Globethics Repository



Health, healing and spirituality : the future of the church's ministry of healing : a German position paper offering ecumenical, diaconal and missiological perspectives on a holistic understanding of Christian witness for healing in western societies

This page was generated automatically upon download from the Globethics Repository. More information on Globethics see https://www.globethics.net. Data and content policy of Globethics Repository see https://repository.globethics.net/pages/policy.

Item Type	Book
Authors	Bartmann, Peter;Jakob, Beate;Laepple, Ulrich;Werner, Dietrich
Publisher	The German Institute for Medical Mission (DIFAEM)
Rights	With permission of the license/copyright holder
Download date	2026-11-16 09:15:00
Link to Item	http://hdl.handle.net/20.500.12424/185539

Health, Healing and Spirituality.
The Future of the Church's Ministry of Healing.

A German position paper offering ecumenical, diaconal and missiological perspectives on a holistic understanding of Christian witness for healing in western societies.

Peter Bartmann, Beate Jakob, Ulrich Laepple, Dietrich Werner

The German Institute for Medical Mission (DIFAEM), Tübingen

Translated into English by WCC language services.
With kind support of EMW – The Association of Protestant Churches and Missions in Germany

Contents

Foreword 5

Preface to the English version 6

1. The desire for healing and the health boom – towards a new discourse of health, healing and spirituality in Germany 8

1.1. The desire for healing 8

1.2. Approaches to healing and schools of healing in Western society 10

1.3. From the “infirmaries” to “health consumerism”: social trends in our attitude to health 11

1.4. New models of health in the health care market: “wellness”, “fast health”, “health enhancement” 13

1.5. Critical remarks on the “cult of health” in Western nations 14

1.6. Conclusion: the need for reorientation in churches, and in social and charitable work institutions 16

2. What is healing? What is health? Foundations for a Christian understanding of healing and health 18

2.1. Healing as restoration of damaged relationships – elements of the Biblical understanding of healing 18

2.2. Contributions from African culture towards understanding health and healing 20

2.3. Ecumenical discussions of health and healing 22

2.4. The World Council of Churches’ definition of health 24

2.5. Definitions of health based on the Christian view of humanity 25

2.6. Broadening our understanding of healing through HIV/AIDS 26

2.7. Weak, sick, disabled – yet “well” 27

2.8. Health above all else? 28

2.9. Conclusions: a public debate on the understanding of health and healing 29

3 Health in the global context – WHO concepts and access to healthcare 30

3.1 Main concepts and aims of the WHO 30

3.2 Health and Justice – Unequal access to Healthcare 33

3.3 Conclusions: expanding the debate on health in Germany 34

4. Health in Germany – special challenges for churches and ministry 36
4.1 The need to define health needs and health resources 36
4.2 The increase in mental illness as a challenge to society 37
4.3 Health promotion for the socially disadvantaged 38
4.4 No one eats alone – the connection between health, nutrition and global justice 40
4.5 Living with chronic illness and disability 41
4.6 Demographic developments and health in old age 42
4.7 Towards cooperation between experts and committed lay people in the field of healthcare 43
4.8 Consequences: A holistic approach to health 45
5. Christianity as a therapeutic religion- from its roots to the present day 47
5.1 Christian healing action today 48
5.2 Churches in dialogue with alternative healing approaches and the esoteric movement 50
5.3 Spirituality as a health factor – epidemiological studies 51
5.4 Consequences: including spiritual factors in therapeutic concepts 54
6. The Church as a healing community – Biblical and theological foundations and contributions from other countries 56
6.1 Healing- the theme of the Bible and the parish's mission 56
6.2 Healing in the Church's history 58
6.3 Rediscovering the Church as a healing community 59
6.4 Christian communities as significant social entities 61
6.5 The healing community as a missionary community 62
6.6 Healing spirituality: Forms and Trends 63
6.7 Examples from other countries 64
6.8 Consequences – rediscovering the ecumenical potential of healing ministry 69
7. Christian communities, networks and Christian social services – places of healing and the creation of a healing ministry 71
7.2 Pastoral Care as a Healing Ministry 73
7.3 Home visits and their role in the healing ministry of the parish 74
7.4 Medical and Church Social Care Services within the Scope of the Parish

Community 76

7.5 Retreat Centres as Places of Healing 76

7.6 Community Health Assets- the RHA Matrix as a guide 77

7.7. Consequences: Recognizing and developing healing ministries in their manifold forms 80

8. Main Concerns and Considerations regarding Future Work 82

9. Bibliography 88

The Authors 92

Foreword

Is there a role today for the churches in the area of health? Is there a link between health, healing and spirituality?

We live in a society obsessed by performance. Good health is therefore highly prized – often more than anything else – and huge effort is put into achieving it. Health is a booming market, often under the fashionable label of “wellness”, and there is a lot of interest in the spiritual dimension of health, particularly outside the Christian churches. Type “healing and spirituality” into any search engine and you’ll find your screen inundated with an almost overwhelming range of so-called “alternative” services that have set themselves up in this market.

During the many years I worked in Christian health facilities in Africa, I learnt that there is always a spiritual dimension to illness and healing. That’s why for many people, especially those suffering with chronic illnesses, a traditional healer was often the first person they turned to. Yet some patients also came to us, saying, “You don’t just have medicine: you pray with us too.”

Many countries of the global South are seeing growth among Christian groups and churches where healing is seen as a usual part of congregational life. Furthermore, in the medical sector, epidemiological studies – particularly in the USA – are providing real scientific confirmation of a positive link between spirituality and physical and mental well-being.

So it is time for us in the congregations, and in the social and community organizations of the Christian churches in Germany to take a measured and critical look at the issues of health, spirituality and healing, and to seek practical ways forwards. To promote this process, the authors of this document have set up a working group on “healing and spirituality”. The group deals with issues relating to health, spirituality and healing from perspectives of medical mission, world mission, organized social work and church planting.

This study seeks to pick up the world-wide and German debate on health which is already under way and to ask where the future challenges and opportunities lie for church and Christian social care in Germany. The document is also intended as a contribution to the 2008-2010 “Week for Life”, which is to focus on questions of the Christian understanding of health and healing and the healing dimension of faith, all under the theme of “Well or sick – loved by God”.

Dr. Gisela Schneider, Director, DIFAEM

Preface to the English version

The world mission conference in Athens in 2005 focused on the theme of healing and reconciling Christian communities as an expression of the holistic mission of the church. It was out of this context – and the WCC study document on the Healing Mission of the Church - that a working group was formed in Germany in 2006 which brought together people from different fields of expertise from medical mission, diaconal services, world mission and congregational renewal. Its major goal was to analyze key trends and challenges which churches face in this particular context with regard to new understanding and fresh expressions of the healing mission of the church.
What are the particular tasks churches, diaconal services and local congregations have to encounter at the beginning of the 21st century in a western society, with an advanced health service system, but on the other hand experiences growing discrepancies in the accessibility to health care, increasing influence of non-western types of religious and quasi-religious healing, as well as a commercialized trend for “wellness products”? What are the specific tasks of churches with regard to the new social, religious and economic landscape of a society which deeply reflects the crisis and shadow sides of globalization and signs of a fundamental transformation in health systems which cannot be sustained financially any longer? What is the role of “spirituality” in processes of curing and healing – viewed with suspicion by some representatives of modern medical approaches, favourably advertised by some representatives of esoteric and non-western types of new healing practices, and ever more courageously practised and offered by Christian congregations, diaconal services and church based hospitals, which take seriously the healing tradition of Jesus and the early church, as no longer something to be dismissed as belonging to the past but something which needs to be rediscovered in a post-modern context?

Longing for healing – this is a new, immensely widespread and theologically relevant factor in many western societies. The churches need to redefine their positions on this issue and become more open to learning from experiences elsewhere in dialogue with partner churches in the southern hemisphere. Theological education for a contexualized healing ministry of the churches – this is a key demand for the way ahead in trying to sharpen the mission of the church in a (post)secular environment. Theological education for faith, health and healing is an issue which affects all sectors of the church, lay members of local congregations, pastors and deacons, as well as health workers and medical personnel. There are many opportunities for strengthening interdisciplinary learning and theological exchange between churches of different denominational traditions, from North and South, with migrant churches and with churches representing new Christian healing movements in global Christianity. These are some of the core convictions of this key document.

The study was introduced at the first German national Christian congress on health and healing (Christlicher Gesundheitskongress) which was held in Kassel in 27-29 March 2008, attended by more than 1000 doctors, health workers, pastors and lay people from all over Germany. The study was published by the German Institute for Medical Mission

(DIFAEM) in Tübingen, but was also supported by representatives of the different institutions which were part of the two years study process leading to its completion, namely *Diakonisches Werk der EKD*, *Arbeitsgemeinschaft Missionarische Dienste* and the Northelbian Centre for World Mission, Hamburg. The study document is made available for the “week for life” which is a campaign of both Protestant and Roman Catholic churches which in the period 2008-2010 focuses on the theme “healthy or ill – still loved by God“. It will be also presented in German Kirchentag 2009 in Bremen. The major goal of this publication in English language is to make this study available for dialogue with wider circles in the international ecumenical dialogue, for encounters with partner churches in the global South and for theological education for healing ministries in different churches.

Our gratitude goes to the Language Service of WCC for the translation into English.
The study document also is available on the website of DIFAEM and WCC-ETE.

Geneva June 2008
Dr. Dietrich Werner

1. The desire for healing and the health boom – towards a new discourse of health, healing and spirituality[1] in Germany

1.1. The desire for healing

Many people in the twenty-first century have come to see good health as the highest priority and the basis for a successful and happy life. The use of modern medicine to fight disease became a central political goal in the nineteenth and twentieth centuries, but it was in the second half of the twentieth century that an awareness grew that health is more than the absence of illness. This vision is expressed in the Preamble to the Constitution of the World Health Organization. However, there are widely divergent ideas in our "health society" as to what this "more" consists of and what contributes to it:[2] some emphasize that improved health in the developed world is largely due to improved living conditions (nutrition, education, working conditions etc.) and less a result of modern medicine, while others stress the as-yet untapped possibilities of medicine not just to fight disease but also to enable a long and active life free from suffering. Still others, critical of "orthodox" medicine, seek alternative ways of healing both physical and mental ailments.

As different as all these perspectives are, they are all motivated by the **desire for healing**, which has become such a central factor of our expectations both as individuals and as a society. The use of the word "desire" shows how profound and wide-ranging are the needs and expectations that pertain to this much-sought-after commodity. The word "healing" shows that these needs and expectations are no longer limited to mere survival or obtaining necessary therapeutic intervention but now concern the possibility of attaining an active and meaningful life in a more holistic sense.

Improved performance in modern health care is matched by rising public expectations for their own health and the performance of their health care system. Good health is beginning to dominate our values and priorities as a society. This affects the contemporary technical-medical system and the world of religion in different ways. When good health becomes the most highly prized commodity, the pursuit of health develops certain quasi-religious traits of its own, and starts to enter into competition with other

1 Spirituality, here, means life lived in relationship to God, that is, to a higher power. Religiosity may mean membership of a religious community without applying that community's values to one's personal life (extrinsic religiosity), but spirituality means a personal acceptance of religious belief (an intrinsic religiosity).

2 Cf. Ilona Kickbusch, *Die Gesundheitsgesellschaft. Megatrends der Gesundheit und deren Konsequenzen für Politik und Gesellschaft* ("The health society – large-scale trends in health and their consequences for policy and society"), Verlag Gesundheitsförderung, Gamburg 2006.

values and priorities. No previous era in history has ever placed such high value on health, either individually or in society as a whole; it is a unique characteristic of our current "late modern" era. We can thus speak (negatively) of a "cult of health", in which individuals run after "healing" – which most often means the greatest and most stable sense of comprehensive well-being they can attain.

Because the search for healing, balance and coherence is becoming such a *leitmotif* in life – religious life, too – health is becoming increasingly important as an **issue for churches** and faith communities. Our contemporaries who express this desire for healing are challenging us to rediscover and re-evaluate that which is healing and life-enhancing in our traditions. If religion is believed to have a healing influence, that then raises questions of the **significance of religion in the health care system and in medicine**.

The desire for healing and the issue of the significance of religion for health and healing both represent new challenges for Europe's mainstream churches and for many of its Christians. While care for the sick is one of Christendom's oldest traditions, undertaken today in contemporary form by Christian social programmes and charities, the churches have still never quite positioned themselves within the "health society" and, indeed, take a critical view of absolutizing the value of good health. But the European churches have also been quicker to take a critical view of the more holistic, religious aspects of the desire for healing than to affirm them or offer any practical response. This is despite the fact that the churches in Europe are well aware that Christians on other continents openly expect and experience healing in the context of church life.

There are serious objections to naively accepting everything to do with healing: from a Christian perspective, it is absolutely not desirable for good health to be the top individual and collective priority in a society, since other values such as freedom, truth and love – love of neighbour and love of enemy – cannot meaningfully be subordinated to one overarching value of health. A concept of purely intrinsic physical and mental health is incompatible with the Christian understanding of what makes a human being, which maintains that holiness in the sense of "being whole", is not primarily to do with physical or mental health. Furthermore, from a European perspective, the diverse practices of healing the sick used in churches in Africa, Latin America or Asia raise a number of very difficult questions.

Nevertheless, the churches certainly should not reject this desire for healing out of hand, no matter how questionable certain aspects of it may be: for Christianity is at root a "therapeutic religion", in which the search for and experience of healing are foundational.[3] We must not draw some direct, ahistorical comparison between the stories of Jesus' healing miracles and the desires felt in modern, developed societies, but neither must we completely neutralize them through historical differentiation. According to the New Testament, the church is called to heal the sick just as she is called to proclaim the kingdom of God (Luke 9:2).

3 For more on this, see Chapter 5.

We need a radical, multidimensional process of reflection in order to clarify **how the church can acknowledge and fulfil this call to heal the sick in today's world**. It must incorporate the biblical witness and the exegesis of that witness, the experience of churches in the northern hemisphere with its highly developed health care systems, the acknowledgement of global health inequality, the experiences and traditions of partner churches in Latin America, Africa and Asia and the desire for healing itself, which so many people experience in so many different ways. Christian services and institutions providing social care as well as church communities themselves are coming to this process of reflection bringing their own traditions and reflections, but also with the need to learn something new in ecumenical conversation with others.

1.2. Approaches to healing and schools of healing in Western society

In today's world, we distinguish between three different levels of healing:

physically, healing means the restoration of physical or mental functions;

psychosocially, it means the restoration of harmonious social relationships, self-awareness and self-determination;

metaphysically and/or religiously, the focus is on processes which create and give meaning, even if restrictions on physical function remain – for instance, coming to terms by coping with serious illness or accidents ("coping with disease").

There is a growing hunger among people for a holistic form of healing that encompasses body, mind and spirit, social relationships and spirituality. In Western societies, a number of different approaches exist which both make this hunger visible and seek to respond to it. Some of these approaches, which may be linked to widely divergent worldviews, assumptions and concepts of humanity, are organized into official "schools" with their own standards, training programmes and treatment programmes.

Put simply, the following schools can be distinguished:

- ⇒ **Classical, orthodox medicine**, which relies on clear, scientifically proven connections and rational verification of effectiveness. Nowadays this area also includes research into psychosomatic health and healing focusing on the links between physical and mental processes of change, such as the many different forms of psychotherapy used to heal psychological illnesses.

- ⇒ **Classical natural remedies** (such as heat and cold therapies, herbal remedies, chiropractics, fasting cures etc.), which are based on the knowledge of natural complementary medicine.

- ⇒ **Treatments derived from specific worldviews**, the majority of which are not susceptible to rational testing for effectiveness, but which have their roots in the

history of Western spirituality and medicine (anthroposophical medicine, homoeopathy).

⇒ **Particular treatments derived from foreign cultures**, which are based on imported or adapted elements of Asian cultural and religious traditions (such as qigong/tai chi, acupuncture, yoga, shiatsu), and which are either partly or wholly unsusceptible to rational testing for effectiveness.

⇒ **Unconventional alternative treatments**, based on special quasi-religious teachings, which are in principle unsusceptible to rational testing for effectiveness (such as aromatherapy, colour therapy, crystal therapy, Reiki, Schüssler's biochemical remedies etc.).

However, the dividing lines between orthodox medicine and so-called alternative therapies are often complicated and not always distinct, since many alternative or complementary therapies, often rooted in centuries-old traditions, used hundreds of years ago to be part of orthodox medicine themselves. However, with the influence of the modern age, orthodox medicine has seen radical transformations (compare it with Hippocrates' teaching about the "four humours"). Furthermore, even within the world of the so-called alternative therapies, the boundaries between its treatments and those of orthodox medicine are in constant flux.

It may be helpful to focus beyond the wide-ranging and unresolved controversy in society with regard to the recognition, legitimacy and scope of the various forms and schools of treatment in Germany and look at the **fundamental conflict between different perceptions of the concept of healing itself**. This is a conflict between, on the one hand, a reductionism about the understanding of healing (so runs a popular accusation against clinical medicine) and, on the other, an overemphasis – an idolization, even – of the whole idea of healing (one of the charges made against some alternative treatments). In the midst of all this, the church and the Christian tradition must point to the holistic, covenantal nature of the biblical understanding of healing while, at the same time, opposing any ideology that might give an inflated, even religious, significance to healing.

1.3. From the "infirmaries" to "health consumerism": social trends in our attitude to health

In the countries where they are available, modern medicine and pharmaceuticals have radically changed attitudes to sickness: whereas the sick used to be seen primarily as people in need of aid and care, who represented a burden on and danger to society, and needed to be helped and shown compassion, many serious and painful diseases can now be cured. With the expansion of health insurance systems since the end of the nineteenth century, more and more people have become able to benefit from these medical and pharmaceutical achievements. Because of this broad demand, which became possible only thanks to compulsory health insurance, health care has grown into a major sector of the economy.

For the German churches, the greatest part in these developments has been played by the **organizations Diakonie and Caritas**. As early as the Middle Ages, the Christian duty to care for the sick was being fulfilled through infirmaries and colonies for the sick; since the nineteenth century it led to the founding of many hospitals and clinics, which for a hundred years (c. 1860-1960) were managed chiefly by nuns and deaconesses. In a "working alliance" with modern medicine, this care became an adjunct to medical treatment and nurses became assistants to doctors. This has led to a persistent tension between the two groups, whereby nurses fulfil a role of closeness to and care for the patient, while doctors stand at the opposite pole of being scientifically accountable and determining the course of treatment.

Even though the hospital represents only part of the care for the sick, hospitals – which are where doctors and nurses are trained – have typified our approach to disease in the nineteenth and twentieth centuries. A serious illness is thus a phase of life in which we place ourselves under medical treatment – ideally in a hospital – in order to receive as much support as possible in our fight against the disease. When a hospital is built in a neighbourhood or district, it carries great social and economic value. New medical innovations and access to experts play an important role for the media as does the infrastructure needed to provide them.

Indeed, the great achievement of the second half of the twentieth century has been that practically the entire population now reaps the benefit of this medical progress: new treatments are not reserved for that small proportion of the population that can pay for them but are made available to the public at large through compulsory medical insurance.

The **expansion of the health care system** has been accompanied by an increase in the social acceptability of services that go beyond help and treatment for ill people and can be described as actual *health* services. The use of these services is no longer associated with "sickness", but enjoys the positive connotations of "health", while the person making use of them is increasingly no longer addressed as a "patient" (i.e. one who is suffering) but as a client. This paradigm shift is most commonly to be found in the market for private health services that exists alongside compulsory medical insurance systems. These services, quite distinct from those provided under medical insurance, are health services made use of by private individuals. They include, on the one hand, services – some of them medically questionable – intended to complement the spectrum of services offered under medical insurance, and, on the other, services that have been excluded from those provided under health insurance since the 1980s as a result of "cost-containment policy" (such as non-prescription drugs, spectacle lenses).

The coming years are expected to see a growth in the proportion of private provision in the health market, while the medical insurance system, which currently holds the dominant share of the market, is expected to see only slow growth.

1.4. New models of health in the health care market: "wellness", "fast health", "health enhancement"

The so-called "second" (supplementary) health market is shaped by private demand, and caters to the needs and views of the wealthier segments of society. These needs and views are influenced by trends that can bring about major changes in health care. For instance, we are seeing the emergence of private clinics that not only offer their clients the best medical and nursing care but also promise particularly pleasant accommodation. "**Wellness"**, as a rule, is becoming a complementary model that fills out the narrower medical perspective. Indeed, a strictly medical perspective judges health care services that promise "wellness" rather unfavourably: their health benefits are seen as doubtful, as is the question of whether "wellness" can or should be a primary goal for medicine at all.

However, in order to be able to satisfy this private demand, even university clinics are setting up wards designed to feel like hotels, where patients' needs are put first. The "wellness" model is even more prevalent in health resorts and establishments providing alternative treatments, special foods etc.

"**Fast health"** is another social trend. It caters to the desire shared by many people to get well as quickly as possible. Treatments have to be as time-efficient as possible and patients introduced back into active life as quickly as they can – even when that is not, medically speaking, the best approach.

There is a third trend known as "**health enhancement"**. This has nothing to do with the treatment of disease, but deals primarily with improving individual performance – for instance, to a level higher than that typical for the client's age.

All three of these trends deserve some critical attention. Popularized by the mass media, they are making their mark on the way the whole of society thinks. They all contribute to the view of **health as primarily a consumer product**, provided through technological intervention, which is nevertheless only available to that segment of the population that can afford it. This leads the majority in society to feel that they are living in a "two-tier system", in which the wealthy supposedly receive better and better care while the vast majority of the population live with the feeling that they are not being cared for enough.

There are at least three reasons why these developments are not to be welcomed.

Firstly, it is misleading to think of health as a consumer product. Restoration of health should be seen as a "coproduction", and the most important coproducer is the patient him/herself. However, we should not ignore the fact that the demands of the private sector do express subjective needs, which can lead to a more patient-oriented form of treatment and care.

Secondly, we need to take a critical look at the power of demand exercised by the wealthier segment of society in respect of the future development of the health system. In the face of stagnation in funding for compulsory medical insurance, private demand is

becoming a significant factor for the development and testing of new treatment methods and medicines. Population groups with higher incomes enjoy on average better health than poorer people in the same society, which raises the question of whether funds obtained in the private sector are finding their way into being used where there is the greatest suffering or where the greatest effect on health is to be had. The fear is that a lot of time and money is being invested in dealing with less serious diseases. The situation is particularly unfavourable for those suffering from rare, serious illnesses: because they are a minority and thus have little buying power, they lack “consumer power” and have to make do with few forms of treatment (and little research into new ones).

