

Micah Global

Integral Mission, Health and Wellbeing

Micah Thematic Paper

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With cooperation of Health and Wellbeing Working Group

July 2018

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Forward

Dr Santosh Mathew has led the community of practice discussion group over the last 3 years, meeting virtually and in Thailand in 2017 to evolve their thinking on Integral Mission, Health and Wellbeing.

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A very big thank you to all who contributed to discussions that led to Santosh drafting this Micah Paper. It is our shared hope that this paper will be a spring board for Christian ministries working in health and wellbeing to celebrate success and lament gaps in our desire to see all communities access good health care services addressing lifestyle changes that promote good health and ensuring those who are challenges with health issues are supported inclusively in their communities.

We recognise that many countries fall short of providing accessible health care services for diverse reasons. We invite the church globally and locally to read this paper, research where their health care access is and unite to enabling it to improve. This will require lobbying for policy changes, walking with health providers to improve services, standing in the gap to provide health care as well as raising the alarm when corruption, poor exploitative care is present.

This is a call to solidarity and action.

About Micah Papers

In preparation for our 6th Triennial Global Consultation (2015) we explored what would be the most effective outcome and all agreed that rather than publishing a Declaration we would set up working groups on thematic issues that were identified. The working groups would be tasked with developing what we will call a **Micah Paper**.

The concept of a Micah Paper is drawn from two types of known publications:

- *White Paper*: the purpose of a white paper is to help readers understand an issue, solve a problem, or make a decision. Types of white papers include:
 - A policy document often produced by governments that set out their proposals for future legislation and or strategy. They can be published as authoritative papers which may contain a draft Bill that is being planned. The paper would provide a basis for further consultation, discussions and actions.
 - A guiding document that informs readers in a concise manner about a complex issue and presents the issuing body's philosophy on the matter.
 - An informational document to promote or highlight the features of a solution, a product or a service.
- *Encyclical Letter*: the purpose of this circular letter was to inform churches about issues of concern and guide them in their response.
 - A letter sent out by the Pope to inform Bishops and the wider church (and even public), in which he lays down policy on religious, moral, or political issues.
 - A doctrinal and/or theological reflection to draw on to inform action.

Every generation faces challenges in their context and should be prompted to reflect with fresh perspectives both theological and practically, drawing on past learning and at the same time renewing perspectives, with an openness for new insights and transformational changes. Micah Papers seek to enable this reflection and encourage a Spirit-led response to the issues of concern faced by our generation.

Purpose: Micah papers should be seen as a consultative tool to enable development of reflective thinking and holistic action. They should play a dual role in presenting integral mission perspectives as well as inviting further opinions and discussions on the issues presented.

1. Description of Health and wellbeing:

For Micah Global, we realize that an adequate understanding of health requires an understanding of the biblical world view. This includes knowledge of God, of the created world, and of who we are as persons created by God and living in the world.

Health and well-being means wholeness, with a person's body, mind, and spirit integrated and coordinated, and able to function creatively in the context of his or her community.

Health involves the community as well as the individual. What one person does affects family, neighbours, and the larger community, both present and future. In like manner, what the community does affects the individual.

A complex relationship exists between health and our behaviour. Similar complexity exists between socio cultural, religious practices and economics of a community and health. What we allow or agree to do collectively, as a community, state or power group or as individuals has a powerful influence on the health of all.

God is the source of all healing, and desires to heal His people and move us toward wholeness.

God, in Jesus, the incarnate Son of God, is the key to life and health. He has overcome the power of evil which seeks to destroy us through disease, despair, disorder, and death. He has shown us how to apply this power to the disorder in the world so that we may move toward the restoration of wholeness and order in humankind and in the created world.

Global communities of Christ followers are God's chosen channel for healing, for the restoration of wholeness, and for the transformation of society. This involves vastly more than medical activities and technical development programs. It has to do with all endeavours that restore wholeness to persons and move persons and communities toward God's intended plan of abundant life for everyone now and in eternity. We also seek to promote better stewardship of the natural environment, including restoration, maintenance and improvement of the land, forests, water and air reserves.¹

2. Reflection on the definition

Ideological concepts and health as a rights issue

Health and continuum of care - Health promotion, disease preventing interventions, and health care should be **accessible** to all individuals and populations in a continuum.

