to have the same love the He has for those in need. Second, the team should be focused on the wide

variety of felt and actual needs the community has. Outsiders should make a genuine attempt to provide relief to the community and provide a vehicle for long-term improvement. Third, the medical team should seek to empower the local body of believers to effectively help their own community. A clear understanding of the goal(s) of the medical mission should be part of the planning from the beginning.

With regards to goal, many interviewees focused on spiritual change, while others on wholistic change. This difference relates to Ballard's description of attitudes regarding Christian social ministry. He describes five major attitudes.[1] This is seen further in Appendix A. Interviewees tended to focus on ulterior motive or on wholism. Rather than supporting one attitude and attacking another, it seems more reasonable simply to note the difference in goals, and promote dialogue between outsiders and hosts to ensure that they share the same goals. The same can be said as far as follow-up. Some saw the role of follow-up to be with the local church or community. Some saw it as, at least in part, in the hands of the outside NGO. A miscommunication or misunderstanding between parties as to their roles long-term can result in follow-up work not being accomplished.

The difference in attitudes between the different parties is important. Most interviewees noted how important it was that members of the medical mission partnership were acting with the "right motives". Many also noted the importance of evaluating the success of the medical mission in both implementation as well as short-term and long-term results. Differences in parties will affect how things are done and how they are evaluated.

**Good or Not at All**

Doing medical mission events poorly is NOT better than doing nothing at all. Poor medical services may be worse than the services already available in the area. It can also lead to unwarranted mistrust of local medical services. Mission events

with no long-term strategy and no skills transfer can lead to dependency in the community, and encourage local government and organizations not to improve local health care. Medical missions that are not built on a healthy partnership can be used by local government and individuals for political ends. Local churches may use it simply to try to lure members away from other churches.

There is always an unhealthy tendency to cut corners on medical missions. This point was made indirectly by some of the interviewees. However, it was observed directly in a number of cases by the difference between how interviewees say medical missions should be done and how they actually do medical missions. This study did not investigate this disconnect between theory and practice. It could be hypothesized that lack of resources or over-commitment (keeping too busy doing many medical mission events) results in missions being done different than was recommended by the interviewees. Since this study did not investigate it, for now the tendency to diverge from the recommended form is noted with caution.

**Research**

Medical Missions need to be planned based on solid prior research. Research must not only attempt to see "how" to do the medical mission, but first "if" the mission should be done at all. Not all sites want a medical mission, and many sites that want one do not need one. There is no such thing as a one-size-fits-all medical mission. Medical missions that are accomplished without research may appear to be effective in the short-term, but there is no reason to expect that they can be part of an effective long-term strategy for wholistic ministry to the community.

Evaluation and monitoring are necessary. It should be done to make changes in an individual event or in the next cycle of work. It should also be done to make improvements on a long-term basis. Evaluation and monitoring should be done intentionally,

honestly, and incorporating metrics. Failure to do this can lead to failure to learn or failure to take advantage of new opportunities that arise.

**Plan for Long-term Work**

A medical mission must always be thought of as a part of a much broader, and cyclic, ministry. In some cases the medical mission team needs to plan to return periodically as a form of medical relief. In other cases, skills transfer needs to happen so that the community can continue on in a cycle of self-development. In yet other cases, the outside organization may need to change its strategy over time. For example, it may transition from medical care, to training, to capital equipment transfer. Regardless of the case, if the long-term strategy does not occur, long-term transformation within the community should not be anticipated.

Related to this, medical mission events should not be thought of as a single event. Rather it should be thought of as part of a longer-term strategy for ministry. While there may be times where one might choose to do a medical mission event with only short-term relief in mind (such as after a disaster), this should not be the norm.

The local church must take on a role in the long-term ministry in the community. In those situations where a viable, self-sustaining body of believers does not exist, development of a local church should be a planned, intentional, outcome of the strategy utilizing the medical mission event. Where a church already exists, it should be empowered to minister effectively in the community. The reasons for this are simple. First, the local church has long-term presence that outsiders do not have. Second, the local church is able to provide the spiritual ministry that other entities in the community lack.

There are occasions where more than one local church exists in the community. Since partnership is important in the ministry

work, it is desirable to create a cooperative, rather than competitive relationship between these churches. Medical missions should not be used as a method to draw people away from one body of believers into another.