Thirdly, there is a more nuanced critique to be made of the “wellness” concept. It is good that people suffering from illnesses are demanding that greater attention be paid to their well-being, including during periods of intensive treatment. This is particularly the case when the success of the therapy is uncertain or when treatment has reached the stage of being purely palliative. We should also welcome the fact that the health care system, which is structured primarily in medical and technical terms, is taking greater account of subjective needs. Of course, there will be disputes as to the effectiveness and influence of the many non-medical “wellness” treatments on offer; nevertheless, we absolutely must pay heed to the fact that “wellness” treatments are leading people towards a greater awareness of their own bodies.

An awareness of one’s own body outside of medicine and sport is probably something that Western civilization – which is permeated by Christianity – has neglected too much. The churches, too, need to pay greater attention to the well-being of the body. Yet too great a focus on one’s own well-being carries with it the risk of neglecting social relationships, environmental responsibilities and spiritual challenges. Dealing with these dimensions of life is indeed a major factor for well-being, understood holistically. Nevertheless, in the Christian worldview, even if a holistic well-being is in part achievable, it is not the ultimate meaning of human life. Rather, meaning is found, within this life that is never perfect and always full of conflict, through relationship with God and by tackling the many tasks that must be done in this world.

1.5. Critical remarks on the “cult of health” in Western nations

The Christian faith has a fundamentally constructive contribution to make to the debate on religion and public health: it needs to determine how Christian communities can fulfil their potential and be practically relevant in the areas of maintaining health, health education and prevention. However, Christianity also needs to be critical of the ideology prevalent in today’s society whereby the themes of health and healing have become freighted with religious significance and taken on quasi-religious connotations.

Theologian and doctor Manfred Lütz described this **trend towards a quasi-religious**

cult of health in detail in his partly satirical book *Lebenslust…*[4] He hit the heart of the matter when he wrote: No doubt about it, we've got a new religion: the religion of health … If there's anything at all up there on the altar, anything we worship and to which we offer all sorts of sweaty sacrifices for sin, it's health. Our ancestors built cathedrals; we build clinics. They knelt; we do sit-ups. Our ancestors were about saving their souls; we want to keep our figure.[5]

According to Lütz, health is widely seen as the highest good there is. We worship it as much as any religion. "There are people," he says, "who only live to stop themselves dying."[6] He claims that the religion of health is the most expensive religion of all time: in Germany, our enormously sophisticated health care system costs more money than the entire Federal Budget, and, while the next Budget is to include a cost containment bill, the reform in health services still does not look like it will bring an end to spiralling costs.

There are clear links between our society's loss of belief in God and the concept of eternal life on the one hand and its religious freighting of the topic of health on the other. The hopes and desires that we can no longer frame and experience in explicitly religious terms are now directly projected wholesale onto the area of health.

People no longer simply look to the health care system to cure them of their sufferings; they want it to provide total healing, healing here and now, forever. Eschatology, too – the study of the last things – has been completely secularized: "apocalypse now". If the last things figure at all, it's in our own lives: to give us everlasting life (in terms of years) we have medicine; for everlasting happiness (in terms of quality) we have psychotherapy. Paradise on an insurance plan. And if it doesn't work – well, we complain, obviously, don't we?[7]

Wherever the church and her theology are faced – even within their own ranks – with such an exaggerated optimism about healing that is so utterly focused on this present life, they must confront it with correction and self-criticism. For this religious inflation of health expectations is accompanied by a belittling or suppression of the frailty, weakness and finitude of human life, and that robs us of a full appreciation of that life and of the truth that people remain human even when, inevitably, they have to deal with death, incurable disease and frailty.[8]

---

4 Manfred Lütz, *Lebenslust. Wider die Diätsadisten, den Gesundheitswahn und den Fitness-Kult* ("Lust for life: against the diet sadists, health madness and the fitness cult"), Munich 2002

5 *Ibid*. p 12

6 *Ibid.* p. 55

7 *Ibid.* p. 16

8 For further detail, cf. also: Burghard Krause, *Heiligungssehnsucht und Heilserfahrung – Ansätze und Perspektiven einer missionarischen Hermeneutik* ("The desire for and experience of healing – approaches and perspectives of a missionary hermeneutic")

1.6. Conclusion: the need for reorientation in churches, and in social and charitable work institutions

"Psychology, as a science, has always been particularly proud of its tradition as a secular, non-religious discipline indebted to the Enlightenment. It has seen faith as narrow-minded, an attempt to flee from reality. Yet these claims can now be upheld only to a limited extent. There are positive correlations that cannot be ignored between certain forms of religious belief and physical and mental good health," wrote Heiko Ernst, editor in chief of the magazine *Psychologie heute* ("Psychology today"), in 2004.[9]

Ernst was writing as a psychologist about his own discipline, but today his words are becoming more and more applicable to medicine and sociology: the disciplines that our society acknowledges as "healing" are, at least in part, becoming open to the inclusion of spiritual factors in how diagnosis and treatment are conceived.

What will be the effect of this increasing awareness of the healing dimension of faith? What will come of the booming spiritual scene on the one hand and the freighting of the concept of health with religious connotations on the other? The situation is far from simple: even though certain "islands of interdisciplinary dialogue" have emerged, between medicine and theology, between proponents of orthodox and alternative treatments, and between institutional treatment centres and loose groupings of individual practitioners, many involved still have reservations.

The churches cannot surrender the whole issue of healing and spirituality to esoteric groups or East Asian teachings about healing. That would render them silent in an area given to them as a core mandate from their very origins.

The crisis in the health system and the growing public interest in health and healing issues mean that there is an urgent need for the church to engage society at large in three new lines of dialogue.

There needs to be a new debate throughout society as to what actually constitutes health and what significance should be afforded to spirituality and religious direction in the wide-ranging processes of health education, religious education and preventive education.

Secondly, there needs to be a broad, interdisciplinary discussion between the various schools, disciplines and forms of treatment with regard to mutual recognition and complementarity and to points of intersection between their conceptions of health, healing and spirituality.

Thirdly, the Christian churches must find a louder public voice with which to participate in the new debate in German society about health, healing and spirituality. In doing this, they can build on ecumenical discussions with other churches and traditions. The

[9] Heiko Ernst, Macht Glaube gesund? in: Psychologie heute compact, Issue 8 (2004), pp.68-9, note p. 69.

churches must ask questions about fair access to health resources and encourage a holistic perspective on health not just focusing on the medical system but addressing other conditions necessary for health and healing.

This position paper is borne out of an awareness that, in Germany, the healing dimension of faith has often been neglected in the past, both in the health care system and in Christian communities, social work and mission, but that new opportunities and chances to work together with others could be developed. Achieving this requires not just that Christians in various areas of health care cooperate and learn from each other better, but that the whole issue of health, healing and faith be brought proactively into a broader process of discussion right across society. To this end, committed Christians need to expand their own horizons and to acknowledge this desire for healing that is being expressed everywhere – including outside the church.

2. What is healing? What is health? Foundations for a Christian understanding of healing and health

2.1. Healing as restoration of damaged relationships – elements of the Biblical understanding of healing

Healings were a central part of Jesus' ministry: that much can be seen from the fact that healing stories make up around a third of the Gospel texts. And yet today, we are often unaware of the huge significance of Jesus' healings; it is an aspect of Jesus' ministry that is particularly hard to "translate" for our own times.

Jesus' healings raise questions. Was Jesus a "healer" of his day, with people flocking to him for healing from their physical and mental illnesses? Were Jesus' healings primarily about seeing individuals set free from their suffering? And these questions lead onto the fundamental question of the biblical view of humanity and the understanding of healing that flows from it.

The Biblical view of humanity as a foundation

The creation story (Gn 1-2) reveals that human beings are a creation of God, made in his image. God creates and blesses man and woman as creatures with bodies, souls and spirits. Every individual therefore possesses an inalienable human dignity that should never be violated.

Furthermore, crucial to the biblical understanding of humanity is the truth that being human means living in relationships. Human life is experienced essentially in and through relationship to God, other people and the created world.

The relationship to God is rooted in the fact that humans are made in his image, and affirmed by God's promise to establish an eternal covenant with them (Gn 9). But the biblical understanding also teaches that an essential part of our humanity is to be woven into the network of the community. In the Old Testament, God's actions are directed towards the nation of Israel – "his" people as a whole – and the individual is always seen as a part of that community. In the biblical and fullest sense of the word, we are "healthy" when we are living in sound relationships – to God, to others and also to the environment: for animals and plants are an integral part of God's good creation, and he mandates people to look after that creation.

Healing as the restoration of damaged relationships

The story of God's people as told in the Old Testament is the story of the struggle for relationship – between God and people, and between people and each other and

between them and the environment. Time and again, people in their freedom do harm to these relationships.

The concept of "*shalom*", which is so important in the Bible, describes an ideal state in which all the relationships desired and designed by God are complete. God's healing or reconciling action in history shows the process whereby he restores his people's relationship to himself[10] and their relationships to each other as well as healing their physical illnesses.[11] This is God's healing work in history; its aim is to bring the world nearer to that state called *shalom*, and it will be fulfilled "in those days" – in the end times, when the Kingdom of God will be here.[12]

In Jesus, God gives his ultimate and irrevocable affirmation of his relationship to people and the world. God reconciles people and the world to himself by giving himself for the world freely, not as a response to human effort.

Jesus' healing work

Jesus comes into the world to bring "life … to the full" (cf. John 10:10 NIV). This "life to the full" corresponds to the sense of *shalom*, and applies not only to physical wholeness and not only to individuals but always encompasses the world as a whole, and centres around life in unbroken relationships.

Jesus comes alongside human beings and cares particularly for those whose dignity was not respected in his day. He notices and takes seriously the physical life of each individual – something that was as significant in those days as it is today: for over the centuries Christians have often found it hard to see the human body as God's creation and hence as something to be highly valued.

On the other hand, though, we must not miss the fact that Jesus' healing ministry has a far greater aim than simply curing the physical or mental symptoms of certain individuals. A few observations in this regard follow.

For Jesus, the healing of people's relationship to God is an essential part of his healing work. If we understand "sin" to mean a disruption of the relationship with God, then Jesus is freely offering healing for this relationship.

The diseases Jesus heals are mainly diseases that harm relationships between people. For instance, people who were lepers, blind, deaf or lame or women suffering from haemorrhaging were excluded from human and religious community. For them, their healing means reinstatement in the community with their fellow human beings and with God.

---

10 Cf. e.g. Hos 14:5; Is 19:22.

11 Cf. e.g. Is 33:24; Is 35:5-end.

12 Cf. e.g. Is 57:18; Jer 33:6.

Seven times, Jesus says to women and men who receive his healing care, “Your faith has saved you/healed you/made you well.” The Greek verb used here, “*sozein*”, refers to the idea of *shalom* discussed before. When a person has a healing encounter with Jesus, the healing is always of the “whole” person – of life in all its dimensions and all the relationships that bind us humans together.

The desire for healing is indeed of significant value in the Bible (see the Psalms, for instance), but not in the sense of some ideal state of sound, spotless physical well-being. Indeed, when it comes to a person’s relationship with God, the Bible can in fact limit the value of health through its use of extreme and polemical terms to press home the ethics of discipleship. For instance, Jesus says, “If your foot causes you to stumble, cut it off; it is better for you to enter life lame than to have two feet and to be thrown into hell. And if your eye causes you to stumble, tear it out; it is better for you to enter the kingdom of God with one eye than to have two eyes and to be thrown into hell.” (Mark 9:45, 47).

The difficulties we have with Jesus’ healings and how to “translate” them for our times are largely due to the fact that we read them through the lens of our own, scientific understanding of healing and health, and, in short, see healing as simply the curing of physical and/or mental deficiencies. In doing this, we forget: the Bible does not call a person healthy if their body is sound but their relationships to God, other people or the environment are broken. When God heals people, he deals with all of this – even today.

2.2. Contributions from African culture towards understanding health and healing

Generally – if simplistically – speaking, it can be said that the view of humankind expressed in the cultures of today's South comes very close to that represented in the Bible. For instance, in the African consciousness, relationship to God is just as vital to a person as integration in a social community. This view of what makes a human being also characterizes their conception of health. According to this understanding, a person whose relationship to God and/or his fellows is out of line cannot be said to be “healthy” in the true sense of the word.

This becomes clear when we look at the example of the traditional West African view of health and healing and the corresponding way in which charismatic groups in Africa practise spiritual healing. Three distinguishing features mark out the West African view of health and healing.

The Akan language of Ghana contains a number of everyday expressions that reveal much about that culture’s understanding of healing. When two acquaintances greet each other in the street in the morning, one can often be heard to say, “*Wo ho tse den?*” (“How are you?” or, literally, “How is your self?”), and the other will answer “*Onyame adom,*” (“Through God’s grace [I’m alive and enjoy good health]”). This shows that caring about another person must, at a fundamental level, always include caring about that person’s

health.

The African understanding of reality thus always credits God for the experience of good health; it is always seen as an experience of his grace and care, not merely as a consequence of physical or physiological circumstances. This can be seen, for instance, from a proverb concerning the opposite experience: "*Oyare to wo mu a eye anyamesem, na enye w'abusuafo na erekum ow.*" ("When sickness hits you, it is God's design, not the witchcraft of your relatives."

Both the presence of good health and its impairment or even total absence are understood in the African psyche always to have spiritual or metaphysical causes. One of the core concepts in this area is known in the Akan language as "*saman Yarba*", or the influence of the ancestors. Sickness and health are understood as the consequences of the workings of ancestral spirits, which are themselves the expression of discordant or harmonious relationships within the tribal community. Every part of reality is determined by numinous powers – we are surrounded by God, the ancestors, demons and ghosts. Prayer can and should be offered for everything that happens in everyday life. There are thus many points of contact between the African worldview and that of New Testament and ancient times.

This African worldview has consequences for diagnosis and treatment, for, unlike in a Western context, these can never be abstracted from their religious dimension: **every treatment of disease includes a spiritual element** – it has to restore the broken relationships in the tribal and family communities. This is why the aspects of social peace, restoring broken relationships and love within the family community are key to understanding and overcoming illness in the African setting.

A fundamental debate was held for the first time between the Western and non-Western worldviews as part of the preparations for the 2005 Conference on World Mission and Evangelism (CWME) in Athens, with particular regard to the interpretation and evaluation of the role of so-called "spiritual powers" in sickness and healing, which the Pentecostal movement and the majority of historic Western churches see in differing lights.

The **policy paper *The Healing Mission of the Church*** (Preparatory paper No. 11, CWME 2005) sets out some vitally important points on this issue in the sections on "Healing and culture – different worldviews, cultural conditions and their impact on understanding health and healing" and "Debate on the concepts of demonology and power encounter".[13]

Those involved in the conversation in the West are being challenged to carry out a critical **review of the limitations of its own worldview**: One of the main reasons why the Western churches – especially the mainline Protestant churches – eschewed the whole

13 The document can be found via the Conference website (www.mission2005.org) at http://www.oikoumene.org/en/resources/documents/wcc-commissions/mission-and-evangelism/cwme-world-conference-athens-2005/preparatory-paper-n-11-the-healing-mission-of-the-church.html.

topic of spiritual powers for several centuries has to do with the specific nature of their worldview going back to the influence of the Enlightenment. Christian theology and the way clergy was trained did not only ignore the topic but often also helped "demythologize" even the biblical talk about demons and spiritual powers. Earlier documents of WCC on healing and health have not tackled the issue adequately either. Currently, a paradigm shift is taking place in Western culture – often referred to as "postmodernity"- which is challenging a narrow rationalistic world-view and theology. (paragraph 35)

For the "Western" churches – the churches of the North – this renaissance of a pre-modern holistic approach presents a fascinating challenge, but one that will not easily be met: the rejection of modern scientific medicine in Africa and elsewhere can be understood as a cultural reaction, whereby a culturally foreign worldview is challenged and adapted to fit local socio-cultural and religious realities, but it may also represent a social protest against the fact that modern medicine has discredited traditional sources of healing while itself remaining available to only a very select few.

On the one hand, then, the churches (and the countries) of the North face painful questions about justice of access to modern health care. On the other, they are also being challenged to rediscover their own pre-modern socio-cultural and religious resources and to establish a relationship of creative tension between these and the modernity that has previously marginalized them. The demand made in the Athens paper to come to grips with biblical teaching on demons and spiritual powers is an especially challenging task, for here the biblical sense must be rescued back from a repressive tradition of exorcism that has caused terrible suffering, particularly for those with mental illness.

Together with our fathers and mothers in the faith, we have all long affirmed the truth of the words of the Nicene-Constantinople Creed (381) that we believe in the Holy Spirit, "the Lord, the giver of life" (*spiritus vivificans*). This quite specifically means that we confess the power of the Holy Spirit over evil powers and spirits and affirm the Spirit's power to heal. Churches and theologians in Germany must ask themselves what the significance of that truth is for the understanding of health and the practice of healing in their own contexts, as they dialogue with churches from across the spectrum of the Charismatic movement, independent breakaway churches and the Pentecostal tradition.

2.3. Ecumenical discussions of health and healing

The connections between health, healing and spirituality have always been part of mission work. This is true both in "internal mission", where the primary involvement was in caring for the sick in the parish and then, with their emergence, in modern hospitals, and in "external mission", which has never lost sight of its threefold fundamental duty of proclamation, education and health care. In 1910 there were around 2,100 Christian infirmaries and twice as many Christian hospitals overseas around the world maintained by Protestant missions.

The whole health care systems of many African and Asian countries were pioneered by Christian churches, before States started to take some part in providing health services in the 60s and 70s.

Intensive **ecumenical cooperation in regard to so-called medical mission** began to develop from the nineteenth century. One key role in this has been played by the German Institute for Medical Mission (DIFÄM) in Tübingen, which in 1964 held the international consultation on medical mission issues that became known as Tübingen I in conjunction with the World Council of Churches (WCC) and the Lutheran World Federation (LWF). This initiative led to the founding of the WCC's Christian Medical Commission in 1968, which has over the last few decades brought together international Christian debate on health and healing and allowed the "voice of the South" to be heard more and more in ecumenical discussion.

The healing mission for churches and parish communities

One of the central ideas of the Tübingen consultation was: "**The Christian Church has a specific task in the field of healing.** This is to say more than simply that the Church has a duty to support all that contributes to the welfare of man. It is to say that there are insights concerning the nature of health which are available only within the context of the Christian faith. The Church cannot surrender its responsibility in the field of healing to other agencies."[14]

The declaration of the Tübingen consultation represented a milestone on the road to a better understanding of healing, calling into question the claims of exclusivity made by purely medical and curative forms of treatment. It saw the development, for the first time, of a conviction that medical treatment of the body was only one element of a multidimensional healing process of which the social, spiritual, nutritional, preventive and health-maintenance dimensions must also be considered essential components.

Alongside this conviction that the Christian faith and the church had a specific and inalienable role to play in the area of healing, there was also the notion that, alongside hospitals and medical institutions, **the parish as a living local community had an indispensable contribution to make to the healing process** – with possible far-reaching consequences for the relationships between social and parish work, between professional medical treatment and pastoral and social care in the local community.

Even today, the ecumenical idea of the irreplaceable Christian responsibility for a spiritual dimension of healing, the plea for a **multidimensional understanding of the Christian healing mission** and the responsibility of the whole community for the healing process still constitute a central hallmark of international ecumenical discourse on health and healing. It is also this fundamental conviction that has given rise to the warnings about the possibility of placing too much weight on the modern, Western, clinically and medically oriented health care system.

---

14 World Council of Churches, *The Healing Church*, World Council Studies No. 3, Geneva 1966, p.37

2.4. The World Council of Churches' definition of health

The WCC's Christian Medical Commission (CMC), in conjunction with the World Health Organization (WHO), then made intensive efforts to draw up the principles of the Community-Based Health Care System. It then launched and led a comprehensive global study process into intercultural perspectives on "health, healing and wholeness" (1979-1988). As a consequence and conclusion of this process, and in response to the Preamble to the Constitution of the WHO,[15] the CMC put forward the following definition of health in 1988:

Health is a dynamic state of well-being of the individual and society, of physical, mental, spiritual, economic, political, and social well-being – of being in harmony with each other, with the material environment and with God.[16]

This definition was approved by the WCC in 1989 and has served as the basis of the ecumenical understanding of health ever since. We have the ecumenical influence to thank for the fact that, not long after this, the WHO in turn amended and expanded its definition of health and now understands health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[17]

The following elements can be seen as positive contributions and as being among the major aims of this broadening of the concept of health at the beginning of the 1980s.

Health is no longer conceived of as solely the condition of an individual; account is now taken of the societal factors that influence individual health.

The well-being of the individual is seen in direct relation to the way society is constituted; the ecumenical partners made this explicit by specifically addressing different elements (body, soul, spirit, economy, politics, society).

Furthermore, the CMC definition assumes that health is not a static concept by which we can distinguish clearly between those who are healthy and those who are not; rather, every person is in constant flux between various levels of maintaining health and fighting infection and disease, hence the term "dynamic state". This kind of process-oriented understanding of health is similar to concepts characteristic of the more recent debate and research on the factors that promote health (*salutogenesis*).

---

15 On this issue, see also section 3.1 below.

16 *The healing Mission of the Church* (Preparatory paper No. 11, CWME 2005)

17 WHO, *Review of the Constitution and Regional Arrangements of the World Health Organization*, Executive Board 101st Session. EB 101/7, Geneva 1997

Lastly, the definition strongly emphasizes that, alongside social, medical and economic factors, the “relationship to God” is also a vital category. It thus accords equal worth to the “spiritual factor” in the understanding of health. This critically distances the definition from the neglect of religious aspects to be found in certain areas of clinical medicine as well as from the deprecation of the medical, scientific or social factors for recovery found in some areas where charismatic religious healing is practised.

This understanding of health has consequences for the understanding of the church’s mission: it means that, alongside the practices of medicine, practical care, psychotherapy and counselling, the Christian duty to the sick also includes spiritual practice. Repentance, prayer and/or the laying on of hands, rituals of gentle physical touch, forgiveness, participation in the Eucharist – such things can have a significant and sometimes extraordinary effect on a person, socially and even physically. These diverse means are all part of God’s work in creation and presence in the church. Contemporary scientific medicine, just like other approaches to medical treatment, is only making use of what is to be found in the world God created.