Continuum of care is a concept involving an integrated system of care that guides and tracks patient over time through a comprehensive array of health services spanning all levels of intensity of care. Whether at home, or for primary, secondary tertiary and quaternary care individuals and populations should have access to cost effective rational and excellent care.

WHO has defined such systems for RMNCH and HIV/AIDS.

For e.g. - "The "Continuum of Care" for reproductive, maternal, newborn and child health (RMNCH) includes integrated service delivery for mothers and children from pre-pregnancy to delivery, the

¹ Adapted from Centre for Health in Mission Definition: <http://centerforhim.org/what-is-health/>

immediate postnatal period, and childhood. Such care is provided by families and communities, through outpatient services, clinics and other health facilities. The Continuum of Care recognizes that safe childbirth is critical to the health of both the woman and the newborn child—and that a healthy start in life is an essential step towards a sound childhood and a productive life.²

Health as a right - This access must be understood in the context of recognizing right to health as a human rights issue.

The 1948 Universal Declaration of Human Rights also mentioned health as part of the right to an adequate standard of living (art. 25). The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights.

The right to health is an inclusive right. We frequently associate the right to health with access to health care and the building of hospitals. This is correct, but the right to health extends further. It includes a wide range of factors that can help us lead a healthy life.

The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the International Covenant on Economic, Social and Cultural Rights, calls these the “underlying determinants of health”.

They include:

- Safe drinking water and adequate sanitation;
- Safe food;
- Adequate nutrition and housing;
- Healthy working and environmental conditions;
- Health-related education and information;
- Gender equality.

The right to health contains freedoms. These freedoms include the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilization, and to be free from torture and other cruel, inhuman or degrading treatment or punishment.

The right to health contains entitlements³. These entitlements include:

- The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health;
- The right to prevention, treatment and control of diseases;
- Access to essential medicines;
- Maternal, child and reproductive health;
- Equal and timely access to basic health services;
- The provision of health-related education and information;
- Participation of the population in health-related decision making at the national and community levels.

This right is both for the individual, the family and the population or the community or Nation. At the same time **health is to be recognized as a responsibility.**

² (http://www.who.int/pmnch/about/continuum_of_care/en/)

³ <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

Individual responsibility of health has received some attention recently with the Health Insurance companies using this for deciding on reimbursements. But many issues related to personal responsibility are unclear for health and wellbeing.

An article in NEJM expresses this well. “The concept of personal responsibility in health care is that if we follow healthy lifestyles (exercising, maintaining a healthy weight, and not smoking) and are good patients (keeping our appointments, heeding our physicians' advice, and using a hospital emergency department only for emergencies), we will be rewarded by feeling better and spending less money. The details of programs that emphasize personal responsibility, however, are often sketchy, and many difficult questions related to individual freedom and patients' autonomy remains unanswered.”⁴

At the same time, recognizing that our body is the temple of the living God and making people aware of their own personal responsibility of caring for body must be communicated and taught.

Similarly, in most communities' family structures are key for individual's health, especially in contexts and situations where state has not taken the responsibility of “right to health” or set up systems for the same. Family responsibility also becomes important in caring for those with life limiting illnesses at home with palliative and or end of life care systems. Engagement and capacity building of family members becomes important in such situations. Even for issues related to adolescent health, involvement of partners and extended family is key.

Employers responsibility for health of its employees especially in the context of occupational hazards and illnesses also is an area of engagement that must kept as a key focus along with other stakeholders.

National and Global responsibility for Health of a nation involves addressing the key challenges of setting up systems for health. Four key challenges as identified by WHO are:

1. Defining essential health services and goods;
2. Clarifying governments' obligations to their own country's inhabitants;
3. Exploring the responsibilities of all governments towards the nations/world's poor;
4. Proposing a national/global architecture to improve health as a matter of social justice.

