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"Keeping faith in faith-based institutions – a practical theology for faithful practice"

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In October 2007, my wife, Eirwen, and I were appointed International Health Services Coordinators for The Salvation Army and tasked with developing and implementing a new health strategy. The Salvation Army works in more than 120 countries with many health programmes including 29 general hospitals, 56 specialist clinics, 135 health centres, 64 mobile clinics, and more than 15,000 local congregations (usually called corps) almost all of whom have a community service programme.[1] The Salvation Army's work in the field of HIV/AIDS care and prevention had taught us important lessons about working with communities and beyond the wall of our institutions. We were tasked with capturing these lessons and sharing a "facilitation" way of working across the worldwide Salvation Army. We were also tasked with envisioning a faithful future for health including hospitals, clinics and congregations.

As my wife and I started this assignment, I was also studying for a Doctorate in Theology and Ministry at King's College London. Under the guidance of my supervisor, Dr Luke Bretherton, I combined my thesis research with my fulltime job. Although it made for a crazy few years of hard work, it enabled me to ensure my academic work was grounded in field experience while also strengthening the strategy with the resources of the academy.

I finally settled on the following research question: *"What characterises faithfully orientated Salvation Army health ministry in the twenty-first century?"* Underpinning my research was a conviction that Christian engagement in health should not be redacted to "autonomy", "rights" or "service" but orientated on the basis of Christian soteriology – the salvation story – understood holistically as the work of redeeming persons who were created by God to be "body-soul-in-relations".

My research had a "developing" world focus but the more I have engaged in the issues, the more I have seen commonalities with the challenges facing people of faith and their institutions in Europe, North America and other "developed" contexts. This afternoon, I will highlight a few of the issues raised in developing the strategy, set out the methodology and identify a few of the lessons learnt. We will then have time for questions before there is time for small group discussions and then plenary feedback to conclude.

1. Identifying the Issues

To develop the strategy I visited more than 40 to listen to practitioners and observing practice. I can report the world is still a very unhealthy place to be if you are poor. 25% of people still lack access to decent primary health care. I could give you many examples but that is not the purpose of today's paper but it is an issue close to my heart because in many places in Africa and Asia the quality of

[1] The Salvation Army, *The Salvation Army Year Book 2010*, p30.

Christian health ministry is declining. As the commercial providers offer the rich exceptional care, I fear the poorest people – the people God calls us to serve – are being forgotten by the state, the commercial providers and even the church.

This afternoon I will highlight some of the key areas of tension:

a) Institution or community?

Many Salvation Army leaders and health workers expressed concern that many of our hospitals and clinics were declining in their quality of service and were not financially sustainable. There was internal disagreement on the way forward. A number of influential western voices were recommending the closure of all Salvation Army hospitals around the world. In the past 25 years, The Salvation Army withdrew from almost all hospital-based health care in economically developed countries. Leaders responsible for the hospital closures justified their actions on the grounds of increasing cost, lack of leaders, the threat of lawsuits, and conflict with state grant makers and regulators over human life ethics. In light of this experience, priority was given to community-based rather than hospital-based health ministry. Community-based health care is perceived to be more fundable, less risky, more effective and sustainable.

Salvationists in developing countries overwhelmingly disagreed with closure proposals. They wanted to continue to serve poor and marginalised people through institutional, congregation and community-based health ministry. The Salvation Army credibility and provide a valuable space in the public square for ministry – particularly in Christian-minority settings where people of other faiths sometimes view Salvation Army corps and community-based initiatives with suspicion.

The title for this paper is "Keeping Faith in Faith-Based Institutions". This is a controversial idea. Faith and institutions are both viewed with suspicion in Western 21st century "post-modern" society. Faith and institutions are characterised as sources of power that tend to abuse and manipulate. In contrast, individuality, fluidity and autonomy are greatly prized in post-modernity. The way to happiness and the good life, we are told, is achieved by self-actualisation, individual freedom and the promotion of human rights, without restrictive institutions.

