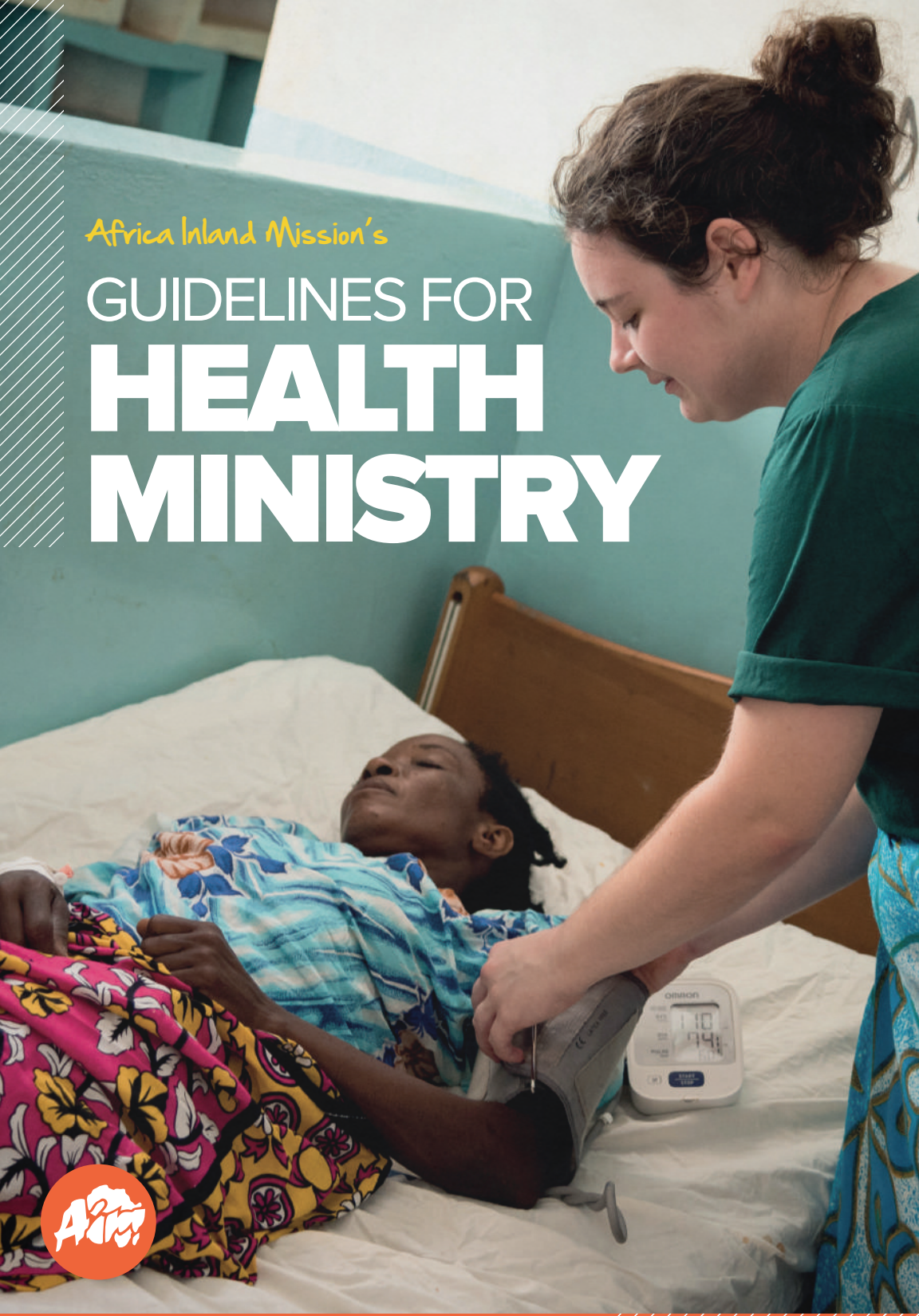


Africa Inland Mission's

GUIDELINES FOR HEALTH MINISTRY

For thus says the Lord GOD, "Behold,
I myself will search for my sheep and seek them out…
I will seek the lost, bring back the scattered,
bind up the broken and strengthen the sick."
Ezekiel 34:11,16 (NASB)