However, there has also been criticism of the broadening of the WHO’s definition of health. Among the weaknesses of this definition of the concept are:

It runs the risk of weakening the central principle of an individual human right to health laid down in the Preamble to the WHO Constitution: societies could abuse the WCC’s concept to give more weight to “the health of the nation” than to the health of their actual citizens.

Moreover, there is a problem regarding the clarity of the definition and the clear-cut demarcation of its limits. It is absolutely right to describe the economy and politics as significant factors for health; however, to take the next step and talk of economic, political and social well-being, and to call that well-being “health” – this is more questionable. First of all, it is hard to say what “economic well-being” actually entails; secondly, economic coexistence is not normally considered a subset of “health” at all.

Nevertheless, the WCC’s health definition remains helpful insofar as the theological concepts of health and healing are understood in light of the overarching themes of “*shalom*” and “the kingdom of God”. Therefore, if we in Christendom are to have a meaningful and fruitful conversation about health, we must be able to talk about the oft-neglected subject of health in a way that clearly reveals the interrelations between it and other parts of life that have emerged in the WCC’s discussions and elsewhere. As part of this, the WCC believes that the churches must oppose the isolated focus on individual health and health care and make it clear that major advances in health can be achieved only through cooperation between the social, economic and political spheres.

2.5. Definitions of health based on the Christian view of humanity

The Christian understanding of health is founded on the biblical view of humanity, which

says that there is more to being human than mere physical function or mental well-being. This means that, according to a Christian understanding, true, fulfilled humanity can be achieved despite and even within physical brokenness.

If we understand health with a biblical view of humanity, we see that it has more to do with living out a meaningful life whatever our circumstances. In addition, other, so-called **anthropological definitions** of health begin to emerge, such as:

Health is the strength to be human. (Karl Barth)[18]

Health is not the absence of malfunctionings. Health is the strength to live with them. (Jürgen Moltmann)[19]

Health is the strength to fulfil the purpose a person has been given in life. (Ulrich Eibach)[20]

One could criticize these definitions of health as being to far removed from our current conceptions of what health means. They can even give the impression of not valuing physical health highly enough. But we must not forget: these definitions have emerged in a context where the value of physical and mental health has been exaggerated. Their intention is not to minimize the importance of a healthy body and mind, but rather to say that physical and mental health are not the be-all and end-all.

All three of the definitions of health given above use the word “strength”. Health seems to be the faculty that gives us strength to live within our individual circumstances. To experience healing, then, means to get back that strength for life through God’s action or through human care in any of its many forms.

2.6. Broadening our understanding of healing through HIV/AIDS

Health is more than physical well-being, and healing must be understood in a multidimensional light. Contemporary African theology is finding this fundamental insight borne out particularly as it deals with HIV/AIDS. Though medical science has not (yet)

---

18 Quoted in Ulrich Eibach, *Heilung für den ganzen Menschen? Ganzheitliches Denken als Herausforderung von Theologie und Kirche* (Theologie in Seelsorge, Beratung und Diakonie, Bd. 1) (“Healing for the whole person? Holistic thinking as a challenge for theology and the church (Theology in pastoral care, counselling and lay work, Vol. 1)”), Neukirchen-Luyn 1991, p. 28 (English translation prepared for this document)

19 Jürgen Moltmann, *Diakonie im Horizont des Reiches Gottes. Schritte zum Diakonentum aller Gläubigen* (“Social care in the perspective of God’s kingdom: Towards the service of all believers”) Neukirchen-Vluyn 1984, p. 90. Translation taken from Ray S. Anderson, *Spiritual Caregiving as Secular Sacrament: A practical theology for professional caregivers*, London 2003, p. 69

20 Eibach, *op. cit.*, p. 28

found a cure for this disease, social and spiritual factors are visibly having a healing effect in the fight against it.

One very painful experience for people infected with HIV or suffering from AIDS is the discrimination and stigmatization they face in families, in the workplace, in social life and, all too often, in church communities as well. HIV/AIDS brings up the taboo issues of sexuality and death, creating a barrier to dealing with the infection openly and without prejudice. This is a major obstacle in the fight against the disease. Even today, women and men within the church equate HIV infection with immoral behaviour and treat those affected as sinners. This experience is as great a burden for HIV-positive women and men as the physical symptoms of their illness – maybe even greater. Whenever this **barrier can be broken down**, whenever victims are **set free from the accusation of guilt and integrated into the community**, they experience it as a very real form of healing. Furthermore, it is observed that the experience of acceptance and affirmation often has a positive effect on the physical state as well.

Many African theologians are now saying that HIV/AIDS has changed their whole way of thinking about healing, and are even talking about "**healing in the face of death**". What they mean by this is that it can also be called healing in a very real sense when AIDS sufferers are able to die at peace with God and with those around them, for, because of discrimination and stigmatization, many women and men still die without ever having talked about their disease with their families, and feeling abandoned and let down by both God and their fellow human beings. It is in these situations that Christians and Christian communities are called to have a healing effect.

2.7. Weak, sick, disabled – yet "well"

At the 2005 CWME in Athens on the themes "Come, Holy Spirit, heal and reconcile" and "Called in Christ to be reconciling and healing communities", Samuel Kabue, a blind pastor from Kenya, gave a remarkable speech on the meaning of healing and health for people with disabilities.[21]

Samuel Kabue has been blind since birth. As a teenager he railed against his fate. Being a Christian, he would ask himself why no healing miracle had happened to him, even though we read in the Bible that Jesus could make the blind see again.

In his speech, Kabue vividly described his experiences with "offers" of healing: people kept inviting him to big Christian healing events in his home city of Nairobi, with huge posters promising healing for all who would give their lives to God. And so he would go along with it, in the hope that maybe God would heal him of his blindness. With hindsight,

21 Rev. Kabue's speech can be reached at http://www.oikoumene.org/en/resources/documents/wcc-commissions/mission-and-evangelism/cwme-world-conference-athens-2005/plen-11-may-doc-no-1-disability-sam-kabue.html

he's now very critical of these big healing events. Yes, he says, of course there were always some people who managed to get out of their wheelchairs, for example, but the majority of people suffering from sickness or disability experienced no healing. And it would then be very hard for them to process the experience they had had, and many of them would ask, "Did I not pray enough? Do I not have enough faith? Am I just a sinner who doesn't 'deserve' God's healing?"

Samuel Kabue spent a long time in intense study, tackling the significance of the biblical healing miracles in great detail, and now insists that Jesus' purpose was not simply – and by no means primarily – to free people from their physical symptoms. For Kabue, healing in the biblical sense is about the **healing of relationships**. Jesus healed women and men by reintegrating them into the religious and social community. For Kabue himself, a healing process began when he started to feel that, even – or especially – as a blind person, his fellow people respected and valued him, and that there was a place for him in the community with his gifts and strengths. People with disabilities, he said, experience healing and reconciliation through "**acceptance, integration and rehabilitation into the heart of society**". Physical healing is for him only one part of the comprehensive healing that Jesus brought – a healing that had at its heart the reconciling of people to each other and to God.

Samuel Kabue is an advocate for the integration of people with disabilities in our parishes and communities. His own example makes it very clear that health and physical perfection are not one and the same: even a man or woman with significant physical limitations can nevertheless be described as "well". Indeed, those with physical weaknesses, sicknesses and disabilities are often "healthier", in one sense, than unrestrictedly able-bodied people.

Samuel Kabue is the head of the **Ecumenical Disabilities Advocates Network (EDAN)** WCC programme, which has drawn up an important document on the issue of health and healing in the context of disabilities, titled *A Church of All and for All – An interim statement*.[22]

2.8. Health above all else?

Anyone who has been ill or feared for the life of someone close to them will know the value of physical and/or mental health. In such circumstances it can seem almost cynical to subordinate the value of health to relationships to God and other people.

And yet: a Christian understanding cannot let health become the most important thing in life, without which life is "nothing" and without value. The Bible will not let itself be interpreted in such a way as to absolutize the value of physical and mental health. Even

22 Central Committee Document, *A Church of All and for All – An interim statement*: http://www2.wcc-coe.org/ccdocuments2003.nsf/index/plen-1.1-en.html

as we stress that through Jesus' incarnation human beings in all their physicality have been accepted, sanctified and often healed, we must remember this: Jesus' love for people was not (solely) about their physical or mental health. Jesus did not care (only) about what today comes under the buzzword of **wellness**; rather, he cared about **wholeness** – about life in right relationship with God, with other people, with creation and with oneself. The basis of all healing is that God has reconciled the world to himself in Jesus (1 Cor 5:19-21). From this new relationship between God, the world and human beings, new relationships emerge between individuals and between humankind and creation, and physical sicknesses are alleviated or healed. But we must not isolate the aspect of healing from disease and remove it from the context of in the reconciling the world to God and linking that to establishing the kingdom of God.

2.9. Conclusions: a public debate on the understanding of health and healing

After this look at various aspects of the understanding of healing and health, one idea that we must take away is that the Christian tradition has a unique and indispensable contribution to make in answering the twofold question of "What is healing?" and "What is health?" We therefore have an important mission to ensure that specifically Christian input is heard in the discussion under way throughout society.

The churches are part of a unique network with intercultural and ecumenical scope, and as such have a great opportunity and responsibility – particularly in the Western context of a technologically highly advanced medical system – both to advocate a society-wide debate and to provide decisive opposition to the reduction of health to merely its physical and physiological dimensions. This is the most important fundamental duty of parish communities and Christian social services in the area of health care: to question and challenge this far too broadly accepted blinkered understanding of health and reductionism in the concept of healing.

Indeed, if every parish or church district were to hold a public discussion forum on the fundamental questions of "What really is health? What really is healing?", it could also have a significant influence towards broadening understanding among the general public.

3 Health in the global context – WHO concepts and access to healthcare

3.1 Main concepts and aims of the WHO

Health is more than the absence of disease

The most famous positive definition of health is to be found in the preamble of the WHO constitution, drawn up in 1946. It defines health as "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[23].

The “political” intention of this definition is to encourage states and societies not to limit themselves to only caring for the sick, but to **fully understand and promote health**. In addition to the healthcare system, other sections of society; such as education or labour protection are also supposed to work to achieve this goal. Thus, the fundamental principle for the WHO and its member states is that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"[24]. The latter part of the statement makes it clear that an individual right to health exists.

Thus, health policy does not merely address the health of the majority of the population – or even of a minority. It must enforce **the right of every single person to the "highest attainable standard of health"**. For older people, the highest attainable standard of health is lower than for the young; in countries which have a rudimentary healthcare system it is lower than in countries with a developed healthcare system. Therefore, while the WHO provisionally accepts that healthcare varies in different countries, it does not accept that there should be any differences between various population groups, races, religious communities, income groups, etc. Thus, within a society, each person has an equal right to the highest attainable standard of health for him or for her.

Doubtless, the WHO´s definition of health sets a utopian goal, which will only be partially achieved. However, this goal does not primarily consist of developing the most extensive medical aid structures everywhere around the world. Instead, it seeks to embed healthcare in an overall concept involving various measures which are nonetheless highly effective in promoting health. They include vaccination, the fight against poverty, hygiene, nutrition, health education, empowerment and the social integration of disabled people,

23 See Preamble to the WHO Constitution: http://www.who.int

24 As above

etc.

In developing countries in particular, these other measures, which fall under the category of "Primary Health Care", are just as important as building hospitals.

The WHO concept of Health Promotion

In 1986, these ideas were included in the **"Ottawa Charter for Health Promotion".** Health promotion is defined as follows:

"Health promotion is the process of **enabling people to exercise more control over, and to improve, their health**. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being."[25]

The charter, signed in the Canadian capital, focuses on the individual's ability to promote their own health. Although there are references to the broad definition of health contained in the Preamble of 1946, the concept of health promotion is based on a different understanding of health, namely as the ability to set one's own aims, to satisfy one's own needs and to react to the challenges of one's environment. This concept takes account of the fact that adverse situations are a part of everyday life. The body is in constant conflict with infections. At the social level, too, life can be seen as a constant struggle to adapt to the environment. The slight difference between health and illness lies in the fact that a healthy body succeeds in its struggle and attempts to adapt, while a sick body's existence is (more or less) threatened.

Health promotion does not primarily deal with treating disease, but rather with **changing (social) living conditions and (individual) lifestyles**. At first glance, it seems that an individual's lifestyle has an impact on health: a healthy diet, lots of exercise, refraining from alcohol, tobacco and other drugs, etc. However, a second look, such as the one taken in the field of epidemiology and public health, reveals that health and individual lifestyles are strongly influenced by social conditions. Thus, health is significantly affected by factors such as a person's income, type of employment (e.g. heavy manual work or high levels of stress), level of education, where the person lives and their family situation. As a result, health promotion is a complex task which, on the one hand, involves empowering the individual to develop healthy habits in their life, and, on the other, involves attempts to influence a large number of socio-political areas, such as labour market policy, education policy and town planning. With regard to the individual, these social factors are described as protective or risk factors. Gainful employment, education, social relations and a stable family environment are protective factors which reduce the

25 Ottawa Charter for Health Promotion (1986), http://www.who.int/NPH/docs/ottawa_charter_hp.pdf

risk of illness or increase the chances of recovery. Risk factors such as unemployment, loneliness, difficult working conditions and a neighbourhood with high levels of environmental pollution, increase the risk of sickness and reduce the chances of recovery.

The Concept of Functional Health

Most recently, the WHO has made another significant contribution to our understanding of health by developing a new classification system to describe health problems and obstacles. The "**International Classification of Functioning, Disability and Health" (ICF)** provides a conceptual basis for addressing various health "components" in relation to one another.

The point of departure of the ICF is the idea that people have different opportunities for dealing with a continuing health problem. Thus, one person who loses a leg may also lose their job, while another person, with aid and other forms of assistance can continue to lead a more or less normal life. Disease, accidents, etc. impair the "functioning" of an individual's life to varying degrees, depending on what (physical, mental, social, material and conceptual) resources are available to them. The aim of the classification system is to determine, in as neutral and accurate way as possible, what disruptions and restrictions a person with a health problem experiences and what capacities and resources they have available to them.

The key notion for the classification system is the concept of "functional health". It stems from the same basic idea as health promotion, and thus defines **health as the ability to meet or satisfy one's own aims and needs in meeting the challenges of the environment as effectively as possible.** Given that the ICF is concerned with describing the situation of people with chronic and serious health problems, i.e. disabilities, the approach provides detailed descriptions with regards to how the body's structures and functions can be disrupted, as well as of the possible restrictions with regards to activities (e.g. everyday life, work, etc.) and participation in society.

This structured approach to health problems is based on the following reasoning: firstly, one should not only rely on a medical diagnosis to determine whether, and to what extent, a person is "disabled" and therefore is unable to work, for example. Instead, in addition to a medical diagnosis, their activities and potential, their participation in social, professional and religious life, should also be taken into consideration. This broad basis can then be used to draw up other supporting measures in order to enable the patient to lead a normal life.

Like the Ottawa charter, the concept of functional health is bound to the political aim described in the WHO preamble: to allow people with long-term health problems access to the highest attainable health standards, namely to physical, spiritual and social well-being. In fundamental terms, the Ottawa Charter (1986) and the ICF (2003) have the same goals in different practical and policy fields. While the Ottawa Charter aims to anchor health research, namely better management of health resources and risks, in various social and political fields, the ICF is an instrument which addresses individual

health problems and social and professional restrictions to participation (disabilities). Both concepts agree that **health is not primarily seen as a product of medical intervention**, but that health problems (and health opportunities) are seen in relation to the environment and the risks and burdens, protective factors, resources and challenges which stem from them.

3.2 Health and Justice – Unequal access to Healthcare

We cannot fully understand and adapt the international WHO debate on health and healing to the German context, if we do not consider the fundamental challenge on a global scale that is the constantly growing divide between the developing and developed world, as well as between richer and poorer sections of societies both in the developing and the developed world. In addition to this, one has to bear in mind the enormous differences in terms of the health situation, health risks, access to health resources and the chance of recovery.

A few pieces of information make the real situation clear:

If one compares, at a global level, population size in different regions of the world and the market share or access to medicines and drugs, the disparities become all too clear. Together, Africa, Asia and the Middle East represent 72% of the world population, but only have access to 13% of medicines and drugs in the world. North America has 5% of the world population, but it has access to 42% of all pharmaceutical drugs and medicines.

On average, the risk of contracting an infectious disease is nine times higher in poorer and low income countries than in wealthy countries.

The WHO has set a minimum standard of 100 nurses per 100 000 inhabitants. Their real distribution varies between a hundred to over 1000 nurses in wealthy industrial countries and between 8.8 and 113 nurses in 8 selected African countries. In terms of doctors per 100 000 inhabitants (20 is the WHO guideline), this figure varies between 200 and 400 in the industrialized West and between 13.4 and 13.2 in eight selected African countries.

Dramatic forecasts have been made about the future distribution of doctors and nurses on the African continent. While in 2000 there were still 280 000 nurses and midwives, by 2015 there are likely to be only 190 000. While in 2000 there were still 90 000 doctors in Africa, by 2015 there are likely to only be 60 000.

Around 30 000 children die every day from diseases that are common and easy to treat.

The healthcare systems in many African countries have already collapsed or are teetering on the brink of collapse. The same applies to the healthcare systems in war-torn countries such as Iraq.

The average life expectancy in many countries has dropped dramatically over the last 20

years and continues to fall. The same is true in many countries of the former Soviet Union.

The share of the gross national product spent on health-related matters, varies greatly between developed and developing countries and the discrepancies are increasing (North America 14% of GNP, Switzerland 11%, France 9.6%, China 5.5%, India 5.1% and Indonesia 2.4%).

Just a brief glance at this shocking data which is regularly produced by the Global Forum on Health Research and the WHO makes it clear how **closely related health and development issues are throughout the world.**

We should bear the following critical questions or suggestions in mind, within the framework of this position paper, for subsequent, broader debates:

What measures can be taken to prevent a total collapse of the healthcare system in many developing countries (especially the least developed countries - LDCs)?

What measures can be taken to ensure that financial resources for healthcare services are managed responsibly, both within individual states and between different countries (investments in high-tech medicine at home, neglect of general healthcare for poorer sections of society in other countries)?

What measures can be taken to prevent large numbers of doctors and nurses from developing countries emigrating to Western countries and cities?

What access to medical care do migrants and refugees and people with no legal residence permit have in our society?

What measures can be taken to ensure the fair distribution of affordable medication (e.g. generic drugs to treat diseases such as HIV/AIDS) in developing countries?

3.3 Conclusions: expanding the debate on health in Germany

The WHO's definitions of health and health promotion have led us to a broader understanding of health and healing:

Health no longer simply refers to physical well-being, but also includes spiritual wellbeing and the social relationships in which a person is involved.

Peoples' living conditions, as well as their social and professional environment also have to be taken into account when describing and solving health problems.

An individual's means and their ability to take responsibility for their own health must also be examined more closely.

Health promotion and disease prevention are tasks for the whole of society and cannot be dealt with by the healthcare system alone.

Developments of the German healthcare system must take the global health situation into account. Germany must contribute to fighting major epidemics (HIV/AIDS, tuberculosis and malaria). However, globally sustainable and pioneering solutions must also be sought to train and increase the number of qualified personnel in the field.

4. Health in Germany – special challenges for churches and ministry

4.1 The need to define health needs and health resources

The health of the population only partly depends on the quality and availability of medical and healthcare services. There are other important factors, such as a person's education, income, career, working environment and social relationships, the quality of their accommodation and living environment. These factors can have a positive impact on health (protective factors) or, as in the case of an unsafe working environment, they can increase the risk of illness (risk factors).

Protective factors can also be viewed as health resources: they decrease the risk of a serious illness or contribute to overcoming disease. Thus, family life and friends are protective factors which reduce the risk of mental illness, and at the same time, are factors which make it easier to overcome various types of serious illness. In the same way, health **risk factors**, such as living in a part of town with a lot of traffic, can be viewed as health burdens.

Recognizing health resources and burdens as such is the first step towards prevention, which, in its broadest sense, needs to be increased in Germany. Prevention measures basically include any activities which increase the health resources available to an individual or group and reduce their health burdens. If one is used to viewing disease and health risks as the object of medical treatment, this understanding of (primary) prevention requires a shift in perspective. In this context, prevention is not simply a matter of following medical advice on behaviour, for example following a balanced diet, taking exercise or reducing alcohol consumption. Instead, it is more about people's living conditions. Normally, living conditions, e.g. the neighbourhood, workplace, level of education, etc. are not primarily considered from the point of view of health. The health aspect is usually only taken on board when health problems become apparent, such as an increase in sick leave within a company or drug taking in youth centres.

There are, however, good reasons for the churches and *Diakonie* health and social work organizations, as well as other social actors, to also take health resources and risks into account, even when there is no evidence of specific health problems. This is because many illnesses with serious consequences develop without any clear symptoms. When symptoms do appear, many of the opportunities to effectively combat the disease or health risk have already been missed.

Churches and church social services, in their various forms: parishes, training institutions, advice centres, leisure facilities, volunteer centres, etc., have a great deal of **potential to promote health resources, as well as reducing health burdens**. Making use of these

opportunities in a responsible manner reflects the church's duty to offer healing[26].

In order to deal with serious health risks and diseases effectively, a structured approach is required. In a society obsessed with health[27], there is a danger that relatively healthy people will ensure that they receive a lot of attention while others, who are more seriously ill, will barely mention their symptoms or, for various reasons, be unable to do so. The following chapters aim to raise awareness of a series of problems, which the Church and its social services could help to resolve.

4.2 The increase in mental illness as a challenge to society

People's spiritual health is an issue that is especially close to the heart of the Church and its social care institutions, as spiritual assistance is a fundamental part of church life. In an age where there is a professional division of labour, therapy for mental disorders forms a separate, specific field which only rarely comes into contact with the pastoral care provided by the church.

In recent times there have been reports of an increase in of mental illness. Thus, although health insurance companies have observed an overall decrease in sick leave (absence from work due to illness); there has been an **increase in sick leave due to mental health problems**[28]. The health report for Germany for 2006, published by the Robert Koch Institute, indicates that mental health problems such as depression, anxiety disorders and dementia have long been underestimated due to a lack of reliable data, and describes improving healthcare in relation to these illnesses as an important challenge[29].