This "post-modern" worldview is having an impact in developing countries. The decline of the western Christian Church and the rise of western individualism has resulted in a collapse in financial donations for institutions in the developing world – particularly schools, clinics, hospitals and orphanages. The missionary expansion in the first half of the 20th century into Africa, South America and Asia stopped in the post-colonial era. There has been a loss of confidence in the western church. A sustainable solution, we are regularly told by the western agencies, is not to fund institutions – that should be the state's role; all service delivery by FBOs is questioned. Advocacy and capacity building is believed to be much more effective.

There is some hypocrisy in this approach. While westerners put their politicians under incredible pressure if they propose closing hospitals or cutting funding to schools, it is argued that development for the poorest countries will occur best in "community" (whatever community means). This is an absurd idea – if Norway, Britain and the rest of Europe need good hospitals and schools to form and sustain healthy people, why do we think it is different in Zimbabwe, Sudan and DR Congo? How will failed states or negligent states deliver quality health and education for their people?

The best practice promoted by western development agencies is even more threatening to FBOs working in developing countries. Despite the fact that the one resilient institutional presence in the poorest communities around the globe is the faith institution – a church or temple or mosque or other faith congregation – people of faith are viewed with suspicion by the development professionals and there is reluctance to partner with faith-based organisations for fear of "proselytization". However, the international development professionals conveniently ignore the influence of their "preaching" of secularism, individualism and thinly veiled atheism.

So, we are sailing into deep and controversial waters this afternoon. Keeping faith in faith-based institutions is contrary to the dominant western approach.

b) The contribution of theology?

As I began my research, I noted similar concerns in the academic literature I was reviewing and in conversations with people around the world. Several Salvation Army leaders felt the communities' capacity to solve their problems was being overestimated and some practitioners were underusing theological resources. Stephen Plant, of Cambridge University, identifies similar trends in other Christian agencies and suggests some are replacing Christian eschatology with a "secular eschatology" derived from non-religious, non-governmental organizations.[2] Secular eschatology promotes hope, without any requirement for God and a "belief in human progress" with trust invested in concepts such as the capacity of science, the capacity of humanity, and human rights to secure a better world. Plant notes that FBOs often promote the notion that human beings can work out their own salvation compounded by a reticence to refer to a "faith" dimension for fear of accusations of evangelism.

Stanley Hauerwas offers a trenchant critique of Christian motive and practice in his assessment of the reasons for the growing popularity of social justice among western Christians. He argues that the current emphasis "springs not so much from an effort to locate the Christian contribution to wider society as it does from Christian's attempts to find a way to be societal actors without that action being coloured by Christian presuppositions".[3]

Paul Gifford, in a recent ethnography of contemporary African Christianity, provides detailed analysis of the extent to which the Kenyan Church is engaged in the 'development business' but notes very few FBOs in Kenya "seem interested in even asking whether there is any specifically Christian way of or contribution to development".[4] Gifford, who claims not to have a theological or denominational interest in his study, reaches a disturbing conclusion:

> "[The] increasing identification of mainline Christianity with Western development aid is something whose significance needs to be acknowledged. As Africa has become increasingly marginalised, excluded from globalising movements and processes, these aid flows and what they involve have become increasingly significant for, even constitutive of, parts of mainline

[2] Plant, "Freedom as Development: Christian Mission and the Definition of Human Well-Being.," p1.

[3] Hauerwas, *After Christendom? : How the Church Is to Behave If Freedom, Justice, and a Christian Nation Are Bad Ideas*, p58.

[4] Gifford, *Christianity, Politics and Public Life in Kenya*, p49.

> Christianity. This is the sense in which one can talk of secularisation in Africa. It is not that Africans are notably becoming secularised, but much of mainline Christianity effectively is."[5]

Gifford's analysis is similar to mine. I observe a reluctance among many FBO practitioners – especially westerns – to articulate the difference that faith makes in their practice. I discussed this issue with employees from several FBOs. Many appear wary of theology and the church taking a central role in policy and practice. "Faith" is left as a loose, undefined label rather than imbued with richness from theological resources such as the Bible and Church tradition coupled with the habits and practices of people enabled by the power of the Holy Spirit.