**Wholistic Work**

Medical mission events are not really about medical, dental, surgical, or eye care, or any of a myriad of services that can be provided. Rather, medical mission events should be about providing health, in the broadest sense. Perhaps a definition of wholistic health such as that developed by Lifewind would be appropriate. In the Community Health Evangelism model (CHE), good health is defined in terms of four good relationships: with oneself, others, God, and the environment.[2]

Training should take on a lead role in all medical mission events. Team members must be trained before the mission as well as on-the-job. The community must be trained, gaining skills that they previously lacked. Training often will require the transfer of material resources to ensure that the training is not wasted.

Training should not be narrowly defined. Rather, the training should be based on the needs of the community. It could include health and hygiene training. It could include spiritual discipleship training. It may also include community development and livelihood training. The possibilities are vast. However, again, it needs to be based on the needs and desires of the community.

**The Spiritual Side of Work**

Medical Missions and the broader long-term ministry in a community is a spiritual work. The ministry is God's ministry, not our own. This dimension of the work must never be forgotten in all of the research, evaluation, goal-setting, strategizing, and training involved in the activity. However, the spiritual dimension must never be used as an excuse to ignore the more mundane (or mechanistic) components of preparation and implementation of

the ministry. In fact, proper planning and strategizing should freely and fully incorporate prayer, meditation, seeking God's will, and other activities that are often considered, rightly or wrongly, as more spiritual. These different activities should be considered not only complementary, but synergistic.

**Implications of the Findings**

The following include some implications that can be drawn, directly or indirectly from the findings.

1. Medical mission events can be used as a component of a long-term ministry. However, they are insufficient in themselves to provide tangible help in the long-term.
2. Medical mission events, if done as per statements from interviewees require a great deal of time, resources, and planning. As such, they should only be done after a great deal of careful research and consideration.
3. Since the recommendations for medical missions from many of the interviewees appear to diverge from how medical missions are commonly done (even those done by the interviewees) it is clear that there are priorities in the decision-making for medical missions that did not come up during the interviews.
4. Acting on the recommendations of this research is likely to result in a reduction of medical mission events accomplished. However, the quality and long-term efficacy of the events that are done should be greater.

**Four Appendices**

Four appendices are added that may be of use to the reader.

Appendix A looks at different attitudes regarding social ministry. The reason for this is that there seems to be major differences of

opinions as to why one should do social ministry (if one should do it at all). Some of these have a decisive effect on how medical missions (a social ministry) is done, and how it is evaluated. Additionally, since it is necessary for hosts and goers/senders to have a common philosophy for effective partnership it is good to have a sense of the range of philosophies that may be experienced in the work.

Appendix B looks at dependence, independence, and interdependence. Common missionary practice has often focused on dependence-- giving from those according to their ability, to those according to their need. However, the need for empowerment is often not dealt with. Some have adjusted their thinking to focus on helping a community to achieve independence. It meets a certain Western ideal. However, there is really nothing in the Bible that suggests that independence is a goal to be sought. The Bible focuses on interdependence. We all need each other. As such, “A” helps “B” and “B” helps “A.”

Appendix C gives some additional thoughts on medical missions including some practical steps for carrying it out and doing follow-up. The focus is on medical mission work in the Philippines, but some of it applies quite nicely elsewhere.

Appendix D provides additional sources of information on medical missions.

# APPENDIX A
# ATTITUDES ABOUT SOCIAL MINISTRY

## Primary Content of Ministry Care

Although medical missions practitioners I have spoken to were consistently more focused on spiritual care compared to literary sources, there were considerable differences between them in this area. Some focused more on the physical care and some on wholistic care. However, a majority focused on spiritual care as the primary ministry and purpose of medical missions. McLennan notes that many evangelical groups that carry out short-term medical missions in Honduras do it primarily to proselytize—many using medical missions primarily to draw people in for evangelism.[1] Figure 7 shows a way of looking at ministries based on a two-dimensional field where one axis is based on temporal needs and the other on "spiritual" needs. While these terms are open to challenge, I will stay with them for now. Man's priorities tend to be focused on temporal needs... but that does not mean that there is no recognition of spiritual needs. It is just dominated by the temporal. God's priorities may be said to focus on spiritual needs. That is not to say that there are not concerns for temporal needs-- they are importan too. It is just that the spiritual needs may be seen as the greater focus of God. Again, this is open to argument, but let's move on.

