DISSERTATION ABSTRACT

Doctor of Ministry
Emphasis in Mission

Adventist University of Africa

Theological Seminary

TITLE: DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON

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Health workers in Buea Adventist Hospital (BAH) have been reluctant to embark on medical evangelism. Notwithstanding, the hospital personnel are known to be welcoming and kind. Unfortunately, they have never gone beyond such steps in their interactions with patients. Research revealed that nothing has been done before in terms of post-contact activities with former patients.

The purpose of this in-ministry dissertation was to develop a spiritual care model for medical evangelism in BAH. The idea was to address the worker's reluctance in matters of medical missionary work. After a brainstorming session and meetings for a capacity building seminar, the researcher put in place a model of spiritual care that had continuity, even after patients were discharged from the hospital.

Outpatients, inpatients, their relatives, and selected workers of BAH constituted the sample for this study. A mixed-method of qualitative and quantitative research approaches were employed.

Seventeen out of 20 workers (85%) took part in the implementation of the model program. Seven participants (41%) returned their forms as an evidence of their involvement in activities pertaining to medical evangelism. Everyone involved in the group discussion agreed that it would be difficult for any worker to have time for medical evangelism activities after daily work hours. Out of 50 patients (and/or relatives) who received a questionnaire, all gave an average mark that positively expressed their level of satisfaction regarding the services at BAH. In the same vein, the 57 ex-patients whom the researcher interviewed by phone also provided data that revealed the positive impact of the model.

Consequently, for sustainability, the researcher recommended that a chaplaincy unit be put in place. The workers' involvement in medical evangelism must not be seen as an event but should become a culture. It is such a mindset that would facilitate the fulfillment of mission in Cameroon.

The researcher concluded that a spiritual care model for medical evangelism is an innovative tool for discipleship. The entire church needs to create awareness around such an approach to missionary work.

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A dissertation

presented in partial fulfillment

of the requirements for the degree

Doctor of Ministry

by

Jacques Yves Nganing Mbende

May 2016

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Ubang!
mia gwa souman,
mi gwa souman;
ba mi gwa souman.
O nin ni Yesu,
Amen!

(Almighty God, I have thanked thee, I am thanking thee,
and I will thank thee. In the name of Jesus-Christ, Amen!)

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In anticipation, I want to thank the readers of this dissertation. If they honestly quote me, I foresee better interest in spiritual care, and how it can be linked to medical evangelism.

CHAPTER 1

INTRODUCTION

Description of the Ministry Context

This section begins with a short description of the Seventh-day Adventist (SDA) medical clinics in Cameroon. Then it will progress to the particular clinic selected for this research, using it as a pilot for the study. Thus, the main elements expected in the description of the ministry context of the Adventist clinics in Cameroon are: years of existence, staff, services and number of patients (ratio per week or per month).

Generally speaking, the SDA medical clinics in Cameroon can be classified into two categories going by the years of their existence. The first category, are those created during the time of the Missionaries. For instance, the Koza Adventist hospital was opened in 1953[1] by two Missionaries: one, a pastor, and the other a medical doctor. The Nanga-Eboko Adventist health center existed before 1967,[2] almost from the time missionaries established educational, religious, and health institutions. The Buea SDA hospital was opened in 1971[3] by a missionary couple; the husband was a pastor, and the wife a nurse.

[1] Mikoas Hermine and Setgo Olivier, Report of the Practicum in the Koza Adventist Hospital from June 26 to August 3, 2013, Adventist University Cosendai, Nanga-Eboko, Cameroon, 5.

[2] Efoua Damaris, Director, Nanga-Eboko Adventist Health Center, interviewed by the author, Nanga-Eboko, October 20, 2013.

[3] Bill Colwell Jr, personal communication with the author, October 28, 2013.

The second category is those clinics that were created in recent years by the local church administration. For example, the Adventist dispensary of Djoungolo, in Yaoundé which was opened on 28 October 1998 can be considered in this category. Briefly, the years of existence of the Adventist medical clinics in Cameroon varies from 60 years, for those among the oldest, to 15 years for those among the youngest.

The staff in these establishments includes very few medical doctors. The clinic at Nanga-Eboko does not have a single medical doctor; the same situation is in Yaoundé. The one in Koza has three, including one surgeon. There is only one medical doctor in Buea. Generally, the vast majority of the medical doctors in the Adventist clinics in Cameroon are foreigners. Nevertheless, almost all the nurses and lab technicians, or assistants, are local people. In total, the clinic in Nanga-Eboko has five workers,[4] 15 medical personnel are in Buea,[5] 18 in Yaoundé,[6] and 60 in Koza.[7]

Those clinics provide the usual services that are expected of any health center. These services include: consultations, minor procedures, family planning, Sexually Transmitted Infections (STI) testing, vaccinations, ante-natal services (early pregnancy consultation), normal assisted deliveries, and basic inpatient care. Nevertheless, one can observe that a big health center has a better capacity to offer these services than a smaller one.

Based on the data collected from those clinics, it appears that in 2003, Yaoundé had a total of 10,546 outpatients; that an average of almost 880 patients per

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[4] Efoua Damaris, Director, Nanga-Eboko Adventist health center, interviewed by the author, Nanga-Eboko, October 20, 2013.

[5] Bill Colwell Jr. to author.

[6] Evina Timothée, Director, Djoungolo Adventist Health Center Yaoundé, interview by the author, Yaoundé, October 14, 2013.

[7] Mikoas Hermine and Setgo Olivier, “Report of the Practicum in the Koza Adventist Hospital from June 26 to August 3, 2013” (Research work, Adventist University Cosendai, Nanga-Eboko, Cameroon, 2013), 8.

month or 220 per week.[8] From May 2011 to April 2012, Nanga-Eboko had a total of 521 outpatients; that is, 43 patients per month or 10 per week.[9] As for Buea, in 2012, it registered 3,623 outpatients, giving a monthly average of close to 300, and a weekly one of 75.[10]

From this general overview of the SDA health institutions in Cameroon, it shall be shifted to the particular hospital for this study, the Buea Adventist Hospital (BAH). A number of details constitute the specifics of this clinic, along with the work done there.

The investigator has chosen the Buea Seventh-day Adventist Hospital because of the number of details that constitute the specifics of this hospital, along with the work performed there. The researcher has been the pastor of the Buea church from 2003 to 2005. It was during that time that the foundation was laid and the construction began. The church was encouraged to pray and support the construction and the workers at the hospital. The medical doctor then appeared very reluctant to open the hospital doors to the pastor for an interaction with the patients. However, observations made by the pastor indicated inadequate spiritual care, and a misunderstanding of medical evangelism among the church members in the community. This resulted in the inability to make the Buea Church a center for health in that community.

Since those years of ministry, the researcher, though now a lecturer at the University of Nanga-Eboko still has the above situation as a burden in his heart. Apparently, only concrete steps towards medical evangelism in Buea church would help to lift that burden. Besides such burden in his heart, the researcher is also an

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[8] Evina Timothée, Director, Djoungolo Adventist Health Center Yaoundé, interview by the author, Yaoundé, October 14, 2013.

[9] Efoua Damaris, Adventist health center, interviewed by the author, Nanga, Oct. 20, 2013.

[10] Bill Colwell Jr, personal communication by the author, October 28, 2013.

adherent member of the Association of Nurses for the French speaking countries; and his name is in the google database for authors who write on the topic of spiritual care. Therefore, conducting this study is very significant to bring more expertise in his ministry concerning this area of research.

Statistics from the research conducted between January and March 2015 seemed revealing. For instance, of the 2,179 patients who came to the BAH, majority were students (702; that is 32%). Given that the town of Buea is known as university city, this suggests that the Adventist hospital is significant to the community. To illustrate the point, the statistics indicate that of the 391 patients that were admitted in the same period prior to the study, the student population represented about 41% of the patients admitted; that is 162 in total. This also indicates that the welfare of the BAH is somehow dependent on the presence of the university in that town.

Statement of the Problem

Medical missionary work is regarded by the Adventist Church as the right hand of the gospel, meaning that it is to be used to prepare the way for the reception of Bible truth. [11] All of the church members, including the healthcare staff should be involved in that task. Thus, Adventist health centers should evidence medical missionary activities as it occurs in the United States of America where there is an association, AMEN- Adventist Medical Evangelism Network.[12] It is in line with this type of expectation that the church gives missionary credentials to nurses and doctors in health institutions.

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[11] Ellen G. White, A *Call to Medical Evangelism and Health Education*, Complete Published Ellen G. White Writings [CD ROM] (Silver Spring, MD: Ellen G. White Estate, 1999).

[12] See the AMEN website for more information: www.AMENSDA.org.

Unfortunately, spiritual care is not mentioned in the list of the regular services offered by this health institution. Nevertheless, the BAH mission statement[13] claims to encourage the idea of total health to their clients. In view of the fact the mission statement does not reflect the practice, there arises a need to investigate the situation and address it accordingly.

Statement of the Purpose

The purpose of this dissertation was to write on spiritual care as the basic component for medical evangelism and to develop strategies pertaining to medical missionary work. This study shall also include the implementation of the above strategies via seminars to health staff and an evaluation of the impact of those suggested strategies.

Justification

In Cameroon, the state allows the public sector to run hospitals in order to improve the number of healthcare facilities. Therefore, there is a socioeconomic status attached to all patients. In this light, there is a need for the Buea Adventist Hospital to examine its quality of services provided to patients and their relatives who come to that health institution. This research sought to provide needed tools for a better intervention regarding the issue of spiritual care.

There is a religious background pertaining to the history of hospitals. For such a reason, many denominations invest in health institutions. Such investment is presented as a possible strategy to carry on mission in the world. The Adventist Church in Cameroon has a long history of providing healthcare services in the

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[13] Bill reports, "As Jesus loved and served, it is our mission to serve and love the people of Buea by providing access to world class health services and education; and to encourage our clients to total health: spiritual; physical; emotional; and intellectual," ibid.

country. This research will explore whether such health ministrations in the Buea Adventist Hospital have always been coupled with gospel ministration. The study will reveal whether the BAH operates from a true Adventist philosophy for wholistic care, or if it simply aims at making money, as any other business in the public sector.

Based on the statement of the World Health Organization (WHO) that prevention is better than cure, there is a mission of health education incumbent to each health institution. Through the future intervention in BAH, this research highlights the need for Adventist health facilities to run health education activities.

Delimitations

The research for this dissertation confines itself to the study of spiritual care as a component of medical evangelism. The research focuses on possible strategies for the ministration of spiritual care to all the patients of the Buea Adventist hospital in a given period. The researcher employs capacity building seminars with the healthcare staff so that they can be empowered to implement spiritual care strategies as a component of medical evangelism. Some of these seminars include lectures on spiritual care, medical evangelism, and the model for implementation.

The study was conducted for seven months, from April 2015 through November 2015 with evaluations after the fifth and seventh months. The reason for this is that such investigations belong to the realm of faith-based realities and necessitate time for friendship before expecting a response to any gospel invitation. The research does not explore post contact with ex-patients mostly for the sake of their conversion into the Adventist Church, but mainly as a way of addressing their spiritual needs. Such approach introduces wholistic healing at the Buea Adventist hospital during the above mentioned months.

Definition of Terms

This study is going to use three main terms with specific meanings in mind: spiritual care, biblical healing and medical evangelism. Spiritual care is understood here as referring to activities that address the spiritual dimension of human beings: kind words, compassionate gestures, prayer, etc. that encourage the sick person to hope for a divine intervention in times of suffering.

Biblical healing in this study is a healing that is inclusive of the medical treatment provided in a health center, and is combined with prayer, that calls for God's intervention if He chooses that a sick person should recover from a disease.

Medical evangelism here stands for any activity that consists of spreading the word of God through the health ministration of nurses, medical doctors, other health personnel, and church members, with the understanding to make churches centers of health.

Methodology

The chronological structure of the dissertation is as such:

1. Gather the material needed for the exegetical study of selected verses that provide the biblical foundation of the research.
2. Gather and explore sources in order to do a literature review.
3. Seek authorizations from various administrators.
4. Gather data via questionnaire and interviews that enable understanding the initial situation.
5. Analyze data and design a brainstorming session and a capacity building seminar.
6. Implement the above-mentioned activities.

7. Do the follow-up via a human resource network and observations on the ground.
8. Do the first evaluation of the intervention. This would be after the fifth month of spiritual care ministration to all the patients (especially those admitted), and post contact with the 30 ex patients. Analyze that evaluation. If the need arises, plan another capacity building seminar.
9. Do the last evaluation of the situation two months after the analysis of the first evaluation; analyze and send suggestions to various local administrations.

The researcher planned that the development of key activities, their implementation and evaluation be done before December 2015. This study has six chapters; and each plays a key role in building the overall understanding of the selected topic. Here is a detailed description of each part.

Chapter 1 introduces the study. It starts with the description of the ministry context where the dissertation will take place. That includes the ministry context of the selected Adventist hospital as well as some few details about the researcher. Before concluding with the description of the expectations for this dissertation, the chapter outlines the following elements: statement of the problem, statement of the purpose, justification, delimitations, definition of terms and methodology.

Chapter 2 does exegetical and theological research. This twofold approach aims at providing a solid biblical foundation and key elements to the research.

The biblical foundation of the dissertation presents God as the Healer in the Old Testament (OT). It then surveys the healing ministry of Jesus in the New Testament (NT). Lastly, a possible link between health and salvation in the entire Bible is explored. The research demonstrates the importance of the ministration of

spiritual care in connection to healing. The chapter attempts to position spiritual care as a key human action that can prepare the patient's heart to be thankful if healing occurs as a result of divine intervention in the patient's life. There is also a survey of the importance of spiritual care even if healing does not take place.

Chapter 3 is the literature review. In the fundamental area of spiritual care, an extensive study is made on the material useful in hospital chaplaincy written by a variety of authors. Following this, the research surveys the writings of Ellen White related to the healing ministry. A number of strategies emanate from them. Besides, some considerations shall be given to significant sources on the ministration of spiritual care by a number of Adventist and non-Adventist contemporary scholars on the given topic. The works of different authors are reviewed in conversation with each other, and their studies compared and contrasted with each other. The central question in this regard is: how should one go about the ministration of spiritual care in order to achieve the expected results?

Chapter 4 comes as a consequence of the elements revealed in Chapters 2 and 3. Based on the research, activities are developed such as a brainstorming session and a capacity building seminar. The methodology of this chapter is mixed-method research. The data collection method includes: participant observation by the researcher in the hospital, a qualitative research through interviews and a quantitative research through the administration of the questionnaire to patients and workers of the BAH. The analysis of the data collected is needed in order to understand the initial situation and design an intervention to bring about a transformation in that health institution.

Chapter 5 details the narrative of the project implementation, which includes a schedule of activities for the selected hospital, the strategic activities pertaining to the

area of spiritual care, and an evaluation of the mixed methods used. In this chapter, two rounds of quantitative and qualitative research methods are going to be implemented. The first one will deal with the collected and analyzed numerical data after the program implementation, while the second one will be based on personal interviews of a few selected individuals chosen from the patients.

The last Chapter is about the general evaluation and the learning from the research. The idea is to provide an overall assessment of the entire intervention. It helps to establish the value of this research. It gives key information on what the researcher has learned in the whole process of conducting his study.

Expectations

At the end of this study, recommendations are given to the local administrations. Administrators can use these suggestions as a roadmap in managing the post contact stage with their clients. The researcher, therefore, expects this study to positively affect Adventist health centers.

It appeared that a study of this kind was the first of such in the history of BAH or Cameroon. As such, the recommendations of this study could be replicated at other Adventist health centers and hospitals. Consequently, it would be expected that the emphasis on the health message in Cameroon would bring about a necessary rethink of the life and mission of the church, in such a way that the Adventist Church in Cameroon might have to return to the practice of medical evangelism. The understanding of churches as centers of health will have to be taken into consideration in carrying the mission of the church. This turnaround shall open doors that have remained closed for the past 90 years Adventist evangelism in the country.

The researcher experienced growth in his learning experience, especially as he is passionate about this area of study that brings together health and faith. Such

personal growth shall eventually lead to a permanent interest and involvement in hospital chaplaincy.

In addition, the key expectation of the study was that pastors understand their role in recognizing the spiritual gifts of the laity and give them opportunity to carry out their responsibility in the various domains of their expertise.

CHAPTER 2

SPIRITUAL AND THEOLOGICAL FOUNDATION

This chapter presents spiritual insights for a strong theological foundation of this dissertation through exegetical and other comparative methods of research. The chapter begins with a study of God as the Healer in the Bible and ends with a presentation of healing as an opened door to discipleship. The research question for the chapter consists in finding what could be the importance of the ministration of spiritual care in connection to healing. Normally, spiritual care belongs to the area of hospital chaplaincy and is not linked to any traditional method of evangelism. Nevertheless, this study explores a possible connection between spiritual care and evangelism. That is why the issue of healing is the pivotal element of this study. The methodology includes an extended exegetical study of biblical healing which allows deriving the elements of spiritual care: prayer, words, touch, compassion, etc. In this chapter, the researcher seeks to reveal the theology that supports the components of spiritual care in order to comprehend their importance.

God as the Healer in the Bible

The Issue of Sickness in the Bible

The consequence of sin for the human race is beyond imagination. Fowler[1] observed that the most devastating consequence of sin for human race is its power to alienate humanity from God and make them a subject to physical, moral, mental, and

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[1] James M. Fowler, "Sin," *Handbook of Seventh-day Adventist Theology (HSDAT)* (Hagerstown, MD: Review and Herald, 2000), 253.

spiritual deficiency. As a result, even non-biblical sources endorse that sickness is a "disordered, weakened, or unsound condition."[2] Specifically, Wilkinson affirms that there would be no sickness[3] in the world if there were no sin.[4] The Scriptures mention some acute diseases. They include *dalleketh* or inflammation (Deut 28:22), *kaddchath* or burning ague (Lev 26:16), and fever (Deut 28:22). Epilepsy, paralysis, cutaneous disorders, and blindness were very common. Mental diseases were prevalent in NT times.