FBOs appear inclined to promote the instrumental capacity of the church to reach vulnerable people but seem to perceive church leaders and theology as barriers to their priorities of effective and efficient initiatives to improve the health of poor people.[6] Most FBOs have accepted partnerships with the global public health establishment who appear to view faith-based groups (including congregations and denominational infrastructure) as simply an effective distribution network for secular initiatives.

FBOs are therefore tempted – including some Salvation Army programmes – to prioritise their value as *organization* above their contribution as a repository of *faith*. FBOs appear to lack the resources to engage in meaningful dialogue in an inter-disciplinary conversation with public health. Reflecting on more than five years of such conversations in the African Religious Health Assets Programme (ARHAP), Jill Olivier writes:

> "In collaborative communication, PH (Public Health) discourse appears to be more powerful than that of RS (Religious Studies) not only because of its links to scientific institutions of power, but also because of its narrative authoritative style. Hermeneutics, interpretation, and reflection does not fare well when it comes into competition with a discourse of certain authority."[7]

In the rest of this paper, I will show how practical theology offers resources to Faith-Based Institutions in responding to these challenges.

2. Applying the resources of practical theology

In recent years there has been an increasing appreciation of the value of reflection in professional practice as against a "technical rationalist" approach.[8] Schön identified an important distinction between reflection-in-action (where the practitioner draws on internalised theory to make an in-the-moment decision) and reflection-on-action, which enables a retrospective review leading to an evaluation of action and revised practice.[9] The reflective practitioner approach has been adopted in a wide range of disciplines including medicine, engineering, architecture, education, social work, and – most importantly for this paper – practical theology.

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[5] Ibid., p50.

[7] Olivier, "In Search of Common Ground for Interdisciplinary Collaboration and Communication: Mapping the Cultural Politics of Religion and HIV/AIDS in Sub Saharan Africa - an Unpublished Phd Thesis," p133.

[8] Schon, *The Reflective Practitioner: How Professionals Think in Action*, p22ff.

[9] Thompson, *SCM Studyguide to Theological Reflection*, p22.

I required a methodology grounded within the discipline of practical theology for a reflection-on-action to seek more faithful practice. Practical theology is a diverse and developing field.[10] It recognises the importance of the complex dynamics of the contemporary human experience and seeks a more faithful *performance* of the gospel[11] rather than confining theology to an historic engagement with sacred texts and traditions.

There are a number of ways of doing theology to take account of the experience of the past (the texts and traditions) and the experience of the present (the context in which Christians of a concrete time and place find themselves).[12] I sought a methodology that values human experience as a place where the gospel is "grounded, embodied, interpreted, and lived out".[13] Stephen Bevans, in seeking a global perspective for theology, identifies this as the Praxis Model – a means of not simply interpreting the world, but changing it. Scripture and Tradition are understood not merely as "vehicles of revelation" but rather "models of action" that invite believers to "join God in God's liberating and saving activity within the weave of human and cosmic history".[14] The Praxis Model offers an appropriate methodology to engage in critical theological reflection on the practices of health ministry by giving opportunity for theological resources to engage with the practice of health services to ensure and enable "more faithful participation in God's work of redemption in, to, and for the world".[15] Practical theology brings together the best theological resources with the best social and natural science can offer to work together for the glory of God.

3. An example of practical theology in action

The Praxis Model is the basis of The Salvation Army's way of working called Faith-Based Facilitation. However, it would be wrong to think this was merely lifted from a text book. Faithful practitioners were already using the model – although they had not written it down.

a) Faith-based facilitation process

Experienced Salvation Army practitioners working in areas of health and development have understood the importance of *process* for many years. An essential characteristic of faithfully orientated health ministry emphasises the contribution of *process* in transforming social relations. It is not enough to merely bring people together to discuss a health issue. They need to be facilitated in their discussions and work to enable the building of strong, deep resilient relationships.

I observed excellent examples of a faith-based *process* way of working during a visit to the western part of Kenya. The Salvation Army has only one health centre in this area but a vast congregation-based health ministry particularly supporting women and children infected and affected by HIV/AIDS. Almost all of the congregations function without support from the health institutions but are able to engage in a significant health ministry by focusing on developing relationships through a structured process of home and community visits, listening activities, reflection, and discussion supported by a limited – but valued – input of health education and minimal treatment activities.