**Figure 7. "Temporal" and "Spiritual" Ministries**

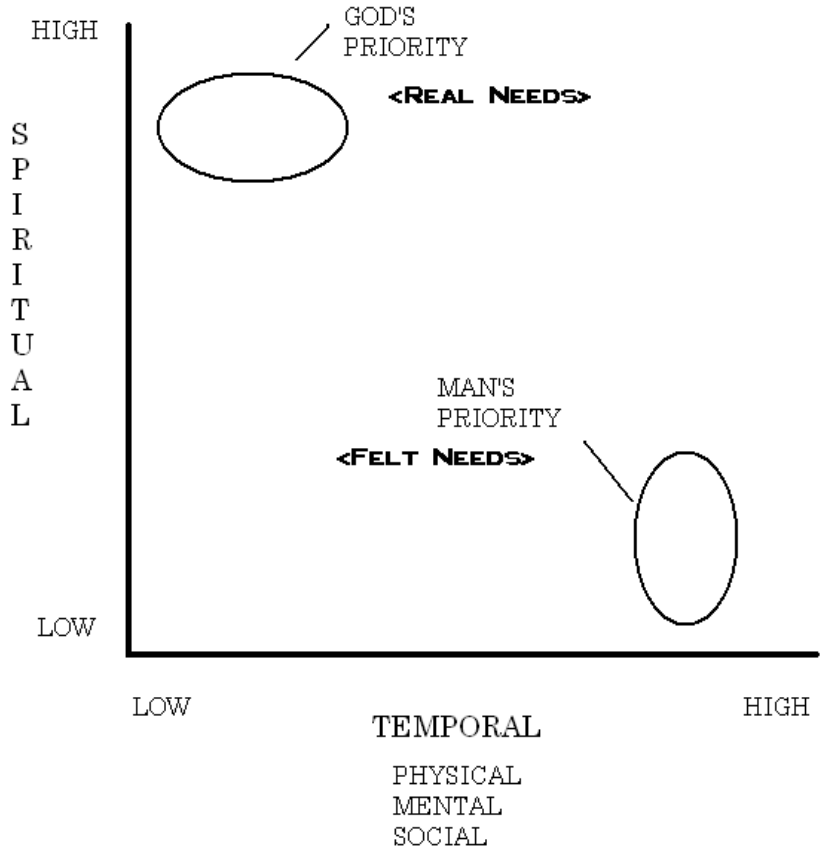



Figure 8 maintains the same two-dimensional field as Figure 7. However, two new regions are added. Ministries that provides a high amount of spiritual care, could be called "spiritual ministries." Ministries that provide a high amount of temporal care, could be called "social ministries." It can be seen that it is possible that ministry work could provide high social care and spiritual care at the same time. This could be described as "wholistic ministries."