States also have a responsibility to govern well – honestly, transparently and accountably – with the full participation of civil society. Yet, health systems among low-income countries are among the most poorly governed.⁵

Engagement of the local community and local governance structures in supporting the families and individuals, advocating with the state for addressing the above challenges of systems and actively setting up local systems cannot be ignored if a nation or a community must be healthy.

At all levels, the right and responsibly must be understood and held together in a creative tension and should undergird setting up of accessible systems. The accessibility focus of such systems should be for the poorest/marginalized in the community and should be recognised as a justice issue. Such systems should be manned by compassionate manpower and advocacy with states should be done to make the same affordable through Universal health access systems or Universal Health Care.

⁴ [Imposing Personal Responsibility for Health; Robert Steinbrook, M.D. August 24, 2006; N Engl J Med 2006; 355:753-756](#)

⁵ [Bulletin of the World Health Organization 2010;88:719-719A. doi: 10.2471/BLT.10.082636](#)

3. Theological foundations

For Micah, Health should be understood as holistic, as given in the definition section. ***“Health and wellbeing means wholeness, with a person’s body, mind, and spirit integrated and coordinated, and able to function creatively in the context of his or her community.”***

Health and healing should be understood as Integral – where health care systems should lead to comprehensive, holistic, and healing of body, mind, and spirit and that is resilient to life’s adversities, including disease, aging, and death.

Understanding of Health and wellbeing as a Justice and righteousness issue is important for our engagement. We need to understand how God holds health and wellbeing as integral in His communication of SHALOM.

In all our engagement and consideration our focus should be on the marginalized of the society and we need to develop an understanding of God’s heart for the poor and marginalized.

As a global community, we should explore together the responsibility of the church in various aspects of health and wellbeing of our nations and communities. To consider a few - In promotion of good healthy life style, in prevention of diseases, in setting up and holding together of integrated health systems, in advocating for accessible and affordable systems for the poor and marginalized etc. Church and its institutions should continue to be an alternate ethical and compassionate community of caring amid corporatization of health care systems.

4. Overview of current responses:

Current frame works - MDGs and SDGs

The United Nations Millennium Development Goals were eight goals that all 191 UN member states had agreed to try to achieve by the year 2015. The United Nations Millennium Declaration, signed in September 2000 committed world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. The MDGs were derived from this Declaration, and all had specific targets and indicators. The MDGs were inter-dependent; all the MDG influence health, and health influences all the MDGs. For example, better health enables children to learn and adults to earn. Gender equality is essential to the achievement of better health. Reducing poverty, hunger and environmental degradation positively influences, but also depends on, better health.

The United Nations Conference on Sustainable Development in 2012, resulted in a focused political outcome document which contains clear and practical measures for implementing sustainable development. The member States decided to launch a process to develop a set of Sustainable Development Goals (SDGs), which will build upon the Millennium Development Goals and converge with the post 2015 development agenda. The SDGs help nations to move towards “transforming our world” by a 2030 Agenda for Sustainable Development.

The 17 Sustainable Development Goals and 169 targets demonstrate the scale and ambition of this new universal Agenda. They seek to build on the Millennium Development Goals and complete what these did not achieve. They seek to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls. They are integrated and indivisible and balance the three dimensions of sustainable development: the economic, social and environmental.⁶

⁶ <https://sustainabledevelopment.un.org/post2015/transformingourworld>

Paragraph 26 of the 2030 agenda for sustainable development addresses health as follows:

“To promote physical and mental health and wellbeing, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030. We are committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education. We will equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, Ebola and other communicable diseases and epidemics, including by addressing growing antimicrobial resistance and the problem of unattended diseases affecting developing countries. We are committed to the prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development.”⁷

It is important that we in Micah align our responses to the existing frameworks followed by the world and nations.

5. Gaps in Health care access

Despite UN and its member nations commitment to 15 years of MDGs and currently the SDGs, Health care access issues, **lack of equity and justice in health care systems, poor quality of services** provided continue to plague many nations and communities. Universal health Care and accessible systems remain a dream for many nations.

For **marginalized communities** of both developed and developing nations, these issues are much more pronounced and magnified. The structures that marginalize these communities prevent them from accessing even available health care.