When it comes to the topic of the source[5] of disease, most of extra-biblical sources[6] readily agree that pagan world diseases were attributed to supernatural causes. Hence, the use of sorcery and magic to combat sickness was rampant. Yet, some passages in the Scriptures may challenge the view on the supernatural causes of diseases. Actually, a few basic sources of disease are divine visitation (Deut 28:27-29),[7] an adversarial devil (Job 2:7), the decline accompanying age (Gen 27:1; 1 Sam 3:2), and accidents (2 Sam 4:4; 2 Kgs 1:2). As the prominent author George W. Reid

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[2] See for instance Merriam Webster Dictionary and Thesaurus, s. v. "sickness."

[3] The diseases recorded in the Bible are many and varied, but imprecise description of them often makes their identification in today's terms difficult. Paul J. Achtemeier, *Harper's Bible Dictionary*, 1st ed. (San Francisco, CA: Harper & Row, 1985), 222.

[4] J. Wilkinson, "Sickness," *The New Dictionary of Theology* (NDT), ed. Sinclair B. Ferguson and David F. Wright (Downers Grove, IL: InterVarsity Press, 1998), 1:287.

[5] Some passages dealing with disease name no cause (Lev 13; 1 Kgs 17:17; 2 Kgs 5:1; Mark 1:30; 5:25). Achtemeier, *Harper's Bible Dictionary*, 222.

[6] For instance, the Ebers papyrus 66 feet long with 877 sections in 10 columns provide substantial reports of diseases and treatment in Egypt, both before and during the time of Moses. George W. Reid, "Health and Healing," *HSDAT,* 758.

[7] The Deuteronomic interpretation of disease is the most emphatic and detailed in ascribing it to sin (Deut 28:22, 27-28, 35, 59-61). Such an interpretation, or its application to specific instances, is questioned in the book of Job and in the account of the healing of the blind man in John 9:1-3. Ascribing all—both good and evil, disease and healing—to the Lord (Deut. 32:39) posed problems. Why should God torment Saul with an 'evil spirit' (1 Sam 16:14-15) or incite David to a census of Israel for which he then punishes Israel with a plague (2 Sam 24)? Achtemeier, *Harper's Bible Dictionary*, 222.

puts it, “the Bible does not encourage a purely naturalistic theory of disease.”[8] Reid’s point is that health and illness impact the whole person, not only the physical component. The essence of his argument is that the biblical understanding of sickness acknowledges a spiritual[9] element in what today is defined as pathological causes of disease. The upshot of all this is reflected in M. Fontaine’s word of conclusion. Writing about the spiritual element implied in sickness, he[10] maintains that Scripture sees disease much more in the perspective of faith than in the medical perception. In other words, Fontaine believes that there is a salvational link between sickness and God’s plan for the sick person.

Scriptural Affirmation of God as Healer

The OT provides the proper background for a Christian understanding of the concept of healing. In the OT, the basic point is made that God is the healer of His people. As rightly addressed by Dederen,[11] the Bible repeatedly attributes healing to God alone (Exod 15:26; Deut 7:15; 32:39; 1 Kings 13:6; Job 5:17, 18; Ps 41:3, 4; 107:17–20; 147:3; Isa 30:26; Jer 30:17; 33:6; Hos 5:13–6:2), not remotely, but in a highly personal sense. In Exodus 15:22–26, after God had delivered His people from Egypt, led them through the sea, and sweetened the water at Marah, He spoke of

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[8] Achtemeier, *Harper's Bible Dictionary*, 222.

[9] There was a tendency in all serious sickness to fall back on religious ritual and ultimately on divine providence (Exod 15:26; Ps 103:3; 147:3; Isa 30:26; Jer 17:14; 30:17). Merrill Frederick Unger, R. K. Harrison, Howard Frederic Vos, et al., *The New Unger's Bible Dictionary* (Chicago, IL: Moody Press, 1988).

[10] Michel Fontaine, *Santé et Responsabilité dans la Bible* (Sarrebruck, Allemagne: Editions Universitaires Européennes), 69.

[11] Raoul Dederen, vol. 12, *Handbook of Seventh-Day Adventist Theology*, electronic ed., Logos Library System; Commentary Reference Series (Hagerstown, MD: Review and Herald, 2001), 761.

Himself as their "healer." Elwell and Beitzel[12] comment that this refers primarily to physical sustenance, but it points to the more encompassing concept of God sustaining His people in an eternal relationship with Himself. In a similar manner, Deuteronomy 32:39 speaks of God as the One who heals. Subsequently, these scholars agree that the context in Deuteronomy implies that this healing power derives from the fact that God is God. This concept of God as the healer is echoed throughout the OT by the psalmists (Ps 6:2; 41:4; 103:3) and prophets (Isa 19:22; Jer 17:14; Hos 7:1; Zec 11:16). As an illustration of God as a Healer, McGee confirms for instance that "leprosy in Scripture is a type of sin. One reason is that it was incurable by human means. Only God can cure sin and save a sinner."[13] That is why when Asa "did not seek the Lord, but the physicians" (2 Chron 16:12), the record spoke reproachfully.

God's Names and His Healing Nature

Most Bible scholars are familiar with the Hebrew word *Elohim*, which means gods or God.[14] Many believe that Elohim comes from *Eloah* as a unique development of the Hebrew Scriptures and represents chiefly the plurality of persons in the Trinity of the Godhead. Eloah is also a basic Hebrew term for the God of Israel, but is used less frequently. Consequently, Eloah just like *El* is a separate though perhaps related generic term for God. Most frequently mentioned suggestions for an original meaning are "power" or "fear," but these are widely challenged and much disputed.

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[12] Walter A. Elwell and Barry J. Beitzel, *Baker Encyclopedia of the Bible*, Map on Lining Papers (Grand Rapids, MI: Baker Book House, 1988), 936.

[13] J. Vernon McGee, *Thru the Bible Commentary*, Based on the Thru the Bible Radio Program., electronic ed. (Nashville, TN: Thomas Nelson, 1997), 2:311.

[14] See Hebrew OT word 430 for the discussion in the TWOT. R. Laird Harris, Robert Laird Harris, Gleason Leonard Archer, and Bruce K. Waltke, *Theological Wordbook of the Old Testament*, electronic ed. (Chicago, IL: Moody Press, 1999), 41.

A study of the various accompanying descriptions of El, where the name occurs in Scriptures, leads to a rather solid conclusion. It should be stated that, from the beginning of the use of this word in Scripture, it was intended to distinguish the true El (God) from all false uses of that name found in other Semitic cultures. Here are a few occurrences with the idea they represent in Scriptures:

1. To denote God's greatness or superiority over all other gods: Jehovah Gibbor Milchamah, "The Lord Mighty in Battle" (Ps 24:8); Jehovah Makkeh, "The Lord that Smiteth" (Ezek 7:8), Jehovah Melech Olam, “The Lord King Forever” (Ps 10:16).
2. To mention Him as the Savior God of Israel: El Emunah, "Faithful El" (Deut 7:9), El Shaddai, "Almighty God" (Gen 17:1), El Gibbôr, "El the Heroic" (Isa 9:5), El Hakabodh, "El of Glory" (Ps 29:3), El Olam, "El of Eternity" (Gen 21:33).
3. To imply the very personal relationship between the El of the Bible and His believers: El Tishuathi, "God of My Salvation" (Ps 18:46), El Hayyay, "God of My Life" (Ps 42:8), Jehovah Nissi, “The Lord My Banner (Exod 17:15), Eli Maelekhi, “God My King” (Ps 68:24), Elohe Mauzi, “God of My Stregnth” (Ps 43:2), Elohim Ozer Li, “God My Helper” (Ps 54:4).

The above summary of contributions corroborates with an age-old belief among Bible scholars. That belief insists that God’s names as recorded in the Scriptures contain various meanings that reveal His nature. To take a case in point, one can refer to Moses. In Deuteronomy 7:9, he chooses to call God, *El Emunah*, because he was convinced of God’s faithfulness towards him and His people. That is to say, God’s name comes as a result of an experience with Him, and depends on His

revelation to the believer. Therefore, a study of the word *word*—in Hebrew, *dabar*—reveals that it also implies an *event*.

In connection to the healing nature of God, the name that is of particular interest is revealed in Exodus, where God tells the people of Israel that He is "the LORD who heals[15] you" (*Jehovah-Rophi* or *Jehovah-Rapha*; Exod 15:26). In this passage, called the Old Testament Divine Healing Covenant, the Lord God not only makes a covenant to heal; He reveals one of His names, Yahweh Rapha.[16] Vincent Cheung agrees with such interpretation when he writes, "The names of God reveal his very essence and his nature, and not arbitrary or peripheral information. Thus, when God reveals one of his names as 'The Lord, who heals you,' he is telling his people that it is his nature to heal, that it is his disposition to restore the health of those who follow him."[17] Basically, Cheung is saying that one must think of healing as God's normal desire rather than the rare exception. Similarly, Reid himself writes, "the Scriptures present God alone as healer."[18] In sum, it appears that God has a name to denote His healing nature. A number of events illustrate God as the sole Healer; for instance, the healing of Jeroboam I.

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[15] Hayford and Van Cleave, 'Heals, *rapha›.'* They explain that to cure, heal, repair, mend, and restore health. Its participial form *rophe›,* "one who heals," is the Hebrew word for doctor. The main idea of the verb *rapha›* is physical healing. Some have tried to explain away the biblical teaching of divine healing, but all can see that this verse speaks of physical diseases and their divine cure. The first mention of *rapha›* in the Bible (Gen 20:17) refers unquestionably to the cure of a physical condition, as do references to healing from leprosy and boils (Lev 13:18; 14:3). Jack W. Hayford and Nathaniel Van Cleave, *God's Way to Wholeness : Divine Healing by the Power of the Holy Spirit*, Spirit-Filled Life Kingdom Dynamics Study Guides (Nashville, TN: Thomas Nelson, 1997).

[16] Ibid.

[17] Vincent Cheung, "Lectures on Biblical Healing" (2001): 7, http://www.aren.org/prison/documents/religion/Religion/LecturesonBiblicalHealing.pdf.

[18] Reid, "Health and Healing," *HSDAT,* 76.

Healing of Jeroboam I

Jeroboam's name signifies "the people contend," or "he pleads the people's cause."[19] M. G. Easton claims that Jeroboam reigned 22 years (976 B.C. - 945 B.C.).[20] The event that is of interest for this study happens in the setting of idol worship. A prophet is sent from Judah to speak against idolatry in Bethel. He found the king standing by the altar, ready to burn incense, and prophesied on the spot. The unforeseen situation occurs when Jeroboam stretched out his hand from the altar and gave the command to arrest the prophet. He could no more pull back his hand to himself (1 Kgs 13:4). To put it bluntly, his hand withered and was unmovable. If one should find out the cause of Jeroboam's illness, Reid has no hesitation to provide an answer. He classifies it in the category of sickness caused by God.[21] In the same line, it appears that John F. Walvoord also agrees when he writes, "When the king's outstretched hand, symbolizing his authority, withered, this illustrated that God's authority was greater than Jeroboam's. God could paralyze Jeroboam's might and render it completely useless."[22]

Verse 6 shows a number of steps taken by the king to recover. First, the king himself begs the man of God to plead for him to the Lord. Second, the prophet actually entreats the Lord. Finally, as a result of all those supplications, the narrator mentions that "and the king's hand was restored to him, and became as before" (v. 6b). In fact, Walvoord elucidates further when he writes: "The king acknowledged

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[19] Samuel K. Mosiman, "Jeroboam," *The International Standard Bible Encyclopedia* [CD ROM], ed. James Orr (Seattle, WA: Jim Gilbertson, 1988-2007), NP.

[20] M.G. Easton, *Easton Bible Dictionary* [CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), NP, s.v. "Jeroboam."

[21] Reid, "Health and Healing," *HSDAT,* 76.

[22] John F. Walvoord, *Bible Knowledge Commentary* [CD ROM] (Seattle, WA: Jim Gilbertson,1988-2007), NP, s.v. "I Kings."

God's power and asked the man of God to ask God to restore his hand, which God graciously did. Jeroboam referred to Yahweh as your God, not 'my God,' thereby testifying to his own idolatry."[23] The healing that God operates in this event reveals a number of things to the author of this dissertation. The presence of that man of God made a difference. The king recognizes him as such. It is true that God heals, but the ministry of presence of His servant, here, is what the king sees and relies on. The Bible also provides the healing of another king.

Healing of Hezekiah

The first mention of Hezekiah[24] in the second book of Kings is seen in chapter 18. The reader is made to know that Hezekiah was 25 years old when he became a king and that he ruled for 39 years[25] (2 Kgs 18:2). Besides, verses 3 and 7 say the young king was right in his doing and that he declared "no" to apostasy which was rampant. From chapter 18 until chapter 20, any reader that takes note of King Hezekiah's life does well if he/she stops at chapter 19. There, the reader sees the king going to the temple twice to seek for help under Sennacherib's threat. He goes there for prayer, and the results are visible.

The next chapter constitutes the focus of this part. Hezekiah became sick and his sickness is identified as a boil (2 Kgs 20:7; Isa 38:21). The Hebrew word there for boil is also found in the plague of Exodus 9:9-11. In discussion of Hezekiah's boil, one controversial issue has been the cause of his sickness. On the one hand, Reid

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[23] Walvoord, *Bible Knowledge Commentary*, "I Kings."

[24] His name means "the Lord strengthens." Warren W. Wiersbe, *The Bible Exposition Commentary OT* [CD ROM] (Seattle, WA: Jim Gilbertson,1988-2007), NP, s.v. "The Making of a King."

[25] Apparently, from BC 726-697. M.G. Easton, *Easton Bible Dictionary* [CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), NP, s.v. "Hezekiah."

argues that the text does not attribute Hezekiah's grave illness to any wrong he had done.[26] On the other hand, Warren W. Wiersbe contends that God had sent that illness to discipline Hezekiah from his compromise with the Assyrians.[27] He observed that the author of 2 Chronicles 32:23-25 refers to Hezekiah who had become proud. Regardless of all that, David Thomas elaborates on "the blessing of sickness"[28] for King Hezekiah. Thomas celebrates the fact that the king's illness gave him the opportunity to turn to God.[29] The view of the author of this dissertation is that, though Hezekiah's boil was not a direct consequence of a personal sin in his life, God allowed the sickness so that he will have more time to reflect on serious issues for him and his house.

Even if any doubt remains about the real cause of Hezekiah's illness, there is none concerning God as his Healer. The subsequent prayer made by the king after his recovery is of interest in this study. It is found in Isaiah 38:9-20. It is an individual psalm of distress, hope, and thanksgiving. In it, he himself says to God: "you have lovingly delivered my soul from the pit of corruption" (v. 17b). In concluding his gratitude, Hezekiah maintains that "The Lord was ready to save me" (v. 20). In making this statement, Hezekiah refers to God's act of healing and His compassion. Hence, to heal is to save. Besides, the key consideration, here, is to observe the role of God's will in the king's healing.

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[26] Reid, "Health and Healing," *HSDAT,* 758.

[27] Wiersbe, *The Bible Exposition Commentary OT*, "The Making of a King."

[28] David Thomas, "The Blessing of Sickness," *The Biblical Illustrator OT* [CD ROM], ed. Joseph S. Exell (Seattle, WA: Jim Gilbertson, 1988-2007), NP.

[29] Ibid.

There is internal evidence from the text that God's will in healing the king could not be taken for granted. Perhaps the narrator of 2 Kings deemed it necessary to include the king's request of a sign. It follows his question: "what is the sign that the Lord will heal me?" (20:8). Admittedly, he would not ask for a sign if it was so obvious for God to desire his healing at that particular time. The sign he asks for (20:10) is even one that necessitates a supernatural intervention. The king asks that the shadow of the sundial move in an unnatural direction. Based on the internal evidence in the passage, the author of this dissertation holds the view that Hezekiah's healing illustrates healing according to God's will as it conveys the idea of compassion. Conclusively, such idea of compassion should motivate the one who brings spiritual care. A look at the NT reveals extensive details on Jesus as Healer.

Jesus as the Healer in the NT

The researcher tries to start this part of the study with a brief survey of the divine nature of Jesus and link it to the issue of healing. Writing his gospel, John claims that the purpose of the book is for the audience to believe that Jesus is the Christ,[30] the Son of God, and as they believe in Him, they may have life in His name (John 20:30, 31). At the start of his book, precisely the first 18 verses, John elaborates on the mission of Jesus. The first three verses proclaim the eternal Word. John says, "In the beginning was the Word, and the Word was with God, and the Word was God" (John 1:1). Basically, the idea is that the Word existed from eternity; and that it was in close relationship with the Father in the beginning; but the Word is distinct from the Father as clarified later (v. 18). In using the term "Word" repeatedly, John

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[30] The Anointed, the Greek translation of the Hebrew word rendered "Messiah", the official title of our Lord, occurring 514 times in the NT. It denotes that he was anointed or consecrated to His great redemptive work as Prophet, Priest, and King of His people. M.G. Easton, *Easton Bible Dictionary* [CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), NP, s.v. "Christ."

implies that Jesus was fully equal with the Father. It can be observed that the third use of "God" in this verse is not preceded by an article. Consequently, Dederen declares, "the anarthrous use (i.e. without an article) of God distinguishes the predicate from the subject of the verb "to be," thus confirming the rendering "and the Word was God."[31] In addition, Warfield states, "There is but one eternal God; this eternal God, the Word is; in whatever sense we may distinguish Him from the God whom He is "with," He is yet not another than this God, but Himself is this God."[32] In other words, Warfield believes that Jesus was thus in some sense a second along with God, He was nevertheless not a separate being from God.