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[10] Pattison and Woodward, "Introduction to Pastoral and Practical Theology," p16.
[11] Swinton and Mowat, *Practical Theology and Qualitative Research*, p4.
[12] Bevans, *An Introduction to Theology in Global Perspectives*, p166.
[13] Swinton and Mowat, *Practical Theology and Qualitative Research*, p5.
[14] Bevans, *An Introduction to Theology in Global Perspectives*, p178.
[15] Swinton and Mowat, *Practical Theology and Qualitative Research*, p6.

Groups work in rural and urban settings, based around congregations and include people of other faiths such as Muslims. The group decides what issues to focus on. For example, there are AIDS widows support groups, teenage health groups (focusing primarily on prevention messages), groups for mothers, babies, and toddlers as well as men's health groups. The groups use a common process way of working using basic facilitation skills, a regular self-assessment process and regular worship activities which retain a faith-distinctive character. Positive outcomes include health education, prevention, and care activities as well as income generation activities to provide on-going financial support for vulnerable group members.[16]

Facilitation is very useful in addressing issues of power. Hearing the voices of the powerless is critically important. Establishing and embedding a way of working which ensures the powerful are disciplined into hearing the powerful is essential. Facilitation is a proven way of helping disparate voices to be heard.

But facilitation can be more than merely a means of correcting power imbalances. I observed many practitioners using facilitation tools but infusing them with faith-based insights and perspectives. In this application, facilitation displayed many of the characteristic of faithful presence such as hospitality and listening. This way of working opened up space for transfigured social relations when it meaningfully engaged with church practices such as Bible reading, prayer, and reflection. I noted facilitation being used as a means of building healthy relationships with people within and outside of the church. However, I noted, that while some faith-based facilitators were skilled in their practice, they were rarely able to articulate this way of working or successfully replicate it across the organization. This relationally dependent way of working was very effective in a few places but was inevitably undermined by a change of personnel.

In other field visits around the world, I observed a lack of consistency in the articulation of theologically informed practice particularly among 'professional' employees. Their methods appeared to be informed by secularist ideologies rather than due to any faith-commitment and theologically informed ways of thinking. Therefore, the decision to develop resources that promoted and enabled more faithful practice.

Given The Salvation Army's engagement in health and development work, resources and tools have to be used by people who do not share the same theological perspectives but are willing to acknowledge that faith traditions and spiritual experiences play an important role in developing healthy people. Theological reflection models – such as the pastoral cycle – offer a connection point for people of different faith perspectives. Cyclical process models are used in the practice of many professionals – the learning cycle, the planning cycle, the care management cycle, etc, Thus, a process approach which validated faith-commitment and theological ways of thinking based on the pastoral cycle was developed.

Another connection point between FBO and secular development practice was identified in the use of facilitation methods and tools. Facilitation is widely used by secular agencies as well as FBOs. In its

[16] The lessons learnt by observing the work in Kenya were particularly instructive in developing a booklet – *Building Deeper Relationships* – that sets out a process and set of tools for a faith-based facilitation way of working being used across The Salvation Army world. Visit www.salvationarmy.org/fbf for other case-studies of faithful practice and the process and tools recommended to sustain faith-based health and development ministry.

secularist guise, it claims to enable people to think for themselves and develop solutions from their own resources.

The team of Salvation Army practitioners developed the following definition and diagram to explain the process and purpose of Faith-Based Facilitation:

> "Faith-Based Facilitation a process and a set of tools which helps, encourages and enables people to speak and, in the light of Biblical truths, make more faithful decisions and enjoy deeper relationships. An intentional searching for spiritual insight (called '*Kairos* Experience') is central to Faith-Based Facilitation. A facilitator does not only have skills and tools, s/he seeks a Christ-like character."

The Faith-Based Facilitation (FBF) process includes the four key elements of the Wesleyan Quadrilateral – Scripture (with other faith texts where culturally appropriate), Tradition, Reason and Experience – but by adopting the action-reflection process it is more recognisable to people familiar with secular models. While the five-stage process is widely used, the recognition of the influence of Bible, Faith Tradition and the work of the Spirit (*Kairos* Experience) makes it distinctively faith-based.