The Church's commitment to mentally ill people touches on an area where several conflicting trends meet, and deserves critical attention. The fact that mental illnesses have been identified as being more frequently the reason for a person's inability to work and hold down a job than they were in the past, does not necessarily mean that more people are suffering from serious mental health problems than before. The only conclusion that can be drawn is that patients, their doctors, and indirectly, employers, health insurance companies and pension funds more frequently agree to define certain problems as a mental illness and then to assess them accordingly in terms of social and

26 See Chapters 5 and 6

27 See Chapter 1, section 1.5

28 See BKK-Gesundheitsreport 2005: Krankheitsentwicklungen- Blickpunkt: Psychische Gesundheit (Ed) Bundersverband der Betriebskrankenkassen, Der BKK Bundesverband als Spitzenorganisation der Betriebskrankenkassen – Info on Illness and Care cover: BKK Gesundheitsreport 2005

29 See Robert-Koch-Institut (Ed) Gesundheit in Deutschland 2006. Gesundheitsberichterstattung des Bundes, Berlin 2006, 39 pp. RKI Homepage (http://rki.de)

labour law. These assessments are backed up by the symptoms experienced by the patients, their search for relief, the fact that doctors are more readily prepared to class mental health problems as such, and the reactions of employers to decreased performance. The granting of “Sick leave” is therefore an attempt to solve a complex problem, whose causes do not merely lie in the condition of individual patients. The quantity of work and the vulnerability of the company, (a lack of) recognition,(a lack of) a work-life balance and the social relationships of those affected are all factors which have an influence on “sick leave” or “early retirement”, granted on the grounds of mental illness.

Church support for mentally ill people should therefore not begin by focusing on a person’s deficiencies. Instead, it should focus on their resources and living conditions, and take social developments into account. One the one hand, this includes acknowledging an individual’s own resources, abilities, skills and social faculties, even though these may be only partly visible, whilst on the other clearly assessing the factors over which the person concerned has little influence (e.g. the local labour market). The church and its social care services can, through proclamation of the Gospel, through educational opportunities and by practising community life, contribute to removing the stigma attached to the afflicted person and ensure that a more conscious effort is made to integrate them into the community life of the parish.

In order to **remove stigmas and ensure the success of integration** processes, Church communities, institutions and services must critically review their ability to integrate people. A glance at the world of work reveals a low tolerance threshold for disruptions of work processes and communication channels that contributes to the exclusion of the mentally ill. The situation is similar for church services, choir rehearsals, educational events, home circles, etc. A Church that is also open to mentally ill people has to develop its social life and organizational culture in such a way as to prevent ritual and regimented behaviour, so that it does not so frequently lead to exclusion.

A further obstacle which must be taken seriously is posed by the so-called “**Come to us” structures within the church**, which pose problems for many people – especially those who are mentally ill or disabled. More than other people, the mentally ill need to be invited in, we need to seek contact and maintain a relationship with them, even through phases of serious illness when they cannot keep in touch themselves. In view of the enormous amount of work carried out every day in the parishes, services and institutions, this is a difficult task: people who cannot ensure that they are remembered, are easily forgotten. A specific prayer of intercession could prevent parishes, services and institutions from forgetting the sick people with whom they currently, for various reasons, have no contact. It would also make it easier to renew contact.

4.3 Health promotion for the socially disadvantaged

Health is a “commodity” that is unequally distributed in society: sections of the population with a low income and lower level of education are more affected by illness and have a

lower life expectancy than their fellow citizens who have a good education and a high income[30]. The **inequality of health opportunities** already manifests itself in childhood: children from socially disadvantaged families have, for example, a higher risk of becoming overweight[31].

There is only a limited extent to which the **differences in health risks and burdens** can be traced back to differences in access to medical and healthcare treatment. To a large extent they are due to differences in health resources and burden: people with lower incomes and lower levels of education are more frequently exposed to higher levels of pollution and live in places with fewer green areas, have comparatively more strenuous and monotonous working environments, consume more tobacco, less fruit and fewer vegetables[32]. In order to improve their situation a variety of measures need to be taken. While there needs to be a change in living conditions (e.g. environmental pollution must be reduced, the number of sports and leisure facilities must be increased etc.) a shift in behaviour is also needed. Generally speaking, this cannot be done through moral appeals and aggressive public awareness campaigns.

At the moment, health promotion measures following what is referred to as the "**setting approach"** look promising. These measures involve stable, rule-oriented environments, e.g. the workplace, school, kindergarten, etc. Here, people can learn new behaviour patterns, including dietary habits, how to deal with addictive substances or exercise habits, as part of a group. As one element of the local setting, the parish community can contribute to health promotion measures.

This is not just a case of changing habits specifically related to health, but rather **changing attitudes to dealing with the social environment**. The feeling of having a meaningful job, being able to influence one's environment, giving and receiving social recognition, the ability to set achievable daily targets and, in the long term, living according to one's own ideas, are all important health factors.

---

30 See Robert-Koch-Institut (Ed), Health in Germany 2006

Gesundheitsberichterstattung des Bundes, Berlin 2006. 87ff, http://rki.de/cln_006/nn_226928/DE/Content/GBE/Gesundheitsberichterstattung/GesInDtld/gesundheitsbericht, templateId-raw, property-publicationFile.pdf/gesundheitsbericht

31 See the results of the Kinder- und Jugendgesundheitssurvey (KiGGS)(Children and Young People's Survey), in: Bundesgesundheitsblatt Band 50 2007, pp 736.

32 See Robert-Koch-Institut (Ed), Health in Germany 2006

Gesundheitsberichterstattung des Bundes, Berlin 2006. 83ff, http://rki.de/cln_006/nn_226928/DE/Content/GBE/Gesundheitsberichterstattung/GesInDtld/gesundheitsbericht, templateId-raw, property-publicationFile.pdf/gesundheitsbericht

Health promotion is practised, at least implicitly, in many areas of church social work, including children's day centres, family education centres, initiatives for the unemployed, neighbourhood cafes, day centres for the elderly or the mentally ill, career training centres and centres to help the homeless or addicts. However, counselling centres and pastoral care also address issues associated with the health of the people concerned, even if priority is give to another field or aspect of their lives.

Health promotion does not merely refer to the Church's social work and pastoral care, but also derives from religious concepts found in the Gospel. Many people, whose healing is described in the New Testament, were socially disadvantaged. The message of the Gospel was, and is, viewed by Christians as a liberating proclamation offering scope for mutual acknowledgement and regard, for meaningful social behaviour, for creating a basic structure for the day and for longer periods of one's life. Today, the **liberating and health-promoting effect of the Gospel** is restricted by various factors, some of which have been known for decades. These include social and cultural obstacles to accessing church life (social background, community structures and cultural barriers).

4.4 No one eats alone – the connection between health, nutrition and global justice

In our modern consumer society nutrition and religion are viewed as separate, "private matters". In contrast to virtually all traditional societies, modern society no longer has any universally binding religious rules for eating. This has had undesired consequences at both individual and social levels. Many people have replaced meals, prepared and eaten together at a set time, with ready meals. These allow people to quickly satisfy their hunger and are often eaten alone. However, eating ready meals is less healthy and often leads to poor diet and the loss of fundamental sensory experiences, practical skills and social contact.

Groceries are produced by a cross-border market, which brings with it almost unbearable working conditions and wages, as well as extreme wastage of natural resources (such as water or energy) and environmental pollution. In the developed world, food is subject to aggressive marketing campaigns and massive price wars, which put pressure on farms and producers around the world.

From a Christian point of view, current practices must be called into question

Food and drink are the staples of life and, at the same time, provide a basic example for consumption. A critical approach is therefore needed to the fictitious images that are propagated by the media when advertising consumer goods, food supplements and diet products. Food and diet products are not only advertised using unrealistic promises of happiness, but the advertising also leads to insatiable consumption.

Shared mealtimes are a vital basis for social and religious life. Thus, good nutrition for

children (e.g. at schools where the children remain in school for the whole day) is not only a question of physiologically correct nutrition, but also provides the basis of social and religious life. Eating disorders and excess weight are not only serious problems for the people affected, but are also the responsibility of society as a whole.

The global production and distribution of food has to be called into question. The living and working conditions of workers in the farming and food industry around the world, the lack of home-grown food in many African countries are must surely be called into question from the point of view of health, justice and sustainability. This is happening, for example, through the campaign „No one eats alone“, organised by “Bread for the World“.

The “secularization” and “individualization” of food and drink deserve to be examined more carefully in their own right. With its many rules concerning food preparation, both the Jewish tradition and the practice of fasting and feasting in the various Christian traditions, provide a point of departure for finding a time to come together – that, of necessity, is temporary and localised- to create a setting for a responsible, circumspect and grateful approach to food.

From a social and political point of view, the following steps appear to be a priority:

Global food security requires a change in trade relations: a fair world trade system needs to take social and environmental criteria into account and must not have a negative impact on the access to food of poor sections of the population.

Food security at home requires a change in farming methods: subsidies for the farming industry are necessary, but they should not exclusively privilege large-scale farms and should serve to protect diversity and sustainability in farming, as well as fostering food security.

Food security also requires a change in consumer habits: everyone can contribute to this shift by cooking with seasonal ingredients and using more organically-grown, regional produce and less meat. In addition to this, everyone can make a commitment to support fair trade.

Finally, food security requires a shift in our attitude to health in terms of our eating habits: more must be done to demand that food that meets the criteria of sustainable health, social sustainability and the environmental sustainability, and that all products are identified accordingly.

4.5 Living with chronic illness and disability

For both individuals and society as a whole, living with a high number of chronic illnesses is an issue for those in countries with a highly developed healthcare system. In itself it is a positive sign, as it means that, although they may still shorten life and make living more

difficult, many illnesses which had previously unavoidably led to death or severe disability, now do not prevent people from participating to a large extent, in social and professional life. The flip side is **living with an illness or disability**, which requires the discipline, energy and skill of the patient in negotiating the terms of his or her treatment and the extent of their involvement in society. In the long term, the patient's family also (to varying degrees) take on a share of the responsibility. Society must react to these altered patterns in the progress of disease. The hope of achieving a full recovery through medical treatment must be replaced with a readiness to include the sick and the disabled in society and in professional life.

For the church, this task is the same but must be viewed from a slightly different perspective. Within the church, people have often subscribed to a narrow interpretation of the New Testament stories of healing that views healing as the full recovery of health and makes a link between living with illness and frailness and sin, although this does generally stop short of specifically equating illness with sin. Sick people are forced to carry an unbearable burden if their illness is traced back not only to a specific misdemeanour, but a specific act that is viewed as a sin, namely as a separation from God. Another concept which must be rejected is the idea that sick people lack the faith to facilitate healing, a view that is sometimes associated with a misinterpretation of the phrase "Go, your faith has made you well" (e.g. Mark 10.52), which frequently appears in the New Testament.

For those living with a chronic illness or disability, life involves the realization that, in circumstances which would cause healthy people to despair, they are able to lead a life that is genuinely full of energy and joy, including relationships with others, in which they are seen in a positive light. Clinging to life, having the will to live when faced with significant limitations demonstrates the vitality and diversity of living beings, as created and willed by God. **A dignified life touched by suffering**, extraordinary participation in the life of society, in spite of great physical limitations, or even miraculous recovery, are examples of different ways of dealing with disease.

From the point of view of faith, it is not people's limitations that stand in the foreground, but the **will to live and the faith of the people affected**. It is up to the church and its social care services to support the chronically ill and the disabled in their lives, to fight alongside them against social prejudices, barriers and disadvantages and to help them express their view of life.

4.6 Demographic developments and health in old age

In recent years, there has been public debate on demographic change and its impact on the healthcare system. This debate has made it clear that many people today still cannot imagine how a generation might **live unaffected by war and major economic catastrophes, and with the support of a highly developed medical system,** with a great number of people living into old age as a result. This is because such living conditions were rare in the 20th century. It comes as no surprise, therefore, that in

discussions some people still basically view old age as an illness, i.e. as a condition in which people are in constant need of care. Depending on one's point of view, this can be viewed as either placing too great a strain on our social security system or as creating a growing demand for new products and services and therefore as potential for economic growth. Others have quite rightly pointed out that "**medicalizing" old age is not in the interests of the elderly themselves**. Instead of being given more medication when they reach old age, people need more attention, active care and opportunities to participate in society.

However, a growth in demand for medical and care services has also been recorded across all age groups. Thus, there is also likely to be an increase in demand, for example amongst the "Golden Oldies", for products and services in the field of geriatric medicine, including gentle treatments for the elderly. However, the growing demand, and the associated costs, are generally mainly due to medical and technical progress and the growing expectations of the population, and only to a small extent are they due to a rise in age-related needs.

Much more important than age-related health costs, however, is the matter of how society reacts to **a declining population**, which poses the real demographic challenge. In the healthcare system this problem will probably manifest itself in a lack of qualified and auxiliary staff. Immigrants from neighbouring countries in Eastern Europe will not be able to fill this gap, as those countries will soon have a similar demographic structure to Germany's.

The Church and church social care institutions have been affected by these changes to an even greater extent because the Protestant share of the population is shrinking faster than the population as a whole and only the minority of immigrants is Protestant. If Church and church social care institutions want to preserve their specific character and develop further, they have to devise a specific strategy to attract potential future staff members and people to manage the Church's social work. In this context, a lot depends on the Church's youth work, its work in schools, vocational schools and vocational training centres for social and care work.

In a phase of demographic change, the Church, which has traditionally been a place in which many Golden Oldies have had a significant involvement, must take advantage of the asset that is its positive attitude towards old age compared to the rest of society. While our youth-obsessed media culture and the world of work have yet to rediscover that old age is an important and positive stage of life, within the Church, respect for the wisdom that comes with **age, experience and cultural memory** that older people contribute is a given. Thus, the Church can provide a beneficial service in a society which, to a certain extent, is afraid of the ageing process. However, even within the Church, very old people who are no longer able to participate actively in parish life are at risk of being overlooked and forgotten.

4.7 Towards cooperation between experts and committed lay people in the field of healthcare

Over the past few decades, in Germany, the number of doctors, psychotherapists, professional care workers, social workers etc. has increased in relation to the total population. In terms of funding, this development has been facilitated by the expansion of the welfare state and, in terms of professional development, it has been facilitated by the professionalization of treatment, care and social work, which has gone hand-in-hand with an increased level of specialization in the different areas of care (e.g. care for the sick, support for addicts, social psychiatry).

The guiding principles of this development are the provision of **comprehensive care and a service to which the patient is entitled, which meets their needs and is of a reliable quality**. These two main principles cannot not be implemented through voluntary initiatives and the personal commitment of individuals and groups alone. This can only be achieved through a professional system. However, this professional system also relies on complementary resources. This includes the readiness of professionals to meet the needs of the patients/clients in a personal and flexible manner and, in part, without remuneration. It also includes the manifold initiatives at local level in which committed people identify care gaps, such as, for example, the provision of healthcare that are adapted to the needs of children, the elderly and those who are socially deprived, as well as specific relief work and lobbying work to bring about structural change. Some of these initiatives are run by self-help groups and organizations. Others, however, are run by committed citizens, who are more acutely aware of other people's plight.

Today, however, cooperation between professionals and committed lay people in the field of healthcare deserves more attention within the Church, and in terms of church social care. The reasons are as follows: generally speaking, medical and care services and products cannot, by themselves, heal sick people. For the affected person, their faith and will to live are important contributing factors, as are their attitude towards their illness and its treatment, their social surroundings and their involvement in society. These factors are not only influenced by the professionals but, where applicable, also by the sick people themselves or the social structures in which they live.

A successful recovery requires **synergy between the medical and therapeutic system and the person affected, their families and supporters**. As long as sick people have sufficient spiritual and social resources at their disposal, the medical and therapeutic system, in dialogue with patients, can focus on its core tasks. If a sick person only has direct access to very few spiritual and social resources, efforts are needed to re-establish access. On the one hand, this is a task for professionals (therapists, social educators, pastors). However, it cannot wholly succeed without input from committed lay people, as professionals alone cannot help sick people participate in society. At this point, the Church and church social care services can, provide a bridge between professionals and committed lay people. Their core competences include mobilizing volunteers, but they are also in a position to foster a dialogue between lay people and professionals.

The period which saw the expansion of the welfare state, may have given many people the misleading impression that paid professionals in the health and social services were virtually able to completely take the place of the specific social involvement of committed individuals. This impression was reflected a fall in the willingness on the part of the

professionals to work together with lay people. In the context of the current restructuring of the welfare state, a move that is linked to significant cuts in government-funded subsidies, the commonly held opinion is that voluntary commitment is more flexible and effective than state action. However, this overlooks the fact that, in the field of voluntary work, most of the resources often do not benefit the intended target group. Instead, the resources have to be used to attract and train volunteers, as well as to organize and fund aid work.

Rather than setting up a schematic opposition between paid professional work and voluntary commitment, it would be more sensible to create differentiated cooperation between professionals in different fields, the patients and their families, who have expert knowledge of their condition, as well as committed helpers, who can help the sick and the persons affected to live their lives in the community. The Church and church social care services have a lot of experience in terms of mediating between various professional cultures, taking a committed approach to on-site problem solving and the various resources of full-time and voluntary co-workers. The probable shortage of (paid) professional and auxiliary staff that is likely to arise in the future, as a result of demographic change, calls the division of labour that hitherto existed between the professional and the lay community into question. In this context, several questions must be asked: to what extent, and within what framework, can work previously done by professionals be delegated to trained lay people? How reliable can voluntary aid and support from outside the patient's own family be? How can people who need support obtain the aid they need, without becoming unreasonably dependent on other people? These questions have to be discussed openly within the Church and the field of church-run social care.

4.8 Consequences: A holistic approach to health

The Church and church social care services must:

focus more on the potential of church work to promote health, paying specific attention to socially disadvantaged groups. The chapter on church parishes will include more specific proposals on how to best exploit the resources available[33]. In a slightly modified form, this proposal can also be applied to other areas of church work (youth work, educational work);

not merely view mental illness as a burden for the individual, but deal with the social factors that contribute to illness. In many cases, social relationships and contacts are extremely beneficial for sick people. In this respect, both parishes and groups involved in other Church and church-run social work contexts can play a positive role.

33 RHA-Matrix, see Section 7.6, also see Section 6.7 (especially the explanations on Religious Health Assets)

view chronic illness, including the resulting limitations on participation in society as an important health challenge of our age. In this context, “healing” does not generally lead to the full recovery of physical and mental health, but to a life in the community, where a loss of capacity is well compensated and patients can exploit the resources available to them;

publicly stress, on a regular basis, the health-related, social and spiritual meaning of shared meals and the human right to have access to a sufficient supply of home-grown food;

regarding the issue of demography, combat the probable lack of professional and auxiliary staff involved in church-focused pastoral work;

work to create a structured approach for cooperation between professionals and committed lay people in the field of healthcare, under which their respective tasks are distributed in a fair and reliable way.

5. Christianity as a therapeutic religion- from its roots to the present day

Today, few people realize that, historically speaking, Christianity started out mainly as a healing movement, and that Jesus Christ was essentially viewed as a doctor and healer.

During his ministry on earth, Jesus' preaching about the proximity of the Kingdom of God was accompanied by signs and miracles through which God's healing closeness could be experienced. In their constant shifts between proclamation of the Good News and healing miracles, the **stories of the apostles** reflect this therapeutic and healing dimension to the image of the Christian faith in the classical Greek world.

The fact that the sick have a stake in God's healing power and are touched by it, is taken as given and is the most important reason for Christianity's missionary vigour throughout its history, from its beginnings on the shores of the Mediterranean, to its expansion through the area. What was important was the theory, in contrast to the religious belief in the ancient world that the sick and disabled belonged in the ungodly sphere of death, and which excluded them from religious life and society. God, made man in Christ, suffers himself and, following the crucifixion, enters the realm of the dead. Thus, he stands by the side of the sick and the weak. Their dignity and their healing are central to the **dual mission of the Church,** namely healing proclamation and healing ministry.

In Western culture, the predominantly science-based view of health and sickness has broadened over the last few decades. Above all, psychological and social factors have been integrated into our understanding of healing and health. Furthermore, many people are aware that, in addition to scientifically recognized medicine, there is a great deal of knowledge and wisdom about healing that has its roots in from older, proven, or different cultures, that has yet to be researched in sufficient depth, or has been neglected in favour of familiar and accepted forms of treatment.

Within the field of medical science, the science-based concept of health and sickness has undergone significant change and expansion in the last three decades, so that the spiritual dimension of healing and health has received more attention. This does not only mean that, in cases that present an ethical challenge or in borderline situations, doctors and care workers are more to see their actions guided by religious values and distinctions. It also means that in new fields of research, such as psychoneuroimmunology, there is a serious research into the cause-effect relationships between religious practices and processes of recovery (i.e. strengthening the immune system).

In Germany, apart from a few pioneering pilot projects, making the connection, and fostering cooperation, between spirituality and medicine, something that has been increasingly promoted in expert debate over the last ten years in the USA and in Britain,

has long been left to either complementary or alternative medicine, a field where many find it extremely difficult to distinguish between serious and dubious alternative healing methods. In the meantime, many people, both in modern medicine and the Church, have become receptive to a more complementary and broader approach to the healing process, and no longer subscribe to a narrow world view where healing is only understood according to the standards and narrow confines of what the scientific and medical view of the world in the 20th century permitted.

Especially in the fields of hospital chaplaincy, and in practical theology as a whole, positive steps have been taken over the last 30 years, to initiate a more in-depth dialogue between theology and medicine, faith and healing. This has also included the concept of Christianity as a therapeutic religion, as developed by Eugen Biser[34].

5.1 Christian healing action today

God's love and devotion to humanity motivates Christians to devote their lives to healing others, both in the field of professional healthcare, in parish communities and in the personal sphere.

What instructions for Christian healing in our own time does the biblical/Christian view of humanity and the healing works of Jesus provide?

The most important insight gained from the ecumenical debate on health and healing has been that health is not only, and not even, „first and foremost a medical problem"[35]5. The scientific view of health, and the healing measures based on it, is important and beneficial, but it needs to be complemented. Christian health work is "religious" in the sense that it "links back to Christ and his healing mission", and entails specific duties, such as respecting the human dignity of every individual, taking a broader view of sickness and healing and taking the "poor" into account.

The **spiritual dimension** has an important place in Christian healthcare work. There is a fundamental openness and readiness to include prayer and healing rites in the process of healing. The Christian precept of care for the excluded, the weak the sick, for strangers, widows and orphans, namely the "poor" in various senses of the word, is a leitmotif throughout the Old and the New Testament. At the start of his public ministry, Jesus uses a reference to the prophet Isaiah -„To bring good news to the poor" (Luke 4.18)- to describe one of the core parts of his mission, in which we are also included . Christian

34 See, for example: Eugen Biser, Kann Glaube heilen? Zur Frage nach Sinn und Wesen einer therapeutischen Theologie, in: Brigitte Fuchs, Norbert Kobler-Fumasoli (Ed), Hilft der Glaube? Heilung auf dem Schnittpunkt zwischen Theologie und Medizin, Munster 2002, 35-56

35 Deutsches Institut fur Arytliche Mission (Ed), Das Christliche Verstandnis von Gesundheit, Heilung und Ganzheit. Studie der Christlich-Medizinischen Kommission in Genf, Tubingen 1990, 6

healthcare work must apply this criterion and therefore cannot exclude certain groups because of economic poverty, their social position or their gender.