John states, "And the Word became flesh" (John 1:14, NKJ). In his epistle, the author says that it was this Word, eternal in His subsistence, God's eternal fellow, the eternal God's self, that has "come in the flesh," was Jesus Christ (1 John 4:2). As the prominent theologian Warfield puts it, "The terms he (John) employs here are not terms of substance, but of personality. The meaning is not that the substance of God was transmuted into that substance which we call 'flesh.' 'The Word' is a personal name of the eternal God; 'flesh' is an appropriate designation of humanity in its entirety, with the implications of dependence and weakness."[33] In making this comment, Warfield is corroborating the age-old doctrine that Jesus, who had just been described as the eternal God, became, by a voluntary act in time, a man. As a result, Jesus is God, and therefore He has the healing nature the same as the Father. The

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[31] Raoul Dederen, "Christ: His Person and Work," *HSDAT,* 167.

[32] Benjamin B. Warfield, "Person of Christ," *The International Standard Bible Encyclopedia* [CD ROM], ed. James Orr (Seattle, WA: Jim Gilbertson, 1988-2007), NP.

[33] Ibid.

following lines will examine two passages that constitute the ground for the study of divine healing in Jesus' ministry. Those passages are Isaiah 53:5 and 1 Peter 2:24.

Jews of Jesus' time expected a kingly messiah bringing political deliverance. Jesus, by contrast, taught that the promised Messiah would bring salvation through suffering and death on behalf of Israel and the rest of humanity. The standard way of viewing the topic about Isaiah 53 has been that it refers to Jesus as the suffering servant. In verse 5, prophet Isaiah insists that the sufferings that Jesus experienced in His flesh bring healing to humanity. He writes, "and by His stripes, we are healed" (NKJ); or "and by his wounds, we are healed" (NIV); even "and by his bruises, we are healed" (CJB).

A whole reading of the chapter pictures Jesus as a seemingly unattractive servant Messiah. Nevertheless, because of the substitutional and undeserved death of Jesus on behalf of His people, healing is brought to them. Such idea summarizes a number of statements made by prophet Isaiah in this chapter. They are: "He has borne our grieves … carried our sorrows" (v. 4); "He was wounded for our transgressions" (v. 5); "The chastisement for our peace was upon Him" (v. 5); "the Lord has laid on Him the iniquities of us all" (v. 6); "For the transgression of my people he was stricken" (v. 8); "You make His soul an offering for sin" (v. 10); "He bore the sin of many" (v. 12), (NKJV). The key idea here is that Jesus' death is salvation as well as healing. As M. Henry puts it, "Sin is not only a crime, for which we were condemned to die and which Christ purchased for us the pardon of, but it is a disease, which tends directly to the death of our souls and which Christ provided for the cure of."[34] The essence of Henry's argument is that by the doctrine of Christ's cross, and the powerful

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[34] Matthew Henry, *Matthew Henry's Commentary on the Whole Bible,* vol 4, *Isaiah to Malachi*, [CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), NP.

arguments it furnishes against sin, the dominion of sin is broken in those who believe and thus they are fortified against that which feeds the disease.

Peter agrees with Isaiah when he writes, “He (Jesus) Himself bore our sins in his body upon the cross, so that, free from sin, we might live for righteousness. By his wounds you have been healed” (1 Pet 2:24, NAB). Peter also underlines the death of Jesus on the cross as power to bring healing to humanity. Common sense seems to dictate that sin is the main problem in this world. Therefore, the essence of the Bible message is to portray Jesus as the solution to the sin problem. Consequently, the healing Peter refers to in the passage under consideration must be a crucial one. According to Warren W. Wiersbe, “The healing Peter mentioned in 1 Peter 2:24 is not physical healing, but rather the spiritual healing[35] of the soul (Ps 103:3).”[36] Wiersbe’s point implies that, one day, when believers will have glorified bodies, all sicknesses will be gone. It is only possible because of the sacrificial death of Jesus on the cross. Nonetheless, before that glorious day, even some of God's choicest servants may have physical afflictions (see Phil 2:25-30; 2 Cor 12:1).

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[35] This idea of spiritual healing influences the understanding on health. Bridges and Weigle advance that health (in this context) refers to the soundness and efficient functioning of body and mind. But it had wider meanings in the year 1611 and before. It was used as a synonym for healing or cure; used in the sense of safety or deliverance; and used in a moral and spiritual sense as the equivalent of salvation. Wyclif’s version of Acts 28:28 is “Therefore be it known to you that this health of God is sent to heathen men.” Tyndale rendered it “this salvation of God is sent to the Gentiles”; but at Luke 19:9 his version has Jesus say to Zacchaeus, “This day is health come unto this house.” In Ephesians 6:17 Wyclif had “the helm of health,” where subsequent versions have “the helmet of salvation.” Ronald F. Bridges and Luther A. Weigle, *King James Bible Word Book*, A Contemporary Dictionary of Curious and Archaic Words Found in the King James Version of the Bible., electronic ed. (Nashville, TN: Thomas Nelson, 1997), 167.

[36] Warren W. Wiersbe, *The Bible Exposition Commentary NT [*CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), NP, s.v. “For our own Sake (1 Pet 2: 18-25).”

Components of Spiritual Care in the Healing Activities of Jesus

A reminiscent of the mission of the Messiah as described by Isaiah is also found in the gospel according to Luke. A careful comparison of Isaiah 61:1, 2 and Luke 4:18, 19 can throw more light on this point. That is why, among the key statements that are recorded, the narrator does not forget to mention that "He has sent me to heal[37] the brokenhearted" (Luke 4:18, NKJV). Following this statement, he subsequently says that Jesus closed the book, gave it back to the attendant and sat down. In addition, Jesus told those present in the synagogue that, "Today this Scripture is fulfilled in your hearing" (v. 21). The remaining part of the narration describes the way the people around Jesus questioned His claim to be the promised Messiah. This part of the study examines the healing activities of Jesus as found in the NT. Actually; the researcher considers various methods used by Jesus and implies their significance for the use of spiritual care. The components of spiritual care revealed in Jesus' healing activities are words touch, laying on of hands, and gestures.

The first method consisted in speaking a word to the sick person. Mark in his gospel (2:10-12) presents a paralytic in Capernaum, carried by four men. Before the key verses that report the healing, the reader is made to know how those people struggled to have their way in the presence of Jesus. They succeeded through the roof (v. 4). Because of the faith of the four men, Jesus forgave the sins of the paralytic (v. 5). Towards the end of the account, the narrator reports the words spoken by Jesus,[38]

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[37] Vine and Bruce, "IAOMAI" (ἰάομαι , (2390)), to heal, is used (*a*) of physical treatment 22 times; in Matt 15:28, A.V., "made whole," R.V., "healed;" so in Acts 9:34; (*b*) figuratively, of spiritual healing, Matt 13:15; John 12:40; Acts 28:27; Heb. 12:13; 1 Pet 2:24; possibly, Jas. 5:16 includes both (*a*) and (*b*); some mss. have the word, with sense (*b*), in Luke 4:18. Apart from this last, Luke, the physician, uses the word fifteen times. W.E. Vine and F.F. Bruce, *Vine's Expository Dictionary of Old and New Testament Words* (Old Tappan, NJ: Revell, 1981; Published in electronic form by Logos Research Systems, 1996), 2:203.

[38] This way of healing is characteristic of the power of Jesus as creator: The spoken word is enough by itself; it is "immediately" (εὐθύς, παραχρῆμα) turned to reality, in analogy to the creative

"I say to you, arise, take up your bed, and go to your house" (v. 11). As one can learn from the original language, *soi legoo* 'to you I say,' the order of the Greek makes the personal pronoun *soi* 'to you' emphatic,[39] (BFBS 'to you I am speaking.'); *eis ton oikon sou* 'to your house,' i.e. 'go home′ (presumably in Capernaum itself, where the incident occurred). In ASV the phrase 'into thy house' is an example of extreme literalism in translation.[40] The concluding verse of that story shows how that healing took place immediately. The former paralytic was able to arise, take up his bed and walk out in the presence of all those who attended. Moreover, the narrator adds that all those who witnessed the event were amazed and they glorified God (v. 12).

There is similar healing taking place in the narrations found in Mark 3:5 and Luke 7:1, 2, 7-10. Those three instances are an illustration of the use of words as a method for healing performed by Jesus. In connection with this particular way of healing (by the use of words), Hughes[41] suggests that Jesus' words have power to forgive sin, heal disease and silence cavilers. As a matter of fact, some Jewish teachers accepted miracles as verification that a teacher was truly God's representative; others did not regard miracles as sufficient proof if they disagreed with the teacher's interpretation of Scripture. In the case of Jesus, Craig clarifies that

> Jewish teachers knew that only God could ultimately forgive (on the Day of Atonement in response to sacrifice); but they also recognized that healing ultimately came from God. … Josephus shows us that many false prophets in Jesus' day claimed to work miracles but actually failed to work them; some

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word that overcame chaos (cf. Gen 1–2: Matt 8:8, 13; Mark 1:41f.; 2:11f.; 3:5; 7:34f.; Luke 13:12f.; cf. also the words of "struggle" in Mark 1:25f.; 5:8; 9:25f.). Horst Robert Balz and Gerhard Schneider, *Exegetical Dictionary of the New Testament*, Translation of: Exegetisches Worterbuch Zum Neuen Testament. (Grand Rapids, MI: Eerdmans, 1990-c1993), 2:144.

[39] R. G. Bratcher and E. A. Nida, *United Bible Societies Handbook NT Series* [CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), s.v. "A Handbook on the Gospel of Mark."

[40] Ibid.

[41] D. C. Hughes, "Mark 2:7-11," *The Biblical Illustrator NT,* [CD ROM], ed. Joseph S. Exell (Seattle, WA: Jim Gilbertson, 1988-2007), NP.

> of Jesus' critics may have placed him in this category. His act in front of these witnesses, however, should have challenged them to rethink their case.[42]

In addition to words, Jesus used another method for healing people – a touch. An example of record is Mark 6:56. The passage refers to an event that took place in the land of Gennesaret. Jesus and His disciples came out of their boat. The population recognized Him immediately and ran in the region to gather all those who were sick in their beds (v. 55). The ill people of that region, from villages, cities or country were all laid in the marketplace. The people endeavored to touch the hem of Jesus' garment. According to the narrator of this second gospel, one should read, "as many as touched Him (Jesus) were made well" (v. 56, NKJV). Other versions suggest: "that they might touch the tassel on his cloak, and as many as touched it were healed" (NAB), or "to let them touch even the tzitzit on his robe, and all who touched it were healed" (CJB). The practice revealed here is in obedience to Numbers 15:37-41. As David H. Stern has observed, "These fringes are made in a special way and have a unique appearance. Their purpose is to remind God's people to obey his commandments."[43]

In the verse above, the sick people were healed by just touching Jesus. It is not a big issue to find out whether they touched Jesus (NKJV) or His tzitzit (CJB). The real emphasis was the fact of coming in contact with Yahweh the Healer.[44] Marvin R. Vincent agrees with such understanding when citing Edersheim who said that

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[42] Keener Craig, *IVP Background Commentary of NT [*CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), s.v. "Mark."

[43] David H. Stern, *Jewish New Testament Commentary [*CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), s.v. "Matthew 9:20."

[44] This way reveals a force behind the healing: this is the unconditional, mountain-moving (volitional) faith of the sick person (Mark 6:5f.; 5:28f., 34; 10:52; Luke 17:19; cf. Mark 11:23; Matt 17:20) or of one who intercedes (Mark 2:3–5; 5:36; 7:25ff.; 9:23f.; Matt 8:5ff.; 15:28), which cooperates with the faith or concentrated will of Jesus (Mark 1:40ff.; 9:24; Matt 15:28). Balz and Schneider, *Exegetical Dictionary of the New Testament*, 2:144.

“according to tradition, each of the white fringes was to consist of eight threads, one of them wound round the others; first seven times, with a double knot; then eight times with a double knot; then eleven times with a double knot; and, lastly, thirteen times. The Hebrew characters representing these numbers formed the words ‘Jehovah One."[45] Similar results occur even when Jesus was the one who initiated the touch with His hand. The following occurrences are an illustration of the same understanding as above (Mark 1:31, 41, 42; 5:40-42).

The third method that Jesus used for His healing activities consisted in the laying on of His hands on sick people. Luke describes Jesus as He was healing every sick person brought unto Him (Luke 4:40), whatever the disease was. The arrangement of the text in the whole composition of the book comes immediately after the report of the healing of Peter’s mother-in-law (vs. 38, 39). The passage under consideration concerns the successive healing of many sick people after the Sabbath’s sunset. The narrator underlines the method of healing. He writes, “and He (Jesus) laid His hands on every one of them and healed them” (NKJV), or “and he put his hands on each one of them and healed them” (CJB). The result of the healing activity of Jesus in the verse is visible. The point is that Jesus healed[46] all of those who were sick and brought to Him.

Nevertheless, the study of this passage has to examine two concerns. The first is to know if the verse gives room to massive laying on of hands to numerous sick people at the same time. The second is to identify what the laying on of hands stands

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[45] Marvin R. Vincent, New *Testament Word Studies [*CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), s.v. “Matthew 9:20.”

[46] Very rarely is there “medical” involvement or “medicines” (Mark 7:33; 8:23), more frequently simply contact such as grasping the hand or touching with the hand (Mark 1:31; 5:23, 41; 6:5; 7:32; 8:23, 25; 9:27; Luke 4:40; 13:13; 14:4). Balz and Schneider, *Exegetical Dictionary of the New Testament*, 2:144.

for in the area of healing. In doing the exegesis of the passage, two scholars write, "*eegagon autous pros auton* 'brought them (i.e. the sick) to him.' Though this is done repeatedly, the verb is in the aorist, to bring out that it refers to every single act of bringing a sick person to Jesus."[47] Therefore, one should wipe out the idea of a massive ceremony, with one person laying hands on all the people at one time. As some may suggest, the laying on of hands is generally interpreted as an act of transmission of something, here is the transmission of spiritual and physical wholeness or vitality. Still in that study, the authors add, "*ho de heni hekastoo autoon tas cheiras epititheis* 'and laying his hands on each of them'. The relationship between this participial clause and the subsequent main verb *etherapeuen autous* 'he healed them' is such that the former refers to the way in which the latter is brought about."[48] In addition, they say, "The imperfect tense *etherapeuen* points to the linear or even repetitive aspect of the healing."[49] Consequently, in the area of healing, the laying on of hands is on an individual basis and it is a transmission of a healing power from God to that particular human being.

The fourth method that Jesus used to heal the sick is made of some gestures, specific actions depending on circumstances. To take a case in point, Mark describes some of those specific actions (7:32-35). The person who was brought to Jesus was deaf and unable to speak. According to a contributor,[50] the inability to speak appears to be traced back to a demonic shackling and binding of the tongue. Jesus puts His

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[47] J. Reiling and J.L. Swelengebel, *United Bible Societies Handbook NT Series* [CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), s.v. "A Handbook on the Gospel of Luke."

[48] Ibid.

[49] Ibid.

[50] G. Dautzenberg, "Mark 7:32-35," *Exegetical Dictionary of the New Testament* [CD ROM], ed. Horst Balz and Gerhard Schneider (Seattle, WA: Jim Gilbertson, 1988-2007), NP.

fingers in the ears of that deaf-mute. He spits and touches the tongue of the sick person (v. 33) who suffered an impediment.[51] In addition, as the narrator puts it, “He sighed.” (v. 34, NKJV). Webster provides an understanding of the word *sigh*. As a verb, it means to take a deep audible breath (as in weariness or relief).[52] As a noun, it is “an often involuntary act of sighing esp. when expressing an emotion or feeling (as weariness or relief).”[53] The upshot of all this is that Jesus showed compassion to the deaf-mute in His healing procedure. The evangelist does not fail to underline the end result. He says, “Immediately his ears were opened, and the impediment of his tongue was loosed, and he spoke plainly” (v. 35, NKJV). In conclusion, the specific actions and gestures here consisted of the manipulation of the fingers, use of saliva and the touching of the tongue, sigh and compassion in the healing process.

As another illustration of the fourth method, Mark refers to a blind man healed at Bethsaida (Mark 7:22-26). In the beginning of the account, the narrator reports that people brought a blind man to Jesus for healing. Instead, Jesus moves with him out of the town, holding him by the hand. There, He spits on the eyes of the blind man and puts His hands on the sick person (v. 23). As a result, the blind man could see human beings as moveable trees. Verse 25 mentions the third use of the hands by Jesus. The first use was to hold the blind man and walk with him. The second was to put His hands on him. Now, the third is to put His hands on the blind man’s eyes where He had previously spat.

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[51] By definition, an impediment is something that impedes; *esp.*: an organic obstruction to speech. Merriam Webster Dictionary and Thesaurus, s. v. “impediment.”

[52] Merriam Webster Dictionary and Thesaurus, s. v. “sigh.”

[53] Ibid.

A detail is given after the mention of the use of hands in verse 25. The narrator adds, “and made him look up” (v. 25, NKJV). It is only after this action, that the passage underlines the restoration and a clear sight. Some people can question whether Jesus failed to heal the blind man at the first attempt and thus needed a second try. According to the outstanding theologian Macalister, “The case of the man in Mark 8:22 whose healing seemed gradual is an instance of the phenomenon met with in cases where, by operation, sight has been given to one congenitally blind, where it takes some time before he can interpret his new sensations.”[54] The essence of Macalister’s argument is that the problem is not on the side of Jesus as the healer, but on the blind man who needed some time to interpret his new sensations. That can explain the reason why Jesus needed to put His hands on his eyes and “make him to look up.” It even gives the idea of assisting the blind man in the interpretation of his new sensations. Macalister agrees when he writes, “the methods used by Him in these miracles varied probably according to the degree of faith in the blind man; all were merely tokens, not intended as remedies.”[55] Indeed, the story in John 9:6, 7, 10, 11, 14, 15 illustrates Macalister’s quotation. Even though the account shows that a sick person can have something to do for his/her healing, the truth is that it is a mere token,[56] not the remedy itself.