The FBF process starts when people identify an issue or event that requires attention **(Stage 1: Issue or Event).** It might be a significant concern, or a regular pattern of activity that needs to be carefully examined to see 'what we are doing and why we are doing it'. Whatever it is, the experience needs to be clearly identified – preferably by a group of people working together – to agree the issue or event.

The experience is then described and analysed as fully as possible in Stage 2 (**Describe and Analyse**). Those who are reflecting (together or individually) are encouraged to identify every factor that is impacting the issue being explored. This contributed to the development of a rich, comprehensive, multifaceted description of the issue/event. Facilitators are encouraged to remain as objective as

possible by paying careful attention to description and analysis while avoiding judgments and opinions.

The third stage of the process involves thinking through the factors that have emerged, sharing ideas and responses **(Stage 3: Reflect and Evaluate)**. The importance of Scriptures, prayer, and quiet reflection as helpful activities for people of faith is emphasised. Tools assisting a process of careful evaluation are used and tough questions are asked and answered.

A well-facilitated time of reflection based on the Faith-Based Facilitation process will normally lead naturally towards a decision which the participants can own and implement (**Stage 4: Decide and Plan)**. Tools have been developed to assist the process if agreement is difficult. The fifth stage translates decisions and plans into deeds (**Stage 5: Action**). Again tools have been included in the resource to assist people at this stage. Like all cycles, the FBF process, does not stop at the last stage, but continues around another cycle in an on-going reflective process.

There is considerable back and forth between the stages in the process of describing, analysing, theologically reflecting, and formulating proposals for revised practice. In adopting this approach, we are attentive to the possibility of God's agency in the work of describing and analysing the culture and context within which Salvation Army health ministry operates. Any confinement of theology to "the analysis of data generated by supposedly neutral social scientific methods" should be rejected.[17]

b) Tools to support the FBF process

The FBF process is supported by a wide range of tools to assist participants develop a comprehensive understanding and response. Simple tools such as listening, exploring, community walks, and visits, community mapping, brainstorming, prioritising, creative thinking, problem solving, self-assessment tools are highly effective in the hands of a skilled faith-based facilitator. These are only some examples from the wide range of helpful tools. Other tools from the social and natural sciences can be used to give particular insights depending on the issue or event under review.

The FBF process and tools are now being used around the world in a range of situations which benefit from a reflective process. These include an adult education session particularly around behaviour change (learning); a home or community visit (caring); A problem-solving session with a group or an individual (counselling); Helping a group or organization write a plan (planning); and Developing a faithful 'voice' to engage with wider society (advocacy). A common outcome in all these applications is the building of deeper relationships.

c) Integrating a number of programmes in one area with a shared *telos*

During our field visits, we regularly identified a lack of integration between a number of faith-based institutions – churches, schools, clinics, and hospitals – in one geographical location. Too often, institutions prioritise closer links with the respective government departments[18] than seeking a continuous chain of faith-based ministry. To encourage discussion and imagining among

[17] Bretherton, *Christianity and Contemporary Politics*, p30.
[18] Ministry of Health or Education

practitioners, the following diagram was developed to illustrate the ***ideal*** of faith-based integrated health care based on shared *telos* and evidenced by deep relationships.

This model of integrated, socially embedded, health ministry gives primacy to responses as close to the family as possible supported by quality relationships between the institutions of household, church, and hospital. The black arrow-lines are not incidental but are central in enabling all participants to develop a shared *telos* which sustains often fragile relationships in chaotic communities. These are fragile relationships requiring careful and on-going attention.

Every aspect of Salvation Army programme should be promoting the same theological anthropology – in other words, the people God created us to be. We are describing this as “healthy persons’. Every part of The Salvation Army, every member and employee, should be working towards the same *telos* – orientated towards the same priority – “healthy persons”.