Following Jesus' example, Christian healthcare work operates **between the potentially conflicting poles of mercy and commitment to justice.**

Jesus did not remain unmoved by human plight, and was indeed touched to the core by the suffering of mankind[36]. He did not pass by any sick person he encountered, but turned to each and every one of them and viewed his or her life and well-being as valuable and worthy of protection.

In addition to caring for individuals, Jesus also saw himself as following the tradition of the Old Testament prophets, who challenged structures of injustice, in line with the Old Testament phrase: „Speak out for those who cannot speak, for the rights of all the destitute"(Proverbs 31.8). Jesus saw himself called to "proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free…to proclaim the year of the Lord's favour." (Luke 4.18-4.19).

Christian healthcare work has a duty to provide both immediate and direct care to the sick and the suffering, as well as undertaking long-term, structural work to combat the root causes of poverty and sickness. Above all, in economically deprived countries, Christian healthcare work addresses issues of social justice.

The image of the Good Samaritan, often used to represent Christian healthcare work, is appropriate, but it does not describe all of its dimensions. In terms of taking on board and continuing this biblical parable one can say the following: first of all, one must take in the man who has fallen amongst thieves and do what is necessary for his health. Secondly, it is equally important to "secure the road to Jericho", and thus prevent him, or anyone else, ending up in the same inauspicious situation.

If we are to subscribe to a specific Christian mission in the field of healthcare, we believe that Christians can contribute important aspects to healthcare work and feel it is their duty to do so. However, this in no way implies that the characteristics and ideals we have referred to are always put into practice, or that non-Christian healthcare work cannot, and does not, fulfil many of these criteria to a large extent.

Christian healing work serves life and views every person as God's creation, possessing an inalienable **human dignity**. Thus, Christians particularly attend to people whose self-regard and human dignity are under threat today. These people include, for example, the economically deprived, migrants, elderly people, women and children.

Christian healing work views people as whole and treats them within the framework of their relationships to their fellow human beings, to Creation and to God. Thus**, social and spiritual factors** are included in therapeutic measures. Christians view the scientific and

36 See, for example, Mark 1.41

medical opportunities for healing as a gift from God and gratefully work with them. However, they see the medical path to healing as only one aspect of healing work.

5.2 Churches in dialogue with alternative healing approaches and the esoteric movement

The new receptiveness of modern medicine and pastoral theology to the relationship between spirituality and healing, offers a great opportunity to develop a more in-depth and holistic view of the process of recovery, as well creating new recognition for the role of religion and the Church, which is also relevant to social policy and the government's promotion policy.

Views of healing can vary greatly, ranging from esoteric religiosity and the alternative healing approaches it inspires, to the Church's approach, in the form of church social work and church services (pastoral care, blessing and anointment). While many therapeutic and healing treatments on offer in esoteric magazines often contain extremely emotionally charged language, which raises excessive expectations, and could be said to view healing as the full development one's own potential in the here and now, in cosmic harmony and in isolation, by means of specific methodical steps and paths, the Christian understanding of healing remains rather more reserved and sober and is linked to the **eschatological proviso of** "the not yet".

Like sickness, health and healing are not simply be interpreted and explained as being the result of one's own efforts. They remain a gift. Although not every illness is curable, everyone, even the terminally ill and permanently disabled, are offered the chance to be "made whole" and to be touched by God's healing love. There is a difference between wholeness and healing: St. Paul continued to suffer from a serious physical illness, the "thorn in the flesh", but he felt loved and vindicated, in other words: unconditionally accepted by God.

In Germany today, introducing people to the fundamentals of this biblical understanding of healing, taking full account of the huge need for guidance in the light of the manifold alternative and complementary healing approaches available inside and outside the esoteric movement, and initiating a critical dialogue on the subject with the representatives of different healing approaches, are important and indispensable duties for the Church and its parishes. Whoever fails to take the religious search for healing today seriously cannot, in their mission work, approach people in a credible and inviting way.

Today, Christians are professionally active and practically involved in many areas of the current healthcare system, both in the field of modern medical science and the field of care work, as well as in one or other of the alternative healing approaches. Thus, although there are Christian institutions within the healthcare sector (care homes, hospitals), where a specifically Christian approach to sickness and health is implemented, there is no separate or exclusively Christian doctrine on healing, sickness

and health. Just as there can be no essentially Christian jurisprudence or engineering, neither can there be an exclusively Christian medicine or pathology There can only be efforts to protect and disseminate Christian values and principles within other, distinctive spheres of knowledge.

At the same time, in response to the failure to seek **a specific Christian profile within the overall concept of healing**, the “Christians in Healthcare" network has attempted to draw up the fundamental principles for a “Christian medical science“ which mirror attempts to create an anthroposophic approach to healing and aim to highlight aspects of our understanding of health and healing that are specific to Christianity. These attempts are to be welcomed, provided they can strengthen the specific Christian profile both in Christian-run institutions within the public healthcare system and private institutions. They may contribute to highlighting fundamental questions concerning ethics and values, which medical science itself is still unable to answer, from a point of view of Christian responsibility.

The power and potential of Christianity as a therapeutic religion can only be developed today in dialogue with quests for meaning that may have a different religious focus, and by consciously practicing what the Church has been entrusted to do throughout its history[37]7

5.3 Spirituality as a health factor – epidemiological studies

How is it that the chief editor of the magazine “Psychologie heute” can write: “Psychologists are discovering that religion is a healing factor in terms of spiritual and physical health which has been underestimated and overlooked for a long time”[38]8

Attempts to initiate a dialogue and to encourage the sciences to open up to the idea of spirituality as a health factor did not come from theologians or the churches, but from the medical profession. First in the USA, now also in Europe[39]9 epidemiological studies are being conducted to identify which factors promote or suppress spiritual and physical health. These studies have also examined the relationship between spirituality and physical and mental health. Most studies have used quantitative data on participation in religious events as a measurement of spirituality. Certain studies have examined the

37 For the whole text: Policy paper “Christliche Identitat, alternative Heilungsansatze und Esoterik heute”, in the documentation service of the EZW, Berlin, 3 and 4/07

38 Heiko Ernst, Macht Glaube gesund? in: Psychologie heute compact, Issue 8 (2004)

39 This research began in the USA, at the end of the 1970s. For around the last ten years, epidemiological research has also been conducted into the relationship between spirituality and health in Europe. In Germany, for example, at the medical/psychological faculties at the Universities of Trier, Heidelberg, Witten/Herdecke, in Austria at the Universities of Vienna and Innsbruck and in Switzerland, at the University of Zurich.

effects of prayer on an individual's health or on the health of others.

To date, more than 1000 such studies have been carried out, some using very large samples and long research periods (up to 90 000 test subjects per study and observation periods of up to ten years). The questions asked have included: what influence has spirituality had on life expectancy, the incidence of cardiovascular problems, and the survival prognoses for tumour patients and the prevalence of depression, and how spirituality influenced the way in which patients coped with illness?

Over 80% of these studies concluded **that spirituality has a positive impact on physical and spiritual health and on the way patients coped with physical and mental illness**[40]**.**

These studies did not set out to find proof of miracle cures. Instead, they examined comprehensible events. Therefore, researchers also asked how the positive impact of spirituality on physical and mental health can be explained in scientific terms. The **spiritual factors that promote health include:**

The avoidance of behaviour which increases risk: on average, people who practice their faith consume less tobacco, alcohol and drugs than people who do not.

Prayer, meditation and religious rites have a measurable influence on biological processes in the body. Thus, for example, blood pressure decreases, as does the production of stress hormones in the body. These processes can be described as stress reduction through relaxation.

Faith contributes to finding a sense of meaning in life.

Believers often live within a supportive social network.

Believers can mobilize resources to cope with illness and when they are dealt a blow by fate (inner "sources of strength", as well as social support)

This list makes it clear that all of these factors are generally recognized as ones that promote health and are not specifically linked to spirituality. Thus, the statistical link that has been established between spirituality and health is probably valid, but it is not an unequivocally causal link.

Thus, certain basic objections to these epidemiological studies can, and have been, raised:

Methodical discrepancies were noted, above all in the older studies.

---

40 A comprehensive overview of these studies up to 2000 can be found at: Harold Konig, Michael McCulloch, David Larson, Handbook of Religion and Health, New York 2001; Dale A. Matthews, Glaube Macht Gesund. Spiritualitat und Medizin, Erfarhungen aus der medizinischen Praxis, Freiburg 2000

Most of the studies were carried out in the USA, where spirituality has a much higher status than in Europe, for example. Thus the results cannot be transposed into the European context without further research.

One must ask whether spirituality can be measured at all. Does participation in religious events really tell us anything about the spirituality of the people concerned? Or are the results due to the fact that sick people do not have the opportunity to take part in church services and are therefore not included?

As before, one should bear in mind that certain forms of spirituality may also have a negative impact on physical and mental health, such as views of God that induce fear and bigoted beliefs in certain religions.

A glance at the literature written on these epidemiological studies, shows that they have as many opponents as supporters. The results of the studies are controversial and are not universally accepted in the United States, either[41]1.

Moreover, from a Christian point of view, other fundamental doubts exist concerning the conclusions on the healing power of faith drawn from these epidemiological studies. Thus, the question arises of whether faith should be misused by a wellness movement that is regarded critically by Christians? Are these studies not based on a concept of health that is too narrow, when compared to the Christian understanding of it? Should a notice now be posted on the church door to inform all who care to read it that: “whoever comes here on a weekly basis will increase their life expectancy by a few percent”? Is it really only a matter of extending our lives by a few years? Should the way in which we practice our faith really be self-serving in terms of our own health? Should we, then, serve the “God of Health” instead of the God of the Old and New Testament, who also embraces suffering and can give it meaning? And finally, would the next step then be to ask the sick whether they perhaps pray or attend religious services frequently enough and suggest to them that those who are sick and do not recover only have themselves to blame?

All these questions must be answered in the negative, as a “yes” would mean instrumentalizing faith and practicing spirituality, with an ultimately dubious aim in mind. This would indeed contradict the meaning of the encounter between God and Mankind in religious practice. As a gift from God, healing is, and remain beyond our reach and, therefore “unattainable“ in real terms.

41 Literature on this topic: Simone Ehm, Michael Utsch (Ed), Kann Glaube gesund machen? Spiritualitat in der modernen Medizin (EZW-Texte 181), Berlin 2005. Bernard Grom, Religioser Glaube- ein Gesundheitsfaktor? In: Dr. Med. Mabuse, September/October 2002, Warum glaubt der Mensch? Religiositat uber Verganglichkeit hinweg? Macht sie gesunder? Und gibt es ein Gottes-Gen? GEO 2006, Volume 1, Gluck, Glaube, Gott. Was gibt dem Leben sinn? Psychologie heute compact, Vol 8 (2004), Glaube und Gesundheit, Warum Hoffnung heilen kann. Psychologie heute 32, Vol 3 (2005)

In spite of all these objections and fundamental doubts, there is still a positive side to these epidemiological studies. They have put spirituality and religion back on the agenda of discussions in the natural sciences. Following a long period where there a seemingly unbridgeable gap between medicine and psychology on the one side and theology on the other, the natural sciences have once again opened the door to dialogue. Given that these studies “speak the language“ of the natural sciences, they can serve to open doors, to allow faith and spirituality to be viewed as factors which promote health, following centuries of being systematically ignored.

Last but not least, this **greater openness on the part of the natural sciences to including spirituality in therapeutic approaches** also represents a challenge for theology and the churches. Thus, at the 2005 Kirchentag in Cologne, a doctor and a psychotherapist asked the representatives of the churches the following provocative question: “Why have you left it up to doctors and psychologists to discover the healing dimension of spirituality”?

5.4 Consequences: including spiritual factors in therapeutic concepts

One significant result of the ecumenical debate on health and healing is the theory that the relationship to God also has implications for people’s health. Other sections of the ecumenical Christian community demonstrate, in their everyday faith and healing practices, that they take the spiritual dimension of healing seriously and that God, and his healing power, has not ceased to be a part of the healing process, both within the field of medical science and beyond it, in the Church and in parish communities, in so far as these promises are simply taken seriously.

Belief in the healing impact of God’s mercy, as it is experienced in faith and spirituality when they are practiced in everyday life, is a common theological principle in churches. Ultimately, it also stems directly from the healing stories of the New Testament. The real hermeneutic challenge is to bring this insight into the modern debate on health in our society in such a way as to ensure that it is acknowledged and understood as a life-promoting resource, whilst also taking into account the modern distinction between the fields of science and everyday life.

The health-related dimension of the relationship to God should not be set up in contradiction to other health assets (e.g. a good social environment, workplace, medical services). Any one who differentiates between healing methods is according to whether they fall into the material or spiritual category and attempts to promote “faith healing” at the cost of, and by undermining, material and physical approaches to healing, therefore runs the risk of creating such a contradiction. In addition to this, more methodological care needs to be shown when discussing theories claiming a direct causal relationship between religious practice and health. This is because one should always be aware of the danger of directly manipulating the relationship with God and abusing the spiritual dimension.

It is up to churches and parishes, unlike these two extremes, to make the relationship to God, as it is lived out and experienced in faith, the fundamental and constant reason for human life, in sickness and in health, and to support people who turn to God precisely in times of sickness and existential needs, through support and rites within the living Christian community.

What does this mean in practice? For example, could the therapeutic dimension of faith be implemented, as is the case in a local parish in Schleswig-Holstein, by setting up a forum for dialogue comprising registered doctors, hospitals and the pastors and deacons of a place or region? The two sides both came to understand the mutual need for each of their approaches to be complemented, and the practical result was that a joint pamphlet (written by local doctors and pastors) or introductory letter to patients is available at many doctors' surgeries. It is designed to appeal to patients' own understanding of health and healing, and invites them to acknowledge and accept a broader and more intensive experience of God and faith. This is why there is an express invitation for doctors and pastors to take on joint responsibility for the different options in terms of pastoral care, and of blessing and unction, as well as prayer for the sick, at a local level.

6. The Church as a healing community – Biblical and theological foundations and contributions from other countries

6.1 Healing- the theme of the Bible and the parish's mission

God is on the side of life
The Christian community, by listening to the witness of the Bible, gets to know a God who wants to bring salvation to his creation and who includes people in his good intentions. The author of the psalms is full of effusive praise for God, who is completely dedicated to healing humanity, "who forgives all your iniquity, who heals all your diseases, who redeems your life from the Pit, who crowns you with steadfast love and mercy" (Psalms 103.3). A God who "remembers that we are dust" is willing to grant His almighty mercy "for ever and ever" to "all who fear him" (verse 11). This dual aspect of salvation, which affects humanity both internally and externally (forgiveness and the healing of afflictions), is fundamental to biblical anthropology and is also reflected in Jesus' ministry, especially his healing works.

God is referred to as "Saviour" throughout the Bible, and in the first part of the Bible, this title refers to the fact that he delivered the people of Israel from Egypt, via the Red Sea and then sustained them in the wilderness, subject to them obeying His law. Within the scope of this experience, God's act of salvation is described as healing**: "I am the Lord, who heals you" (**Exodus 15.26)

The prophets' criticism of godlessness is the necessary flip side of God's healing intentions, and entails making His people jointly responsible: "You have not strengthened the weak, you have not healed the sick, you have not bound up the injured, you have not brought back the strayed, you have not sought the lost" (Ezekiel 34.4).

The Laments, with their remonstrations and appeals to God's grace, also assume that this God is incompatible with "damnation" of any kind. This God obviously did not teach humans to accept and surrender to injustice and suffering, as the Psalms prove. The witnesses in the Bible may have known that God does not only create life but also brings death. "However, instinctively and after all is said and done, he stands on the side of life. That is why we appeal to his innermost being, to his heart, when we call for His help in times of sickness and death". Faith in this God, who releases us and is merciful, is not transformed into a contradiction because there is sickness, death and dying in the world. Thus, faith in this God also means faith in the expected triumph of his healing, as foretold by the prophets (see Isaiah 2 and 3).

Jesus heals and calls on us to heal
Jesus addresses this expectation (Isaiah 61.1) at the start of his ministry, in his speech in Nazareth: "The Spirit of the Lord is upon me, because he has anointed me to proclaim

good news to the poor. He has sent me to proclaim liberty to the captives and recovering of sight to the blind, to set at liberty those who are oppressed, to proclaim the year of the Lord's favour." (Luke 4.18).

Jesus makes it clear that this anticipated "year" now begins with Jesus' coming and delivers the proclaimed time of healing: "I must proclaim the good news of the kingdom of God to the other cities also; for I was sent for this purpose." (Luke 4.43). In Jesus' case, his preaching is accompanied by healing acts, so that Jesus' healing works, aid and preaching form one indivisible whole. The Gospels show that God's reign cannot simply be described with words, but is also revealed through people's actions. Seeing and hearing are therefore also part of human experience (see, amongst others, Jesus' testimony to John the Baptist in Matthew 11.2-6, particularly v 2). The Gospel of John even allocates a significant and high-ranking revelatory function to sight (see John 15.24 and 10.37). The traditional epistemological tendency to dismiss the miracles as "mere illustrations" or as "having an ambiguous meaning" in terms of the revelation of faith, does not hold water in biblical tradition[42].

Jesus' coming is described in the New Testament as a battle. This basis for understanding his ministry is summed up in 1 John (3.8) in the phrase: "The reason the Son of God appeared was to destroy the devil's work" Thus Jesus threatens not only demons, but also diseases (Luke 4.38 onwards) or speaks of „the spirit of infirmity" (Luke 13.11). The narrative in Mark 3.27 makes Jesus' view of the kingdom of God as a battle clear: "But no one (here meaning the Devil) can enter a strong man's house and plunder his property without first tying up the strong man; then indeed the house can be plundered".

Thus, the **coming of the Kingdom of God, and God's reign as revealed in Jesus' works,** are not simply an act of friendship towards humanity, but an incursion into the sphere of the dominion of evil, from whence territory will be wrested both with forgiveness and with healing. Battle and victory as retaliation against the destructive power of evil are a thread which runs throughout the whole of the New Testament, including in the Revelation to John. Through its belief in the certain victory on the Cross and Jesus' resurrection, the Church of Jesus Christ is involved in this battle.

These are not marginal statements in the New Testament. They play a prominent role, and refer to the fact that Jesus' task to preach and to heal, must continue. That is what Jesus' pre-paschal commission states: "Preach *and* heal" (Matthew 10.7) as well as the post-paschal instructions in Matthew 28.18-20 (see also Mark 16.5-20). John 20.21 also speaks of this mission: "As the Father has sent me, so I send you", which can only be understood as one that goes beyond spreading the Word and includes the mission to heal.

Service to the sick in early Christian communities

The Acts of the Apostles show us in many places (see 4.29-31, 6.8, 8.6) that the apostles

42 See Wolfgang J. Bittner, Heilung, Zeichen der Herrschaft Gottes, Schwarzenfeld 2007, S.30-32)

and early church communities really did understand and lived out their mission in this way. St. Paul also includes statements in his letters, which are - after all – missives written in specific circumstances, that make it clear that deliverance miracles belonged to his ministry and his experience (see 2 Corinthians, 12.12, Romans 15.18f, 1 Corinthians 2.4 and 1 Thessalonians 1.5 and 1 Corinthians 12.9.28).

The observation that healing was, to a certain extent, “normal” in the early Christian church is highlighted by a specific text, which today is becoming more important for theologians and parishes, namely **James 5.13-16.**

This is a church community code on healing, that reveals aspects of the subject which are still important today:

Christians shall not trivialize sickness, but take it seriously as a problem in its own right.

Sickness shall be viewed as a community matter, it shall be taken into account in the community’s organizational structure and even be a matter for the community leaders to address.

The text encourages a trust which takes improvement in the patient’s condition, and even their recovery, as almost a given. Experience further confirms this trust.

Prayer, anointing and forgiveness respond to the needs of the sick in a holistic manner (see also Psalms 103.3-6 and Mark 2.9 onwards)

The early Christian healing mission, as described in James 5, consisted in visiting the sick, praying for them, (mutual?) acknowledgement of sin, the laying on of hands and anointing. It is reflected in all Christian traditions and expressed even in the form taken by the Liturgy. It can also be seen to serve as an example of how healing ministries in local churches should be organized today.

6.2 Healing in the Church’s history

At discussions within parishes or at training courses on church social care, the idea is sometimes mooted that a broader healing movement only existed within the early, charismatic Christian church, and that the phenomenon later waned and people focused on purely practical social work, aid and care services, which remains the Church’s core duty today.

Although, in this chapter, we cannot provide a comprehensive overview of the history of healing ministry in the history of the church and of Christianity, one thing is certain: acts of healing, caring for the sick, pastoral care and the blessing of the sick are not limited to the early period of the Christian church, but have existed in all phases of its history.[43]

43 see Bittner, Healing pp60

Healing charisms, healing liturgies and healing prayer have played, and still play, a significant role in many Christian traditions within the ecumenical Christian community. In spite of the fact that the Western European Protestant part of the Christian community has, perhaps, partly lost sight of these things, we must avoid incorrect judgements or allowing our own prejudices to influence the criteria by which we assess the history of the Christian church as a whole.

Thus, to this day, the Orthodox tradition still uses many prayers for the sick, which form part of the sung Liturgy. The Roman Catholic tradition features the sacrament of anointing the sick, one of the seven fundamental sacraments of the Catholic Church, which it rediscovered following the Second Vatican Council and liberated from its narrow definition of "last rites". The history of the religious orders is inextricably linked to providing practical care to the sick and needy, and many orders offer prayers of intercession for the sick, as well as blessing and anointing them.

Hospices for the sick and houses run by deaconesses have, throughout the history of the Protestant church, made a significant contribution to implementing and developing the healing ministry of the Church in many parishes and church hospitals. In 1545, for example, during the final year of his life, Martin Luther wrote a detailed letter of instruction on blessing the sick.