**Figure 8. Types of Ministries**

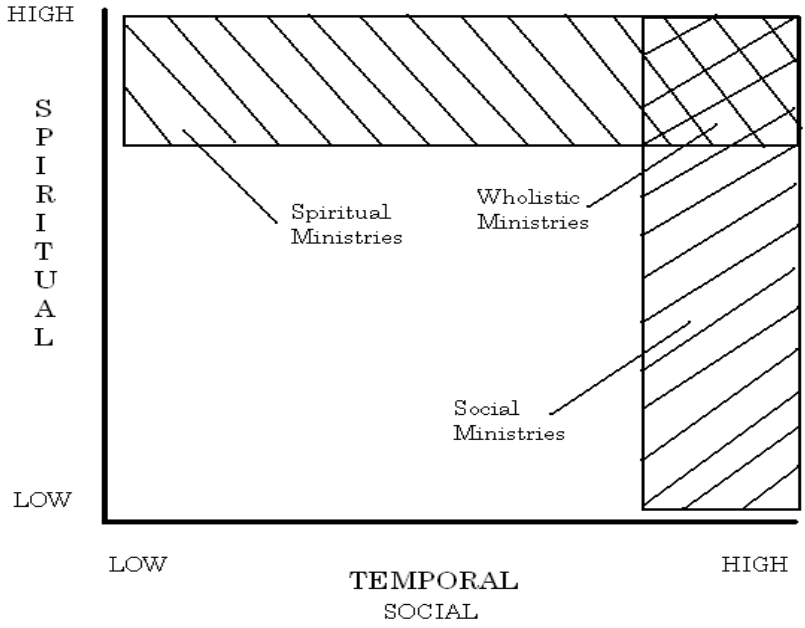



**Figure 9. Attitudes Regarding Ministry**

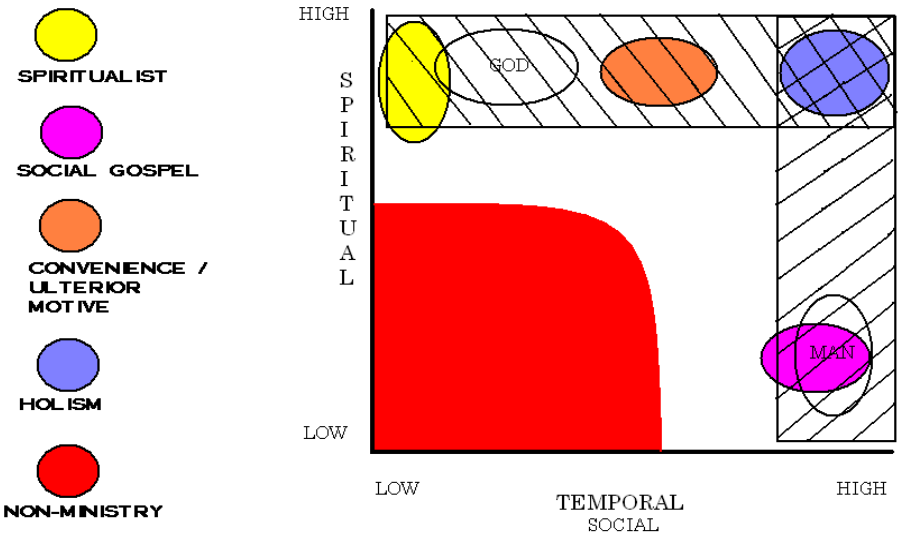


Figure 9 maintains the fields of 7 and 8. But then ministries based on different attittudes is shown. The differences in ministries appear to result from a basic theological difference regarding the role of social ministry in the Christian context. Ballard describes five common attitudes that Christians have regarding social ministry. The first is avoidance. It assumes that Christian ministry is to be "spiritual". Evangelism and discipleship are the center of Christian ministry. Other work distracts from this. The second is convenience. It also is focused on the spiritual, but accepts that doing social ministry is okay as time and resources allow. Those with this attitude will likely be more involved in social ministry than those with the first attitude, but it is not viewed as their "real" ministry. A third attitude is focus on the social gospel.[2] The view equates Christian ministry with social ministry. A fourth attitude can be described as "ulterior motive". It assumes that social ministry is valued to the extent that it positively affects spiritual ministry. The fifth attitude is wholism (note that Figure 9 shows the alternate spelling of "holism"). It says that both social and spiritual ministries have inherent value. Christian ministry and mission should draw its inspiration from the life of Christ—who appeared to care for the whole person, both spiritually and socially.[3] At least two of these attitudes appear to be held by the interviewees. They are Ulterior Motive, and Wholism.

This difference in attitude is important and should not be minimized. It is, however, true that the framework still accounts for this issue. Figure 6 notes the necessity of having a common philosophy and theology of various groups. In other words, rather than assuming one viewpoint is correct and the other is wrong, it is assumed that a productive medical mission can result from those who share a common understanding of the mission's goal. Additionally, the requirement of right motives is still maintained. Therefore, it is not necessarily wrong to have ulterior motives as long as concern for the felt needs of the community is still a motivation.

## APPENDIX B
## DEPENDENCE, INDEPENDENCE, AND INTERDEPENDENCE

"Pastoral Counseling Across Cultures" by David W. Augsburger[1] provides some interesting insights into our attitudes about dependence and independence. A great deal of the written material in the areas of psychology and counseling come from a "Western" worldview. In this mindset, independence (an individual who has internal control and takes internal responsibility for his/her life) is considered healthy. Independence, assertiveness, and self-sufficiency are thought good and those who lack such traits are considered in need of diagnosis and treatment.

Within a more "Eastern" worldview, a different attitude is found. Solidarity with one's social group is prioritized, so a more dependent person (an individual who accepts external control and accepts more of an external responsibility for life) is seen as healthy. Independence is seen as unhealthy.