Against the conception of people as “autonomous rational individuals”, is an orientation towards “*healthy persons”* understood as “body-soul-in-relation”. A priority for “soul” over “body” in early Salvation Army practice resulted in some fragmentation of Salvation Army mission between corps and social – “body” work was left to the social services professionals and the corps focused on the work of saving and sanctifying souls. Such dualism was, and is, unfaithful and will require long-term attention for recovery.

In light of this, The Salvation Army has prioritised health practices with a ‘relational’ dimension. In other words, medical conditions that benefit from long-term relationships as against those which generally require short-term, high technology interventions. The following list of conditions were identified: addictions, diabetes, disabilities, end-of-life care, eyes, HIV/Aids, hypertension, infectious diseases, leprosy, maternal and child health, mental illness, and nutrition. All of these conditions benefit from community-based as well as institutionally-based interventions in the education, prevention, care, and treatment dimensions of primary health care. They are all best responded to with an integrated, continuous chain of care from home-to-hospital-and-back supported by people

of faith at every link of the chain. In non-health faith-based initiatives, can similar "relational" priorities be identified? Initiatives that intentionally build deeper relationships?

The reorientation of mission hospitals in developing countries towards a relational, reflective process with a primary health care priority requires a significant and sustained process of change. Reforming health care ministry is not a quick and easy task. It will require leaders who are committed to building relationships with worshipping congregations who, in turn, are prepared to support and sustain tension-dwelling clinic-hospitals. Such a move opens up opportunities for congregation and clinic-hospitals to be 'faithfully present' with families and individuals engaging in prevention, health promotion, home care, and rehabilitation initiatives as people take greater responsibility for their health.

There are risks in developing congregation-based health services. Firstly, the instrumentalisation of health services is a particular risk for churches engaging in 'direct health care' services. The 'instrumental' attitude manifests itself in the congregations wanting to 'do something' about the plight of 'the poor' rather than commit to deep relationships with people. Thus, it is critically important that congregation-based health ministries (and other FBO health services) affirm, enhance, and appreciate the faith works of the poor themselves as they find both their agency and identity in the task of improving their own health.

A second area of concern is the trend by FBOs – encouraged by the funding priorities of government funders and secularist public health frameworks – to promote community-based health programmes rather than congregation-based initiatives. FBOs developing health or development programmes in a particular location may invite churches to participate but, often, only as one voice among many. There is little attention given to the importance of the habits and practices of faith or clarity of *telos*. Therefore, it is important that faith leaders are able to discern the *telos* of the funding agencies. Are funders promoting a secularising concept of persons – such as the 'autonomous rational individual' or are they creating space for the development of 'healthy persons'? A disagreement over *telos* does not preclude partnership but it should alert faith leaders to the dangers of changes in the institutional character.

In order to resist a drift towards any form of unfaithfulness, the coupling of community and faith-based programme with a worshipping congregation should be a priority for FBOs. This enables the habits and practices of the worshipping congregation to sustain the faithfulness of the service. Bretherton argues neither the worship habits or social actions of the church and its members are adequate evidence to distinguish Christians from non-Christians. Rather the specific difference between the church and other communities is the nature of their different relationships with God:

> "Distinctiveness lies in how God is present to and within the church. Distinctiveness does not necessarily lie in what the church looks like or does… God is at work in all creation, and all may be justified in Christ; however, before the *parousia*, it is given particularly to the church to be the witness to, and the place of, transfigured social relations."[19]

Therefore, we can conclude that a faithfully present church or hospital is evidenced not by duty or ritual but by transformed social relations. As transformed social relations are sustained by the

[19] Bretherton, *Hospitality as Holiness : Christian Witness Amid Moral Diversity*, pp107-8.

