Community Healthcare Missions in a Muslim Context

In recent decades, the population explosion in the world, along with advances in information and travel technology, has led to an unprecedented worldwide interaction between different people and their cultures. In the post-Enlightenment era, the religious constitution of the world has become less and less homogenous, as different people and religious groups are allowed multiple forums through which they can engage one another. In this context, Christians are presented with the opportunity for tremendous global access in sharing their faith, but they are also faced with the challenges of communicating beliefs that are culturally relevant and applicable.

Throughout the 20th century, healthcare missions have been effective means of providing holistic care to people groups worldwide. Through the historic evolution of healthcare mission models - from the hospital mission station to the empowerment of local community workers - missionaries have constantly had to adapt to the people groups they have sought to reach. In contemporary times, missions with Islamic communities require adaptation more than ever. In light of heightened political instability between Christians and Muslims, there is a great need for Christian healthcare missionaries to approach their ministries with special care and sensitivity. Indeed, healthcare in missions with Muslims must incorporate a comprehensive understanding of the cultural context and begin at the local, personal level in which trusting relationships can be developed. These principles are encompassed in the Community Development Education model developed by Stan Rowland.

In the study of ministries with Islamic communities, there must be an underlying understanding that Muslims inhabit every continent of the world, and there is great diversity in the expressions of their beliefs. Research must be done under the premises of trends and generalities, with the awareness that there is not one monolithic group of people with one type of faith. With this disclaimer, important issues in healthcare missions with Muslims can be discussed.

"Muslim society is more than just a theological tenet. It is a complete culture. Islamic society is a way of life. It is the society's religion, the politics, the family, the economics, the way of life. It is more than a set of beliefs or a
For these reasons, entire nations operate with Islamic law as the governing principle, and there is no separation of religion and state. Because the Islamic worldview blends the secular and spiritual worlds, Muslims may see Christianity as integrated with Western culture, including stereotypes such as liberal sexual morals, abuse of drugs and alcohol, and individualistic thinking. There is often an initial shock among Muslims outside of the West at the low standards of public morality portrayed by people they believe are Christians. Thus, it is paramount that missionaries are able to demonstrate the high moral standards of Christianity in a way that is not Western, but fully immersed in the local culture. "They appreciate people who do not smoke, who do not drink, who are modest in their dress and deportment, and who use careful language. This fits in with their idea of what a role model should be."3

As a pervasive, all-encompassing belief system, Islam requires strict conformity of its members. The values of individualism and personal achievement are minimal in comparison to the West, and the most important consideration is that of the group, particularly the family.4 Thus, individual behavior is controlled by society, and making an independent decision such as accepting the gospel may be countercultural. In a Muslim community, converting the whole family is foundational to the local church because of the communal approach to decisions.

In a law-based culture, Muslims follow strict moral standards, and submission is a key theme that pervades society. However, with such a works-based mentality, love is sometimes missing in the family context.5 Christians who show love within their own families, as well as for their Muslim neighbors, can reveal a love-based faith that leads to healthy relationships. Missionaries who go with their families can, therefore, have a unique impact on their communities through their family dynamics.

An Effective Healthcare Mission Model

The history of healthcare missions has undergone significant changes in the last few decades. Early missions hospitals consisted of a campus built by expatriates as the main site of work and ministry. Confronted by pressing needs and high demand for services, healthcare professionals and mission administrators focused on efficient curative systems.6 In the 1970's, there was a marked shift toward training locals in their own communities, leading to the banners of health promotion and disease prevention. This allowed for holistic care, including spiritual, social, and emotional health, in addition to physical well-being. This comprehensive perspective has proven to be much more effective in reaching people groups with the gospel, but especially so in the Muslim context.

"The classic walled mission compound, passing out religious literature just does not fit into Muslim culture. Reaching the Muslim individual in a meaningful way that will result in his/her choice to change lifestyle is, I perceive, much more dependent on personal relationships and credibility than we will experience in many other cultures... As a rule, personal loyalties are extremely important, and personal friendship is the only thing that will rise above religious and political differences."7

Such personal relationships can be facilitated greatly by missionaries who work with locals in their own communities to address needs that the locals themselves identify. This demonstrates the value of the locals' point of view and trust in their ability to produce change. Contrary to the hospital station, initiating programs in the locals' own communities creates a sense of ownership and brings change.
to the attitude of the people. Location is thus a pivotal factor in effective healthcare missions because of the values of service and community that are expressed.

Stan Rowland's Community Development Education (CDE) model is ideally suited for healthcare missions with Islamic communities. The program is directed at the "broad-based first tier of the community." The philosophy involves teaching people to do as much as possible on their own; going to the people; emphasis on changed lifestyles and conditions through preventive medicine and health education; training content that is transferable and multipliable; and "aggressive evangelism, follow-up, and discipleship to saturate the target area for Christ." All of these strategies lead to close working relationships based on growing rapport and trust. The key components that can transform Muslim communities are the vision to multiply and the use of one-on-one discipleship through everyday home visits between locals. Having a balance of physical and spiritual work is considered so important that patient loads are sometimes decreased in order to provide room for spiritual ministry.

Many mission organizations provide communities with short-term relief that lasts only as long as the expatriate missionaries are there. When the missionaries leave, the benefits to the people quickly evaporate because they are dependent on the missionaries' skills. CDE is the exact opposite, seeking to place most of the responsibility in the hands of the local community members, so that long-term development can take place without the need for expatriates. "The medical work is an ideal way to approach Muslims and it is certainly needed, but it must fit into the perceived needs of the community... The emphasis on temperance and lifestyle is appreciated and supported by all segments." CDE believes that the best way to understand the perceived needs of the community is by asking the locals to identify the most pressing needs, and then address them through change in lifestyles, one member at a time.