Each of these descriptions of worldview is a gross simplification. But these simplifications still help us, for looking at the two idealizations, we can see problems. Since we are social beings forced to interact with each other without destroying each other, pure independence should not be seen as worthwhile goal. However, to completely place one dependent on social norms and traditions limits the awesome potential for the individual to grow and positively affect society.

This begs the question, "What is the Biblical ideal… independence or dependence?" A look at the model of the ideal (or Biblical) church provides insight. The ideal church appears to model neither independence nor dependence. Rather, it describes a relationship of interdependence. We see this in several ways.[2]

A. The description of the primitive church in Jerusalem. Acts 4:32-37 describes a body of believers with great cohesiveness. They offered from their abilities and accepted help in their lackings. Sharing was a basic characteristic of their interaction. The early church was an interdependent body.

B. The description of relationships within the church. One way this can be seen is in the "one another" passages in the epistles. How should members interact?

They should…

Honor one another Romans 12:10
Live in harmony with one another Romans 12:16
Accept one another Romans 15:7
Instruct one another Romans 15:14
Agree with one another I Corinthians 1:10
Serve one another Galatians 5:13
Bear with one another Ephesians 4:2
Submit to one another Ephesians 5:21
Forgive one another Colossians 3:13
Admonish one another Colossians 3:16
Encourage one another I Thessalonians 5:11
Offer hospitality to one another I Peter 4:9
Be humble to one another I Peter 5:5
Fellowship with one another I John 1:7
Love one another II John 5

These (and there are others) show independence, since they show capability to offer something to another. Yet they also show

dependence since they show we have needs that must be met by others. This is an interdependent body of believers.

C. The body analogy of the church shows this as well. Reading I Corinthians 12:14-31, one sees the church as a body united yet made of individual parts or members. These members have abilities that the other parts of the body need. Yet no member is so capable that he/she can do without the other members. The church, in this analogy is an interdependent, interconnected membership.

If interdependence is the ideal, then perhaps the there are flaws with both the Western and Eastern ideals. Take, for example, the Western ideal of independence. Where might this ideal have led us astray?

1. Consider church-planting. From Henry Venn, Rufus Anderson, and John Nevius of the 19th century, the ideal for new churches is expressed in terms of the "3-selfs". New churches should be self-governing, self-propagating, and self-supporting.[3]

Some add a fourth self, "self-theologizing". On some level, this ideal is sound. If a new church maintains an inability to govern itself, to multiply itself, or support itself, it is dependent on others. This will hamper sustainability and growth. Certainly, dependence does not appear to be the Biblical ideal. However, it is quite possible that a genuine risk of the "3-selfs" is the mistaken assumption that the capability to act independently implies that independence is itself an ideal. But perhaps the utilization of each others' strengths (not just at an individual level, but at a church level) is a good thing.

2. Community Development. One of the major fears in community development is creating dependence in a community. Relief work tends to create dependence because it provides short-term help without skills and material transfer for longterm

betterment. Many involved in "COMDEV" see their work within the community as the transitioning from a dependent community to an independent community. But perhaps, again, interdependence is a healthier goal, where different communities can share their strengths to support each other for the common good.

3. Missions. This is an area where interdependence has been growing. Years ago mission organizations often sought to act as strictly independent agents. In other words each organization has its own sending component, logistics component, literature component, member care component, and so forth. However, the sheer cost and redundancies created became unacceptable. Therefore, there has been a growing trend to specialize in areas of strength and work with likeminded groups that have strengths that complement their own. This is sometimes described as collaboration. Even if one ignored interdependence as a Biblical ideal, it certainly is an economic ideal.[4]

4. Pastoral Care. The tendency to promote independence has its potential flaws.

a. Is it healthy to attempt to create independently minded individuals in a society that promotes social cohesiveness and, in fact, considers a high level of independence to be a mental or social malady?

b. Is it good to always assume that guilt or shame (motivators toward social norms) are unhealthy? Would a society that maintains itself only through punishment and reward maintain long-term viability?

c. Would it be preferable to develop people who feel an obligation to share from their strengths but be willing to accept help in their weaknesses? Wouldn't this be a healthy characteristic in almost any society?

Interdependence will always be the difficult goal. Independence is fairly simple to understand, as is dependence. But to develop

bonds of giving and receiving moves one away from simplistic psychological model. It would challenge any culture, yet appears to be a worthy and biblical goal to strive after.