This study of the methods used by Jesus in his healing ministry has a crucial importance for the ministration of spiritual care. Ultimately, in connection to the research question, this part of the study provides the biblical and theological tools that

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[54] Alex Macalister, “Blindness,” *The International Standard Bible Encyclopedia* [CD ROM], ed. James Orr (Seattle, WA: Jim Gilbertson, 1988-2007), NP.

[55] Ibid.

[56] Something given or shown as a guarantee (as of authority, right, or identity). Webster, s.v. “token.”

identify the spiritual care. It shows that spiritual care includes the use of words, healing touch, the laying on of hands, prayer, and special actions. In the chapter, those special actions encompass the manipulation of fingers, the use of saliva only or with clay.[57] Likewise, it is also possible to hold the sick person's hand, take a walk with him/her, and assist him/her in the interpretation of his/her new sensations.

Healing in the Writings of Ellen White

The word *healing* occurs 3,104 hits in the E. White writings database. Precisely, that word is extensively used in 10 of her books, 29 periodicals, four pamphlets, one manuscript releases, and six miscellaneous collections. For instance, in the book *The Ministry of Healing*, she uses that word 67 times, and 87 times in *Medical Ministry*. In the first book, it is in the ninth chapter "Teaching and Healing" that the use is highly repeated. For the second book, section three "The Christian Physician and his Work" and section thirteen "Medical Missionary Work and the Gospel Ministry" are much more based on the issue of healing. While much shall be said in the chapter on the review of literature, there are a number of basic affirmations that White makes about the Great Healer. In her attempt to clarify the source of the healing power, she confirms the Bible claim that God is the "Great Healer."[58]

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[57] One should notice that the saliva utility was to mix the clay. Fausset says clay is: "a mixture of dust and spittle" (*Fausset Bible Dictionary*). On one hand, Mc Clintock declares: "Our Savior anointed the eyes of the blind man with a salve made of clay and spittle (John 9:6), a simple preparation, which, it would be manifest to all, — could have in itself no curative virtue" (McClintock and Strong Encyclopedia). Along the same line, E. G. White says: "There was no healing virtue in the clay or in the pool where the blind man was sent to wash; the virtue was in Christ" (*From Heaven With Love* 319:1). Tokunboh Adeyemo agrees with the idea that healing was not in the clay or the pool; but he observed that if the blind man has not gone to wash in the pool, there would be no healing for him (*Commentaire Biblique Contemporain*). Therefore, one must not undermine obedience to Jesus who heals. The researcher views the modern type application of the use of saliva, clay as the necessity to rely on Jesus in spite of the use of medication.

[58] Ellen G. White, *Medical Ministry* (Mountain View, CA: Pacific Press, 1932), 11.

In White's comment on James 5:15 that says the prayer of faith shall save the sick, she affirms: "God is just as willing to restore the sick to health now as when the Holy Spirit spoke these words through the psalmist. And Christ is the same compassionate physician now that He was during His earthly ministry. In Him there is healing balm for every disease, restoring power for every infirmity."[59] In saying so, she does not only confirm the biblical truth about God as the Healer, she also asserts Christ as a compassionate physician in whom are found healing and restoration from every infirmity. Therefore, E. White supports the fundamental ideas established from the Bible: God is the Healer, Jesus had a healing ministry here on earth, and the Holy Spirit is still able to bring healing in this contemporary age.

In conclusion to the entire first section of this chapter, it is important to underline some essential points. God is the sole Healer and healing is absolutely divine. A close look at almost all instances of healing in the entire Bible shows that God always uses a human agent who either prays, speaks, touches, or does any other things that serve as channels for God to intervene. Obviously, those things must be in the agreement with the clear biblical teaching and exclude any use of magic, deviation, hypnosis, etc. that are forbidden in the Scripture. The author of this dissertation considers all these actions done by human agents as 'spiritual care.' In fact, all actions recorded in the Scriptures as human contributions for biblical instances of healing serve as the theology for the ministration of spiritual care as presented by the researcher. The following section explores healing as an open door to discipleship.

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[59] Ellen G. White, *The Ministry of Healing* (Mountain View, CA: Pacific Press, 1905), 226:1.

Divine Healing as an Opened Door to Discipleship

Definition of Discipleship

In discussing the question of discipleship, the researcher is not dealing with a man's salvation. Common knowledge seems to indicate that only God is best placed to conclude in the issue of salvation. This study deals with a person's relationship to Jesus Christ as his/her Teacher, his/her Master, and his/her Lord. From a biblical perspective, many people agree that discipleship is the act of being what Jesus meant by 'disciple.'[60] The English word 'disciple' is a translation of the Greek *mathetes*. In Greece, the word was used when a student was very close to a teacher with the aim of acquiring not only theoretical knowledge, but practical as well. It is used in the NT to indicate a total attachment to someone in discipleship.[61]

Until one is able to distinguish the various usages of the term 'disciple,' it is not obvious to comprehend what is involved in discipleship. Pentecost for instance, grants that, "The word disciple means a learner, a pupil, a scholar, one who comes to be taught. The idea of teaching and learning is preeminent in the word disciple."[62] Obviously, the Bible gives evidence that it is possible to approach the Word (Jesus) simply by having one's intellect stirred, by listening to some new thing without any

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[60] As a noun, it is a follower of the doctrines of a teacher or a school of thought, one of the personal followers of Christ (including his 12 apostles) during his earthly life. As a verb, it means to assist and mentor new believers to mature in the knowledge of the Lord through continual oversight of their life and through edification and discipline. It is based on Christ's injunction to teach [new converts] "all things whatsoever I have commanded you." The discipling approach is seen by its advocates as the quickest way not only to multiply but also to develop disciples who will also be soul-winners. George Thomas Kurian, *Nelson's New Christian Dictionary: The Authoritative Resource on the Christian World* (Nashville, TN: Thomas Nelson, 2001).

[61] N.A. *New International Dictionary of the New Testament Theology* (1975), s.v. "disciple" (mathetes), 484,486, quoted in Russell C. Burrill, *Recovering an Adventist Approach to the Life and Mission of the Local Church* (Fallbrook, CA: Hart Books, 1998), 16.

[62] J. Dwight Pentecost, *Design for Discipleship: Discovering God's Blueprint for the Christian Life* (Grand Rapids, MI: Kregel, 1996), 10.

relationship to the truth or without any impact of that truth on one's life (cf. most of the curious who used to listen to Jesus while preaching or teaching, Matt 5-7). Pentecost argues that "one becomes a disciple in the Biblical sense only when one is totally and completely committed to the person of Jesus Christ and His word. Apart from that commitment to Him and His word, one has no right to call himself a disciple of Jesus Christ."[63] To put it bluntly, discipleship involves commitment. It involves identification with Christ in His shameful death. It is a matter of renunciation of oneself; it is about setting aside one's own aims, goals, ambitions, and desires in life. It involves sacrifice for the sake of the Lord Jesus Christ. It implies setting aside one's own will and one's own rights to his/her life and acknowledging that Jesus Christ has the right to be obeyed, the right to rule (cf. Matt 8:18-22; Luke 10; John 14:15; 15:14). Naturally, Burrill argues that the word disciple itself does not suggest a rapid conversion to the person discipling, but a slow process by which one is made a disciple.[64] Therefore, the author of this dissertation views discipleship as a lifelong experience.

Spiritual Gifts, Healing, and Discipleship

In his first letter to the Corinthians (12:1), Paul uses the term *peri de ton pneumatikon* to elaborate on spiritual gifts. Those words are rendered in the ASV "Now concerning spiritual gifts." Commenting Paul's use of the above term, McClintock and Strong assert that, it is "a phrase used to denote those endowments

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[63] J. Dwight Pentecost, *Design for Discipleship: Discovering God's Blueprint for the Christian Life*, 10.

[64] Russell C. Burrill, *Recovering an Adventist Approach to the Life and Mission of the Local Church* (Fallbrook, CA: Hart Books, 1998), 16.

which were conferred on persons in the primitive Church."[65] Basically, the authors are saying that those endowments are charismata, or grace gifts. The word *charisma*, with a single exception (1 Pet 4:10), occurs in the NT only in the Pauline Epistles, and in the plural form is employed in a technical sense to denote extraordinary gifts of the Spirit bestowed upon Christians to equip them for the service of the church.[66] The idea that transcends from those definitions is that spiritual gifts are skills and abilities specially given by the Holy Spirit for use in ministry.

G. E. Rice[67] makes it clear that the purpose of spiritual gifts is for the completion of the mission entrusted to the church. In other words, Rice believes that spiritual gifts are the tools through which church members can achieve a number of things. For instance, to introduce the gospel into new fields (Acts 1:8), proclaim Christ with boldness (4:31), work signs and wonders to the glory of God (2:43), strengthen fellowship and the spirit of community (2:44-47), combat error with truth (6:10), and impart the benefits of the various gifts for the nurture of the saints (1 Pet 4:10, 11). Commenting the impact of spiritual gifts, Rice affirms: "These gifts, under the ministry of the Holy Spirit, will equip church members for the work of ministry including winning people to Jesus."[68] The author of this dissertation observes that the above quotation from Rice is the very key and fundamental detail to the study. The reason is that this is an official source from the church to give a ground for the research approach about making disciples via health ministry. In a nutshell, Rice

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[65] John McClintock and James Strong, *McClintock and Strong Encyclopedia [*CD ROM] (Seattle, WA: Jim Gilbertson, 1988-2007), NP, s.v. "Spiritual Gifts."

[66] J.C. Lambert, "Spiritual Gifts," *The International Standard Bible Encyclopedia* [CD ROM], ed. James Orr (Seattle, WA: Jim Gilbertson, 1988-2007).

[67] George E. Rice, "Spiritual Gifts," *HSDAT,* 617.

[68] Ibid, 637.

views spiritual gifts as crucial to nurture and up build the flock, as well as to proclaim the gospel outside the fold.

Overview of Spiritual Gifts and Their Significance for the Study

While everyone can survey the four lists that the NT presents about the spiritual gifts (1 Cor 12:8-10, 28-30; Rom 12:6-8; Eph 4:11), the author of this dissertation agrees with the classification suggested by Lambert.[69] He distinguishes the gifts connected with ministry of the word from those connected with practical service. In the first category, he includes apostleship, prophecy, discerning of spirits, teaching, kinds of tongues, and interpretation of tongues. The second one is made of working of miracles, ruling, help, and healing. The interest of this part of the study is the gift of healing and it will be developed in subsequent lines.

This study includes a brief examination of spiritual gifts in order to present them as the equipment given to the church to carry the mission. Consequently, the significance of the spiritual gifts for this study is to reveal the healing power of God that is still available. In other words, with emphasis on the gift of healing that will soon be considered, it is important to say that God can still heal in and through His church. Hence, spiritual gifts do not only serve the purpose of edification of the church, but also recruitment of members for her service. The Holy Spirit is the One at work to make sure the same principle of God as the Healer can still function through the mission of the church. In regard to the research question of this study, the author suggests that because spiritual gifts serve to recruit members and edify them, it is possible for people to be endowed with the gift of healing to achieve their mission and

[69] Lambert, “Spiritual Gifts,” *The International Standard Bible Encyclopedia* [CD ROM].

bring disciples in the church. Hence, there is a necessity to examine the gifts of healing.

Gift of Healing

The renowned church growth writer Christian A. Schwarz talks about the gift of healing in one of his books.[70] A number of online authors give lessons on that same topic. The writers of 'cyber space ministry'[71] are some of them. According to both Schwarz and those writers, the gift of healing is the special ability that God gives to certain members of the body of Christ to serve as human intermediaries, through whom it pleases God to cure illnesses and restore people to wholeness. Many people assume that the gift of healing is about removing diseases from the spirit, soul and body.[72] Therefore, Wilhelm is right in affirming that "gifts of healing are supernatural enablement given to a believer to minister various kinds of healing and restoration to individuals through the power of the Holy Spirit."[73]

In accepting Wilhelm's view, one should not see it as contradicting the standard view reminding that, "The gift of healings refers to supernatural healing without human aid; it is a special gift to pray for specific diseases."[74] As Scriptures make it clear, healing can come through the touch of faith (Jas 5:14-15); by speaking

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[70] Christian A. Schwarz, *Découvrez vos Dons* (Paris: Editions Empreinte Temps Présent, 1988), 94.

[71] Cyber Space Ministry, "Services Gifts," accessed 2 February 2014, http://www.cyberspaceministry.org.

[72] David Holt Boshart, Jr, "Teaching the Gift of Healing," accessed 2 February 2014, http://www.christcenteredmall.com.

[73] Wilhelm, Joseph "Charismata". *The Catholic Encyclopedia III* [CD ROM], ed. Charles George Herbermann et al (New York, NY: Appleton, 1913), NP.

[74] David Holt Boshart, Jr, "Teaching the Gift of Healing," accessed 2 February 2014, http://www.christcenteredmall.com.

the word of faith (Luke 7:1-10); or by the presence of God being manifested (Mark 6:56; Acts 19:11-12).

The reader of this dissertation has certainly noticed the interchangeable use of the terms 'gift of healing(s)' and 'gift(s) of healing' in this study. The reason is that according to Duffield and Van Cleave,[75] in the Greek of the NT, both words gift and healing are plural. The Bible speaks of 'gifts' of healing because there are three types of healing: physical (diabetes, blindness, cancer, deafness, etc.), emotional (jealousy, worry, discouragement, and other destructive attitudes), and spiritual (unbelief, indifference, and guilt, etc.).

In his book, Schwarz[76] deplores the tendency to attribute the lack of healing to a lack of faith on the part of the sick person. He emphasizes that the sick person is already fragile and in despair. Telling him/her about a lack of faith is a way to deepen his/her suffering. Instead, he suggests one should rather keep quiet if healing does not occur. For that reason, the people having the gift of healing need to realize that God does not promise to heal everyone who asks or who is prayed for. Thus, they should remember that Jesus did not heal everyone who was sick or suffered while He was on earth. Therefore, the use of the gift they have does not depend on them who have received it but on God who has given them that charisma ('grace gift'). That is why the researcher maintains that the gift of healing is used in accordance with the One who has given the mission to the church and wants the making of disciples.

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[75] Guy P. Duffield and Nathaniel M. Van Cleave, *Foundations of Pentecostal Theology* (Los Angeles, CA: Foursquare Media, 2008), 337.

[76] Schwarz , *Découvrez vos Dons,* 95.

Healing and Discipleship in OT

The study explores an instance of healing whereby the healed person became a convert and worshiper of the God of Israel. One should quickly recall the essence of the earlier discussion about discipleship. It revealed a few key points about the biblical understanding of that concept. There must be a commitment to the Lord. It involves setting aside one's own will and one's own rights to his life and acknowledging that the Lord has the right to be obeyed, the right to rule. The illustration at stake is about Naaman (2 Kgs 5:1-19). To be more specific, one can start where the biblical writer refers to the way he was cured of his leprosy (2 Kgs 5:14, 15).

In reference to the Lord of the Hebrews, the psalmist says, "He shall deliver the needy when he cries, the poor also, and he who has no helper"[77] (Ps 72:12). Internal evidence from the account in the second book of the Kings shows how healing occurs. Naaman had to go down and dip seven times in the Jordan River. In relying on prophet Isaiah who talks of "the sons of the stranger who join themselves to the Lord" (Isa 56:6), many commentators include Naaman among those sons of the stranger. For instance, Krummacher declares, "Naaman, which signifies well-formed, beautiful was a heathen, born and educated in all the idolatrous blindness of his people."[78] Notwithstanding, he had been faithful to his convictions of right, and had felt his great need of help. E. White concludes that Naaman was in a condition to receive the gifts of God's grace. She says, "He was not only cleansed from his

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[77] It was necessary that Naaman should first resort to all human remedies, and proves them worthless. He was directed to Israel, not by any dictate of science, but by the simple word of a captive child in slavery. Friedrich Wilheim Krummacher, *Elisha: A Prophet for Our Times* (n.p., Pleasant Places, 2005), 170.

[78] Krummacher, 104.

leprosy,[79] but blessed with knowledge of the true God."[80] One should not bypass the detail of Naaman being faithful to what he knew because obedience is crucial in matters of discipleship. After his healing, he goes back and makes what Krummacher considers as a "confession, an irrevocable renunciation of the service of idols, an eternal and joyous renunciation of the kingdom of darkness … and the first token of homage and devotion which he presents on the altar of Jehovah."[81] Moreover, in verse 17 of the passage at stake, Naaman speaks of himself as Elisha's servant and requests from him two mules' burden of earth. According to Krummacher, it is for the purpose of worship. He explains that Naaman desires to have a few sacks-full of Israelitish earth, material earth, but to which he attaches a kind of spiritual importance. He designs, that immediately upon his return home, every vestige of his former delusion shall be abolished and effaced. No idolatrous image, no heathenish symbol shall be tolerated in his house, but an altar to the living God shall be erected there, that to everyone it may testify of the great blessing which had been conferred upon him.[82] This reminds the researcher of what it takes to be a true disciple. Ultimately, as a new convert, Naaman will henceforth be a worshiper of the true God of Israel and His follower. Those are vital elements for being a disciple.

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[79] Leprosy in Scripture is a type of sin. One reason is that it was incurable by human means. Only God can cure sin and save a sinner. J. Vernon McGee, *Thru the Bible Commentary*, Based on the Thru the Bible Radio Program., electronic ed. (Nashville, TN: Thomas Nelson, 1997, c1981), 2:311.

[80] Ellen G. White, *The Desire of Ages* (Mountain View, CA: Pacific Press, 1898), 239.