Since 1990, natural disasters have affected about 217 million people every year, and about 300 million people now live amidst violent insecurity around the world.

With **natural and man-made disasters** on the increase, health access becomes much more challenging for all communities affected by these disasters, especially marginalized communities. Marginalization could be due to behaviours, gender, disability, caste, ethnicity, religion, economic and social factors, or extremes of age and productivity or other reasons. Similarly increasing ethnic and international conflict situations make health and health care access for affected communities much more challenging. Health care infrastructures have been decimated in some of the recent conflict situations.

An article in NEJM well summarizes the issue – “The effects of armed conflict and natural disasters on global public health are widespread. Much progress has been made in the technical quality, normative coherence, and efficiency of the health care response. But action after the fact remains insufficient. In the years ahead, the international community must address the root causes of these crises. Natural disasters, particularly floods and storms, will become more frequent and severe because of climate change. Organized deadly onslaughts against civilian populations will continue, fuelled by the availability of small arms, persistent social and political inequities, and, increasingly, by a struggle for natural resources. These events affect the mortality, morbidity, and well-being of large

⁷ http://www.who.int/gho/publications/mdgs-sdgs/MDGs-SDGs2015_chapter1.pdf?ua=1

populations. Humanitarian relief will always be required, and there is a demonstrable need, as in other areas of global health, to place greater emphasis on prevention and mitigation.”⁸

North–South divide is broadly considered a socio-economic and political divide. Generally, definitions of the "Global North" include the United States, Canada, Western Europe, as well as Australia and New Zealand. The Global South is made up of Africa, Latin America, and developing Asia including the Middle East. The North is home to all the members of the G8 and to four of the five permanent members of the United Nations Security Council. Though the economic and political divides have been reducing, health disparity continues to be a major challenge, especially for politically unstable and smaller economies in African continent and Asia.

Urban rural divide in health access and health indices has been a major challenge for many decades. Urban communities tended to have more easily accessible health care. But at the same time, urbanization is creating emerging challenges in health and development. The average annual rate of change of the percentage urban is 1.1 percent in Africa and 1.5 in Asia. And such urban communities most of them mobile and migrant residing in resettlement colonies, shanty towns or slums have minimal access to affordable health care. Emerging new disease epidemics due to poor living conditions become an added challenge.

Economic divides and health disparity is well known. With escalating costs of health care, lower socio-economic communities going into poverty after a catastrophic health care incident is becoming more frequent. Stories of crop failures, poor income, catastrophic health care, leading to abject poverty, and suicides are quite common in Asian agrarian communities. High interest loans taken for health care leading to bonded labour due to inability to pay back loans also are not unusual in poor communities.

Gender divides continue to be an issue that impact health of many communities. Poor or late access for girls and women for health care, female feticide continues to a challenge to sustainable and inclusive growth. Many communities these are evidenced by drop in Women/Male ratios despite increasing in literacy and awareness.

Increasing life expectancies across the world and this changing demography is making many nations to have a large population of elderly who have poor access to health care. Lack of supportive geriatric care systems, large scale migration of children, leaves many aged neglected and with poor access to supportive systems.

Physically and Mentally Challenged individuals and communities always had challenges in accessing health care. Though much has been done in raising awareness of the needs of such individuals and communities, across the globe in many locations, health care institutions are not disability friendly or easily accessible. Dearth of health care providers sensitive to the needs of such individuals remain an added challenge.

Many such other disparities in health access continue to plague nations preventing communities from moving towards “transforming our world” by 2030.

6. Major Issues of Concern

In addition to the gaps there are some current issues of concern across the globe which impede access and movement towards the dream of healthy nations and communities.

⁸ [N Engl J Med 2013; 369:1836-1842.](#)

Growth of health as a business

The shift of Health from being a service sector to a business and industry has changed the climate and spectrum of Health care across nations. What people really want is health whereas doctors and hospitals focus on producing health care. Health care a means to that end of being healthy, has become an increasingly expensive one.