BACKGROUND

Medicine has an unassailable pedigree in the long history of Christian mission. From the early chapters of the Pentateuch (when Abraham prayed for God to heal Abimelech's family; Gen 20:17), to the final chapter of the New Testament canon (where the leaves of the tree of life are for the healing of the nations; Rev. 22:2), we read of God's concern for the physical wellbeing of the people he created. Our Lord set a particular example, as the Synoptic Gospels are replete with examples of his compassion for people, manifested in a variety of ways, including physical healing.

This Scriptural foundation is borne out in the Church's life over subsequent centuries; however, in terms of formal medical mission endeavours, this has arguably been most prominent in the nineteenth century and onward.

While missionary efforts had flickered in embryonic form throughout the preceding centuries, the arrival of Columbus on the shores of America at the end of the fifteenth century, and the Reformation / Counter-Reformation shortly thereafter, certainly ushered in a new era of missiological endeavour. Catholic and Protestant churches increasingly sent workers forth into the wider world to make the name of Jesus known. Over time, these efforts differentiated in a wide variety of ways, departing from being primarily the domain of male preachers. Theological, educational, agricultural and literary

initiatives and institutions took form and expanded in the service of Christian witness. Professionals of all stripes employed their training and skills for the furtherance of the Gospel.

Medicine and medical workers were certainly not excluded from this evolution in methodology. Whereas at the beginning of the nineteenth century medicine could be said to be primarily an accidental addition to evangelistic strategies, by the end of the century it was very much more the foundation of an intentional strategy of medical missions. This was true in India, China, Africa and indeed the rest of the world. One driving factor for this was the explosion in scientific understanding and medical knowledge over the course of the latter half of the century, including principles of asepsis and hygiene, the development of anesthesia, an understanding of bacteriology and the underlying causation of a wide variety of diseases, and the discovery of X-rays. These provided medical workers a previously unimaginable armamentarium in discharging their medical role and responsibilities. These they did, through work in hospitals and health centres, mobile clinics, community health work, health education, research, etc. There were few avenues not explored as health care professionals dispersed around the globe in their mission endeavours.

PHILOSOPHY

What underlying motivations have animated individuals' decisions to serve in these ways? Broadly speaking, four major categories have been advanced to justify the existence of medical missions: strategic, imitative/obedientiary, humanitarian/philanthropic, and utilitarian.[1]

Strategic reasons supersede all others in the minds of many, especially those who would subsume anything and everything to the overriding pre-eminence of direct evangelism and the conversion of people to Christ. Medical missions are then acceptable because they overcome barriers and gain a hearing for the gospel when no other method may be effective. For example, national legislative barriers to Christianity can be circumvented by a Christian doctor whose skills are needed and welcome in a country otherwise hostile to the gospel message. Even geographic obstacles may be overcome by medical missions, as healthcare institutions attract persons from scattered rural settings to a central location where they may more readily be confronted by the claims of Christ.

Rejecting strategic reasons as adequate grounds for medical missions, others adopt the imitative/obedientiary rationale, citing the example of Christ who healed the sick and went about doing good, perfectly merging evangelism and social action. They see Christian healthcare mission primarily as a witness to the historical fact of the healing ministry of Jesus Christ, and reject all other explanations, thus (writing specifically of hospitals): "There are some purposes a `Christian' hospital does not fulfill. One is the purpose proposed by supporters of the `bait thesis.' According to them, the mission hospital should act as bait to allow fishers of men to hook patients into the Christian `boat.' Though the bait thesis stems from a legitimate concern for winning men to Christ, it fails as a valid purpose for a hospital. The failure lies not in the evangelistic zeal, but in the abuse of people… We do not manipulate. We witness. The love of Christ should constrain men and we dare not cheapen that love, even for evangelistic success…