[81] Krummacher, *Elisha: A Prophet for Our Times*, 181.

[82] Ibid, 204.

Healing and Discipleship in NT

The way the Scriptures talk about a disciple has been explored earlier in this study. As Pentecost reports it, more than 250 references are made to disciples in the gospels; and they all reveal the special relationship Jesus had with His disciples.[83] To put it another way, it was a personal, unique and intimate relationship—a relationship based on the knowledge of the person of Christ, a love for the person of Christ, submission to the person of Jesus Christ, and obedience to the commands of Jesus Christ. In view of showing the link between discipleship and healing, the researcher reminds of an earlier discussion on spiritual gifts where he attempted to demonstrate that they do not only serve to edify the church but to form it as well. The essence of his argument was that certain spiritual gifts can help to recruit members in the church. The gift of healing seems to be one of them. The book of Acts provides a few functions of the gift of healing as related to discipleship in the NT church.

Acts 9:10-18 presents Ananias who healed Paul's eyes. After what has been Paul's life in the past, he now becomes Christ's disciple and serves Him. Therefore, the first function of the gift of healing, here, alludes to the fact that it gives the opportunity to follow Jesus and serve Him. Acts 9:36-42 describes Peter as he raises Dorcas, and it gives her the opportunity to continue her service on behalf of the needy. Hence, one can conclude that the second function of such a charisma is referred to open the door to a continual service as a disciple of the Lord. Acts 3:1-8 and 9:32-35 are respectively about the lame man at the temple and Aeneas at Lydda. Both of them are healed by Peter. They all witness about the Lord and give glory to

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[83] J. Dwight Pentecost, *Design for Discipleship : Discovering God's Blueprint for the Christian Life* (Grand Rapids, MI: Kregel, 1996), 10.

God. Thus, the third function of the gift of healing suggests witness and giving glory to God.

It appears that, after the time of Jesus, His disciples continued His healing mission. The gift of healing appeared to have been used by the Holy Spirit to affirm the disciples' message in the eyes of Gentiles and for the edification of the newly formed Christian Church. Its function in discipleship was to give glory to the risen Lord, follow and serve Him and be strengthened in the walk with Him. In relation to the research question, this part contributes in making a number of points. It advances that there are biblical evidences of healed people who either were converted to God (e.g. Paul), or were strengthened in their walk with God (e.g. Dorcas). Because there was always a human intermediary, it is possible to present human contribution as healing channels in the church. Church members, in general, and health workers, in particular, are to embark on the ministration of spiritual care.

Contemporary Expression of the Gift of Healing in the Church

As it was noticed earlier, the gift of healing is not the personal possession of the member who exercises it within the church community. In the gospels, the Good Samaritan uses natural means to cure illness (Luke 10:34). The author of Colossians 4:14 calls Luke the beloved physician. The same author in 1 Timothy 5:23 counsels

the use of wine[84] to counter stomach infirmities. According to Cottle,[85] the use of natural remedies and the supernatural reality of the gift of healing were not thought to be mutually exclusive in the church; they were, rather, complementary, because sickness was no longer viewed as God's punishment of sin. He states, "The gifts of healing continued in use during the first two centuries after Christ. The operation of these gifts gradually diminished, due, no doubt, to the growth of ecclesiasticism and asceticism. The ritual of the Church became formalized and impersonal."[86]

From his study of Acts 2:22 and 14:3, Houdmann insists that "Although God does still heal today, His healing through the gift of healing belonged primarily to the apostles of the first-century church to affirm that their message was from God."[87] In making this comment, Houdmann believes that God still performs miracles and heals His people. Based on what transcends in the first part of Houdmann's quotation, the researcher accepts that there are people who have the gift of healing even today. God uses them in miraculous ways to heal sick people. The idea is that such a gift has not

[84] There are secular definitions of the word 'wine' that have become almost universal. For instance, Webster defines it as: "the alcoholic fermented juice of fresh grapes used as a beverage." *Merriam Webster Dictionary and Thesaurus*, s.v. "wine." On the contrary, Bacchiocchi, who is concerned with the biblical understanding of the word, observes that such definition does not mention unfermented grape juice as a possible meaning of 'wine'. S. Bacchiocchi, *Wine in the Bible: A Biblical Study on the Use of Alcoholic Beverages* (Berrien Springs, MI: Biblical Perspectives, 1989), 43. He further investigates the writings of Parkinson, Gentry, Aritotle, Ginzberg, among others, to finally conclude that *wine*, *vinum*, *oinos*, and *yayin* "have been historically used in their respective languages to designate the pressed juice of the grape, whether fermented or unfermented." Bacchiocchi, p.50 In his explanation of 1 Timothy 5:23 where the apostle Paul charged Timothy, "No longer drink only water, but use a little wine for your stomach's sake"; he explains that Paul's recommendation does not violate the principle of abstinence observed by Timothy; and that the use of a little pure wine juice was recommended not for the pleasure of the belly but for the medical need of the stomach. Whether the wine was fermented or unfermented it does not support the regular use of wine in any way. Ibid, p. 212, 213. However, the broader context excludes the use of alcoholic drink, as it speaks of a total abstinence.

[85] R.E. Cottle, "Healing, Gifts of" *The International Standard Bible Encyclopedia* [CD ROM], ed. James Orr (Seattle, WA: Jim Gilbertson, 1988-2007), NP.

[86] Cottle, ibid.

[87] S. Michael Houdmann, "Gift of Healing," accessed on February 2, 2014, http://www.gotquestions.org.

diminished with the time. Nevertheless, another idea derives from Houdmann. The gift of healing belonged primarily to the apostles of the first-century church to affirm that their message was from God. The researcher's understanding from such view is that the gift of healing nowadays is better expressed in the church through its ministries. Those are venues to express the healing acts of God that are more visible in the societies around the world (like health institutions and education on preventive healing). Therefore, the researcher advocates health institutions as an example of actual expression (among many others) of the gift of healing in the church. He does not exclude the possibility of having some believers used by God as intermediaries for a prayer of healing, but that would normally be in a group as in James 5:14, 15 and not as a single person demonstrating the charisma of healing.

Besides this aspect of healing, there is even the greater one about prevention of diseases. According to E. White, an interesting human task for healing is to abide by the laws of health. She declares, "God will not work a miracle to keep those from sickness who have no care for themselves, but are continually violating the laws of health and make no efforts to prevent disease."[88] Hayford and Van Cleave emphasize this aspect of obedience as a condition for the fulfillment of God's healing promise. They state, "From this covenant in Exodus 15 (v. 26) we know that the Lord will never cease to heal His people. We, of course, must take note that the promise is conditional. To receive the healing we must be obedient to His wishes."[89]

On the basis of the fact that the actual expression of the gift of healing is performed through the ministries in the church, the researcher argues that the church

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[88] Ellen G. White, *Medical Ministry* (Mountain View, CA: Pacific Press, 1932), 14.

[89] Jack W. Hayford and Nathaniel Van Cleave, *God's Way to Wholeness : Divine Healing by the Power of the Holy Spirit*, Spirit-Filled Life Kingdom Dynamics Study Guides (Nashville, TN: Thomas Nelson, 1997).

has to be a healing church. Thus, the ministration of spiritual care has to be carried by all church members. It should not be left to health institutions alone. There is a key argument from this conclusion. If it is admitted that the church,[90] in general, has to embark on the ministration of spiritual care, more can even be expected from the workers in health institutions of the church. The writings of E. White also imply the idea of healing as an open door to discipleship.

Ellen White on Healing as a Door to Discipleship

As it was mentioned earlier, a large part of E. White contribution shall be considered in the chapter dealing with the literature review. Notwithstanding, there is a clear indication that she envisaged a close relation between healing and the possibility to become a disciple. Looking, for instance, at the approach of the physician Luke, she notes the following: "In his work as a physician he ministered to the sick, and then prayed for the healing power of God to rest upon the afflicted ones. Thus, the way was opened[91] for the gospel message. Luke's success as a physician gained for him many opportunities for preaching Christ among the heathen."[92]

Consequently, White implies that it is the divine plan that one should work as the disciples worked. Physical healing is bound up with the gospel commission. In the work of the gospel, teaching and healing are never to be separated.[93] The similar idea is also contained in her other book concerning the medical ministry. Actually, she

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[90] Thompson et all declare: 'Let's say the church is the divine hospital… we all continually need help.' W. Oscar Thompson, Carilyn Thompson Ritzmann and Claude V. King, *Concentric Circles of Concern : Seven Stages for Making Disciples* (Nashville, TN: Broadman & Holman, 1999), 11.

[91] In the opinion of the researcher, White's statement points out the "healing power of God" and a way that thereby is "opened for the gospel message." Hence, he defends the idea of healing as an opened door to start discipleship.

[92]Ellen G. White, *The Ministry of Healing* (Mountain View, CA: Pacific Press, 1905), 141.

[93] Ibid.

specifically calls the attention of physicians. She states, "Our physicians need a deeper insight into the evangelistic work that God expects them to do. Let them remember that if they do not work for the healing of the soul as well as for the healing of the body, they are not following the example of the great Medical Missionary."[94] She urges them to study the word of God diligently, that they may be familiar with its promises and may be able, in tenderness and love, to point sinners to the Great Healer. In conclusion, E. White confirms healing as an opened door to discipleship.

The essence of this second section is to affirm that the various instances of healing in the Bible are not narrated only for the sake of telling the story of each healing event. A close look at numerous healing occurrences reveals how the healed person subsequently either became a follower/worshiper of the true God of Israel or was reclaimed as a disciple of Jesus. It is such move that the researcher uses to imply the theology of a medical evangelism model deriving from healing event. Consequently, some strategies would originate from that model of medical evangelism.

The research question for the chapter consisted in finding what could be the importance of the ministration of spiritual care in connection to healing? The study reveals that the ministration of spiritual care is a mere human contribution that can serve as channels for God to intervene and heal the sick person. God could probably do without the human agent if He wants. Not all instances of the human contribution would lead to healing. Nevertheless, almost all instances of healing include the human contribution through the ministration of spiritual care. For the biblical instances where divine healing has happened alongside the ministration of spiritual care, there is an

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[94]Ellen G. White, *Medical Ministry* (Mountain View, CA: Pacific Press, 1932), 41.

evidence of entrance, restoration, or progress in a relationship of discipleship with God, the Great Healer. Hence, the ministration of spiritual care is important and connected to healing from two angles: the pre-healing stage, and the post-healing experience. This provides a foundation for the researcher to develop a model for medical evangelism based on the post contact dimension of interaction with former sick people who have attended the Buea SDA health center in Cameroon. Before arriving at that, the following chapter develops the literature review of the dissertation.

CHAPTER 3

LITERATURE REVIEW

This chapter is a review of the key literature in the fields that are explored. They are three of them: medical evangelism, biblical healing, and spiritual care. Each one is important because of the special role it plays in the overall understanding of the dissertation. The area of medical evangelism is the setting in which spiritual care is developed as a method of evangelism. The field of biblical healing is of great interest because an understanding of its ultimate goal allows engaging in medical evangelism even if some people are not baptized. The subject of spiritual care is explored as a department of knowledge useful in evangelism.

This review uses a good number of recent publications in the various domains. Nevertheless, it also includes authors that wrote some decades ago. The reason is that most of their statements have remained foundational even for the most updated understanding in those areas of learning.

The research question for the chapter consists in finding how should one go about the ministration of spiritual care so that it can be conducive to personal or social well-being? The progression of the chapter follows this order of enumeration: medical evangelism, biblical healing, and spiritual care. In this chapter the researcher expects to provide an approach that serves as guideline for the ministration of spiritual care in a health center setting.

Medical Evangelism

Evangelism in its Bigger Picture

Medical evangelism is part of evangelism. In order words, a study on medical evangelism should see evangelism in a bigger picture. Therefore, even before elaborating on evangelism, a brief comment should be made regarding the issue of salvation. In discussing the four facts of salvation, Willmington argues that salvation is always through a person.[1] In addition, Geisler and Rhodes do not only agree in presenting Jesus as that person, but they also believe that Peter in Acts 4:12 used a "narrow exclusivism"[2] in presenting Jesus as the only one given to men for their salvation.

Even if one should agree with such a view, it seems somehow difficult to agree on what is evangelism. To start, Terry reminds that Calvin's strong belief in election discouraged him and his followers from doing evangelism.[3] Then, Reid mentions a number of misconceptions about evangelism.[4] Finally, Delos Miles lists six conceptions of evangelism found in the writings of Christian theologians. Converting people to the Lord Jesus Christ is number two on that list.[5]

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[1] H.L. Willmington, *Willmington's Book of Bible Lists* (Wheaton, IL: Tyndale, 1987), 298.

[2] Norman L. Geisler and Ron Rhodes, *When Cultists Ask : A Popular Handbook on Cultic Misinterpretations* (Grand Rapids, MC: Baker Books, 1997), 199.

[3] John Mark Terry, *Evangelism : A Concise History* (Nashville, TN: Broadman & Holman, 1994), 79.

[4] For instance, the mute approach suggesting that evangelism is simply living a good, moral life, or the professional fisherman approach believing that evangelism is a job for specialists only. Alvin L. Reid, *Introduction to Evangelism* (Nashville, TN: Broadman & Holman, 1998), 4.

[5] Delos Miles, "The Lordship of Christ: Implications for Evangelism," *Southwestern Journal of Theology* (Spring 1991): 45.

While agreeing with Miles, the researcher equally values other authors' opinions about evangelism. For instance, Ratz and Tillapaugh view it as "a way of life."[6] May be, it is the reason why Aldrich developed the concept of life-style evangelism. According to it, "a person must trust the witness before believing the message."[7]

As Hayford and his colleagues[8] demonstrate that the power of the Holy Spirit helps in witnessing, E. White emphasizes that drawing nearer to Christ gives the desire to share His grace to others.[9] Indeed, the idea is really to share and not to impose. In matters of faith and conversion, people should be allowed to freely make out their minds, with no constraint. For example, Terry complains that Charlemagne attempted a forced conversion's action toward the Saxons. He states, "During his military occupation Charlemagne declared that both refusing to accept baptism and showing disrespect for Christianity were crimes punishable by death.[10]"

Even though Oden[11] does not support such idea of an imposed baptism after an evangelistic endeavor, he acknowledges that baptism is a starting point, and that the

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[6] Calvin C. Ratz and Frank R. Tillapaugh, *Mastering Ministry: Mastering Outreach & Evangelism* (Portland, OR: Multnomah, 1990), 24.

[7] Joseph C. Aldrich, "Lifestyle Evangelism: Winning Through Winsomeness," *Christianity Today*, 7 January 1983, 13.

[8] Jack W. Hayford, Gary Curtis, Robert W. Anderson et al., *Answering the Call to Evangelism : Spreading the Good News to Everyone*, Spirit-Filled Life Kingdom Dynamics Study Guides (Nashville, TN: Thomas Nelson, 1997), 43.

[9] Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 524.

[10] J. M. Terry, *Evangelism : A Concise History* (Nashville, TN: Broadman & Holman, 1994), 53.

[11] Thomas C. Oden, *Ministry through Word and Sacrament* (New York: Crossroad, 1989), 107.

church is entered through it. On the contrary, the *Chafer Theological Seminary*[12] totally negates the idea that water baptism is part of the gospel. In the researcher's view, water baptism is not absolutely necessary for someone to enter the kingdom of heaven (cf the thief on the cross). Notwithstanding, one should experience it upon conversion, because Jesus provided the standard and set an example to be followed (cf. John 3:5, Matt 3:13-17). Far from corroborating the Graeco-Roman idea in religion that negated conversion as a decisive break with the past,[13] the researcher instead estimates Graham's conviction that priority should be given to follow up[14] in matters of evangelism. Furthermore, Webber most recently wrote that, "Discipleship is a lifelong process."[15]

Definition of Medical Evangelism

When Terry decided to summarize Aldrich's view of life-style evangelism, he reported, "When non-Christians see the character and caring of Christians, they will want to become Christians also."[16] In such a perspective, it appears that evangelism is more of being than doing. A few years after Terry's publication, Evans similarly supported Aldrich's view. He added, "The gospel will not only transform your

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[12] Chafer Theological Seminary, *Chafer Theological Seminary Journal Volume 3* (Chafer Theological Seminary, 1997; 2002), 3:8.

[13] Stephen J. Chester, *Conversion at Corinth: Perspectives on Conversion in Paul's Theology and the Corinthian Church* (London, UK: T&T Clark, 2005), 5.

[14] J. M. Terry, *Evangelism : A Concise History* (Nashville, TN: Broadman & Holman, 1994), 169.

[15] Robert Webber, *Ancient-Future Evangelism : Making Your Church a Faith-Forming Community* (Grand Rapids, MI: Baker Books, 2003), 70.

[16] Terry, ibid, 195.

relationship with God. It will also transform your relationship with people."[17] With such a basic idea in mind, one can attempt formulating what medical evangelism stands for.

Historically, in the setting of Seventh-day Adventists, Dysinger observes that there has been confusion in defining medical evangelism. Nevertheless, he mentions an agreement that "Medical evangelism had to refer to telling the public that God wants to help humankind move towards restoration of his original perfect health."[18] For the researcher, there is no doubt that an idea of proclamation derives from the above quotation and it deals with the gospel. Also, that definition of medical evangelism also provides its methodology which is the restoration of the original perfect health. The working definition in this dissertation presents medical evangelism in terms of being and doing that spread the Word of God through the health ministration to the public. It is a whole person approach.

Importance of Medical Evangelism

An increasing number of authorial actions highlight the importance of spreading the gospel message through health ministration. Given that the idea in it is to help humankind move towards restoration of the original perfect health, E. White claims that the purpose of health reform is to secure the highest development of body, mind, and soul.[19] According to both Aldrich and Webber, evangelism is a process[20]

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[17] Anthony T. Evans, *What Matters Most : Four Absolute Necessities in Following Christ*, Includes Indexes. (Chicago, IL: Moody Press, 1997), 343.