No detailed reconstruction has yet been produced of the history of the Church's healing ministry and its reality within the ecumenical diversity in the Church, although this would certainly be a fascinating project. However, wherever the issue of faith and healing is raised in terms of greater cooperation within the ACK (Council of Christian Churches in Germany), and is examined in depth, one taps into the rich potential of this topic in relation to the Church's history and in intercultural and ecumenical terms.

6.3 Rediscovering the Church as a healing community

Ecumenical contributions
The Tübingen consultations in 1964 and 1967 affirmed that the local congregation or Christian community is the primary agent for healing. It was emphasized that, given the need for and legitimacy of specialized Christian institutions like hospitals, primary health services and special healing homes, every Christian community, as the body of Christ, has a significant and relevant role to play in terms of healing.

Since the end of the 1990's, more attention has also been paid in international ecumenical discussion to rediscovering the church as a healing community.

In 2000, a WCC consultation on "Faith, Health and Healing" was held in Hamburg. It sought to establish a new link between the path to learning followed by the medical

profession and Christian healing ministry in different churches.[44] In 2003, two large ecumenical assemblies focused on the core issue of redefining the Church's understanding of its healing mission. The Assembly of the Lutheran World Federation in Winnipeg, Canada, focused on the issue of "For the healing of the world" and, in June 2003 in Trondheim, the Assembly of the Conference of European Churches (CEC) also proposed a vision of the Church as a community of healing and reconciliation.

Finally, the **World Mission Conference in Athens in 2005** was held under the motto of "Come, Holy Spirit, Heal and Reconcile. Called in Christ to be reconciling and healing communities".

The WCC background document for the World Mission Conference in Athens (2005), entitled "The Healing Mission of the Church" defines the Church as a healing community:

"The nature and mission of the church proceeds from the Triune God's own identity and mission with its emphasis on community in which there is sharing in a dynamic of interdependence. It belongs to the very essence of the church – understood as the body of Christ created by the Holy Spirit– to live as a healing community, to recognize and nurture healing charisms and to maintain ministries of healing as visible signs of the presence of the kingdom of God.

To be a reconciling and healing community is an essential expression of the mission of the church to create and renew relationships in the perspective of the kingdom of God. This means to proclaim Christ's grace and forgiveness, to heal bodies, minds, souls and to reconcile broken communities in the perspective of fullness of life (John 10.10). "

"The way people are received, welcomed and treated in a local community has a deep impact on its healing function. The way a network of mutual support, of listening and of mutual care is maintained and nurtured in a local congregation expresses the healing power of the church as a whole. All the basic functions of the local church also have a healing dimension for the wider community: the proclamation of the word of God as a message of hope and comfort, the celebration of the Eucharist as a sign of reconciliation and restoration, the pastoral ministry of each believer, individual or community intercessory prayer for all members and the sick in particular. Each individual member in a local congregation has a unique gift to contribute to the overall healing ministry of the church."[45]

This preparatory document also stresses the importance of the healing gifts in communities:

"According to the biblical tradition the Christian community is entrusted by the Holy Spirit with a great variety of spiritual gifts (1 Corinthians 12) in which charisms relevant to the

44 Documented in: IRM Vol. 356/357, January/April 2001 (Booklet on topic of "Faith, Health, Healing")

45 The full text can be found at: https://www.mission2005.org/Dokumente.1041+B6Jkw9Mg_0.html

healing ministry have a prominent role. All gifts of healing within a given community need deliberate encouragement, spiritual nurture, education and enrichment but also a proper ministry of pastoral accompaniment and ecclesial oversight. Charisms are not restricted to the so-called “supernatural“ gifts which are beyond common understanding and/or one’s personal world view, but hold to a wider understanding in which both talents and approaches of modern medicine, alternative medical approaches as well as gifts of traditional healing and spiritual forms of healing have their own right. Among the most important means and approaches to healing within Christian tradition mention should be made of

the gift of praying for the sick and the bereaved
the gift of laying on of hands
the gift of blessing
the gift of anointing with oil
the gift of confession and repentance
the gift of consolation
the gift of forgiveness
the gift of healing wounded memories
the gift of healing broken relationships and/or the family tree
the gift of meditative prayer
the gift of silent presence
the gift of listening to each other
the gift of opposing and casting out evil spirits (ministry of deliverance)
the gift of prophecy (in the personal and socio-political realms)[46]

6.4 Christian communities as significant social entities

Christian communities, whatever form they may have taken in the past, have always created a common space where the sick and the healthy live together, as do the strong and the weak, the stable and the unstable. They live according to the principle of *absolute acceptance*, through the words and works of the living Christ, reconciled with God and one another. They wait in hope is the coming of the Kingdom of God. This future prospect creates a longing for healing experiences in the here and now, as promised to the Christian community. However, at the same time, it also limits our expectations to a certain degree and makes us wait, in the hope of God’s full salvation.

According to Acts 2.42, Christian communities are based on “the teaching of the apostles”, “fellowship”, “the breaking of bread” (supper, Eucharist) and “prayer”. These roots are, literally, “resources” on which Christians draw time and time again. They have a blessed, healing power, which must be developed both at an individual and at a social level.

In social terms, parishes are unique entities, providing opportunities for a whole range of

46 The full text can be found at: https://www.mission2005.org/Dokumente.1041+B6Jkw9Mg_0.html

encounters, a network for people to meet and visit each other, celebrate together and help each other. “Parishioners are people from all classes and age groups. Nothing takes places outside the scope, out of earshot or sight of the parish community. Every joy, every sorrow, every trouble occurs within its sphere. Parishes have a comprehensive “living potential” which encompasses Heaven and Hell, birth and death, joy and sorrow, youth and old age, the giving and receiving of aid, relief and support, freedom and security, the individual and society[47].”

This **extensive, living potential** must be discovered within the parish and developed, in the light of God’s promise. Not only spiritual, but also physical, organizational, organic and spiritual relationships are involved, as is reflected in the term “the Body of Christ” used to describe the Christian community in the New Testament. Mutual responsibility, together with the relevant gifts (“charisms”), must define the body language of a parish (1 Corinthians 12, Peter 4.10, Galatians 6.2).

The New Testament is certain that healing takes place at all levels - physical, mental and spiritual - and that the healing process occurs within the Body of Christ, and might include tangible experiences of healing (see, for example, James 5.13 onwards). Reflections on a Christ who forgives, helps and heals, thus determine the direction of the parish community’s mission: “As the Father has sent me, so I send you” (John 20.21).

6.5 The healing community as a missionary community

This mission crosses parish borders and extends far beyond them into city districts, neighbourhoods, towns and villages. Neither the solemn statements from churches nor the extensive Church or church-run social care agencies can replace the advocacy of a local community on behalf of its members. The Willow Creek Community (Chicago), which has also become famous in Germany, has hit the nail on the head in its statement: “The local Church is the hope of the world”.

This **potential for hope** provides a guiding light beyond the parish and becomes “missionary”, when suffering ceases to be taboo, suppressed and made anonymous, and when people find that they can bring their pain, illness, their experiences of separation and their break-ups into the Christian community and not be left to deal with them on their own.

This prospect poses enormous challenges for our parishes. How can they become a place where one can experience a healing and reconciling power? How can we empower our parishioners to include and implement healing pastoral care for others in their lives? How do we create and manage healing opportunities?

These questions are also important in relation to mission work. Many people can only be

47 Paul-Hermann Zellfelder-Held, Solidarische Gemeinde. A text book for developing the parish in the field of Christian social work, Neuendettelsau 2002, S. 19

approached about their faith and their relationship to God once their physical and mental needs have been addressed, and when the witness of words is accompanied and qualified by witness involving pastoral and social work or healing ministry.

6.6 Healing spirituality: Forms and Trends

Since the beginning of the Church's history, caring for the sick, developing the charismatic gifts of healing and combining Christian faith and care for the sick, in special networks and church communities, have had a visible presence and created a web of support.

Ultimately, the meaning of a **Christian spirituality of healing,** and how it is shared and transmitted internally, can never be experienced alone, only together with other people. Relevant networks can allow people to experience and develop the following characteristics of healing spirituality:

Healing spirituality in the Christian tradition takes as a given the currency and effectiveness of healing gifts, measures and powers in Creation, within people and in interpersonal relationships, both within the boundaries of scientific explanation and beyond them.

Healing spirituality is expressed in practical acts which addresses illness and affliction by introducing a religious dimension. The age-old Christian virtues and customs of singing, praise, recalling oneself of God's goodness, prayer, blessing and being blessed, the laying on of hands and anointing with oil, all have the power to bless and to heal and produce tangible effects, although these effects may not be guaranteed in every single case, or be measurable.

Healing spirituality in the Christian tradition now needs to include, as part of our religious identity, our own physicality, our concept of our own bodies, our breathing, movement and personality. People who emanate spirituality are consciously present in their bodies and include their bearing and physical gestures in acts of prayer and healing.

In the Christian tradition, a healing spirituality means that every encounter with another person who is ill, afflicted or is searching for healing takes place in an attitude of prayer: it is not a person's professional skills, abilities, techniques or energy that are the focus of attention, but rather an open, searching attitude of acceptance and paying one's undivided attention to another person, in a spirit of prayer for God's healing.

Practising a healing spirituality also means being aware of one's own wounds, limitations, weaknesses and boundaries. The model of Christian healing spirituality is the wounded healer who, by dealing with pain, suffering and death, experiences God's embrace, as well as restoration, salvation and being raised up again by God.

Healing spirituality in the Christian tradition rejects the wielding of power by one person

over another, even in spiritual terms, within a pastoral or therapeutic relationship. It allows the other person the freedom to find their own answers.

Healing spirituality in the Christian tradition can be expressed in explicitly verbal forms (Biblical promises, prayer, blessings). However, there is no obligation to verbally express it. There are situations when the spirit can speak louder than words.

When it comes to creating and developing an internal attitude of healing spirituality, there are no novices or advanced students and there is no hierarchy of developmental stages (as opposed to the Reiki stages of learning). There is only constant renewal and step-by-step progress, as we always, fundamentally, remain inbetween poles of possible failure and possible success in our own lives, and in our openness to God.

We need **specific places, times and rituals** for renewing this healing Christian spirituality, either alone or with others. Today, church social care networks, spiritual fellowships and service or self-help groups in parishes can be places in which the rapidly growing search for healing spirituality takes on a living form, and where the sick, their families, those experiencing divorce, failure or addiction can find answers.

6.7 Examples from other countries

Contributions from the Anglican Church

Perhaps the most well-developed tradition of healing ministry in the Church exists in the local parishes in England. Anyone acquainted with the Anglican Church in Great Britain must have quickly noticed that it has a different concept of healing, prayer for the sick and anointing of the sick. Many Anglican Church dioceses hold regular services for the sick, and it is assumed that the spiritual gifts of healing power are still being conferred on the Church today. There are many “Homes of Healing”, with a specific Christian approach to healing (e.g. at the Burrswood Clinic).

Almost every diocese has a priest who is an “Advisor on the Healing and Deliverance Ministries”, who is directly appointed by the Bishop or by a “Pastoral Committee on Healing”. As early as 1958, a comprehensive official study was commissioned in England by the Archbishop and entitled “The Church’s Ministry of Healing”. It provided the basis for the later development of healing church services and social care provisions in many parishes. This study, which involved doctors, nursing staff, hospital and prison chaplains, as well as bishops, served as a model for the most recent follow-up study which aims to take stock of the situation, develop new framework recommendations and draw up a basic introduction to various aspects of the healing ministry of the Church. The 400 page study was published in 2000 in London under the title “**A Time To Heal. Report to the House of Bishops on the Healing Ministry”**[50] and is now in its third edition.

The study is based on the principle that “The healing ministry is part of the mission of the Church, not an optional or extraneous activity. In fact the whole of the Church’s mission

could be described as healing in a very broad sense."[48]1

This study opens up a broad dialogue between the Church and those working in the healthcare system and parish-based healing ministries. Some of the individual contributions include a historical introduction to the history of healing ministry in England, healing in the biblical tradition, various types of healing ministries in the Anglican church, ecumenical cooperation on healing ministries with, and in, other churches, the relationship between church healing ministries and professional healthcare services, the specific needs of the healing ministries, in terms of care for the dying, deliverance ministry, as well as the dialogue between the Church and complementary healing approaches or alternative medicine.

The chapter on "Developing the Healing Ministry in the Parish" (A Time to Heal, p. 258-281) provides an excellent overview of the various forms and scope of healing ministries in the parish, which can be viewed as a compendium on the types of healing missions which exist in the Anglican context.

Contributions from Norway

In Norway, interesting developments have taken place over the last ten years or so, in terms of discovering the potential of the Church, and its parishes, in the field of healthcare.

Like the rest of Europe, the churches and healthcare services in Norway had drifted far apart over the centuries. However, at the end of the 20th century, voices were heard in Norway which loudly questioned the "biological and psycho-social" model of health and healing, both from a lay and a church perspective. Since the start of the 1990s, the Norwegian Church, representatives of Christian health work and the Ministry of Health have taken part in exchanging information and have led a fruitful dialogue on the role of the Church and its parishes in the field of healthcare.

In 1999, the Health Ministry presented a Bill to the Norwegian Parliament on the values relevant to the health services: "On the Values of the Norwegian Health Services". This Bill stated that a person is one whole, made up of body, mind and spirit, and that, in terms of health and the healing process, people's existential and spiritual dimension of should also be taken into account. This Bill, which referred unequivocally to biblical anthropology, was adopted in 2001 by a large, cross-party majority in the Norwegian Parliament.

Since then, there has been more cooperation between church and state organizations in Norway, for example on health education and matters relating to the sick, the elderly and marginalized groups. Politicians have realized that the public healthcare system can benefit enormously from synergy between state and church structures.

48 A Time to Heal, p. 37

Deacons have a key role to play. They are women and men in parishes who care for people and groups at risk, and in emergency situations either provide assistance themselves or seek help. Most of the time, these people have basic medical or nursing training, but their service includes care for both the persons' physical health and their social relationships and, for example, also involves prayer[49].

Community-run health services

In 1968, the World Council of Churches (WCC) set up the **Christian Medical Commission (CMC) as a Christian health commission**. Alongside the mandate to define a Christian concept of health, healing and wholeness[50], the CMC was given the task of developing new ways of implementing Christian healthcare work, especially in the developing world, as it had become clear that the current practice of transposing Western medical systems onto existing structures in developing countries was not able to improve the health of the local people on a sustainable basis. This was because the Western medical system was mainly focused on cures and on large, generally technologically advanced, hospitals. Thus, it did little to change the real causes of disease, such as poor hygiene and malnutrition. In addition to this, it was also very expensive, and therefore only accessible to a privileged section of the population.

The CMC, in cooperation with the German Institute for Medical Mission in Tübingen, made a significant contribution to developing the concept of **Primary Health Care** (PHC), which became binding for WHO member states in 1978. The aim of this concept is prevention and it focuses on local religious communities managing healthcare work.

In the years after 1978, many developing countries implemented community-run health services, especially in Latin America, Africa, India and Indonesia. Many church and lay communities trained village healthcare assistants who, equipped with basic medical knowledge and basic medication, could diagnose and treat many diseases, or refer patients for treatment to larger centres. This, for example, led to an improvement in awareness of hygiene and healthy eating, and to a drop in infant and child mortality in many regions.

For parishes, this re-evaluation of community-run healthcare provides a chance to experience being a healing community and having a healing influence, alongside medical and scientific healing methods, in other spheres.

The **case of a parish in the Eastern Cape in South Africa** demonstrates that healing has a physical, social and spiritual dimension, and that parishes can combine these

49 This information on developments in Norway is based on unpublished articles and on interviews with Dr. Tor S. Haugstad, Oslo Center for Peace and Human Rights, Dr. Haugstad was one of the initiators of the dialogue between the Church and the State in Norway.

50 See Chapter 2.3 and 2.4 above

features in a specific way:

An AIDS project, which aimed to break the wall of silence surrounding HIV/AIDS, was set up in 1996 by the Moravian Church in the Eastern Cape of South Africa, and was mainly run by volunteer parishioners. In view of the stigma attached to, and discrimination against, people who were infected or sick, even (or especially) in South Africa, the country with the highest infection rate in the world, the name of the project also described the programme: the Xhosa word "**Masangane"** means "**We embrace and touch each other".**

Prevention was the initial aim of the Masangane project and it focused on women and children. Educating young people included organising sports activities and singing groups. The programme also tried to improve the living conditions of young people, for example, by providing aid to youngsters, to enable them to attend school and obtain training.

In 2002, Masagane began to treat AIDS patients using specific AIDS medication. This was groundbreaking in two respects. In view of the fact that treatment involving AIDS medication had, until then, always taken place in health institutions, Masangane provided an exemplary model of how it was possible to provide AIDS sufferers with life-prolonging medication within a community structure and in rural areas.

However, Masangane has now extended its scope far beyond medical treatment. The women and men involved in the programme meet in the parish hall, forming a sort of self-help group, where they exchange information and provide mutual support. Many of them had been totally isolated for a long time and had not dared to talk to anyone about their HIV infection. For those affected, being part of a community once again is just as important a part of experiencing the healing process as treatment to prolong their lives.

Healing also has a spiritual dimension within this programme. Singing, praying and reading the Bible together form an important part of Masangane. One young woman described her experience as follows: "It is the Word of God that heals and liberates me". During the Sunday parish church services, most young women and men have the opportunity to talk about their illness and their experiences of healing. This makes a significant contribution to breaking the wall of silence surrounding HIV/AIDS and is therefore an important factor in its prevention.

For the people who have been cared for by Masangane, none of the highlighted aspects of the programme can be separated from one another. Extending life, reintegrating people into a community, and the experience of healing through God, are all aspects of healing that belong together and complement each other.[51]

"**Religious Health Assets"– religions and religious communities as resources**

51 Information on this subject can be obtained from the German Institute for Medical Mission (Difam) or the Evangelical Mission in South Western Germany (EMS), for example on the Internet site http://www.ems-online.org/77.html

which promote health

Following the epidemiological studies mentioned above which, over a period of many years, examined the influence of spirituality on people's health, there has, since 1992, been a greater awareness of the influence of religion and religious communities on public health, and this issue is now the subject of scientific research. Here, too, the impetus has mainly come from the USA. Thus, for example, in 1992, the Rollins School of Public Health at Emory University in Atlanta, set up the Interfaith Health Program (IHP) in order to examine this relationship.[52]

The programme teaches people to view religious communities in a different light. Instead of noticing and pointing out their shortcomings, as is often the case, their **capabilities and health potential** are stressed. This context applies a very broad definition of "health".

Specifically speaking, the work of the IHP includes, for example, joint courses for people who work in the community, or have been trained for pastoral service, and people who work in the public healthcare sector, or are training to do so. They learn about the relationship between religion and health and are encouraged to take action to promote health.

The aim is to encourage a healthy lifestyle and use the community network to help socially underprivileged or sick members of the community, as well as fostering cooperation and synergy between religious and public healthcare structures.

Gary Gunderson, the programme leader, highlights **eight strengths ascribed to religious communities:** "*Communities accompany, convene and they connect people. They provide sanctuary and a framework. They bless, they pray and they endure."*[53] These community strengths "*are channels, through which, we hope, God comes into our midst and allows life to flourish in our communities*".[54]7

The concept of "Religious Health Assets" is embedded in this context. An "**asset",** initially an economic term related to wealth or the items on a balance sheet, is used here to describe the **strengths, riches, potential and resources belonging to religions and to religious communities with respect to health.**

A global process began in Atlanta to document and raise awareness on other continents of the "assets" which belong to religions and religious communities. In 2003, the first step, in cooperation with Cape Town University, was to create the "African Religious Health

52 This programme is not limited to Christianity, but also involves other religions in its research. Information at: http://www.ihpnet.org/

53 Gary Gunderson, Deeply Woven Roots, Improving the Quality of Life in your Community, Minneapolis, 1997, p 22 (own translation)

54 Ibid. (own translation)

Assets Program" (ARHAP). ARHAP aimed to make sub-Saharan Africa aware of the meaning of religious structures in relation to health in the broadest sense.

Thus, amongst other things, it sought to demonstrate that churches have networks with branches that spread to the farthest corners of the land, and which harbour health-related potential which has yet to be fully exploited by governments or international donors. For example, instead of creating new state structures to fight HIV/AIDS, it would make sense to use existing religious community structures and to create synergy with state structures[55]8.

At the request, and with the support of the World Health Organization (WHO), ARHAP conducted quantitative studies in Lesotho and Zambia, which recorded the contribution made (as a percentage share) by religious organizations and communities to the fight against HIV/AIDS. The results were as follows: in Lesotho around 40% and in Zambia around a third of all initiatives to combat HIV/AIDS were run by religious organizations and communities. Moreover, the study also showed that religious organizations make a special contribution to fighting HIV/AIDS. They do this through factors that cannot be measured directly, such as spiritual assistance and the transfer of knowledge in religious communities.[56]9

The WHO press release issued when the ARHAP study was published in February 2006, stated that "Faith based organizations play much a greater role in HIV/AIDS care and treatment in sub-Saharan Africa than previously recognized." The results of the study prompted the WHO to call, amongst other things, for greater cooperation in the future between religious and state organizations in healthcare work and the involvement of parishes in healthcare work.[57]0

6.8 Consequences – rediscovering the ecumenical potential of healing ministry

To a significant extent, Europe has initiated and influenced the ecumenical debate on health, healing and the healing community since the mid-twentieth century. However, within Europe, and especially in Germany, the theological concept of a healing community has barely been acknowledged, and there has been precious little dialogue between theology and medicine.

---

55 More information on ARHAP can be found on: http://www.arhap.uct.ac.za

56 The whole scope of the study can be found at: http://www.who.int/mediacentre/news/notes/2007/np05/en/index.htm

57 The text of the press release can be read at: http://www.who.int/mediacentre/news/notes/2007/np05/en/index.htm

At the start of the third millennium, this process, which initially started in Europe, may move in the opposite direction. We have the opportunity to learn from, and be inspired by, local churches and movements in the younger churches. We can rediscover the opportunities, the "assets" of these local churches in the field of healing, and view them in a different light: the Eucharist as a healing Sacrament, healing rites, the diverse gifts of the Spirit to members of the parish, joint prayer for each other and for others, the opportunity to create a social network and to foster an atmosphere of acceptance and goodwill in parishes.

In today´s world, our parishes face both duties and opportunities - in our society in particular, people long for physical and mental healing, healing for their damaged relationships and they seek sanctuary and support.

This is particularly the case for young people. Many of them view faith as an important matter. In a world that has, in many ways, become confusing, the question of finding a meaning in life has become especially relevant. They seek support and healing and are open to transcendence.