## APPENDIX C
## COMMENTS ON MEDICAL MISSIONS

This book (or booklet) is about guiding principles for doing medical missions, not the actual steps of carrying out such missions. However, here are some things to think about when doing medical missions. Some reiterate what was talked about before, but some are different. These are from my own experience and are not necessarily the views or experiences of others.

### Process

Figure 10 shows a common medical mission. There is nothing magical about this. In fact, one of the advantages of medical mission events is their flexibility. All sorts of other aspects of care can be added, in parallel with the other services or linearly in the process. However, volunteers need to be aware of the flow. It is good if there are extra volunteers who provide crowd control, roving help, and station queueing support.

Figure 11 describes a way of looking at growth through the process of one medical mission. The vertical distance between the upper and lower lines describes the number of people involved. Because of its shape I call it the Fish (or Ichthus) Model. Regions D through H essentially is the CPM (Church Planting Ministry) Model. I add A-C to show the entire process from the beginning.

**Figure 10. Basic Flow for a Medical Mission**

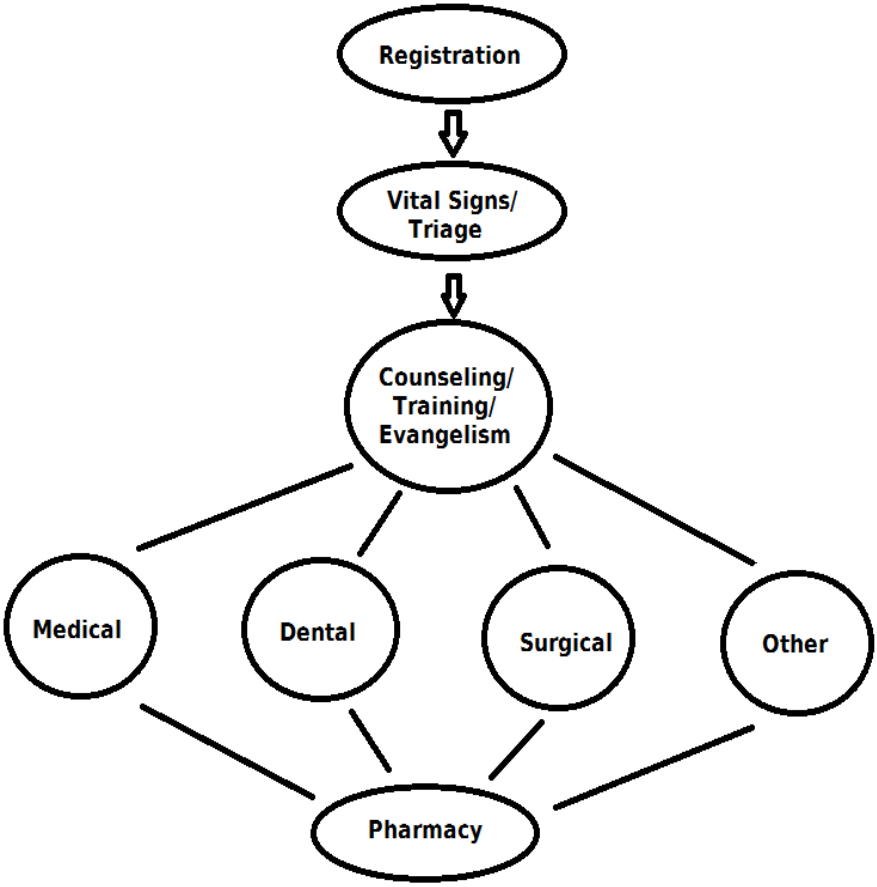
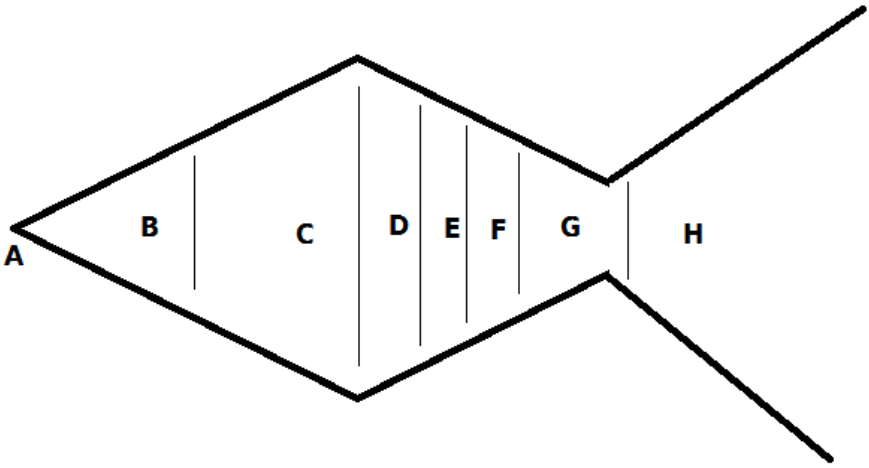