[18] P.W. Dysinger, *Health to the People* (Victoria, Canada: Trafford, 2007), 25.

[19] Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 526.

[20] J. C. Aldrich, "Lifestyle Evangelism: Winning Through Winsomeness," *Christianity Today*, 7 January 1983, 16.

and the work of the church is to make disciples.[21] Thus, medical evangelism is important in order to focus on the whole person approach since health is wholistic.

As it was observed, "No one goes through a tragedy without their faith being challenged and transformed."[22] Since conventional wisdom admits that there are lots of tragedies in the world, E. White sees evangelistic medical missionary work as a means of converting people to the truth.[23] Moreover, she does not only claim that "Medical missionary work is the right, helping hand of the gospel, to open doors for the proclamation of the message,"[24]she also insists that "God reaches hearts through the relief of physical suffering."[25] Later in the same book, she believes that such a work of presenting the gospel to heal the sick will add to the church many souls of such as shall be saved.[26] Most recently, Paget and McCormack gave an example of a woman who joined a church as a result of the caring she received during her crisis.[27]

Strategies in Medical Evangelism

When Dysinger reports the nuts and bolts of medical evangelism in the Adventist setting, he makes the following evaluation, "Perhaps the most significant result of Tindall's medical-evangelism approach proved to be the solid long-term

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[21] R. Webber, *Ancient-Future Evangelism : Making Your Church a Faith-Forming Community* (Grand Rapids, MI: Baker Books, 2003), 43.

[22] Review and Expositor, *Review and Expositor Volume 89* (Review and Expositor, 1992; 2004), vnp.89.3.379.

[23] Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 513.

[24] Ibid.

[25] Ibid.

[26] Ibid, 545.

[27] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2006), 8.

establishment of people 'in the faith.'"[28] Basically, the above statement is an illustration that Dysinger provides in his book. The aim is to say that Tindall has an approach in medical evangelism; one could talk of an approach or model. Also, the author's point is that such a model in medical evangelism proved to be very effective in solidly converting people in the Adventist faith. Therefore, it is possible to expect an enlargement of church members in this field of medical evangelism. While Dysinger gives more details about the model used by Tindall, the author of this dissertation similarly develops a model that is based on spiritual care.[29]

The key understanding for the strategies in medical evangelism is to create a good spiritual atmosphere. A subtitle that is added in E. White's book talks of "a *judicious* (emphasis supplied) way of presenting the message in health center."[30] Such a word is carefully chosen, that is why it is strategically important to create such an ambiance in health centers if one wants to embark on medical evangelism.

The following are other strategies that are derived from her writings. First, she talks of simple treatment plus prayer that can results in an opened door.[31] This idea allows anticipating some results in the increase of members. Second, she refers to medical evangelism in homes and cities.[32] This domain of medical evangelism is very broad and one can put in place specific methods in penetrating cities. So, if one

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[28] P.W. Dysinger, *Health to the People* (Victoria, Canada: Trafford, 2007), 31.

[29] That is why the title of the dissertation is: Development of Spiritual Care Model for Medical Evangelism in Buea Adventist Hospital, Cameroon.

[30] Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 537.

[31] Ibid, 516.

[32] Ibid, 533.

develops a program called Cities Evangelism, medical evangelism for cities could be one of the approaches.

Third, she says one can include cooking classes in doing medical evangelism.[33] The aim in conducting those classes could be to show how the original diet was a key component of the original state of health. Studies in medical field generally agree that a lot of people get sick because of the type of food they eat. Fourth, she urges the church to embark on health literature distribution as a part of medical missionary work;[34] even to the point of putting health literature in the sick person's room and having a library in a health center.[35] Bonhoeffer supports the idea of given tracts and Bible literature to sick people provided they are in a condition to read.[36]

Fifth, E. White argues that there must be parlors in sanitarium to conduct talks.[37] In her words, those talks ought to be simple, earnest, short, and about hope in Jesus Christ. She instructs on having daily religious services and indicates the type of messages to be preached.[38] Her reason is that there is need of putting an emphasis on health education in order to prevent sickness.[39] It is often said that prevention is better than cure. Before such idea became almost a slogan in this contemporary society, it

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[33] Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 526.

[34] Ibid, 536.

[35] Ibid, 537.

[36] D. Bonhoeffer, *Spiritual Care*, trans. Jay C. Rochelle (Minneapolis, MN: Fortress Press, 1985), 58.

[37] White, ibid, 538.

[38] Ibid, 539.

[39] Ibid, 525.

has permeated E. White's writings long ago. Specifically, she states, "Teach the people that it is better to know how to keep well than how to cure disease."[40]

Sixth, E. White made statements supporting the idea of persistent prayer in a sanitarium.[41] Such idea is seen as a strategy because if physical recovery happens, some sick people could experience conversion.

Reasons for Establishing Health Centers

William E. Alberts is among the most recent authors cited in this dissertation. The reason for this is that he develops the idea of a hospital at the crossroad of humanity. His book illustrates the main idea he holds. Therefore, Rev. Alberts explains, "In a hospital, the common humanity people share comes to the fore and tends to transcend their differences."[42] A few years before that publication, Dysinger reported some details on the genesis of the Loma Linda University (LLU) in the United States of America (USA). He reminds that E. White urged John A. Burden to get the school opened for training "medical evangelists."[43]

Besides such reports given by Dysinger, there are primary sources where E. White herself gives specific guidance concerning health centers. As an illustration, she insists that sanitariums should be near important cities, but in suitable places away from the cities.[44] Although E. White does not say directly what is a "suitable place," her other publications allow assuming what it refers to. Most certainly, the idea

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[40] Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 526.

[41] Ellen G. White, *Selected Messages, Book 3* (Review and Herald, 1980; 2002), 295.

[42] William E. Alberts, *A Hospital Chaplain at the Crossroads of Humanity* (Boston, MA: Emi Feist Catalog, 2012), 17.

[43] P.W. Dysinger, *Health to the People* (Victoria, Canada: Trafford, 2007), 22.

[44] White, ibid, 534.

behind is to ensure an environment for rest, far from the noise of big cities. From this point, one can imply that health centers are created in order to provide a suitable place that will contribute for the recovering of patients.

Along the same line, Sorajjakool and Seyle suggest the following idea: "Perhaps this is why sick people come to the hospital. It is a place of hospitality, a place that offers the embrace of illness in the presence of care."[45] T. Moore[46] agrees when he provides the origin of the word "hospital." It comes from *hospis*, which means both "stranger" and "host," plus *pito*, meaning "lord" or "powerful one." Sorajjakool and Seyle conclude with the following words: "The hospital is a place where the stranger can find rest, protection, and care."[47] This is another reason why health centers exist—to provide care in times of illness.

While reading E. White's arguments on the establishment of hospitals, the idea of spiritual care permeates her statements. To take a case in point, she has various formulations of the reason why health centers had to be established. First, she states, "Our sanitariums have been presented to me as most efficient mediums for the promotion of the gospel message."[48] Second, she specifies the matter when she writes, "The conversion of souls is the one great object to be sought for in our medical institutions. It is for this that these institutions are established…Oh, what precious

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[45] S. Sorajjakool, and B. Seyle, "Faith, Illness, and Meaning," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 89.

[46] T. Moore, *Care of the Soul: a Guide for Cultivating Depth and Sacredness in Everyday Life* (New York: Harper Perennial, 1992), 175.

[47] Sorajjakool and Seyle , Ibid.

[48] Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 536.

opportunities are thus offered to sow the seeds of truth."[49] And finally, she cautions, "This is the work for which our sanitariums are established—to correctly represent the truths of the Word of God and to lead the minds of men and women to Christ."[50]

The essence of E. White's arguments is that health centers are established to be used as a possible channel to help sick people. It is a place that is supposed to be suitable to impress their minds with the Word of God. It is also an opening to impress minds out of what the Word of God has done to those who work for the restoration of patients. Nevertheless, one should not bypass the adverb correctly used by E. White because it is meant to make a difference. It implies that there are guidelines to follow in using a hospital as an opportunity to represent the truths of the Scriptures. May be that is clearly needed in order to *lead the minds of men and women to Christ* (emphasis supplied) as the last part of E. White's claim puts it.

Expected Characteristics of Workers in Hospitals

E. White celebrates the fact that Luke is called "the beloved physician" in the Scriptures as well as in her writings. Although she does not say so directly, she apparently assumes that Luke was an exemplary worker in the field of medical missionary. E. White mentions his co-operation with Paul in the work at Philippi. According to her, "Luke continued to labor for several years, doing *double service* (emphasis supplied) as a physician and a gospel minister. He was indeed a medical missionary."[51] Such emphasis about a double service allows expecting that workers in health centers do not see themselves only as medical workers, but employees who are

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[49] Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 537.

[50] Ibid, 538.

[51] White, ibid, 544.

missionaries as well. This could serve as ground for E. White to insist that workers in Adventist health centers ought to be Christians[52] who have a living connection with the Great Healer.[53] Her point is that those workers ought to be soundly converted.

Evans seems to detect one reason for such point. It is that, if those workers are truly converted, the gospel transforms the relationships with God and the sick.[54] That is why E. White expects those who work in hospitals to make the gospel attractive.[55] She even indicates avenues for making the gospel attractive: through pleasant words and kindly deeds. Since those employees function as gospel workers, she also expects them to be set apart that they will have to pray and lay hands on sick people.[56]

Nevertheless, E. White makes it clear that medical missionary work is not only for missionary physicians and nurses.[57] As a matter of fact, she is not the only author with such a view. Terry reports Adolf Harnack who listed ten different ministries performed by Christians. He includes *support of the sick and infirm* (emphasis supplied) in that list.[58] Ultimately, while E. White underlines the necessities for

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[52] Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 534.

[53] Ibid, 538.

[54] A. T. Evans, *What Matters Most : Four Absolute Necessities in Following Christ*, Includes Indexes. (Chicago, IL: Moody Press, 1997), 343.

[55] White, ibid, 536.

[56] Ibid, 546.

[57] Ibid, 545.

[58] J. M. Terry, *Evangelism : A Concise History* (Nashville, TN: Broadman & Holman, 1994), 38.

church members to following the example of Christ,[59] Rowell implies the pastor also must be in the midst of the practical execution of ministry.[60]

Biblical Healing

Overview of Sickness

In Rice's effort to conceive a *theology of wholeness*, he builds on the idea that, "Illness is a 'whole person' problem."[61] This implies that a person who is sick must be seen as having a problem that affects his or her whole human being. In Bonhoeffer's argument supporting spiritual care to the sick, he maintains that sickness can make somebody to be driven to extreme resistance toward Christ.[62] That is a key reason why Christians should seriously consider the issue of sickness. Sorajjakool and Seyle agree when they affirm, "Illness has the potential to evoke deep theological reflection in those who are suffering."[63] In other words, they believe that the way an individual perceives God and God's involvement in his or her life is strongly affected by illness.[64]

People who engage in such reflections usually come out with different formulations of why there is sickness or why a person does suffers. B. Croft believes

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[59] Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 524.

[60] Jeren Rowell, *Thinking, Listening, Being: A Wesleyan Pastoral Theology* (Kansas City: MO, Beacon Hill Press, 2014), 23.

[61] R. Rice, "Toward a Theology of Wholeness: A Tentative Model of Whole Person Care," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 17.

[62] D. Bonhoeffer, *Spiritual Care*, trans. Jay C. Rochelle (Minneapolis, MN: Fortress Press, 1985), 57.

[63] Sorajjakool and Seyle, Ibid, 77.

[64] Ibid, 86.

that sickness and suffering are part of the consequences of sin in this world because of man's disobedience.[65] Bonhoeffer had previously shared the same opinion in saying that sickness and pains are "a law of the fallen world."[66] The idea is that, to be ill is a real thing that can happen to people in this world. In their own words, the authors of *Trinity Journal* differentiate two types of problems in the Christian's life: "self-inflicted and others-inflicted wounds."[67] Nevertheless, one should not bypass the idea of old-age diseases. It gives evidence that there are no causes as the only one-sin.

Whether caused by self or others, Arnold and Talbot conclude that some people live in torment.[68] Therefore, Neufeld and Neuffer acknowledge that illness has a concomitant spiritual aspect. They explain, "Just as there are illnesses which are basically psychological with their organic manifestations, there are also spiritual illnesses which have psychologic and organic attributes."[69] Ultimately, they imply that, if a physician is to be a doctor of the whole man he/she cannot ignore the soul of the patient if he/she would practice enlightened medicine.

Besides, anyone familiar with the Church Fathers should agree that they viewed sickness as an occasion to serve God and grow in virtues.[70] In other words,

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[65] Brian Croft, *Visiting the sick: Ministering God's Grace in Times of Illness* (Grand Rapids: Michigan, Zondervan, 2014), 17.

[66] D. Bonhoeffer, 56.

[67] Trinity Evangelical Divinity School, *Trinity Journal Volume 24* (Trinity Evangelical Divinity School, 2005), vnp.24.2.191.

[68] J. Heinrich Arnold, John Michael Talbot, *Freedom from Sinful Thoughts* (Walden, NY : Plough, 2014), 2.

[69] Don F. Neufeld and Julia Neuffer, *Seventh-day Adventist Bible Student's Source Book*, Commentary Reference Series (Washington, DC: Review and Herald, 1962), np.

[70] Trinity Evangelical Divinity School, ibid, vnp.24.2.201.

they addressed the God-human relationship when they discussed the role of sickness. That is because they basically viewed sickness as coming more from God than from Satan.

The author of this dissertation uses the Bible in order to make an informed evaluation of such view on sickness. In the Bible sickness does not just come from Satan. Often it comes from God and Satan working in collaboration, for example in the book of Job (2:6-8; 7:5), and in the book of Revelation (6:7, 8; 9:1-3, 6, 11). Paul's "thorn in the flesh" was at the same time a messenger from Satan and simultaneously permitted by God (2 Cor 12:7-9).

Overview of Biblical Healing

Biblical healing here refers to the way the Bible portrays healing. Ferguson and Packer[71] give a few fundamental elements to explain the scriptural view of healing. First, it includes the whole person and all means of healing, whether medical or nonmedical, physical or spiritual. R. Rice[72] confirms this view. He shows how the physical and spiritual are interrelated for a meaningful healing. The same idea permeates in a number of healing events in the Scriptures. Following are varied healing methods provided by the authors of *Master's Seminary Journal*. They include: prayer (Gen 20), hand into his bosom (Exodus 4:6, 7), God's predetermined time limit (Dan 4:28-37), dipping seven times in the Jordan River (2 Kgs 5), unexplained actions

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[71] Sinclair B. Ferguson and J.I. Packer, *New Dictionary of Theology*, electronic ed. (Downers Grove, IL: InterVarsity Press, 2000), 287.

[72] Rice, "Toward a Theology of Wholeness: A Tentative Model of Whole Person Care," ibid, 22.

(1 Kgs 17:17-24), without anything (Gen 21:1, 2), combination of events (2 Kgs 20:1-11), looking at an elevated serpent (Num 21:4-9), unknown means (Job 42:1-17).[73]

Second, because God created the body and the mind with limited powers of self-healing, He placed healing agents in the environment. This idea of healing channels in the nature implies that healing is conditional, a process,[74] and each person must[75] contribute to the restoration of his or her health. Dysinger[76] reports some of Dr. J. Kellogg's actions who based his treatments on health principles.

Third, in order to achieve the complete restoration of human well-being, healing on the basis of redemption is required. This is provided by God through the ministry and work of Jesus Christ.[77] The key point is about redemption. This implies repentance, baptism, and salvation. It affects other aspects of daily life. A number of authors of a *Theological Commission* agree that the healing brought by Christ is integrative.[78] They interpret healing in the broadest sense of inclusiveness, thus they do not limit it only to physical ailments but to illnesses of oppression, racial

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[73] The Master's Seminary, *Master's Seminary Journal Volume 14* (The Master's Seminary, 2006), vnp.14.2.274.

[74] See for instance, Review and Expositor, *Review and Expositor Volume 98* (Review and Expositor, 2001; 2004), vnp.98.2.232.

[75] E. White is categorical on that. She insists that sick people *must* (emphasis supplied) agree to become temperate in order to be restored to health. Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 2002), 528.

[76] P.W. Dysinger, *Health to the People* (Victoria, Canada: Trafford, 2007), 14.

[77] Oden for instance portrays Jesus as "Saviour and Physician." Thomas C. Oden, *Becoming a Minister* (New York: Crossroad, 1987), 79. R. Rice has earlier explained, "The Greek word for 'heal,' *sozo* also means 'save,' so it nicely expresses the view that spiritual and physical restoration are aspects of one comprehensive experience." Rice, "Toward a Theology of Wholeness: A Tentative Model of Whole Person Care," ibid, 20.

[78] World Evangelical Fellowship. Theological Commission, "A Digest of Articles and Book Reviews Selected from Publications Worldwide for an International Readership, Interpreting the Christian Faith for Contemporary Living."; Description Based on: Vol. 24, No. 1 (Jan. 2000), vol. 25, electronic ed., Evangelical Review of Theology: Volume 25 (Exeter, England: Paternoster Periodicals, 2001).

discrimination, tribalism, joblessness, and all sorts of conflicts in one's life. It is wholistic healing which does not make any distinction between the body and soul. It becomes possible when one is connected to Christ.

The above three perspectives in which Ferguson and Packer view biblical healing have implications for the Church. They themselves elaborate on what is at stake. The idea is about *the ministry of healing*[79] *of the church* (emphasis supplied). They explain that the phrase "ministry of healing" is commonly used to describe the church's involvement in healing which has continued from the early centuries of its history. Basically, such involvement has to be a comprehensive one. Describing it, they declare,

> It includes medical healing on the basis of creation as when the church founded hospitals (from the 4th century AD), provided hospices and grew medicinal plants in the herb gardens of monasteries. Since the rise of an organized medical profession, the church has continued this ministry through the work of Christian doctors and nurses, and medical missionaries. In a similar way, the church has complemented medical care with physical and spiritual care, through prayer and the laying on of hands, and sometimes with anointing with oil.[80]

Through this statement, Ferguson and Packer are corroborating the age-old practice that most denominations always establish health centers on. They do that for the sake of the wholistic approach to restore health to mankind. Their claim also supports the idea of double ministration in hospitals: the physical and spiritual care.