As an answer to this, nations started focusing on **Universal health care**, (also referred to as universal health coverage, universal coverage, universal care or socialized health care) usually refers to a health care system that provides health care and financial protection to all citizens of a particular country. Despite all best efforts, at least half of the world's population cannot obtain essential health services, according to a new report from the World Bank and WHO. And each year, large numbers of households are being pushed into poverty because they must pay for health care out of their own pockets. Currently, 800 million people spend at least 10 percent of their household budgets on health expenses for themselves, a sick child or other family member.⁹

State supported, or private run **Health insurance (HI) systems** were seen as an answer to providing universal health coverage, especially for the marginalized, the elderly and those who have poor access to care. Despite different models of HI in developed nations and some developing nations, only a small percentage of the world have access to insurance. Those insured too continue to grapple with challenges of high premiums, poor quality of care and various other challenges. The marginalized and poor in some nations have been structurally or systematically excluded from accessing insurance systems.

Pharmaceutical companies and the development of drugs and pharmaceuticals and proactive support to profit driven drug development is one contributory factor of escalation of health care expenses. Various policies related to pricing of drugs and trade agreements that favour companies or developed nations have always been a challenge. Nations reluctance to have minimum pricing for essential drugs, or make essential medicines available, or lack of support for low priced quality assured generic medicines by physicians and other such practices have been detrimental in bringing down cost of drugs.

Increases in international commerce and in the movement of people—two defining features of **globalization has an influence on health**. More goods go more places today than at any point in history. More people travel farther, more frequently, and come in contact with more people and goods, than at any point in history. This increased movement of both goods and people increases opportunities for the spread of disease around the world. And it's not just goods and services that can travel across oceans and state borders—so can diseases like AIDS, malaria, or tuberculosis. A renewed understanding of the challenges of this context is key in the changing context of the world at large.

Environmental consequences of **climate change**, such as extreme heat waves, rising sea-levels, changes in precipitation resulting in flooding and droughts, intense hurricanes, and degraded air quality, affect directly and indirectly the physical, social, and psychological health of humans. Between 2030 and 2050, climate change is expected to cause approximately 250 000 additional deaths per year, from malnutrition, malaria, diarrhoea and heat stress.¹⁰

The **social determinants** of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health

⁹ http://www.who.int/healthinfo/universal_health_coverage/report/2017/en/

¹⁰ <http://www.who.int/mediacentre/factsheets/fs266/en/>

inequities - the unfair and avoidable differences in health status seen within and between countries.¹¹

Though many generic determinants have been recognized, there are many context specific community and region specific which sometimes are recognised. For e.g., Domestic violence and gender identity contribute much to poor women's health in some regions of the world. Many such determinants need to be recognized and addressed if communities are to move to health and wellbeing.

In addition to this, spiritual dimension of life and religion as a social a social determinant of health need to be understood and addressed. The complex, multifaceted role that faith and faith traditions play in determining individual health and indicators of public health is much less understood and is an area for study and consideration.

Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.¹²

Technological advances and technology driven health care has widened the gap of access with the poor with poor being unable to access costly procedures and interventions, even lifesaving ones.

Yet another challenge for health and wellbeing has been the **Neglected tropical diseases** (NTDs). NTDs are a diverse group of communicable diseases that prevail in tropical and subtropical conditions in 149 countries – affect more than one billion people and cost developing economies billions of dollars every year. Populations living in poverty, without adequate sanitation and in close contact with infectious vectors and domestic animals and livestock are those worst affected. Effective control can be achieved when selected public health approaches are combined and delivered locally. Interventions are guided by the local epidemiology and the availability of appropriate measures to detect, prevent and control diseases.

The current and recent **Pandemics** like Avian Influenza A(H5N1), Influenza A H1N1, Viral haemorrhagic fevers, Zika virus, and the ongoing HIV/AIDS in addition to the threat of increasing prevalence of MDR/XDR TB etc. continue to challenge many nations. Antibiotic resistance is slowly becoming another pandemic which has the potential to grow out of proportion and challenge the practices of Modern medicine worldwide.

Each year, about 85 percent of the world's children receive **vaccines** that protect them against tuberculosis, polio, diphtheria, tetanus, pertussis, and measles. These vaccines save about 2.5 million lives, and the hepatitis B vaccine, although not as widely used, saves about 600,000 lives. Despite this success, more than 3 million people die from vaccine-preventable diseases each year. Approximately 1.5 million of these deaths are in children less than 5 years old. Of the top 10 causes of death in those less than 5 years old, several are infectious, meaning they can be transmitted from one person to another.