While one of the most effective methods of witnessing the love of Christ, the Christian hospital is not primarily an evangelistic stratagem. Though instrumental in church growth, it does not exist to enhance the prestige or

1. This categorization is taken from A. F. Walls, "'The Heavy Artillery of the Missionary Army': The Domestic Importance of the Nineteenth-Century Medical Missionary," in *The Church and Healing*, ed. W. J. Sheils (Oxford: Basil Blackwell, 1982), 287-297. For a comprehensive treatment with a slightly different categorization, see Christoffer H. Grundmann, *Sent to Heal! Emergence and Development of Medical Missions* (Lanham, MD: University Press of America, 2005), 201-225.

growth of the Church. Although it must re-educate people in the community, its primary purpose is not building a healthier society. The Christian hospital derives its reason for existence from one historical fact: Jesus healed."[2]

Philanthropic reasons are generally apprehended by non-evangelicals as justification for their activities, however, evangelicals as well recognize the validity of these arguments and cite them as legitimate, though secondary. The suffering so prominent in the third world cannot help but evoke a response from those who would demonstrate care and compassion in a tangible way. More than merely a witness to the healing ministry of Christ, medicine and medical mission represents a practical, necessary reply to the evident needs of our fellow human beings.

Utilitarian arguments are less prominent today than a century ago, when a primary function of the missionary doctor was to maintain the health of the mission staff in the light of very significant missionary morbidity and mortality; nevertheless, the health of missionary staff remains a legitimate function of medical services on the mission field.

Though the reasons listed above differ, they are not independent but rather interdependent. In the absence of any evangelistic outreach for instance, a witness to Jesus' healing ministry is improperly divorced from the overall context of Christ's ministry on earth. Nevertheless, some are clearly of greater significance than others. After all, there is an essential distinguishing characteristic which differentiates Christian from secular health work overseas, and the fact that we serve a risen Christ, who is that characteristic, and who longingly desires that all would come to salvation through belief in His name, that fact cannot be glibly discounted or ignored. Christ both ministered to people's needs and proclaimed His Kingdom; so too does medical missions - it is not limited to any one role. But just as the ministry of Christ's life on earth constituted an integrated whole and yet was very much focussed toward a specific goal, so too is medical missions, encompassing a broad range of functions, yet directed toward furthering the Kingdom by declaring the gospel of Jesus Christ.

This gospel, the message of salvation which we proclaim, is defined by statements like "Christ in you, the hope of glory" (Col. 1:27); "Jesus Christ, and Him crucified" (1 Cor. 2:2); and "For I delivered to you as of first importance what I also received, that Christ died for our sins according to the Scriptures, and that he was buried, and that he was raised on the third day according to the Scriptures" (1 Cor. 15:3-4). We are saved by this gospel message alone but recognise that it does not come alone, as acts of Christian compassion and service (while not the gospel message *per se*) stem from it; they are some of the wonderful and expected fruits of the gospel in the lives and ministries of Christians. The second great commandment of loving our neighbour goes hand in hand with the great commission of making disciples of all nations, and compassionate medical care goes hand in hand with verbal proclamation of the gospel, including among UPGs (AIM's priority). Although AIM does not consider acts of compassion in themselves to be sufficient as gospel proclamation, when combined with verbal proclamation, acts of compassion, including medical ministries, speak powerfully and provide a compelling demonstration of the love and grace of Christ.

2. David J. Seel, "Is Jesus at Home in a Christian Hospital?" *Christian Medical Society Journal 10* (Spring 1979): 4.

AIM'S HEALTH MINISTRY HISTORY

AIM's medical work reflects the historical development and diversity of medical missions; in its annals can be found examples mirroring a wide variety of models of health care service. Theodora Hospital (the forerunner of Kijabe Hospital) was founded in 1915; since then AIM's medical work has grown and branched out in many different directions (both geographically and professionally). Over the years AIM has placed hundreds of health professionals in over fifteen different African countries, in ministries urban and rural, institution and community based, static and itinerant, providing preventive, curative, rehabilitative and palliative care services, as well as health education and training. This is an impressive legacy.