The third point earlier presented deals with complete restoration through redemption in Jesus. The author of this dissertation argues that because the church has to develop a *healing ministry* (emphasis supplied), a response of mankind to the issue

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[79] According to Ferguson and Parker, it seems that the phrase 'the ministry of healing' was first used as the title of a booklet by the Rev. A. J. Gordon DD of Boston, MA (1836–95) in 1881. Ferguson and Packer, ibid, 288.

[80] ibid

of redemption (salvation) in Jesus, is an indication that those members will have to be brought together. It could eventually be through baptism, but the emphasis is about initial discipleship. The upshot of all this is that the researcher celebrates the fact that the idea of the healing ministry of the church justifies the possibility of making converts also through a double ministration in health centers. It also implies the good atmosphere that should reign in the church in order for members to be in good health regarding all other aspects of their life.

R. Rice seems to master the overall picture that portrays the issue of healing ministry of the church. He even has an original way of putting it. He talks of "ministryhealing" (in one word). He himself explains, "We could use it (that word) to express the notion that healing and ministry belong together – to show that healing is a form of ministry and ministry is a dimension of healing."[81] The essence of Rice's argument is that ministryhealing seeks to be a ministry that heals and a healing that ministers.

Discussion on the Occurrence of Healing

Part of the theological foundation for this dissertation has revealed that God alone is the Healer. There is no doubt on that. Healing is according to His will. The material so far considered confirms such a view. The issue at stake now is whether God heals all illnesses and diseases. As much as possible, the researcher critically puts into conversation part of the previous material, a few other authors, and his own understanding in order to see the conditions in which healing occurs.

[81] Rice, "Toward a Theology of Wholeness: A Tentative Model of Whole Person Care," 16.

If someone asks whether God heals all illnesses and diseases, the researcher argues that it is not a "yes" or "no" question. It is such that demands an elaborated answer. The reason is that one must first clarify which view of healing is implied in the question and what type of illness is assumed in that same question. Both details are needed in order to provide the most applicable answer.

Ferguson and Packer have provided three workable views of biblical healing in the previous part. Supposedly the word "heal" in the question at stake refers to either the first or second view. It is good to recall a few details concerning these views. In both of them, to "heal" means to "recover" from diseases or illnesses. Such recovery can come through the use of medical treatments or not (1st view), and natural remedies (2nd view). Another effort now is about the specific sense of illness. Both perspectives view it as a medical challenge, whether physical or spiritual (1st view), physical ailments that can be solved by the use of natural health principles (2nd view).

Now that details have been clarified, the question is asked whether God heals all diseases and illnesses. Even based on the clarifications, the answer of the author of this dissertation is not "No," but "Not necessarily." He says so because God[82] can sometimes heal in such setting and sometimes not. The following are three fundamental reasons to support his answer.

First, this world is a sinful one.[83] If one properly understands what a sinful world is all about, then it is obviously a place subject to sickness and disease. The *norm* (emphasis supplied) should be the consequences of sin: sickness, suffering, and

[82] As a matter of fact, the authors of *Trinity Journal* believe that only God knows why some people are healed (i.e. recover from a disease), and others are not. They conclude, "Healing or lack of healing is not indicative of anyone's faith or lack of faith." Trinity Evangelical Divinity School, *Trinity Journal Volume 26* (Trinity Evangelical Divinity School, 2007), vnp.26.1.17.

[83] See for instance Norman L. Geisler, *Systematic Theology, Volume Three: Sin, Salvation* (Minneapolis, MN: Bethany House, 2004), 80.

death. Second, sickness can help some people to remain connected to God and continually depend on Him. For instance, Church Fathers viewed sickness as an occasion to serve God and grow in virtue.[84] Third, the healing miracles of Jesus are mostly seen by many authors as a "foretaste of His coming kingdom."[85] As the word indicates, it is a *foretaste.* In order words, it is not yet time for their full display. Thus, they must be rare. Describing the healing miracles of Jesus, Rice claims that they have a "proleptic"[86] quality. Thus, Chafer concludes, "The death of Christ provides no absolute cure for physical ills, though it does so provide for spiritual ills."[87]

Assuming now from the question at stake, that "to heal" refers to the third view developed by Ferguson and Packer, it is good to remind that the idea in that perspective is about the total restoration. In order words, redemption through Jesus. Also, the type of illness here is not limited only to physical ailments. For instance, it can include selfishness, oppression, racial discrimination, tribalism, and all sorts of conflicts in one's life. The idea is that no medical treatment can be relevant or effective in treating such type of illness.

As details have been clarified, the question is asked whether God heals all diseases. Even based on the clarifications, the answer of the author of this dissertation is not "Yes" but, "Conditionally" or "On one condition." And the condition is for the

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[84] That was why they did not emphasize healing. Instead, their focus was on ways in which illness can be spiritually constructive. Trinity Evangelical Divinity School, *Trinity Journal Volume 24* (Trinity Evangelical Divinity School, 2005), vnp.24.2.202.

[85] Anthony T. Evans, *Who Is This King of Glory? : Experiencing the Fullness of Christ's Work in Our Lives*, (Chicago, IL: Moody Press, 1999), 199.

[86] He explains that they are present manifestations of a future reality. They show what life will be like when God's reign is fully realized. Rice, "Toward a Theology of Wholeness: A Tentative Model of Whole Person Care," ibid, 18.

[87] Lewis Sperry Chafer, *Systematic Theology*, (Grand Rapids, MI: Kregel, 1993), 7:185.

person to be willing, to accept that God does it for him/her. The researcher says so because God is surely willing and able to heal (save), but He requires the willingness of each person. Following are three fundamental reasons to support this answer.

First, the real issue is about the sick person, not the sickness. Rice argued that Jesus' concern in healing people was toward the victims and not the disease.[88] Truly, the Scriptures indicate the time when there will be no more sickness, suffering, death, etc. (Rev 21:4). Second, the Scriptures (Isa 1:18; John 3:16) do not only tell about the evangelistic heart of God, but also portray what He requires from any person who answers His calling. The person must come and accept God's saving grace. Third, the ultimate question is whether everybody believes in Jesus.[89] In other words, do all sick people really believe or would believe upon their recovery. One can remember the experience of the nine lepers (Luke 7:11-19) who went their way even after recovering and did not come back to *thank Jesus*[90] and *praise God*.[91]

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[88] Rice, "Toward a Theology of Wholeness: A Tentative Model of Whole Person Care," 20.

[89] As Hayford and his colleagues put it, "What's on trial in the world today is whether or not Jesus Christ is believable as the Son of God…" Jack W. Hayford, Gary Curtis, Robert W. Anderson and his colleagues, *Answering the Call to Evangelism : Spreading the Good News to Everyone*, Spirit-Filled Life Kingdom Dynamics Study Guides (Nashville, TN: Thomas Nelson, 1997), 43.

[90] The authors of *Trinity Journal* suggest that the response to the experience of healing is more important than the healing itself. Trinity Evangelical Divinity School, *Trinity Journal Volume 26* (Trinity Evangelical Divinity School, 2007), vnp.26.1.13.

[91] D. Jeremiah believes that the purpose of healing is to praise God. David Jeremiah, *A Bend in the Road* (Nashville, TN: Word, 2000), 160.

Spiritual Care

What is it?

As a concept, spiritual care is understood as a reference to activities that address the spiritual dimension of human beings—prayer, compassionate gestures, kind words, etc.—that encourage the sick person to hope for a divine intervention in times of suffering. In practical terms, Paget and McCormack define it as: giving people food, water, shelter, and clothing.[92] Moreover, they suggest that spiritual-care ministries could imply: scriptural instruction, interpretation, prayer, meditation, spiritual direction, presence, listening, and reflection.[93] As a result, Bonhoeffer enlarges the scope of spiritual care above the traditional conception of a sick person (1st and 2nd view according to Ferguson and Packer). He has specific chapters on spiritual care to those who are tempted, for home visitations, funerals, weddings, baptisms, etc.[94]

Despite of the above views of spiritual care, one could still be confused when it is associated with the field of medical evangelism. Therefore, Rev. Alberts complains that "It is about empathy, not evangelism. About connecting with, not converting. (it is about) empowering, not gaining power over."[95] Nevertheless, it necessitates a whole-person approach.[96] Carla Gober does not only agree with Dysinger, she pleads that it should be included to some degree by every medical

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[92] It is in reference to their comment of the parable of Matthew 25. Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2006), 7.

[93] Such ministries are viewed as components of spiritual care. Ibid, 18.

[94] D. Bonhoeffer, *Spiritual Care*, trans. Jay C. Rochelle (Minneapolis, MN: Fortress Press, 1985), 51-76.

[95] William E. Alberts, *A Hospital Chaplain at the Crossroads of Humanity* (Boston, MA: Emi Feist Catalog, 2012), 16.

[96] P.W. Dysinger, *Health to the People* (Victoria, Canada: Trafford, 2007), 14.

professional.[97] A key objective in doing that would be to inform the health personnel about the spiritual care process. James Greek enumerates components that affect such a process. They are: creation of a trusting atmosphere, evaluation of the patient, listening skills, identifying with humanness, prayer, the caregiver's own heart preparation, etc.[98]

It is important to provide here a brief comment on the crucial components of spiritual care and the reasons why it is important in the field of medical evangelism. First, love as an element of care giving. Sorajjakool and Seyle write, "Through the experience of love, a hurting patient knows that although the pain and chaos may remain, his or her life takes on a new meaning."[99] In making this comment, the authors urge that love is what can help people to bring grace to individuals who face with the disruption of their lives. Consequently, the researcher argues that as spiritual care includes love, it is a good way to share the divine grace to sick people in health centers. The idea is that in doing so, those who are ill will experience God's love from such interaction. An emphasis on the divine saving grace is needed because there are some patients who are sick due to personal sins that lead to a guilty conscience. Love as an element of care giving helps to set them free.

Second, compassion is a motivator for spiritual care. As Reid reminds the components of Jesus' earthly ministry, he states, "He (Jesus) showed unusual

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[97] C. Gober, "Spiritual Care for the Dying and Bereaved," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 116.

[98] J. Greek, "Spiritual Care: Basic Principles," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 98.

[99] S. Sorajjakool, and B. Seyle, "Faith, Illness, and Meaning," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 89.

compassion for people."[100] If spiritual care would be used as a model in medical evangelism, the people involved would have to be compassionate in an unusual way.

Third, listening skills is a necessity in the area of caring. While Berkley describes what it takes to "understand the world"[101] of the sick, Rev. Alberts urges to "listen" to patients. The idea behind is to help lift the spirits of the sick persons. Giving that Larson and his co-authors[102] study signals to help develop good listeners, the author of this dissertation emphasizes the key role of listening in spiritual care. It is only as one listens to what patients are saying and what they are not saying that an adequate response would include presenting the third view of healing as redemption.

Fourth, laying-on of hands can possibly be used in care giving. Nonetheless, scholars disagree on its importance. On one hand, Shelley insists that God's answer to prayer works "through the laying on of hands."[103] On the other hand, Bonhoeffer observes that dangerous and exotic elements can easily creep into the practice of laying-on hands.[104] This study has revealed the theological importance of such a practice. The researcher observes that the church regulates its use. In addition, Rice

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[100] Alvin L. Reid, *Introduction to Evangelism* (Nashville, TN: Broadman & Holman, 1998), 31.

[101] James D. Berkley, *Called into Crisis: The Nine Greatest Challenges of Pastoral Care*, The Leadership Library, vol. 18 (Carol Stream, IL :Word Books, 1989), 123.

[102] Bruce Larson, Paul Anderson and Doug Self, *Mastering Pastoral Care*, Series Statement from Jacket, Mastering Ministry (Portland, OR: Multnomah Press, 1990), 105.

[103] Marshall Shelley, *Building Your Church through Counsel and Care: 30 Strategies to Transform Your Ministry*, Library of Leadership Development, vol. 3 (Minneapolis, MN: Bethany House, 1997), 98.

[104] D. Bonhoeffer, *Spiritual Care*, trans. Jay C. Rochelle (Minneapolis, MN: Fortress Press, 1985), 59.

indicates other physical gestures useful in spiritual care. He lists, "taking a position close to the patient, speaking directly to, and looking at the patient."[105]

Fifth, touch is a powerful tool in spiritual care. As many writers underline its role, Greek[106] also acknowledges that placing one's hand on the patient's forearm conveys the message of unhurried care. His point is that health care giving involves a lot of proper touching people. While some may disagree with such idea, the researcher agrees with Shelley[107] who insists on the crucial role of the motive in touching. His reason is that the misuse of a tool does not mean that the tool is useless. Obviously, there are cultural differences even in this issue of touching. In other words, it is possible to find a culture where to touch a hand, forearm or shoulder of the opposite gender is acceptable; while in another culture it may be rude. Therefore, healthcare workers must get acquainted with various standards of different cultures, especially when ministering to a patient of the opposite gender.

Sixth, music therapy is an opening for spiritual care. Terry reports that Charles and John Wesley used music effectively to reach and teach their converts.[108] In other words, music is seen as a powerful medium that could be utilized in evangelism. As far as medical evangelism is concerned, Hayford and McDonald believe that music is a type of balm that had healed and soothed the human spirit for centuries.[109] In their

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[105] Rice, "Toward a Theology of Wholeness: A Tentative Model of Whole Person Care," 32.

[106] J. Greek, "Spiritual Care: Basic Principles," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 100.

[107] M. Shelley, *Building Your Church through Counsel and Care: 30 Strategies to Transform Your Ministry*, Library of Leadership Development , vol. 3, 99.

[108] John Mark Terry, *Evangelism : A Concise History* (Nashville, TN: Broadman & Holman, 1994), 110.

[109] Jack W. Hayford and Tom McDonald, *Toward More Glorious Praise: Power Principles for Faith-Filled People*, Spirit-Filled Life Kingdom Dynamics Study Guides (Nashville, TN: Thomas Nelson, 1997).

opinion, music facilitates the healing process. It can create an environment in which sick people focus on God's power rather than their present circumstances.

The researcher's expected result in presenting the above components of spiritual care would be an increase of church attendance in the communities that embark on spiritual care. In regard to church attendance, Koenig indicates almost thirty research studies that have found that people who attend church live longer than those who do not attend it.[110]

Why Have it?

The answer to this question complements the information on the importance of the components of spiritual care. The idea is to focus on key facts that justify spiritual care. First, the crises that lead to spiritual care are an overwhelming reality. Greek[111] describes what leads to the world of spiritual care. He explains that individuals often wrap their identities around success, wealth, prestige, family, or accomplishments. Then a crisis hits and they find themselves in the hospital waiting for the results of medical tests. He adds that in these vulnerable moments the things that once brought comfort lose their power. Many feel a need for greater help; help from outside themselves.[112] That is how people enter the world of spiritual care. Given that the experience of a crisis is a reality that nobody can argue with, life crises are strong evidences in support of spiritual care.

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[110] Harold G. Koenig and his colleagues, "Does Religious Attendance Prolong Survival? A Six-Year Follow-Up of 3,968 Older Adults," *Journal of Gerontology (Medical Sciences)* 54A (1999): M370-76.

[111] J. Greek, "Spiritual Care: Basic Principles," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 96.

[112] Greek insists, "In providing spiritual care it is our privilege to strengthen the link between the patient and his or her spiritual resources," ibid.

Second, the human response to crisis cannot be improved by science. Even for those sick who hope to rely on their faith, one is not always sure of a peaceful ending of the crisis. Greek notices two types of responses by people: some people's faith grows stronger under trial while others struggle.[113] A reason why one cannot predict exactly what would be a response to crisis is William James' unsuccessful scientific study. Partridge, says James, had hoped to put religion on a scientific basis through the scientific study of religious experience.[114] Because of its failure, Hunter discusses the limits of human sciences in bringing healing.[115] He results in the necessity of relying on God in order to understand human functioning. Based on such comment, the researcher insists that even for the medical personnel that achieve amazing results, the power behinds comes from God.

Third, the acceptance of the divine solution leads to the creation of a community. Commenting the important aspect of the earthly ministry of Jesus, Rice reveals the goal of His ministry. He states, "The goal of his (Jesus) ministry healing was the creation of community; the reconciliation of people to one another as well as to God."[116] According to the author of this dissertation, such a goal allows expecting initial discipleship in the life of some sick persons who recover from their diseases. His reason is that, since many writers agree that "people accuse God; they ask why God has burdened them with this sickness, this death, this failure, this marital

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[113] J. Greek, "Spiritual Care: Basic Principles," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 97.

[114] Christopher Partridge, *Introduction to World Religions* (Minneapolis, MN: Augsburg Fortress, 2005), 26.

[115] William F. Hunter, editor, Rosemead Graduate School of Professional Psychology and Rosemead Graduate School of Psychology, *Journal of Psychology and Theology: Volume 20*, electronic ed. (La Mirada, CA: Rosemead Graduate School of Professional Psychology, 1997).

[116] Rice, "Toward a Theology of Wholeness: A Tentative Model of Whole Person Care," 24.

problem,"[117] a biblical response should be given to them. Such an answer would include Jesus as the ultimate solution, and an introduction inside the community of all those who have had similar experiences.

Who Does it?

