

# **HEALTHY MEDICAL MISSIONS: Principles for the Church's Role in Effective Community Outreach in the Philippines<sup>1</sup>**

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## **ABSTRACT**

This article is based on the structural component of the dissertation, “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.” The research was built around semi-structured interviews of individuals involved in medical missions in the Philippines, particularly in the Ilocos Region of Northern Luzon. Nineteen such individuals were interviewed, including medical professionals, medical ministry organizers, and church leaders. The interviews were analyzed utilizing grounded theory analysis, a form of qualitative analysis that focuses on developing a model based on multiple perspectives of a phenomenon.

Analysis of the interview sources led to a visual model, the Medical Mission Structural Model. It is put in an organic form—a trillium (or three-petaled flower). One flower is shown as healthy with the acronym “REAL” making up the parts of the flower. R is the center of the flower, with E, A, and L comprising the petals. “**REAL**” (or successful) medical missions have **R**ight Motives, **E**ffective Partnering, **A**ctive Community Participation, and **L**ong-term Presence. With proper understanding of the terms, this model can be used to show visually what happens when key components of a medical mission are missing. Another form of the Structural Model is when the opposite occurs. The flower structure forms the acronym “WILT,” and is shown as a weak or dying plant. Medical Missions WILT (fail) when they have **W**rong Motives, **I**neffective Partnering, **L**ack of Community, and **T**emporary Planning. Wrong Motives takes the center of the flower while the other letters comprise the petals. This model is meant to provide a memorable form for use in training and troubleshooting medical missions.

## **INTRODUCTION**

Medical Mission Events are extremely common in Philippines. They are done by all sorts of groups—government and non-government, religious and secular, national and international. However, there is a question as to their efficacy. 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, 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.

Assuming that the over-arching goal is that the community and its residents are helped by the medical mission event, the question is how to ensure this happens. Medical mission events 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 (particularly in the Philippines), it is worth the effort to determine if medical missions can be done to make effectiveness likely.

Nineteen medical missions practitioners, particularly those who work in the Ilocos Region of the Philippines, were interviewed. Six of these were medical/dental professionals, six were church leaders,

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<sup>1</sup>This article is based on some of the findings in the dissertation, “Strategic Use of Medical Mission Events in Long-Term Medical Mission Events in Long-term Local Church Outreach: A Consultant-style Framework for Medical Mission Practitioners in the Ilocos Region, Philippines” (Asia Baptist Graduate Theological Seminary, 2012).

and seven were medical mission organizers. The interviews were semi-structured based on questions developed from literary research. The interviews were coded developed into a model utilizing grounded theory analysis. Grounded theory analysis is a form of qualitative analysis first formally described by Glaser and Strauss.<sup>2</sup>

For the purposes of this article the following definitions are used:

**Medical care.** Utilizing the broader definition sometimes used to describe primary health care, per the World Health Organization Symposium, 1982, Medical care includes “health promotion, prevention of disease, nutrition, basic sanitation, health in the workplace, and first-line medical care.”<sup>3</sup> 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.

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

## STRUCTURE

Figure 1 and Table A 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 adorning (Titus 2:10) the gospel.<sup>4</sup>