It is insufficient, however, for a forward-looking organization to simply perpetuate the past or build on historical foundations laid decades ago. As an organization, AIM regularly evaluates its goals, objectives and methodologies, and its health ministries certainly reflect this.[3] A focus on reaching Unreached People Groups (UPGs) has long been part of AIM's ethos. Recently this priority has been revisited and sharpened, such that all ministries are now sifted through this filter.[4] Pursuing this single-minded emphasis has not been without apprehension and angst. Well-established health ministries have had to come to grips with the fact that, although originally sited in unreached territories, they are now located in well-evangelized areas surrounded by thriving local churches. Praise God, but it is now appropriate for us to consider moving on from these existing ministries or reframing them in some way. This is not necessarily an easy task. Doing so can affect individuals' (and their families') long-term ministries and dreams, relationships with local communities, partnerships with national churches, etc.

3. See, e.g. Africa Inland Mission International, *Health Review Report* (Bristol: AIM International, 2004), 1-41; Africa Inland Mission International, *Ministry on Purpose: AIM International Health Ministries Strategy Paper* (Bristol: AIM International, 2007), 1-32; Dixon, Robert, Ian Campbell and Geoff Protheroe, *Health Ministry Review 2011-12* (Bristol: AIM International, 2013), 1-50.

4. Africa Inland Mission International, "GMP01: Purpose, Mission, Values and Framework", in *AIM Member Handbook 2016* (Bristol: AIM International, 2016), 1-2.

ENDS, SUB-ENDS AND THE 'FRAMEWORK'

It is fitting here to consider the Ends and Sub-Ends of AIM[5], under which all AIM activities are subsumed. The Global Ends Statement is: *In dependence on the grace and power of the Lord, with priority for unreached people groups, the gospel proclaimed, disciples made, and Christ-centered churches formed among all the peoples of Africa.*

Arising from this Ends Statement, five Sub-Ends have been identified:

1. An increasing percentage of AIM members proclaim the gospel and make disciples among UPGs and/or directly mobilize African believers for this task.
2. At least four new UPGs engaged with the gospel annually by AIM.
3. A rapidly growing number of African believers missionally equipped and mobilized for church planting with priority to UPGs.
4. A growing number of Africans from UPGs in diaspora are engaged with the gospel.
5. A rapidly growing number of church leaders are equipped to lead Christ-centered churches.

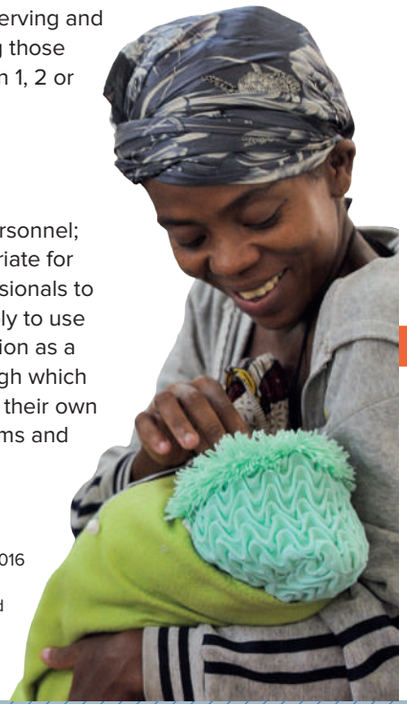
As already noted, all activities under the AIM umbrella must support the organization's progress toward the above Ends and Sub-Ends.

As will all AIM ministries, AIM healthcare ministries, whether old or new, need to be evaluated by their conformity to and effectiveness in achieving the ends of AIM, as well as how well they align with the AIM 'Framework'.[6] With regard specifically to that Framework, where does their **primary** ministry focus?