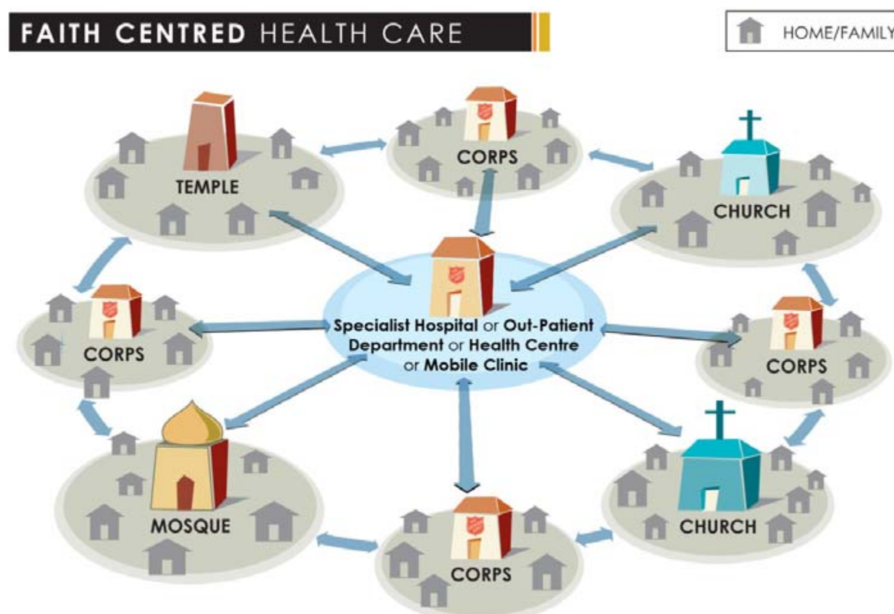
worshipping practices of Christian disciples, FBOs need to seek evidence of transformed social relations as an indicator of faithfulness.

d) Developing partnerships for the common good

Another characteristic of faithfully present Salvation Army health ministry is the building of partnerships with other groups – faith-based or not – based on 'mutual interest' through a process of reflective practice. A tradition-specific practical theological approach to health ministry – such as FBF – can help this process. This goes against the dominant trend in interfaith dialogue where partnerships are sought around 'shared values' such as 'justice' and 'human development'. Indeed, some people perceive theology and the habits and practices of specific faith-groups are perceived by some to be potentially divisive.

The way forward is, I propose, the promote the use of a process of reflective practice to enable people of different faiths to work and talk together by affirming and acknowledging the contribution of their faith without collapsing different theologies into a morass of commonality. Therefore, partnerships should be developed with the resources of practical theology to enhance and embed beliefs and practices rather than attempting to distance them.

The contribution of faith in practical tasks as it can be a particularly fruitful means of developing common ground between people of different teleological convictions. However, the expectation should not be that people leave their faith at home – but rather that a shared concern for the health of everyone in the community creates a space for engagement between people of different faiths. The following diagram has been helpful in stimulating discussion and legitimating inter-faith partnerships by Salvation Army health programmes.



In this model, faith congregations maintain their distinctive traditions but come together at the health institution or health issue in a common response to a shared concern. Admittedly, this is an idealistic model and the reality is often an environment of contested and conflicting relations. However, Salvation Army experience has shown that barriers can be overcome and relationships

developed if the process is properly facilitated. A process of relationship building is required to foster dialogue and bring congregation, community, and health professionals together. My visit to the Lutheran Hospital in East Jerusalem last year showed me an excellent example of this theory in action.

Conclusion

This paper promotes an appreciation of tradition-specific approaches to health and development work. Rather than pretend that differences are inconsequential, a faith-based facilitation approach intentionally acknowledges differences. Rather than seeing faith as a difficulty to be worked around or ignored, practical theology offers resources to take faith seriously. This is not an isolationist move but rather one that seeks to bring everyone with all their resources to the cause of improving the health of all people – particularly poor and marginalised members of our global community.

In my book – *Keeping Faith In Faith-Based Organizations* – I propose Salvation Army health ministry in the twenty-first century should seek the characteristics of *movement* for the development of "*healthy persons",* who are formed and sustained by the *habits and practices* of worshipping congregations in the power of the Spirit, who support clinic-hospitals, households, and other institutions and groups with a *theologically reflective* process way of working, resulting in faithful presence, and the transformation of *social relations* as God intends. I do not presume these are the same characteristics for Lutherans from Norway. However, I am sure you need to know what they are. If your faith does not drive your organisation, whose faith does?"

Questions for discussion groups

1. What forces encourage us away from being faithful?
2. What resources do we have to sustain being faithful?
3. What specific actions could we take to increase our capacity for faithfulness?

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