**Figure 11. "Fish" Model**

A: The idea of a medical mission comes to one person or a small group, and there is the decision to attempt to move forward with the idea.




B. This is the team-building phase. Buy-in is developed within the community and with outside help. Partnerships are developed and plans are worked out.

C. Others are told about the mission. The community is invited and the outside team supporters are told and encouraged to pray and help in tangible ways. Eventually a maximum number of people are involved as the entire community (ideally) is involved or invited, and the outside team is sent off.

D. This describes those involved in the medical missions. This number is smaller because not everyone who is invited

actualy comes. In the Philippines approximately half to 2/3s of those invited actually come (at least in rural areas).

E. This describes those who respond to the Gospel based on assent. In some cultures, assent to the Gospel (expressed perhaps in saying the “sinner's prayer,” perhaps). In some cultures, such as the Philippines, this sort of response may be made without any real conviction. As such it may not be the most useful guide for follow-up. However, it is important to keep records of all who attended and all who made this decision.

F. It is also useful to find a narrower filtering of those who come. This may be with a desire for Bible Study, or for home visitation. In the Philippines, for example, many will express an interest to “pray to receive Christ” as a way of expressing gratitude for the medical care provided. However, there is no such feeling of debt to agree to a Bible Study (for example) so it is often a better guide for community spiritual response.

G. After the medical mission, the hosts can do follow-up. They would probably start with Group F as priority, then to Group E, and finally Group D. However, in all likelihood those who actually act on their spoken decision will be smaller than the other groups. So for example, in the case of a Bible Study, one may have hundreds attend the medical mission, with dozens responding in faith, and perhaps 2 or 3 dozen desiring a Bible study. Of these, perhaps 10 or 15 actually respond. These can be put into 1 Bible study, or perhaps 2 growth groups, or maybe a handful of accountability groups.

H. It is from the core group G that growth will occur with multiplication of small groups, or development of house churches, or creation of a church, or whatever.

**Additional Points**

- Focus on local medical assets as much as possible. In the Philippines (at least) there are many medical professionals who are willing (and even are passionate) to be involved in Christian medical missions. Additionally, laws regulated by the Department of Health and Philippine Regulatory Commission make it more difficult (and expensive) to bring medical teams from overseas, legally at least. These rules are in a state of flux, so it is best to search what the rules are beforehand. Foreign medical personnel should work in assisting local medical personnel, or providing technical expertise in specialized areas. There are certain types of medical mission work (cleft palate reconstruction for example) where a predominately foreign team may be necessary.
- As much as possible, use new locally distributed medicine. Be careful of old medicines, especially in the area of expiration date. Be even more careful of free samples. These almost always disappoint. Limit medicines brought in overseas. There are customs regulations that apply and can kick in when you don't want them to. While some countries may benefit from medicines brought in from outside, in the Philippines there are plenty of inexpensive generic medicines that can be purchased from wholesale distributers. <Don't buy retail... the cost mark-up can be phenomenal.> If bringing in medicines, ensure the paperwork is done properly. Many people get away with poor (or no) paperwork, but you never know when that will cause problems.
- Determine what services you have time, manpower, and funds for. For example, consider dental. Does one want to cavity filling. A single dentist with assistant may be able to do 30 to 50 tooth extractions in one day with very little cost (lidocaine, needle, gauze, antiseptic, and gloves are the main costs). The cost per patient for doing fillings

increases dramatically, and the number patients that can be treated per dentist per day reduces dramatically. Additionally, special equipment, such as a portable dental drill, and perhaps even an electric generator may be needed. Doing fillings may be a great idea... but decide what you can do beforehand.