Many young people seek and find the answers to their needs and questions in Eastern religions and new religious movements. Do our Christian communities also appeal to people on a quest for meaning and to young people in particular? Are they able to provide sanctuary, in other words, are they healing communities?

In order to once again be able to see the broad scope of the healing ministry of local communities, a dialogue on the meaning of health and healing, and the capabilities of the communities, could be initiated. Those who work in the field of healthcare should take part in this dialogue, as should those involved in parish work[58].

This very exchange of information and cooperation between the local communities and professional healing ministries, namely Caritas and Diakonie, could prove fruitful for both sides. Following a period over the last few decades when healing was "outsourced" away from the local communities, today the time has come to rediscover that healing powers in the parishes complement professional work and to ensure fruitful cooperation. A community can support and provide relief to the women and men working in healing ministry through prayer and through support services.

58 See Dietrich Werner, "zur Wiederentdeckung des heilenden Dienstes der Gemeinde. Zehn Thesen zum Gesprachseinstieg, in: Evangelisches Missionwerk in Deutschland EMW (Association of Protestant Churches and Missions in Germany) (Hrsg), Heilung in Mission und Okumene. Impulse zum interkulturellen Dialog uber Heilung und ihre kirchliche Praxis (Weltmission heute, Nr. 41), Hamburg 2001, 64-68

7. Christian communities, networks and Christian social services – places of healing and the creation of a healing ministry

As a result of the growing healthcare crisis and people's increasing need to avoid simply surrendering to hi-tech medicine and medical procedures which focus on mending bodies, a new quest has begun which is not only limited to the healthcare system, but also includes a religious and spiritual dimension. While they make use of the range of treatments offered by modern medicine, many people also seek more contact with various forms of healing spirituality within the Christian churches. This has presented parishes in Germany with a special challenge and, as a result, the healing dimension of faith has now been rediscovered, actively developed and deepened spiritually in many areas of church life.[59]

7.1 Church Services as Places of Healing

Local church services harbour great **pastoral and healing potential**. They already include the necessary elements of meeting and greeting other people. The prerequisites for the healing process which, in fact, themselves exert a healing influence, include knowing other people's names, a sense of belonging and regard, hospitality and attentiveness. Other factors include silence, the language of spaces, time for contemplation and expressing devotion to God through singing, listening and prayer, in lamentation and praise. In reality, this description of a church service as a healing event, something taken as a given, often turns out to hold yet untapped potential, which it remains for us to discover and consciously develop.

The burden of disease that people bring into the environment of the church service, should be addressed not only implicitly, but also explicitly: "and they brought to him all the sick, those who were afflicted with various diseases and pains… and he cured them" (see, for example, Matthew 4.24). The subject of sickness is particularly raised in church services in the form of prayer, above all in intercessory prayer, in which the sick may be anonymously included or, certain cases, also mentioned by name.

Information included in church services on home visits, care services or old people's homes and other church-run social care services, helps to remove taboos and highlight the difficult living conditions of members of the parish. Thus, not only the intercessory

59 For example, the Protestant Church Conventions in Hannover and Cologne, also see reports on the meetings of the Association for Missionary Services in: Heilungssehnsuch und Heilserfarhungen in der postsakularen Kultur- unterwegs zu einer missionarischen Hermeneutik", epd documents 16,/2005, and Evangelisches Missionswerk in Deutschland (Association of Protestant Churches and Missions in Germany), EMW (Ed), Von der heilenden Kraft des Glaubens, Ein Arbeitsheft fur Gemeinden und Gruppen, Hamburg 2005

prayers, but the sermon and, in fact, the church service as a whole, are given a more practical and concrete dimension and act as advocates on behalf of the afflicted.

Certain parishes have a tradition of persuading workers from social care centres and nursing homes to bring dementia patients to Sunday morning church services specifically organized for them by the parish community (at the usual time and together with the whole congregation). Special church services involving the sick, i.e. “Church Services for Patients”, organized by church-run community health and social service centres or local parishes, deliberately include sick people and bring their burdens into the healing presence of God. According to a Pastor familiar with this tradition, “it partly stems from frequent celebrations of the Eucharist at the homes of sick and elderly parishioners, who have expressed a clear longing to attend church.”[60]

A community which accepts healing as a result of faith, and takes it seriously, may also hold special church services in cases of sudden illness, following a tragic death or in times of disaster. Thus, it also simultaneously performs a public service in the community.

Blessing and anointing as healing rites

People’s problems can also be addressed in a “Blessing Service”. A Berlin parish ends its monthly church service with an opportunity for everyone to come up to the altar with their personal requests and receive a blessing and prayer from trained assistants. By then, the rest of the congregation have already sent home with a benediction[61].

Unction or anointing is a more intensive form of blessing. It appears in the New Testament in connection with sickness (see in particular James 5.13 and Matthew 6.13 and Luke 10.34) and can accompany, and catalyse, the healing process. Unction is a treasure with which the parish community has been entrusted and which, although it had more vitality in the early period of the Church, is being rediscovered today. Through the symbolic act of unction, and the power of fragrant, healing oils, the blessing becomes more physically tangible. The blessing reaches “under the skin” and touches the soul.

Traditional rituals which are part of the church service can also be **complemented through** blessing and anointing, which **has a personal character**. Although there may be no direct biblical blueprint for church services focused on blessing and unction, they use Jesus as an example, as he addressed people directly in his acts of healing, both in pastoral and personal terms. Thus, making unction and blessing mass phenomena would diminish their value and constitute a misuse of these concepts.[62]

---

60 Described in more detail in Ulrich Laepple, Gemeinde als Heil-Land (Brennpunkt Gemeinde Studienbrief D 3), published by AMD (Arbeitsgemeinschaft Missionarische Dienste/Association of Missionary Services), pp. 14

61 Sven Schonheit, in: Laepple, Gemeinde als Heil-Land, pp.14

62 Zur Begrundung und Gestaltung von Salbungsgottesdiensten, see Donata Dorfel, Gottesdienst mit

However, it is not just in church services, but also in hospital chaplaincy that blessing and anointment provide an escape from the sometimes overwhelming burden of words. They are an effective sign of God's proximity and provide a meaningful complement to pastoral visits. They stimulate and influence the soul of the person receiving the blessing, but in their own way, whether it be in the form of tears or words of gratitude.[63]

Blessing and anointment have also found a place in the context of mission work. For over ten years, a growing number of German parishes have been celebrating the "Thomas-Messe" ("Mass of St. Thomas"). The service is named after St. Thomas, the young man who wanted to see and feel before he would believe, and who is commonly known as "doubting Thomas". These "Church Services for Doubters and Seekers" include the offer of a personal blessing and anointing as part of the healing process, in the holistic sense of the term.[64]

7.2 Pastoral Care as a Healing Ministry

If a community has its ear to the ground, it takes people's longings and suffering seriously. These people may include children hungry for love, confirmation candidates from broken homes, people on the brink of a mental precipice and in crisis, people in distress as a result of illness, as well as older or weak people who have experienced loss and separation and who run the risk of becoming isolated.

These cases require pastoral care based on the belief that God's salvation affects the person as a whole, namely physically, spiritually and in interpersonal terms.[65] Although it is also viewed as a spiritual event, this kind of pastoral care takes the form of counselling, through which the healing process begins.

The scope and intensity of the "suffering of our times" also means that healing cannot be provided exclusively by church officials, namely pastors, which has consequences for the structure of the parish, as the "healing needs" of a large parish cannot be addressed exclusively by large events, or remain in the hands of ministers. Thus, healing pastoral

---

Salbung und Segnung., Theologische Hinfuhrung und Liturgischer Entwurf, in: Evangelisches Missionswerk in Deutschland e.V, EMW (Ed), Von der heilenden Kraft des Glaubens, Ein Arbeitsheft fur Gemeinden und Gruppen, Hamburg 2005, 52-57

63 See Bernard Storek, "Die Guttat zu olen", Erfahrungsbericht eines Krankenhausseelsorgers, in: Evangelisches Missionwerk in Deutschland, e.V, EMW (Ed), Von der heilenden Kraft des Glaubens, Ein Arbeitsheft fur Gemeinden und Gruppen, Hamburg 2005, p46-51

64 See www.thomasmesse.org

65 Sven Schonheit: "Der auferstandene Christus will damals wie heute Menschen in seine Nahe ziehen und ihnen konkret dienen. Dies betonen wir in Verkundigung, Unterricht und Seelsorge" in: Laepple, Heil-Land, p 14.

care must involve many parishioners. It can take place in home circles and small local groups, namely spaces of sanctuary, where people are involved in each other's lives, where they pray for each other and offer pastoral care. In these small groups, learning the steps of faith, spontaneous church social work and pastoral care are interconnected. They are "temporary spaces of healing"[66].

A personalized form of church social work, involving prayer, takes the following promise seriously: "And call upon me n the day of trouble; I will deliver you, and you will honour me" (Psalms 50.15). It would be beneficial for those responsible for providing pastoral care (they need not be ordained) to draw up a framework that is simple and easy to implement. This framework may consist of five steps[67]:

Asking about the petition and the pain;

Joint reflection on the causes and nature of the problems (sickness as the mirror of the soul);

Thinking about the content of prayer (prayer for external and/or internal healing);

Prayer, perhaps involving the laying on of hands and blessing;

Thinking about the future

Some parishes, especially those in areas which are prone to social conflict, have created the post of an "*Officer for Pastoral Affairs",* sponsored by an association of patrons, for example. Others have appointed *a social worker qualified in theology* to handle youth work and who operates between the spheres of the parish and the local community (community work, schools, youth office) and combines spirituality with providing social advice in her work. This kind of work also has a healing dimension[68].

7.3 Home visits and their role in the healing ministry of the parish

If a parish establishes a service involving home visits and sets great store by the quality of its parish visiting work, this reflects the evangelistic principle of "reaching out", which appears frequently in the New Testament. A community does not wait for people to appear or come knocking with their troubles. Instead, it allows itself to be inspired by the concept of "seeking" and "finding", used by Jesus to describe his ministry (see Luke 15,

66 Paul Toaspern, in: Laepple, Heil-Land, p. 13

67 Dieter Keucher, Heilungsverstandnis und Heilungspraxis in der Geistlichen Gemeinde-Erneuerung, in: Heilungssehnsucht und Heilserfarhrung in der postsakularen Kultur, epd-Dokumentation 16, p. 25-30

68 Gabriele Pack, Die missionarische Hand braucht die diakonische Hand, in mi-di (Mission und Diakonie), Vol. 1, 2004, pp 6 (published by the AMD)

Matthew 18.11). In other words, the parish takes the initiative itself and asks questions, investigates and, within the framework of its local community visits, goes out to see people in their homes.

In this context, it is elucidating that in the New Testament, the word “visit” refers to two groups: “I was sick and you took care of me, I was in prison and you visited me” (Matthew 25.36) and “Religion that is pure and undefiled before God, the Father, is this: to care for orphans and widows in their distress.....” (James 2.27). Both groups are marginalized and have a stigma attached to them.

In our society, widows and orphans no longer lack rights in the same way as they did in ancient times. However, many people today do frequently feel that they have been left at the mercy of the authorities and excluded from society. Experiences of bereavement often involve a measure of grief that can overwhelm people if they are left to cope with it on their own. Grief is an experience which is linked not only to death, but also the loss of love, the loss of a partner through divorce, or the loss of a job, and is a fundamental problem for virtually everyone. Thus, counselling in situations involving bereavement and loss is one of the main duties of the local church and touches on one of its core competences.

The results of modern research into bereavement have shown that a supportive presence is necessary during the mourning process, either at the person’s deathbed at home or the intensive care ward, in the chapel of rest, the morgue, the flat belonging to the deceased or at the funeral. Support in these places often plays a decisive role in providing fruitful bereavement counselling for those left behind. Home visits, undertaken while the deceased was still alive, are also helpful in terms of bereavement counselling, as they symbolize membership of a network that creates meaning, and represents the Christian community.

It has, at least, been acknowledged that bereavement counselling can, in addition to practical measures, also involve memorial services for the dead which, in a similar manner to Catholic commemorative masses, can assist the mourning process and heal loss.

Home visits should address not only those in mourning, but also the sick. Sick people often withdraw from the world. Certain events take place within the walls of apartments and hospital rooms that lead to social exclusion or self-exclusion from society. The Christian community, and its home visits, is called upon to provide a type of church social care which seeks, and therefore heals, which breaks down such walls and aims to liberate people from their loneliness and remove the stigma attached to them.

Experience has shown that many volunteers can be recruited for this purpose, as long as sufficient stress is placed on providing these workers with the necessary training, qualifications and professional and pastoral support. If this is achieved, precisely this work will prove to be an important asset to the concept of a healing community. In addition to teaching communication skills, training must focus on the healing acts of blessing, unction and prayer.

7.4 Medical and Church Social Care Services within the Scope of the Parish Community

The above-mentioned Tübingen declarations, made by the German Institute for Medical Mission, (Chapter 4.3), state that "One of the most urgent tasks of our time is to ensure that the Christian community, *together with Christians in the medical profession*, once again acknowledges that the ministry of healing is encumbent upon it, and implements it accordingly"[69].

The medical profession and church-run social and healthcare centres are accessible to the parish community Even if the local church and the independent social care services, whose workers often do not belong to the parish community, have grown apart, the local church should deliberately try, wherever it can, to seek a connection to them by promoting joint **church services for patients** and **cooperation involving the local church's home visits**. This reciprocal relationship involves requests for further training in "home care", a mutual exchange of information and the offer of intercessory prayer during church services. If a care worker from the church social care centre attends, and participates in a Eucharist for the sick, a specific statement is also made.

"Health education" should also include **contact with doctors**, who are often members of the parish, and advice should be sought on medical matters. Both sides can profit, as the parish can assist the medical services when their skills have reached their limits (e.g. by offering a supportive community and pastoral care) and the community, in turn, profits when doctors contribute their professional skills to community work, in terms of education, training and public awareness.

Self-help groups, which may include bereavement groups, groups of people with the same serious illness, Alcoholics Anonymous, drug addicts and the unemployed, often meet in parish centres and should be taken into account in the search for the healing potential of the parish. Even though they may not have started out as local church groups and might have come in "from the outside" to simply use the parish hall, they should be met with hospitality, interest and love, without being completely monopolized by the parish community. Local churches thus need to support and communicate with these groups. From this, opportunities may arise which could benefit both the parish and members of such groups.

7.5 Retreat Centres as Places of Healing

69 World Council of Churches, Auftrag zu Heilen (Studien des Okumenischen Rats Nr 3), Geneva 1966, 39

During the last few decades, the Protestant Church has also experienced a revival of retreat work and a growing awareness that not only *actio*, but also *contemplatio,* deserve special attention and a dedicated space. Many *Landeskirchen* have built "Houses of Contemplation". Religious communities also often settle in historic churches or monasteries, thus consciously seeking a connection to the old tradition of contemplation.

To people familiar with retreats, these centres offer them the opportunity to take time out, a chance to unwind from the stress of an often confusing, overwhelming and unhealthy everyday life. They offer silence, meditation, a structured- i.e. cyclical - daily schedule (e.g. prayers of devotion said at regular times of day) and a supportive network, which allows participants access to a "space" of healing power. The fact that they can then consciously focus on themselves, and listen to their inner voice, often allows repressed mental and physical pain to surface for the first time. Hidden psychological wounds are revealed and physical afflictions are acknowledged. Thus, it becomes possible to make the mourning process more comprehensive, in a healing manner, and to release what has been suppressed. Physical exercises, such as the Gerda Alexander technique or breathing therapy (eutonics), help people to use their bodies to access their minds, and to then give their mind the attention it deserves.

The aim is not "relaxation" but rather concentration, the authenticity of faith, and a sharper focus on one's life, with a view to facing the everyday challenges that will reappear after the retreat is over. The search for healing power and a fresh start is supported by meditation, joint silence in the presence of God, prayer and the offer of personal pastoral care. The sanctuary of a supportive community also facilitates rituals such as the washing of feet or unction with oil, which, as signs of God's healing will, have a healing effect.

7.6 Community Health Assets- the RHA Matrix as a guide

Parishes and other church institutions which do not primarily address health issues, often find it difficult to identify health resources and tasks. A holistic concept of health does not simply involve managing care services, hospitals and other medical and care institutions. A parish can also promote health if its parish centre is accessible to everyone, and serves as a meeting point for disabled people, if it has a non-smoking, and possibly a no alcohol policy, and thus is a suitable place for people suffering from addiction. It is part of a parish community's duty to ensure the health of its staff, which is also an important asset. Apart from these health-related issues, which every public institution and association must also address, the local church, as a religious community, should also ask itself what specific health assets (and risk factors) exist. A relatively broad concept of "religious" assets is recommended in this case, as narrowing the concept (e.g. to the healing effect of prayer) often proves controversial within the parish and makes it the object of theological debate.

Within the framework of the AHRAP's research programme, a matrix was developed to thoroughly examine the issue of religious health assets. With some minor alterations, this

matrix can also be applied to the European context. The matrix is based on the idea that religious communities have health assets which, like unused financial resources, are worthless if they are not invested. Just like a company's balance sheet, a parish community should take stock of their tangible and intangible health assets and enter them into the matrix as follows:

Tangible and intangible health assets along the vertical axis,

Direct and indirect positive health outcomes along the horizontal axis.

This then produces four fields which show the health assets and their positive outcomes (diagram on following page).

In the case of South Africa, this matrix revealed the real contribution that religious communities made to improving the health situation in the country, which had been placed under great strain by HIV/AIDS and malaria. Intangible assets include behaviour which promotes health and principles to which parish communities adhere, such as sensitivity to others, endurance and creating a sense of belonging. Of course, tangible assets such as hospitals, ambulances, meeting places for self-help groups, etc. were also included. The positive health outcomes were extremely varied and included healthy behaviour, the existence of church choirs, the practice of laying the dead to rest and, by means of a funeral service, making it easier for the living to carry on with their lives. The matrix can also be used to show that, for example, self-help groups and healthy behaviour can be viewed as both health assets and positive outcomes, depending on one's point of view.

If observations on the health situation in Europe are entered into the matrix, different focal points emerge with respect to the content. While in Africa, as a result of the HIV/AIDS pandemic, the survival of the individual or the family is the primary goal, in Europe

Diagram 1: Religious Health Assets Matrix[70]

Intangible Assets	*Intangible assets with a direct impact on health*	*Intangible assets with an indirect impact on health*
	Prayer **Time for sick people** **Health awareness**	**Personal sense of meaning in life** **Social contacts** **Feeling of belonging to**

70 Übersetzung und Anpassung einer von Jim Cochrane entwickelten Matrix, vgl.: Jim Cochrane, Religious Health Assets (RHAs) – Conceptual and Theoretical Framework, in: Difäm, German Institute for Medical Mission (Ed.), Religion, Faith and Public Health. Documentation on a Consultation held at Difäm, Tübingen, Germany, 9-11 February 2006, pp. 14-45, 24

	Being prepared to help **Sensitivity to problems** ...	**God/other people** **Openness to social or political issues** ...
Tangible Assets	*Tangible assets with a direct impact on health* **Care, Counselling, etc.** **Parish centres that are open to all** **Room for self-help groups** **Leisure opportunities for disabled people** ...	*Tangible assets with an indirect impact on health* **Educational/training opportunities** **Religious services providing a structure to the week** **Sacraments and rituals providing structure in times of crisis** ...
	Direct impact	*Indirect impact*
	Positive impact on health	

the main focus involves the parish maintaining reliable contact, in the neighbourhood, with people who have a long-term illness or who live alone (e.g. people suffering from depression), and developing youth work which deals seriously and consistently with drug problems. Alongside the desired direct health outcomes, the matrix also shows the indirect positive influence of parish community work on health. Thus, it is obvious that people who participate in parish life, structure their lives around it, maintain contacts with others and take on board suggestions relating to their personal lives, do a lot for their health and, in return, receive health benefits.

The “Health Balance Sheet” of a community will, in each case, present a varied picture, which must, of course, be analysed thoroughly. Alongside assets with a positive health outcome, there will of course be those with questionable or negative effects. The question must also be raised as to who might benefit. Will it really be the people who need them most urgently, or will certain assets *de facto* only benefit a small group of more privileged people?

In addition to tangible assets, the matrix also shows intangible assets. These come in various shapes and sizes, but all share the fact that they are not “tangible”. Prayer for the sick belongs to this group of assets, as do the special skills and the commitment of individual parishioners to identifying problems and tackling them. A parish’s “intangible” assets also include bringing social problems to public attention and, thanks to personal contacts, persuading doctors to give a lecture in the parish hall.

Rather than being a classification system, the matrix provides a reason to stop focusing

on the amount of work that has to be done and instead focus on the assets of a parish and what it might contribute.

7.7. Consequences: Recognizing and developing healing ministries in their manifold forms

Although the healing dimension of the Gospel has various, implicit effects within the scope of activity of the parish, the opportunities for healing ministry are so extensive that they should be viewed and handled by parish communities as a matter in its own right, involving a separate mandate. Otherwise, one might not only fail to identify specific opportunities and assets, but also deficits related to healing. One cannot influence the unknown. It is a matter of training, rooted in theological insights and, given the "suffering of our times", which paves the way for practical action. It involves preaching, teaching, pastoral care and building community structures. Training volunteers and raising their awareness have a key role to play here.

One aspect of this practical action is a specifically Christian healing ministry, which consists of blessing, prayer and the laying on of hands. It does not depend on energetic scientific or empirical, statistical proof of its effectiveness. According to widespread belief and biblical tradition, Christian blessing and the laying on of hands do indeed produce effects that are part of God's healing mercy in creation. However, the Christian faith does not depend on scientifically verifiable or measurable results, relating to the success of prayer and healing blessings, to prove its veracity or persuasive power. The therapeutic and healing power of faith, in which the Christian tradition believes, lies beyond results that can be statistically proven. Any research which tries to deliver evidence regarding the verity of the Christian faith, solely on the basis of its therapeutic, measurable effects, runs the risk of turning Christianity into a therapeutic technique and making prayer a kind of predictable magic.

There is insufficient awareness of the fact that issues of health or illness within a community deeply affect the local church and the field of church social care in a variety of ways and that, in turn, the local church and church social care organizations can make a difference, through their advocacy and by setting an example for society. Awareness must therefore be raised, both locally and on a cross-regional basis. The concept of a "round table", if implemented, could motivate parishes to address medical, social and health-related issues, as well as the subject of healing ministry.