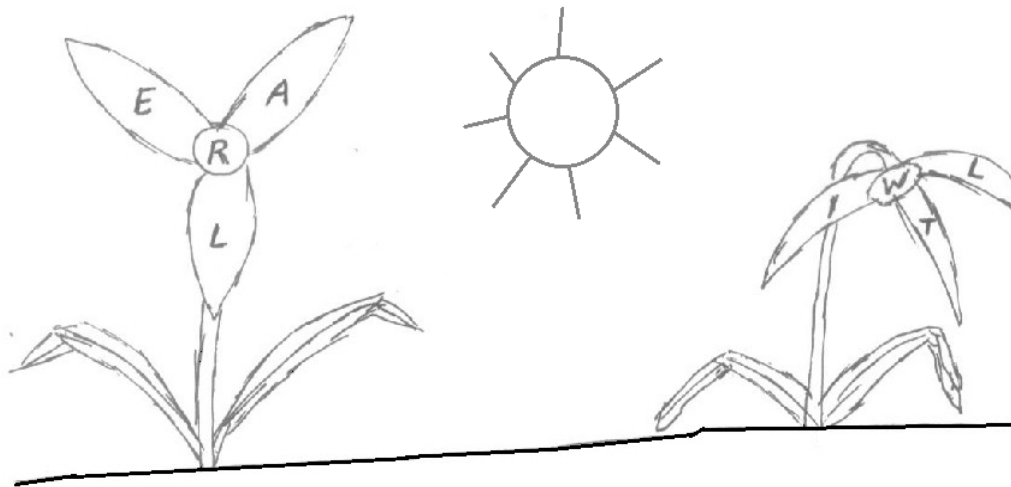
The goal in medical missions is that it is “REAL”. The acronym stands for Right motives, Effective partnering, Active community participation, and Long-term strategy and planning. The visualization of this model came quite naturally for the four qualities in REAL. Giving Right Motives a central place 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 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 the Development Cycle component. The community effective works together with right motives in a long-term strategy to improve itself.

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<sup>2</sup>Barney G. Glaser and Anselm L. Strauss. *The Discovery of Grounded Theory Strategies for Qualitative Research* (Chicago: Aldine Publishing, 1967).

<sup>3</sup>David Van Reken, *Mission and Ministry: Christian Medical Practice in Today's Changing World Cultures*. A/Bgc Monograph Series (Wheaton, IL: EMIS, 1987) <http://bgc.gospelcom.net/emis/vrekenmono/vrekencont.htm> (accessed 22 September 2006).

<sup>4</sup>Plants are common models for health and growth in the Bible. For example, healthy and growing followers of God are described as branches on a vine in John 15, and as a fruiting tree in Psalm 1.



**"REAL" Medical Missions**

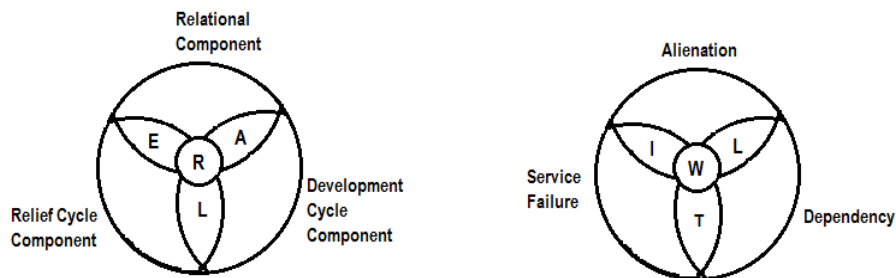
Medical Missions that have:

- 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



**Figure 1. Structural Model**

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. Therefore, one can have REAL medical mission events or events that WILT. The related visual framework is also in Figure 1. 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.

Component Missing	Graphic	Result
<b>Long-term Strategy and Planning</b>		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.
<b>Effective Partnering</b>		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.
<b>Active Community Participation</b>		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.
<b>Right Motives</b>		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.

**Table A. Structural Model as a Consultation Tool**

The main purpose of developing this visual framework is 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 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 A. 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.

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)**

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 (non-government organization) 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 unit (LGU) 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.

“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.<sup>5</sup>

### **Final Thoughts**

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. 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.<sup>6</sup> 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.

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. I 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 or even local churches for selfish purposes.

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.

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

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<sup>5</sup>The relationship between relief (short-term) and development (long-term) ministry is noted but not delved into greatly in this article. However, it is covered more fully in "Model for Church-based Relief and Development" by Robert H. Munson as part of the same dissertation. <http://www.slideshare.net/bmunson3/visual-model-for-christian-relief-and-development>. Additional references that are beneficial in this are "Partnering with the Local Church" and "Project Cycle Management," both by Rachel Blackman, and "Kingdom Development: A Passion for Souls and a Compassion for People" by Jeffrey Palmer.

<sup>6</sup>Ballard, Jerry. "Missions and Holistic Ministry." In *World Missions: The Asian Challenge: A Compendium of the Asia Mission Congress '90*. Seoul, Korea: Asia Mission Congress, 1990.

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.

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.

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