- Determine services also based on your volunteers. Use volunteers who are trained in the area they volunteer. Medical care should be done by licensed medical doctors. Dental care should be done by licensed dentists. In some cases, non-professionals can assist in some of the work, but they should be actively overseen by the professionals. Activities like eyecare or physical therapy can be done if the volunteers and equipment are available. Otherwise, don't promise.
- Don't short-change the medicine. If you can't afford to give out recommended medicines in recommended doses, then you can't afford to do the medical mission.
- Limit the number of patients. With evangelistic events the common belief is that if 50 attendees is good, then 500 is better, and 5000 is excellent. This is NOT true with medical missions. If you can easily handle 300 people, you can probably handle 400. If 700 come, you will have perhaps 300 people who leave with a positive feeling about your ministry, perhaps 200 who were annoyed but received some level of care, and another 200 who are extremely unhappy at you and what you represent. If you have more than 20 or 30 people really unhappy at you after the mission event, you are likely to have problems in the community. It is better to turn away people at registration than bring them part-way through the system and then turn them away.
- Evangelism is commonly done at these types of missions, but wisdom should be used. One-on-one works best with adults. Low-pressure group evangelism can be done with children. Do not pressure for a decision. In the

Philippines, people will often say what you want them to say because you are giving them stuff. Getting people to say “The Sinner's Prayer” looks good in the statistics, but that doesn't mean that there is any change of heart. Expressing God's love in a way that is recognized and understood is more important than getting them to say some words. However, track decisions made, and those that desire spiritual follow-up, bible studies, and prayer. These can be provided to the local host for follow-up.

- Although I only have done a few medical missions in areas with a sizable Muslim population, from my experience, I would not recommend direct evangelism. The methods commonly used in the Philippines for evangelism are almost universally based on a Christian worldview. High esteem for the Bible and the words of Jesus and the Apostles as quoted in the Bible are assumed. These methods don't work very well with those without a Christian worldview. Additionally, in some places, direct evangelism can cause an unnecessary backlash. Demonstrating God's love and mercy is likely bear more fruit in the long run.
- It is best to involve the local community in ways they can. The community should not be charged for the services (or if they are... such as for prescription eyeglasses... the costs should be announced to each beforehand so that there is no confusion). However, it is good for the host to feed the team, coordinate the space used, and provide lodging for the team (if needed). The community should be part of their own solving of problems. They should be interdependent with the team, not dependent.
- Work with local government. Medical mission teams often like to work only with a local school or church, but long-term change should involve local government so it is good to model that practice by bringing together different organizational units within the community, including the local government.

- Medical Histories should be taken and records kept. Commonly, medical missions like to rush people through. However, if long-term releationship and wholistic health is sought, good records and medical tracking should be in place.
- Despite rumors to the contrary, children are NOT little adults. They think and behave very different. A great deal of accommodation must be made for them, including (ideally) fun things for them to do. When I am not needed for other things, I would make balloon animals for the kids. That little activity was surprisingly beneficial.

Medical missions is a very broad topic and a short booklet will not cover the topic at all adequately. For this reason, Appendix D (along with the Bibliography) is added to provide additional resources for the reader.

# Appendix D
# Medical Mission Sources

Here are some books and articles that might be found useful for those looking into various aspects of medical mission work.

Miriam Adeney, "When the Elephant Dances, the Mouse May Die." In *Short-term Missions Today.* Ed. Bill Berry (Pasadena, CA: Into All the World Magazine, 2003), 86-89.

Stephen Bezruchka, "Medical Tourism as Medical Harm to the Third World: Why? For Whom?" *Wilderness and Environmental Medicine,* November 2000, 77-78.

Erich Bridges, "Global Medical Alliance Connects Missionaries, Church Partners." International Mission Board. 2007. http://www.imb.org/main/news/ details.asp? LanguageID=1709&StoryID=5861 (accessed 08 January 2009).

Jeffrey L. Bryant, "Assessing the Long-term Health Benefits of Medical Humanitarian Civic Assistance Missions." *US Air Command and Staff College,* March 1997. http://stinet.dtic.mil/cgi-bin/GetTRDoc?AD=ADA398474& Location=U2&doc=GetTRDoc.pdf (accessed on 27 October 2008).

James R. Cochrane, "Religion, Politics and Health for the 21st Century." *International Review of Mission 95, Nos. 376/377, January/April 2006: 59-72.*

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