The example of the Anglican Church, which appoints so-called "Healing Advisors" in its dioceses, and thus keeps the issue of healing ministries on the agenda and present in people's minds within its institutional structure, can provide inspiration for our churches in Germany. An advisory body of this kind, charged with the task of providing training and education on spirituality and healing ministry to church social care services and parishes in particular, by means of lectures and seminars, would provide a suitable response to needs arising from the social and existential questions which people raise in relation to illness, healing, spirituality and health.

In Germany, where the topic of health is vigorously debated in public, and is characterized by restrictive government regulations on the one hand, and (unrealistic) expectations and offers of treatment on the other, partly encouraged by the existence of a strong esoteric movement, churches and parishes are called upon to provide guidance and information.

8. Main Concerns and Considerations regarding Future Work

Towards a new dialogue between theology and medicine on the fundamental issues of spirituality and health

This position paper, having examined biblical, church social care-related, ecumenical and missiological points of view, has attempted to highlight the following developments in the field of healing ministry and their consequences:

The prevalent social trends in the field of health and the commercialization of healthcare require critical attention and their impact on the healing ministry of the Church and its social care services must be critically addressed.

The healing dimension of faith may have far-reaching implications in the Church's various spheres of action and for its numerous dialogue partners. This matter now requires attention.

We need to develop an interdisciplinary dialogue on the future of health, healing and spirituality in Germany (regional round table talks involving doctors, alternative health practitioners, theologians/deacons and healers). This reflects the contents of the position paper and should be implemented wherever possible.

The Church and its parishes must not stay silent during this period of massive upheaval, both in society and the healthcare system. Instead, they must raise their voices and make a contribution. By so doing, they could tap into the rich traditions of healing with which they are familiar in their own religions, and engage with people who are now calling for, and who need, more space for spirituality, time for pastoral and human support in the form of care and aid, as well as tangible, healing blessings in church services and the liturgy.

Thinking about the various forms of Christian healing ministry can have practical consequences for current practices in the Church, in church social care services and mission work, and can contribute to innovations aimed at raising the profile of the Christian faith and qualifying existing practices.

The final part of the text aims to highlight and provide examples of practical conclusions and specific considerations relating to future work in this field. This paper is not an end in itself and, instead, should act as a useful catalyst in the long-term process of learning and dialogue within the Church, and in the field of church social work, in Germany.

In this context, the following ten key points and considerations regarding future work can be viewed as contributions to an ongoing process of finding a new direction for healing ministry, both in the Church and in parish communities, as well setting the tone of a

much-needed campaign this field:

1. *Spirituality* is a health factor that must not be underestimated

In theology, medicine and science, we have now moved beyond the stage of undermining, suppressing or neglecting the religious dimension of health and the healing process. However, still not enough thought has been given to the consequences for hospitals and care work, for local church healing ministries and various therapeutic approaches.

We therefore need a new, more in-depth dialogue between theology, medicine, the Church and the health sector concerning the practical consequences of a greater focus on holistic approaches to spirituality and health. Far beyond the mere, pragmatic task of regulating room usage for self-help groups in parish buildings or drawing up authorization requirements for courses in church-run family education centres, the decisive task facing the Church and parish communities today is that of promoting and initiating further dialogue on sickness, health and healing in society as a whole.

For the church, one of its core duties is to tap into Christian faith as a driving force behind, and advocate for, holistic healing, and to inject life into it. If we could create a large number of "round tables" for *future dialogue on health, healing and spirituality*, and develop new forms of healing ministry, involving representatives of various healing approaches, prevention and therapy methods, who could each make their individual contribution to the healing process and health, alongside contributions from other disciplines, a lot would be achieved in terms of fostering mutual understanding, a more in-depth dialogue and a revitalized practice of bringing healing to people.

2. In spite of the far-reaching reforms implemented by the Federal government, the German *healthcare system* remains in a state of crisis.

The rapid rise in costs within the German healthcare sector is set to continue and, as always, this sector is swallowing up more money per year than the entire federal budget. All experts agree that a balanced health promotion strategy needs to start by placing more emphasis on prophylactic treatment, prevention, health education and more extensive health training.

We need a broader dialogue in our society on the future of health and healing in Germany. What is really necessary, helpful and makes sense in terms of promoting our health? We need a dialogue on these issues, a kind of consultation or mutual advisory process, involving not only scientists and practitioners of alternative medicine, but also the healthcare system and the Church, as well as scientific, humanities-based, missiological, cultural and anthropological points of view, avoiding outdated and unproductive stereotypes and polarities. This dialogue is urgently needed by society as a whole and is also vital for the future of our healthcare system, as health is a precious commodity that is becoming increasingly expensive. *The Church can, and must, become a space where a "third culture" (John Brockmann) can be created, in the form of an interdisciplinary dialogue on sickness and healing.*

Few issues are so centrally relevant to all of the basic aspects of how our society is run as health and healing. In contrast to the growing trend of viewing health as primarily a consumer good, a product of technological innovation, we need to hear significantly louder voices calling for a more inclusive understanding of health, and the active participation of patients, taking their religious life beliefs and practices into account, as part of the process of coping with disease and recovery. In the context of the healthcare crisis, many committed doctors and nurses are calling for the Church and church social care services to speak up and to provide more guidance.

3) So far, the *Protestant and Catholic churches* have not, beyond their own church-run social care and charitable associations, adopted a sufficiently credible common position or spoken out with one voice on the core issues of health, spirituality and healing.

Great Britain and Ireland have had a "Christian Council on Health and Healing" for many years. This institution deals with fundamental issues concerning the interdisciplinary dialogue on Christian faith, health and healing and brings them into the national arena, in cooperation with committed professionals from the Church, the field of pastoral psychology and the healthcare system.

Germany has no such platform. The fact that different spheres of competence have been made into separate pillars, has resulted in very differentiated specialist discourses within individual fields and institutional landscapes, including church social care, community care, nursing, clinical medicine, pastoral psychology, medical ethics and the hospice movement. However, on a national level, there is no visible or tangible evidence of the Christian community taking an overall responsibility for matters relating to the presence of Christianity, in social care and mission work, within the healthcare system.

Unlike the Church of England, which, in 2000, drew up a national report and pastoral framework recommendations for the healing ministry of the Church and its parishes ("A Time to heal"), most German regional churches, as well as the Evangelical Church in Germany, have no overarching platform or any binding framework recommendations to define and facilitate the further development of the various forms of healing ministry in the Church, i.e. institutional social care, care in parishes and independent networks. Although the recommendations contained in the Evangelical Church in Germany's 20006 study, which was entitled "Church of Liberty" and highlighted significant opportunities and areas where the Protestant Church could strengthen its mission profile, did mention social work (Beacon 8), no mention was made of healing ministry, which really ought to be one of the fundamental aspects of the Church's mission profile.

At national level, too, we need something akin to a regular, **joint "round table" on health, spirituality and healing in the Christian churches.** It would be desirable to create a "**Christian Health Conference"** or an "**Ecumenical Working Group on Healing Ministry in Christian Churches in Germany"**, possibly as a follow up to the Christian Health Congress, due to take place in March 2008, or linked to previous forums such as the preparatory round for the "Week for Life" organized by both major Churches.

This kind of platform, which could meet on a biannual basis, would allow representatives of various Christian churches to draw up framework positions and common agendas/aims in the following subject areas:

- ⇒ raising the profile of Christianity in existing church social service and care-based institutions,
- ⇒ different forms of healing ministries in the parishes,
- ⇒ interdisciplinary cooperation forums aimed at promoting a Christian model culture within the healthcare system in the 21st century,
- ⇒ establishing a more in-depth dialogue between the developed and the developing world on health, healing and justice, with partner churches in the developing world,
- ⇒ a better exchange of information on "best practices" –proposals on healing ministries in local churches, care homes, hospitals and special, church-run institutions,
- ⇒ more specific, pastoral framework recommendations for the healing ministry, which also set boundaries to prevent distortion and abuse.

4) In order to create a Christian profile in the medical and care services, or to strengthen Christian motivation and gain experience, it would be useful to establish a culture of mutual support, the sharing of experience and spiritual learning.

Other countries (Great Britain, for example), have had positive experiences with various lay networks which, within the context of a living, healing spirituality, provide a spiritual grounding, help to raise the profile of spirituality and facilitate a real, spiritual life within a lay brotherhood or sisterhood. Many regional churches traditionally still have deaconesses' houses or diaconal lay brotherhoods or sisterhoods (e.g. "Nazareth" in Bethel). In other areas, networks such as "Christians in the Healthcare Sector", or associations of Christian doctors, use Christian values and guidance to motivate, provide a sense of direction and bring people together within the medical profession. It would be worth trying to see whether successful experiences with spiritual brotherhoods would be possible in Germany, on a similar basis to the American "Order of St. Luke" or the "Order of St. Raphael", which combine an interest in strengthening the healing ministry with a living, spiritual brotherhood.

5) Each parish has a share in the healing ministries and gifts of the Church as a whole

It may be helpful for the church leadership and parish councils to address issues relating to healing ministry, and its various forms, in a more in-depth manner within the scope of the local parish, and set their own local agendas for healing ministry. Not everyone has to

achieve everything, but each parish should put into practice one aspect of the healing ministry of the Church.

6) At district level, too, the relationship between healing ministry, church social work and other healthcare institutions, should take on a visible form.

The Anglican Church in England has had good experiences in this respect, in that it has appointed “healing advisor” in each diocese, whose task is to advise specific parishes and, with a view to implementing healing and blessing services, promote medical and theological cooperation and further inquiry in this field.

In every church district, we also need officials charged with the task of strengthening and defining healing ministries and work in local churches and in our national church.

7) More attention needs to be paid to health, healing and spirituality in the training, and further training, of pastors and deacons, as well as of doctors and nursing staff. Existing course models for the relevant training courses should be revised and made accessible.

In many places, we need a decentralized system of training courses on health, healing and spirituality to teach these subjects to current staff and, vice-versa, to introduce new experiences gained in this field into the teaching material. An important step might be to regularly offer the Diaconal Academy and the Association for Missionary Services regular further training and qualification courses in this field.

8) There are many opportunities throughout the *ecclesiastical year* to regularly tackle the subject of health, spirituality and healing in depth.

Parishes could address the issue of healing on a regular basis, both in the spring (in connection with the “Week for Life” in April) and in the autumn, at the end of the church year, and in connection with the last Sunday of the ecclesiastical year. Examples of how more attention can be drawn to the subject in local parishes, services and works include the regular “Day of Healing Ministries” in England and the “Healing Ministry Week” organized by the Christian Health Association of India (CMAI), the umbrella organization for Christian healthcare work in India, and held every February. We need a “Sunday of Healing Communities” in Germany that is organized, as far as possible, in cooperation with all Christian churches.

9). Interdisciplinary Christian healing centres must be promoted in Germany

In other countries (e.g. Great Britain), interdisciplinary healing centres can have a very positive impact.

They highlight, in one location and in a distilled form, the specific characteristics of a holistic healing ministry. Thus, not only do the patients benefit, but these centres also send out a message to hospitals and care homes in the area. Examples in Great Britain include the Christian hospital in Burrwood, near London, and Holy Rood House in Thirsk.

We need these kinds of centres in Germany, too. They highlight, through their practical example, the rich variety within Christian therapy and care for the sick. Many places already have such centres or cooperate with doctors' clinics or health centres. It would be beneficial to promote and develop this field.

10) The unequal distribution of health resources throughout the world, and increasingly also at home, is a scandal for which there can be no justification.

The churches view themselves as advocates for people who, both in Germany and across the world, have inadequate access to medicine, healing and healthcare. We need to create a new coalition in the field of healthcare to redress the balance between the developed and the developing world. For example, if the healthcare systems in various African countries are to avoid total collapse within a few years, we need a much stronger commitment from the government, and from society, to the principal aims of the Millennium Declaration of the United Nations, which has made a serious commitment to improving health standards.

Every hospital and care home in Germany needs a solidarity fund, and we also need an alliance between the developed and the developing world (either in the form of a direct partnership or through mission work and development agencies such as the EED) to redress the balance between the developing and the developed world in the healthcare sector, and to stabilize the healthcare systems in numerous countries in the southern and eastern parts of the world.

9. Bibliography

Friedrich Aschoff, Christopher Noll, Paul Toaspern, Heilung (GGE Special Issue, published by GGE), Hamburg 2002

Eberhard Bibelriether et al.., Heilsame Berührungen. Segnungsgottesdienste gestalten. Gemeindeakademie Rummelsberg, Schwarzenbruck 1997

Wolfgang J. Bittner, Heilung, Zeichen der Herrschaft Gottes, Schwarzenfeld 2007

BKK-Gesundheitsreport 2005: Krankheitsentwicklungen – Blickpunkt: Psychische Gesundheit Ed. v. Bundesverband der Betriebskrankenkassen

Christliche Identität, alternative Heilungsansätze und Esoterik heute, in: Materialdienst der EZW, Berlin, 3 und 4/07

Church of England (Ed.), A Time to Heal. A Report to the House of Bishops on the Healing Ministry, London 2000

Jim Cochrane, Religious Health Assets (RHAs) – Conceptual and Theoretical Framework, in: Difäm, German Institute for Medical Mission (Ed.), Religion, Faith and Public Health. Documentation on a Consultation held at Difäm, Tübingen, Germany, 9-11 February 2006, pp. 14-45

Come Holy Spirit, Heal and Reconcile, Special Issue IRM January 2005

Divine Healing, Pentecostalism and Mission, Special Issue IRM July/October 2004

Deutsches Institut für Ärztliche Mission (German Institute for Medical Mission) e.V. (Ed.), Die vernachlässigten Dimensionen. Auseinandersetzung mit Gesundheit und Heilung im ökumenischen Prozess, Study Booklet Nr. 3, Tübingen 2000

Deutsches Institut für Ärztliche Mission (German Institute for Medical Mission) e.V. (Ed), Das christliche Verständnis von Gesundheit, Heilung und Ganzheit. Studie der Christlich-Medizinischen Kommission Genf, Tübingen 1990, 9

Simone Ehm, Michael Utsch (Ed.), Kann Glaube gesund machen. Spiritualität in der modernen Medizin (Protestant Centre for Religious and Ideological Issues, Issue 181), Berlin 2005

Ulrich Eibach, Heilung für den ganzen Menschen? Ganzheitliches Denken als Herausforderung von Theologie und Kirche (Theologie in Seelsorge, Beratung und diakonie, Bd.1), Neukirchen-Vluyn 1991

Health, Faith and Healing; Special Issue IRM January /April 2001

Heiko Ernst, Macht der Glaube gesund? In: Psychologie heute compact, Issue 8 (2004) 68-69

Evangelisches Missionswerk in Deutschland e.V., EMW (Association of Protestant Churches and Missions in Germany) (Ed.), Von der heilenden Kraft des Glaubens. Ein Arbeitsheft für Gemeinden und Gruppen, Hamburg 2005

Brigitte Fuchs, Norbert Kobler-Fumasoli (Ed.), Hilft der Glaube? Heilung auf dem Schnittpunkt zwischen Theologie und Medizin, Münster 2002

Glaube und Gesundheit. Warum Hoffnung heilen kann. Psychologie heute 32, Issue 3 (2005)

Glück, Glaube, Gott. Was gibt dem Leben Sinn? Psychologie heute compact, Issue 8 (2004)

Bernhard Grom, Religiöser Glaube – ein Gesundheitsfaktor?, in: Dr. med. Mabuse, September/Oktober 2002

Ders., Wunder sind nicht zu erwartetn. Wie spirituell kann die Psychotherapie sein? In: Psychologie heute 35 (2008) Issue 2, 56-59

Christoffer Grundmann (Ed.), …Christus den Herrn sein lassen. Eine Auswahl von Aufsätzen, Vorträgen und Predigten von Martin Scheel (1917-1990), Verlag an der Lottbek 1993

Gary Gunderson, Deeply Woven Roots. Improving the Qualitiy of Life in your Community, Minneapolis 1997

Klaus Haacker, Krankheit, Gebet und Heilung, ThBeitr 36 (2005), Issue 6, 289–293

The Global Health Situation and the Future of the Church in the 21st Century, IRM 95, Nos. 376/377, 2006

Heilung in Mission und Ökumene. Impulse zum interkulturellen Dialog über Heilung und ihre kirchliche Praxis, EMW Studienheft Weltmission heute Nr. 41, EMW (Association of Protestant Churches and Missions in Germany) Hamburg 2001

Heilungssehnsucht und Heilserfahrungen in der postsäkularen Kultur – Unterwegs zu einer missionarischen Hermeneutik“, Document published by the Protestant Press Association 16,/2005

Reinhard Hempelmann, (Ed.), Christliche Identität, alternative Heilungsansätze und moderne Esoterik, published by the Protestant Centre for Religious and Ideological Issues, Issue 191, Berlin 2007

Beate Jakob, Dietrich Werner: Die heilende Dimension des Glaubens. Antworten auf eine wachsende Sehnsucht, DIFAEM Study book No. 5, Tübingen 2007

Dieter Keucher, Heilungsverständnis und Heilungspraxis in der Geistlichen Gemeinde-Erneuerung,in: Heilungssehnsucht und Heilserfahrung in der postsäkularen Kultur, Protestant Press Association document, 16, S. 25-30S

Ilona Kickbusch, Die Gesundheitsgesellschaft. Megatrends der Gesundheit und deren Konsequenzen für Politik und Gesellschaft, Verlag Gesundheitsförderung, Gamburg 2006

H. König, M.McCullough, D. Larson, Handbook of Religion and Health, New York 2001

Burghard Krause, Heilungssehnsucht und Heilserfahrung – Ansätze und Perspektiven einer missionarischen Hermeneutik, Protestant Press Association document 16/2005, S. 16ff, bes.19f

Ulrich Laepple, Gemeinde als Heil-Land (Brennpunkt Gemeinde Studienbrief D 3), published by AMD (Arbeitsgemeinschaft Missionarische Dienste – Association of Missionary Services), Berlin 2006

Manfred Lütz, Lebenslust. Wider die Diätsadisten, den Gesundheitswahn und den Fitness-Kult“, München 2002

Morris Maddocks, The Christian Healing Ministry, SPCK, Third Edition 1995

Dale A. Matthews, Glaube macht gesund. Spiritualität und Medizin, Erfahrungen aus der medizinischen Praxis, Freiburg 2000

Jürgen Moltmann, Diakonie im Horizont des Reiches Gottes. Schritte zum Diakonentum aller Gläubigen, Neukirchen-Vluyn 1984

Ökumenischer Rat der Kirchen, Auftrag zu heilen (Studien des Ökumenischen Rats Nr. 3), Geneva 1966

Gabriele Pack, Die missionarische Hand braucht die diakonischen Hand, in mi-di (Mission und Diakonie), Nr. 1, 2004, S.6.f (published by the Arbeitsgemeinschaft Missionarische Dienste, AMD – Association of Missionary Services)

Robert-Koch-Institut (Ed.) Gesundheit in Deutschland 2006. Gesundheitsberichterstattung des Bundes, Berlin 2006

Michael Utsch, Spirituelle Psychotherapie: Modetrend oder Modell mit Zukunft? In: Psychologie heute 35 (2008) Issue 2, 52-55

Wolfram Weimer, Credo. Warum die Rückkehr der Religion gut ist, DVA München 2006

Dietrich Werner, zur Wiederentdeckung des heilenden Dienstes der Gemeinde. Zehn Thesen zum Gesprächseinstieg, in: Evangelisches Missionswerk in Deutschland, EMW (Hrsg.), Heilung in Mission und Ökumene. Impulse zum interkulturellen Dialog über Heilung und ihre kirchliche Praxis (Weltmission heute Nr. 41) Hamburg 2001

WHO, Review of the Constitution and Regional Arrangements of the World Health Organization. Executive Board 101st Session. EB 101/7. Geneva 1997

Paul-Hermann Zellfelder-Held, Solidarische Gemeinde. Ein Praxisbuch für diakonische Gemeindeentwicklung, Neuendettelsau 2002

The Authors

Dr. theol. Peter Bartmann, M. A., MBA, born in 1963, is a protestant theologian and health economist. He lives with his family in Berlin. In 1999, he began work for the Social Service Agency of the Evangelical Church in Germany and 2004 moved into in the field of health policy. In 2004 he was released from his duties to work on a research project at the Science Centre in Berlin, on the situation of chronically ill people with low incomes. This project is sponsored by the Volkswagen Foundation. He is also involved in voluntary work with children and young people in the local parish.

Dr. med. Beate Jakob, born in 1954, studied medicine and theology in Tübingen. She worked at the internal department of the university clinic in Tübingen between 1980 and 1983. She then moved to Kenya to work at a missionary hospital (1990-1992). This was followed by work for the German Institute for Medical Mission (Difäm) in Tübingen as a policy advisor, initially on a voluntary basis (1993-1999), and then part-time. Beate Jakob is married with seven children.

Ulrich Laepple, born in 1948 in Ulm, studied protestant theology in Tübingen, Edinburgh and Göttingen. He worked as a teaching assistant at the church secondary school in Wuppertal, teaching the New Testament (1974-1977) and then as regional pastor at the training department of the Evangelical Church in the Rhineland (1977-1980). Later, he worked as a parish priest in Essen (1980-1991) and as a theological collaborator at the Office for Parish Development and Missionary Services of the Evangelical Church in the Rhineland (1991-2002). Since 2002, he has been in charge of the field of strengthening parish development in the field of Christian social care and missionary work at the Association of Missionary Services within the Evangelical Church in Germany. He has published books on the subject of mission, parish communities and Christian social care. Ulrich Laepple lives in Berlin, is married and has three children.

Dr. theol. Dietrich Werner, born in 1956 in Oldenburg. He studied evangelical theology in Göttingen, Tübingen, Edinburgh, Bethel and Geneva. He worked as the parish priest in Oldenburg and taught at the Ecumenical Institute at Ruhr University Bochum (1989-1993). He then became Director of Studies at the Mission Academy at the University of Hamburg (1993-2000), and later worked (2000-2007) as a policy advisor at the North-Elbian Centre for World Mission and Church World Service (Hamburg) and as Director of Studies at Jensen Christian College (Breklum/Northern Friesland). Since October 2007, he has been working for the WCC as program coordinator of the WCC program on „Ecumenical Theological Education“(ETE). His published works include: “Leitfaden ökumenische Missionstheologie”, Gütersloh 2003; “Wiederentdeckung einer missionarischen Kirche. Breklumer Beiträge zur ökumenischen Erneuerung”, Schenefeld 2006.
Dietrich Werner
currently lives in Geneva/Bossey, is married and has five children.