1. Are they disciple-making among the unreached people groups of Africa?
2. Are they mobilizing churches and believers to missional disciple-making, with priority for unreached people groups of Africa?
3. Are they equipping leaders for African churches?
4. Are they serving and supporting those engaged in 1, 2 or 3 above?

HEALTH MINISTRY STRATEGY

Determining the particulars of whatever health ministry in which AIM plans to engage relates to specific details: what exactly are we planning to do? What will the health ministry in question look like 'on the ground'? The answers to these questions must be in agreement with the ministry priorities established by AIM's leadership and are largely determined by the relevant Team / Unit / Regional personnel; it is inappropriate for health professionals to join AIM simply to use the organization as a vehicle through which to implement their own ministry dreams and plans.



5. Africa Inland Mission International, *International Council Policy Manual* 2016 (Bristol: AIM International, 2016).
6. Africa Inland Mission International, "GMP01: Purpose, Mission, Values and Framework", in *AIM Member Handbook 2016* (Bristol: AIM International, 2016), 1-2.

Two separate **Strategic Principles** have been identified that give guidance in such matters[7]. The first is:

1. Each health ministry will be an expression of a clear vision and strategy, reflecting the overall ministry direction of AIM.

In practical terms, this signals the creation of a Vision and Strategy Paper (VSP) to undergird each individual health ministry. As VSPs are the joint responsibility of Unit and Regional leadership, there is plenty of scope to accommodate the aspirations and plans of AIM's leadership. It goes without saying that the individual health professionals involved in the health ministry would also have input when the 'clear vision and strategy' is defined. Adherence to this Strategic Principle fulfils four purposes: it ensures that every health ministry advances AIM's Purpose and Mission; it ensures that each health ministry is undergirded by careful thought and planning; it ensures that every health ministry is accompanied by a formal, written VSP; and it provides scope for input from the various stakeholders involved in the ministry.

The second Strategic Principle focuses specifically on short-term personnel, but again highlights that AIM's health ministries and the activities in which its health ministry members are engaged are purposeful rather than *laissez faire*.

The second Principle is:

2. Short-term assignments for health ministry will be intentional.

A brief exegesis of this short phrase is in order. Intentionality implies that the assignment aligns with AIM's overall ministry direction as well as Unit / Regional objectives. Like all short-term assignments, any short-term health ministry assignment (including medical electives) should support an existing long-term ministry and its personnel. In some situations, the short-term assignment may primarily function to lay the groundwork for a future health ministry or to prepare a health professional for future ministry. Finally, these assignments should involve monitoring and evaluation after the fact to improve similar experiences in the future.

HEALTH MINISTRY STANDARDS

As already noted, the contexts of AIM's various health ministries vary widely as do the backgrounds of our many health professionals. This diversity both reflects and generates experience that enhances our capacity for engaging in health ministry across the continent; it can also (less helpfully) present subtle challenges in maintaining commonality of focus and direction, as our personnel and the ministries in which we are engaged respond to the assorted pressures of our different local settings. Recognizing this, we are intentional in

7. See Africa Inland Mission International, *Ministry on Purpose*, 12-13.

seeking to foster unity among our health ministry membership in terms of clarity of purpose and coherence in philosophical approach to ministry. Accordingly, ten Health Ministry Standards have been drafted;[8] these remain foundational to the essence of what it is to be an AIM Health Professional.

AIM health ministry members will contribute to the goal and vision of AIM by their commitment to the following Standards:

1. CHRIST-LIKE RELATIONSHIPS

We are committed to personal relationships that model Christ-likeness in our ministry / profession. Recognising the particular pressures and stresses that health ministry personnel often experience, we commit to humbly showing love, patience, care, respect and grace as we minister through professional and personal relationships with colleagues, co-workers, patients, and family in our various contexts.