With demographic changes of increasing life expectancy, increasing prevalence of NCDs, Dementias, and other **chronic illnesses Palliative care, end of life care and Hospice systems** are very key in

¹¹ http://www.who.int/social_determinants/sdh_definition/en/

¹² www.who.int/healthsystems/topics/equity/en/

people must live and die well. A good understanding of the various aspects of the same, is important if effective services must be set up.

The quality forum describes the components as given below.

“Palliative care generally refers to patient and family-centred care that optimizes quality of life by anticipating, preventing, and alleviating suffering across the continuum of a patient’s illness. Historically, palliative care referred to treatment available to patients at home and enrolled in hospice. More recently, palliative care has become available to acutely ill patients and its meaning has evolved to encompass comprehensive care that may be provided along with disease-specific, life-prolonging treatment. End-of-life (EOL) care refers to comprehensive care for a life-limiting illness that meets the patient’s medical, physical, psychological, spiritual and social needs. Hospice care is a service delivery system that emphasizes symptom management without life-prolonging treatment and is intended to enhance the quality of life for both patients with a limited life expectancy and their families.”¹³

With more than **60 million refugees and internally displaced people** worldwide in 2015 -16, the health of such mobile communities has become a major challenge globally. Setting up systems of care and support involves a proactive multistate holder state mechanism and support of voluntary agencies and faith-based organizations.

Oral health yet another neglected area of health, is essential to general health and quality of life. It is a state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual’s capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing. WHO highlights these facts,¹⁴

- Worldwide, 60–90% of school children and nearly 100% of adults have dental cavities.
- Dental cavities can be prevented by maintaining a constant low level of fluoride in the oral cavity.
- Severe periodontal (gum) disease, which may result in tooth loss, is found in 15–20% of middle-aged (35-44 years) adults.
- Globally, about 30% of people aged 65–74 have no natural teeth.
- Oral disease in children and adults is higher among poor and disadvantaged population groups.
- Risk factors for oral diseases include an unhealthy diet, tobacco use, harmful alcohol use and poor oral hygiene, and social determinants.

More than a billion people in the world today experience **disability**. These people generally have poorer health, lower education achievements, fewer economic opportunities and higher rates of poverty. This is largely due to the barriers they face in their everyday lives, rather than their disability. Disability is not only a public health issue, but also a human rights and development issue.

WHO’s action plan calls nations for them to remove barriers and improve access to health services and programmes; strengthen and extend rehabilitation, assistive devices and support services, and community-based rehabilitation; and enhance collection of relevant and internationally comparable data on disability, and research on disability and related services. Achieving the objectives of the action plan better enables people with disabilities to fulfil their aspirations in all aspects of life.¹⁵

¹³ https://www.qualityforum.org/Projects/Palliative_Care_and_End-of-Life_Care.aspx

¹⁴ http://www.who.int/oral_health/publications/factsheet/en/

¹⁵ <http://www.who.int/disabilities/actionplan/en/>

Diseases of dietary excess and imbalance now rank among the leading causes of illness and death in the developed nations. But this is no more a problem in the developed nations alone. Diet plays a major part in top 10 causes of death in both developing and developed nations, coronary heart disease, cancer, stroke, diabetes mellitus and atherosclerosis being some of the diseases. Many developing nations have increasing numbers of diet and life style related diseases and diseases of excess.

Children-at-risk are persons under 18 who experience an intense and/or chronic risk factor, or a combination of risk factors in personal, environmental and/or relational domains that prevent them from pursuing and fulfilling their God-given potential.