CDE begins with a training team of three to four Christian members, preferably nationals, who are skilled in discipleship, evangelism, and practical areas of healthcare and community development. They work with community members in assessing needs and establishing a community health committee. The committee chooses 12-18 volunteer workers who will be trained as Community Health Evangelists (CDEs). The training team will teach them to address spiritual and healthcare needs through twice per week sessions, over a span of five to six months. After completing training, CDEs conduct home visits with neighbors, teaching public health and prevention strategies in the context of spiritual discipleship. Because CDEs model what they teach by living out the principles in their lifestyles, long-term change can happen in their community. Sustained one-on-one relationships produce transformation, and because each new person becomes a multiplying agent, the broader neighborhood can be reached with the gospel and improved health.

CDE is a model that is designed to work in any situation because its foundational ideas are universal. However, its relational and long-term methods are especially suited to Muslim communities which are based on loyal friendships. Muslims evaluate expatriates from the West in order to determine their motives for moving into their community.

"It is obvious to them that the technical people, the professors, technicians, come for at least one over-riding reason. For many, it is money. Often expatriates come because of their expertise in transportation, the educational, the engineering, and other fields... It is perceived that others are coming for their personal prestige. They may be people on a research project writing books."
CDE makes it clear from the beginning that the goal is to help develop communities in a holistic manner with no hidden motives. The gospel is shared through teaching relationships, and even if it is not accepted, the work continues on. Because of the barriers to Christianity with Muslims, the CDE model may take more time to reach people spiritually, resulting in a slower process of multiplication. However, ministries with Muslims rarely produce rapid conversions because the nature of change comes through the patient development of genuine friendships. The healthcare program of CDE offers material that is immediately relevant and desirable to community members. In trusting discipleship relationships, the hope is that they find the deeper truth of the Trinitarian God.

Discussion and Implications

Muslim communities offer many unique opportunities for Christian healthcare missionaries. There are opportunities to reconcile Muslims and Christians through mutual understanding and respect for one another's traditions. Genuine, loyal friendships can be cultivated between expatriates and locals, in which the gospel can make a profound impact. When Muslims accept Christ into their lives, they are making a commitment of enormous cost. In these ways, the transforming power of God's love can be experienced by both the Muslim and the Christian in the process of conversion.

Along with the many opportunities presented by Muslim communities, missionaries must also face significant challenges in their ministries. One difficult challenge is to work within a background of global political tension between Muslims and Christians. Missionaries may encounter a lack of acceptance or compromised safety in this environment. Christians must dispel stereotypes of Christianity that equate it with Western culture, including ideas of loose morals and individualistic determinism that disregards family and community. The lifestyle of a healthcare missionary will be closely scrutinized, and both high moral standards and a commitment to the community must be demonstrated.

The message must be communicated that the Christian faith is not confined to the West, but it is a worldwide faith with universal principles. Christianity is relevant to every people group, and the gospel must be shared in a way that makes sense in the worldview of the people. The history of Christianity in Africa provides a poignant example of how faith communicated outside of the cultural context can cause grave damage to a people. For centuries, colonial patterns of domination, combined with European missionary efforts, have communicated the message that to be Christian meant being European. Africans were taught that their cultural values were deficient or evil, and they needed to deny their heritage in order to fully embrace Christianity. African theologians have pointed out that, ironically, their values and customs are often closer to those represented in the Scriptures and in the story of Jesus than those of the European colonizers. Inculturation theology has thus become the most prevalent and developed theological school in black Africa. In inculturation, "an effort is made to incarnate the Gospel message in the African cultures on the theological level."14 Though inculturation of faith has been a prime issue on the African Christian agenda, it is currently more of a goal than an actualized fact.

Inculturation is a necessary perspective in healthcare missionaries, especially from the West, who work with Islamic communities. In the CDE model, locals assess their community health needs and develop solutions that they believe will be most effective. Whether it is means for sanitary water, safely delivering a baby, or preventing disease; the community members decide what needs are most dire. The same approach is taken in sharing the gospel. In dialogue with Muslims, the Qu'ran cannot be dismissed as heresy, but it must be understood and treated with respect. Only then can it be compared to the Bible and result in meaningful conversation. Principles regarding the approach to
the Qu’ran among missionaries include the following: genuine respect for sacred text, leading to credibility in Muslim communities; using Qu’ranic thought patterns to explain biblical truths; and encouraging investigation and study in the Qu’ran, which can lead to the same in the Bible. Inculturation paradigms can be used with the CDE model in both healthcare and discipleship, so transformation can occur within the culture of the people.

One of the basic tenets of Islam is that God is absolutely transcendent, beyond the knowledge of human beings. Although Christ is considered a prophet, he cannot be considered divine because God cannot be known in such an intimate manner. This is a profound difference from the view of the Christian God, who is loving and relational. Missionaries cannot reconcile such differences with Muslims abruptly, but it must come through gradual, long-term relationships. Christians must essentially become Christ to them, healing and promoting health to meet physical needs, while fostering trusting friendships based on love rather than obedience. The leap from an unknowable God to a fully relational God can thus be shortened as people experience the love of Christ through Christian workers on a daily basis. Applying CDE to the Muslim context marries the spiritual gospel with physical healing and communal living. Through multiplying discipleship, wholistic transformation can occur in Islamic communities.

References

3. Ibid, 206.
10. Ibid, 57.