2. EMPOWERING OTHERS

As we develop leaders and help everyone stand mature in Christ, we affirm the value of all people as created in the image of God and worthy of our investment and service. We seek to equip others by formal and informal mentoring, coaching and training. We further seek to enable others by advocating for justice and encouraging their freedom, responsibility and dignity in Christ.

3. TEAM MINISTRY

We shall function in effective teams (which may include non-health ministry personnel). We affirm our mutual responsibility to each other in terms of pastoral care, accountability and interdependence. We further affirm our God-given mutual dependence on each other as team members living in community.

4. HOLISTIC LIFE AND MINISTRY

Recognising that mankind is created in God's image as an integrated being, we shall live, minister and practice our profession in a holistic manner appropriate to the local context. This includes developing functional capacity in the language of the local people/setting.

5. STRATEGIC PARTNERSHIPS

As members of the Body of Christ, we affirm the importance of working in unity and fellowship with local partnerships, including but not exclusively denominational churches. We shall integrate into local health systems by co-operation, collaboration or by fulfilling complementary roles. We shall avoid competition and duplication. We shall serve rather than dominate.

Working definition: *Made between AIM and churches or secular organisations, strategic partnerships are those which are valuable and key to advancing C3A3P (Christ Centered Churches Among All African Peoples). Such partnerships commonly involve Vision and Strategy Papers (VSPs) and Memoranda of Understanding (MoUs); to ensure maximum strategic value, VSPs may be jointly drafted with the local partner if it is a Christian organisation with similar goals. (Partnerships with external organizations are usually defined by a negotiated MoU, whether or not it is a Christian organisation.)*

6. IDENTIFIABLE END POINT MINISTRY OBJECTIVES

Our ministry will have a purpose and an endpoint to guide our strategic thinking and practice. We acknowledge that there are other stakeholders in our ministry who have valid input into defining these parameters and evaluation criteria. The end point objectives will be derived from the goal of AIM and the relevant VSP in operation.

Working definition: *One or more SMART (Specific, Measurable, Achievable, Realistic, Time-bound) objectives - not necessarily health-related - which are to be achieved to indicate that AIM's vision expressed in the VSP for this particular health ministry is complete.*

7. SUSTAINABLE IMPACT

Our ministry will equip, train, develop and enhance national leadership in those amongst whom we minister. Our intent is that they will be able to develop these ministries independently of AIM, recognising that this takes both time and intentional preparation. Our ministry will affirm and empower local ownership of ministry and build capacity to initiate, manage and embrace change.

Working definition: *A defined lasting change, arising from appropriate interventions, that contributes to good or improving health or other impact for the Gospel and that is expected to outlive the presence and input of AIM personnel, meeting the needs of the present generation without compromising the ability of future generations to meet their own needs.*

8. ACCOUNTABILITY

We affirm our accountability to AIM, our ministry partner organisation (where present) and to each other. We acknowledge the importance of God's personal leading in the individual member's life and ministry. AIM's overall ministry direction (locally as well as globally) together with a personal sense of leading, will form the basis of the evaluation of our ministry.

Working Definition: *A demonstrable on-going personal commitment to account (and be held accountable) for life and ministry through multiple relationships, for example to God, to AIM leadership, to colleagues, and to national governments and partner organisations. Major accountability relationships should be defined by Receiving Region leadership (e.g. through VSPs, MoUs, Job Descriptions, etc.) and will be expressed through a variety of mechanisms or personal interactions, with the expectation that health ministry personnel will show humility and transparency as they seek to better serve the Lord Jesus and those within their personal spheres of influence.*

8. See Africa Inland Mission International, *Ministry on Purpose*, 10-11. Originally (in MoP) these were called Health Ministry Values. However, the AIM Member Handbook (GMP01) sets forth other AIM 'Values' (God-centered, ministry-focused, member-oriented) that are also highlighted in the 'Framework'; to avoid confusion, the Health Ministry Values have been renamed Health Ministry Standards. It should be noted that their number has not changed and no text has been deleted, although in a few places a 'working definition' or other short additions have been made for clarification.