Understanding children-at-risk is especially important for the global church in the 21st century because while the history of Christian mission has always been marked by concern for children, too often church-based efforts have prioritized children who exist in families or overemphasize certain solutions (such as orphanages) that have not always been in children's best interests. Other churches have failed to fully appreciate the responsibility they must bear for the state of children within their own communities and beyond. Instead, we invite churches everywhere to promote and expand the effective missional work with children that they are currently doing, and strive to develop innovative, integrative, systemic and collaborative approaches that will realize the Kingdom of Heaven more fully for children, their families, and their communities.¹⁶

Health promotion helps reduce excess mortality, address the leading risk factors and underlying determinants of health, helps strengthen sustainable health systems, and places health at the centre of the broad development agenda.

Most countries are experiencing unprecedented societal transformation as a result of population growth and urbanization together with environmental and other changes. This process is often accelerated by globalization in trade and communication, and complex emergencies. New approaches are required in the light of these changes in order to address the broader determinants of health.

Within the context of primary health care, health promotion is critical to improving outcomes in the prevention and control of both chronic and communicable diseases, and in meeting the health-related Millennium Development Goals, particularly among poor and marginalized groups.

Carrying out health promotion in settings where people live, work, learn and play is a creative and effective way of improving health and quality of life. Health promotion has a crucial role to play in fostering healthy public policies and health-supportive environments, enhancing positive social conditions and personal skills, and promoting healthy lifestyles.¹⁷

James Campbell Director Health Workforce Department, WHO, shares in his report - **Health workers** are the critical pathway to attaining the health targets in Sustainable Development Goal (SDG) 3 (health and well-being). An adequate, well distributed, motivated and supported health workforce is required for strengthening primary health care and to progress towards universal health coverage (UHC); detecting, preventing and managing health emergencies; and promoting the well-being of women, children and adolescents.

But investing in the health workforce also represents an opportunity to create qualified employment opportunities, in particular for women and youth, further spurring economic growth and

¹⁶ <https://www.lausanne.org/content/statement/children-at-risk-missional-definition>

¹⁷ <http://www.who.int/healthpromotion/about/en/>

productivity. Emerging economies are simultaneously undergoing an economic transition that will increase their health resources envelope, and a demographic transition that will see hundreds of millions of potential new entrants into the labour force. The confluence of these factors creates an unprecedented opportunity to design and implement health workforce strategies that address the gaps in equitable and effective coverage that characterize many health systems, while also unlocking economic growth potential. In this sense, health workforce investments can contribute significantly towards SDGs 4 (education), 5 (gender) and 8 (decent work).¹⁸

Health charities and impact

There has been lack of clarity of the long-term impact of interventions done through health charities who have had a hit and run approach to their engagement with communities. We need to review the intended and unintended impact of such health charities with a perspective of long term sustainability and try to understand and document changes on health and wellbeing of such communities.

God's ideal health care system and outcome

As given in the definition section for Micah global, Health and well-being means wholeness, with a person's body, mind, and spirit integrated and coordinated, and able to function creatively in the context of his or her community.

Health involves the community as well as the individual. What one person does affects family, neighbours, and the larger community, both present and future. In like manner, what the community does affects the individual.

An ideal health care system should lead to this outcome. A system that leads to an individual enjoying this wholeness in his or her life and in the context of family and community. A system that facilitates family and the community at large, to enjoy this wholeness.

7. Strategic approaches

It is the background of such and many other disparities, and emerging concerns (many not mentioned here) that we need to explore how Micah Global should engage and prioritize. Any engagement must be **contextually relevant and culturally specific**. But at the same time the membership and churches should have a clear foundational understanding why we do what we do.

The current global frame works like SDGs are those that should guide our responses and strategies. At the same time there will be various ways in which as Micah Global could look at the biblical basis and our engagement. Given below is one such frame work through which we could explore our engagement and understanding of Health and Wellbeing.

- a) In the book of Leviticus God, through the laws He gave, desired Israel to be a Holy nation, at the same time a **Healthy Nation**. In the Levitical model of Israel safe health behaviour's, Preventive and promotional national structures, Priest as the point person for health and healing, and access for those in margins of the society were part of the structures God envisioned. And with these structures the Healthy and Holy Nation of Israel would become a missional nation – the nations around would see Nation of Israel and understand they are different because God Jehovah is in their midst.

¹⁸ <http://www.who.int/hrh/BienniumReportRevised2017.pdf?ua=1>

We as the larger family of Micah Global should explore how we can pray for our nations to be healthy, explore together what structures are required to be a healthy and just society. At the same time, Micah members should be advocates for such structures to be set up in communities, states and nations. Micah members should empower churches to pray, and advocate for their nations to be healthy through establishment of systems and structures.

- b) For this to happen, churches should have a **vision of the SHALOM** that God promised and envisioned. We need educate and build the understanding of churches and Micah members of the hope for future, the SHALOM as promised, given in the prophetic utterances of Isaiah and Zechariah and pictures of the new heaven and new earth in Revelation.

We need to educate churches to hold on to the hope of the “here but not yet, but inaugurated and advancing Kingdom of God”. We need to help membership and churches to reflect on how to redeem our vision for “SHALOM”, the future hope and what it means today as we live in a broken world.

We need to address the issues of spiritual abuse and neglect in churches that stop people taking conventional medical treatments and or those who declare that all illness is due to sin. At the same time, we need to educate and empower the church to pray for the sick and help the church to understand how this prayer complements and dovetails in with conventional medicine.

- c) At the same time, we need to constantly go back to the life Jesus modelled. **The Incarnational engagement** with those in the margins of the then society, the Integral and wholistic method of touching lives, the Intercessional life and Interdependent methodology of engagement. We need to redeem the motivation of our master – the heart that was moved with compassion. We need to challenge each other to reflect on how to realign our lives in line with the master’s model.
- d) And as church communities, we need to redeem the first Century church model, the **church as a caring and healing community**. A community that was caring at the same time Apostolic, Prophetic, Evangelistic and Empowering. We need to help each other to reflect on how to rebuild such caring communities that reach out to those in the margins of the society at large.
- e) We need to educate ourselves from the history of the missional movements of early centuries, how they were motivated by understating of Jesus life and the caring community models. How they held the “**Imago Dei**” as key to their engagement with all those whom they set out to care.

These reflections should lead to actions at a macro level, at the level of states and nations, and **policy advocacy**. At the same time the reflections should lead to models **of incarnational caring communities** that become prophetic models. These should be rooted in **clear understanding of the word** and what it teaches about **churches role in health and wellbeing** and supported by **prayer for the nations** so that they will set up structures for healthy nations.

Few questions that emerge out of this model that could be used by churches and members to reflect are given below.

- How can we redeem praying and working for a healthy Nation?
- How can we restore the SHALOM perspective and align ourselves to where God is moving in our nations?

- How can role model and build, motivate and mobilize, people living out the Masters model of life?
- How can we renew our community life and a facilitate communities of caring and healing?
- What are the SDGs that we can focus on and contribute towards with the above biblical basis as our foundations?

There could be other frame works through which one could look at the role of churches in Health and well-being. Whatever frame we might use, we should see to it that churches and members recapture our mandate, to be a channel of health healing and wellbeing.

8. Recommended action / outcomes / next steps

Our responses to such a variety of contexts and complexities will need to multi-faceted and with multi-stakeholder engagement.

A few suggested components of our possible responses are given below.

- Prayer** – raising prayer for our nations, our leaders and people in decision making positions,, the people who have limited or poor access for health and wellbeing, and communities that are marginalized
- Advocacy** – with community, state and national structures to set up systems of equitable access for those in the margins of the society
- Training**, perspective and capacity building with various stakeholders, with church as a core and key participant on a clear understanding of Health and wellbeing from biblical basis.
- Research** and knowledge management, to understand the context of our nations and locations and create evidence on issues of access for those who are in the margins of the society
- Setting up systems** of health promotion, disease prevention, health care and wholistic support for those in need
- Developing SDGs** based specific responses for identified communities and locations
- Sharing of the models developed and lessons learnt at Micah and other such sharing platforms.

9. Ongoing learning

- References for further review
- Recommended books and publications
- Suggested training available
- List of organizations / individuals working in this area
- Establish a Community of Practice on the topic for Micah to continue as a learning /sharing platform
- Case studies from member organizations

1. <http://centerforhim.org/what-is-health/>
2. (http://www.who.int/pmnch/about/continuum_of_care/en/)