9. PROFESSIONAL COMPETENCE
We shall exemplify professional excellence appropriate to our ministry context. We shall learn from the local situation, colleagues and co-workers and contextualise our ministry, while not compromising the integrity of the Gospel. We shall maintain our professional regulatory obligations within our host and mobilizing countries.

10. COMPASSIONATE CARE
Compassion and justice as an outworking of God's character is indispensable to authentic health ministry. While we acknowledge its foundational importance as an essential element of health ministry, compassion is not an end in itself for AIM members.

These ten Health Ministry Standards define the benchmark traits of AIM's health ministries and its member health professionals; unwavering commitment to these Standards will helpfully facilitate our labours together. They outline the broad strokes of ministry process and how we minister from day to day.

CURRENT AIM HEALTH MINISTRY

It is important to be strategic in deploying the resources at our disposal, and aligning that with AIM's overall mission and ministry focus. This has resulted in increased attention to how to engage UPGs through medical ministry. Why this great focus on Unreached People Groups? We serve among UPGs, not because their indicators of health status are worse, or their local health resources are more limited, but because UPGs do not yet have the Gospel; in non-UPG settings that is not the case. We prioritize and engage UPGs because they have spiritual needs that cannot be overlooked. Church planting among African Unreached People Groups is why AIM exists.

A particular challenge is that many UPGs are in 'creative access' settings, where identifying appropriate means of engaging those UPGs is challenging. Determining suitable opportunities and deploying personnel into those situations, when local precedents and foundational relationships are lacking, requires considerable preparatory investment. Increasingly, partnerships with other organizations (e.g. governments, non-governmental organizations, or faith-based organizations) provide opportunities to place company workers in suitable health care settings.

As AIM healthcare workers, we seek to discharge our responsibilities to the best of our abilities, wherever and in whatever capacity we serve. We strive for excellence in health care, mindful of the resource limitations in our particular settings, which in some cases might dictate rather rudimentary technology and in others more sophisticated tertiary care approaches. We seek to improve and expand the knowledge resources of the communities in which we serve. We contribute to local health systems, offering input when appropriate. We serve in places of substantial physical need and suffering. We acknowledge the authority of national governments where we serve and observe the appropriate legislative and regulatory frameworks in those nations.

We are also followers of Jesus who are seeking to proclaim the Gospel, living out the good news of Jesus Christ in our lives and verbally communicating it as well. While our Lord's deeds spoke volumes, he did not shy away from proclaiming the Kingdom of God verbally, and neither should we. This does not necessarily mean that we are evangelists or even gifted in evangelism. But as AIMers we desire to see the church established in the places we serve, through testimony in both word and deed.

So yes, we certainly engage in healthcare ministries to the best of our abilities, and commit ourselves and our service daily to the Lord in prayer, but where and among whom we work is a critical question - we particularly focus on doing so in UPG settings. Furthermore, this does not imply a purely passive approach to ministry; as our International Director has so clearly stated "it is not sufficient to put medical personnel in a UPG situation. Unless their heart burns with the desire to see the church established, they will not be effective in moving us towards our ends".[9]

Health Ministries are but one expression of ministry within AIM, and, like all other AIM ministries, they fall within the standard AIM ethos and administrative structures. The information set forth in the AIM Member Handbook (see specially the first section: GMP01 Purpose, Mission, Values and Framework) applies to all AIMers; this includes those engaged in Health Ministries. A desire to see Christ-centered churches among all African peoples applies to all AIMers, whether involved in Health Ministries or not. Likewise, AIM health professionals acknowledge a priority for engaging Unreached People Groups, as well as a dependence on prayer to undergird our daily lives and activities.

These "Guidelines" do not supercede the Member Handbook, but rather build upon it, setting forth background and additional guidance pertinent specifically to those engaged in Health Ministries.

9. Personal email communication to G Protheroe, June 16, 2014.

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