This part provides information about caregivers, those who are expected to minister spiritual care. First, Bonhoeffer speaks of "spiritual curate"[118] as one who provides spiritual care. Also, an idea that permeates in the writings of most authors in this field is that to be a spiritual curate is to answer a calling to serve—God's call for His people to care for the needy and afflicted.[119] The key point here is that God expects some people to be spiritual curates, or caregivers. Normally, it is among God's people that one should expect a raise of caregivers. The researcher believes that spiritual curates are people of God who decide to answer the specific call to minister spiritual care in health centers (for instance).

Second, caregivers have themselves experienced hardship. Tozer and Bailey add that there are men (and women) of sorrows whose witness to mankind welled out of heavy hearts.[120] The researcher acknowledges that there is logic in such a divine selection and wisdom. Because, if a caregiver has experienced the patient's situation, he/she would be best placed to understand what the person can be going through. Nevertheless, he does not imply that one cannot minister spiritual care to someone

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[117] D. Bonhoeffer, *Spiritual Care*, trans. Jay C. Rochelle (Minneapolis, MN: Fortress Press, 1985), 33.

[118] Ibid.

[119] Brian Croft, *Visiting the sick: Ministering God's Grace in Times of Illness* (Grand Rapids, MC : Zondervan, 2014), 16.

[120] A. W. Tozer and Anita M. Bailey, *God Tells the Man Who Cares* (Camp Hill, PA.: WingSpread, 1992), 1.

excepts if one has lived the same situation. His idea is that the one who experienced it is best placed as compared to the one who has not lived it through.

Third, spiritual caregivers should not be expected to come only from a particular group of people. Despise of the fact that Bonhoeffer insisted much on spiritual care as a work of the pastor; he also refers to the universality or priesthood of believers.[121] In such a way, care giving is for all believers (the pastors as well as the members). That is why the researcher advances that spiritual caregivers can also be raised in a health center in order to embark on medical evangelism.

Who Receives it?

The answer to the question who received the care giving describes two key points that characterize sick persons in every hospital. Such description brings details that are related to the place of spiritual care. They serve as indicators if one would like to embark on the area of medical evangelism. Following is an enumeration of such crucial points.

First, sick people are not sophisticated machines that need repair, but persons that need care. Rice agrees and adds that such persons need caregivers who have special skills in restoring relationships.[122] The researcher explains that from the perspective of spiritual care as a model of medical evangelism, sick people should not be dehumanized in the assistance they receive in hospitals. They should be considered as people with needs. For some of the sick persons, those needs can find meaning if the spiritual dimension is addressed.

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[121] D. Bonhoeffer, *Spiritual Care*, trans. Jay C. Rochelle (Minneapolis, MN: Fortress Press, 1985), 60-64.

[122] Rice, “Toward a Theology of Wholeness: A Tentative Model of Whole Person Care,” 32.

Second, there is a growing interest in studies that suggest the healing nature of the belief in the Word of God. Paget and McCormack report that many people believe that God's Word heals.[123] Greek observes that people in hospitals tend to be more open to spiritual care.[124] Bonhoeffer adds that the sick inquire about Christ more than do those who are in a good health condition.[125] On the contrary, Rev. Alberts reports an instance of a patient who claimed not to need the help of a religious person. Nevertheless, that does not invalidate the place of the Word of God as a healing tool for care receivers. Rather, the author of this dissertation explains that it is an indicator that sick people are free to be receptive to care giving activities or not. This fact also confirms the previous point explaining that sick people are not sophisticated machines that need a repair. So, even if a caregiver is convinced on the place of the Word of God as a tool for healing, the care receiver is the one to value such instrument of healing.

How to Minister it?

The answer to the question how to minister spiritual care is twofold. The approach starts with specific ways of doing spiritual care and ends with some cautions in such ministration. To be more specific, the researcher insists on elements of care giving in a hospital setting. It could be by the health personnel or church members. Since a previous part has listed the components of spiritual care, this one provides the methodology in ministering those elements.

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[123] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2006), 33.

[124] J. Greek, "Spiritual Care: Basic Principles," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 108.

[125] D. Bonhoeffer, *Spiritual Care*, trans. Jay C. Rochelle (Minneapolis, MN: Fortress Press, 1985), 57.

First is about the ministering of genuine love and touch in care giving. This kind of love is godly, available, and can even be sacrificial. A proper way of ministering it is to create what Greek calls a "safe atmosphere".[126] The idea is that the caregiver must not appear rushed, trying to cover as many questions as possible in order to move on to the next patient. Otherwise, it will look as if the information needed is more important than the person. Ministering genuine love implies focusing on the patient so that the person experiences the availability of the spiritual curate both verbally and nonverbally. Actually, a good tip for that could be through an eye contact, proper touching, and sitting down in a chair so the eyes are on the same level; even the direction of the body and the tones of the voice are influenced by love.

Second is concerning the ministering of compassion and the use of words. To take a case in point, Bonhoeffer argues that in spiritual care, compassion cannot stand alone, there is need to bring the whole truth of sin and grace.[127] In other words, he believes that the mission of spiritual care falls under the general mission of proclamation. He states, "Caring for the soul is a special sort of proclamation."[128] Based on that comment, the author explains that the service in spiritual care consists of bringing people to God and to salvation. He even insists that one must use many Bible verses and hymn stanzas known from the memory. For him, they are more effective than using one's own words.[129] A more beneficial option would be to possibly ask a patient of his/her favorite Bible texts and read them with a brief

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[126] J. Greek, "Spiritual Care: Basic Principles," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 99.

[127] D. Bonhoeffer, *Spiritual Care*, trans. Jay C. Rochelle (Minneapolis, MN: Fortress Press, 1985), 60-64.

[128] Ibid., 30.

[129] Ibid., 59. He clarifies what the sick needs to know (that they are special and uniquely lodged in God's hand, and that God is the giver of life whether in this world or the next). Ibid.

explanation or sing the patient's favorite song/hymn. While doing so, Bonhoeffer still cautions that the spiritual curate should not tell the sick that it will soon be all over, because he has no certainty of that.[130] The idea, according to the researcher is simply to try to be what Greek calls "a person of hope."[131]

Third is related to listening while ministering spiritual care. Technically, Greek suggests that the spiritual curate should "tackle the hard questions prior to the visit."[132] His idea is about the need of taking time away from the challenges of life in order to think on how to handle a hospital visit. Indeed, the spiritual curate may be aware that the patients to visit are wrestling with hard questions and might address them to him or her. It helps to anticipate and it makes listening more informed. With that, the researcher argues that the spiritual curate would be able to tailor questions to the patient's needs rather than simply entering a generic conversation.

Fourth is a blend of prayer and adequate medical attention in handling a physical emergency crisis. On the first hand, there are theorists who contend that a spiritual approach to life fosters wellbeing. For instance, Pike claims that many people in crisis consider their religious faith as a resource in their deliberations.[133] Because of that, some spiritual curates might think that prayer must be the first thing to do when an injury or a disease strikes. On the other hand, some psychologists in crisis

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[130] D. Bonhoeffer, *Spiritual Care*, trans. Jay C. Rochelle (Minneapolis, MN: Fortress Press, 1985), 58.

[131] J. Greek, "Spiritual Care: Basic Principles," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 109. Berkley adds that hope is a vital ingredient for recovery. James D. Berkley, *Called into Crisis : The Nine Greatest Challenges of Pastoral Care*, The Leadership Library, vol. 18 (Carol Stream, IL : Word Books, 1989), 121.

[132] Ibid, 110.

[133] Patricia L. Pike, editor, Rosemead Graduate School of Professional Psychology and Rosemead Graduate School of Psychology, *Journal of Psychology and Theology: Volume 25*, electronic ed. (La Mirada, CA: Rosemead Graduate School of Professional Psychology, 1997).

counseling describe the priority of medical care. As an illustration, Berkley prioritizes getting immediate medical attention before achieving any other goal.[134] However, for the author of this dissertation, it is preferable to blend prayer and medical care in handling the priority. He clarifies that at the same time when medical care is being given, the spiritual curate can be praying in his or her heart. Later, specific moments should be arranged to pray for the sick and with the sick if the person agrees.

Fifth is a discussion of whether caregivers should communicate their religious concerns to the sick. The researcher examines this question because it ultimately influences the way spiritual care is ministered. Generally, there are two views regarding this point. The first group of people thinks that it is manipulative or coercive for caregivers to broach religious issues with patients. The second group believes that since people have spiritual needs, they often become aware of them when they suffer. Hence, spiritual curates can provide a valuable resource at that time. The researcher belongs to the second group of people. Rice agrees with the idea of the existence of the two views. More importantly, he suggests what should be the real issue whenever that question is considered. In his own terms, he explains, "The crucial question is how to respect a person's religious integrity and emotional vulnerability as we address their spiritual needs."[135] The author of this dissertation accepts such a conclusion. His argument is that every patient has some belief in some

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[134] James D. Berkley, *Called into Crisis: The Nine Greatest Challenges of Pastoral Care*, The Leadership Library, vol. 18 (Carol Stream, IL :Word Books, 1989), 115.

[135] Rice, "Toward a Theology of Wholeness: A Tentative Model of Whole Person Care," 33. In accordance to this conclusion, Hunter argue, "We must actively incorporate the spiritual side of the human person in our work." William F. Hunter, editor, Rosemead Graduate school of Professional Psychology and Rosemead Graduate School of Psychology, ibid. Ultimately, Greek explains, "In providing spiritual care it is our privilege to strengthen the link between the patient and his or her spiritual resource." J. Greek, "Spiritual Care: Basic Principles," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 96.

divinity. Using the spiritual resource of the patient does not mean the caregiver is necessarily communicating his or her religious concerns.

Sixth is whether the spiritual curates should use the rogerian or nouthetic approach in counseling the sick. The researcher briefly introduces each method. To start, Lyn Elder portrays Rogers as the foundation of much pastoral counseling.[136] Surprisingly, Jay E. Adams argues that rogerian approach avoids help, advice, value judgments, and applying divine declaration to counselee's problems.[137] The essence of such a comment is that the rogerian counseling has a humanistic presupposition. As Adams puts it, "it begins with man and it ends with man. Man is his own solution to his problems."[138]

On the contrary, nouthetic counseling is counseling that involves face to face confrontation by one person to another, out of loving concern for him/her, in order to bring about the changes God desires in his/her life.[139] Because of that, healing in the sense of redemption in Jesus demands a change from the sick who is not a convert. For example, Jay E. Adams asks the counselee to repent and believe in Jesus.[140] Adams is an example of person who uses "nouthetic evangelism" where nouthetic

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[136] J. Lyn Elder, *Pastoral Care*, *An Introductory Outline*, mimeographed (Mill Valley, CA: n.p., 1968), Appendix 2.

[137] Jay Edward Adams, *Competent to Counsel: Introduction to Nouthetic Counseling* (Grand Rapids, MI: Ministry Ressources Library, 1986), 92.

[138] Ibid, 82.

[139] http://www.nouthetic.org/what-is-nouthetic-counseling retrieved on 19 September 2014. Since 1993, the movement has renamed itself Biblical counseling to emphasize its central emphasis on the Bible. The *Baker Encyclopedia of Psychology and Counseling* states that "The aim of Nouthetic Counseling is to effect change in the counselee by encouraging greater conformity to the principles of Scripture. http://en.wikipedia.org/wiki/Nouthetic_counseling retrieved on 19 September 2014.

[140] Jay Edward Adams, ibid, 70

counseling is conjoined with evangelism.[141] The author of this dissertation believes there are similar expectations between nouthetic evangelism and medical evangelism as presented by Jay E. Adams and E. White respectively.[142] Thus, he prefers the nouthetic approach rather than the rogerian one in counseling.[143]

Ultimately, spiritual curates must refrain themselves from "evangelizing"[144] in the sense of seeking to proselytize or take unfair advantage of a patient in a vulnerable situation. That is why the researcher values what is the "hospital policy"[145] about sharing faith with patients. In making such a comment, the idea is that one has to *respect*[146] patients' faith while attempting to meet their needs, and accept *their theology.*[147] In putting those words in italics, the researcher seeks to indicate that his hypothesis of spiritual care as a model for medical evangelism in a health center requires a free will participation of those who would be caregivers and care receivers.

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[141] Jay Edward Adams, *Competent to Counsel: Introduction to Nouthetic Counseling* (Grand Rapids, MI: Ministry Ressources Library, 1986), 70.

[142] E. White makes it clear when she elaborates on the reasons why sanitariums are established. She says: "If we are to go to the expense of building sanitariums in order that we may work for the salvation of the sick and afflicted, we must plan our work in such a way that those we desire to help will receive the help they need. We are to do all in our power for the healing of the body; but we are to make the healing of the soul of far greater importance. Those who come to our sanitariums as patients are to be shown the way of salvation, that they may repent and hear the words, Thy sins are forgiven thee; go in peace, and sin no more." Ellen G. White, *Counsels on Health* (Washington, DC: Review and Herald, 1923), 272.

[143] His reason is that a spiritual curate cannot remain neutral in this spiritual perspective. See also Paget and McCormack, ibid, 21.

[144] Ibid, 53.

[145] C. Gober, "Spiritual Care for the Dying and Bereaved," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 127.

[146] J. Greek, "Spiritual Care: Basic Principles," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 98.

[147] Stephen B. Roberts, *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook* (Woodstock: VT, Sky Light Paths, 2012), 5.

To sum up this study, it appears that various authors have explored the fields of medical evangelism, biblical healing, and spiritual care. The researcher discovered key ideas that brought new insights. Medical evangelism is part of a big picture called evangelism. It implies using the field of health to help Humankind move to a complete restoration of their original state of health. Biblical healing includes a whole person approach. God is supreme in deciding whether He brings recovery from a physical ailment or not. Also, He gave limited self-healing power to humans through the use of simple health principles. The most important is that complete healing must include redemption through the acceptance of Jesus as Saviour and Physician. It is this third view of healing (Ferguson and Packer) that explains why some healed patients in health centers can possibly either be converted or grow to (initial) discipleship. It happens only if proper ways are followed to minister to those patients. Therefore, spiritual care is understood as a reference to activities that address the spiritual dimension of human beings.

In regard to the research question, the author of this dissertation provides an answer which is informed by the insight gained from the review. It is when spiritual curates respect the patients' faith, accept their theology, do not impose their religious concerns to them, and correctly use the nouthetic approach of counseling that the ministration of spiritual care can achieve the expected results.

Ultimately, there is a relationship between this literature review and the central topic of the research. Many authors have explored the possibility of making converts from a ministration of spiritual care to sick people. They all insist that a proper methodology should be followed in doing that. In the best case scenario, this perspective of medical evangelism can easily lead to initial discipleship (or continual growth in it). The condition is that the patients themselves should be the ones seeking

meaning for unanswered existential questions that allow using their spiritual resources.

CHAPTER 4

A SPIRITUAL CARE MODEL

The fourth chapter presents a strategy of developing a spiritual care model for medical evangelism in the selected health institution. The ministry context of the researcher integrates the training of future nurses as well as pastors. At the time of the writing of this chapter, one third of the nurses serving at BAH are former graduates of Cosendai University where the author of this dissertation teaches. Post contact with them becomes an empowerment to make them more effective in their practice. The overview of the chapter essentially includes: the presentation of the context and Buea Adventist Hospital, research design, data analysis, and the program development.

Presentation of the Context

In order to present the context where a field research will take place, it is important to provide some highlights about it. Therefore, the first part of the chapter discloses a background of the place, its landscape and climate, the demography, the economy, cultural information, and religious belief and affiliations.

Background

Many historians have established a link between the town of Buea and the name given to the country where it is found. For example, Gerhard Erbes believes that the Phoenicians discovered the 'Theo Oekama' (Chariot of fire), possibly mount

Cameroon (*situated in Buea,* emphasis supplied) during an eruption.[1] Ultimately, Erbes' point is that, though the name "Cameroon" derived from the Wouri basin in the town of Douala (called "Rio dos Camaroes"), it is the "Theo Oekama" (situated in Buea) that first attracted the Portuguese who came from North Africa, stopped at Buea, moved to Douala, and named the country Cameroon after the Wouri river.[2] Erbes even underlines that the German administration that was first based in Douala, was later moved to Buea. He asserts, "They created plantations, built roads, railways and houses, schools and ports, using forced labor."[3] Thus Buea became an organized city where healthcare was available even for the patients coming from surrounding villages.

Landscape and Climate

The town of Buea is historically significant for the country of Cameroon[4] because the Mount Cameroon is found in Buea. Admittedly, it is described as the "volcanic massif of southwestern Cameroon, rising to a height of 13,435 feet (4,095 m) and extending 14 miles (23 km) inland from the Gulf of Guinea. It is the highest peak in sub-Saharan western and central Africa and the westernmost extension of a series of hills and mountains that form a natural boundary between northern Cameroon and Nigeria"[5]. Some sources stand on the point that Buea tends to be

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[1] Gerhard Erbes, "Cameroon's History, from Colonisation, Annexation, German, French and British Rule, Independence and the Rise of Nationalism," accessed 19 August 2015, about:reader?url=http%3A%2F%2Fcameroon-tour.com%2Forigins%2Findex.html.

[2] Ibid.

[3] Ibid.

[4] The country stretches on a surface area of 475 650 km2." "Generalities on Cameroon," accessed August 19, 2015, http://www.statistics-cameroon.org/manager.php?id=11.

[5] "Mount Cameroon," *Encyclopædia Britannica*, 2015.

humid and cool because it stands at the foot of Mount Cameroon[6]. Thus, the weather is generally cold. Such can be convenient for family members who want to take their sick ones in hospitals located in a nice environment.

Demography

Due to the presence of a State university in the town of Buea, it is not always accurate to determine the exact figure of the population at a point in time. Even, the current population of the whole country is said to be approximately 20 million people; predominately urban (58 per cent of Cameroonians live in urban areas; UNFPA, 2010)[7]. Some sources affirm that "About 150,000 people live in Buea."[8] It follows that the people who live in Buea would preferably go to any health center when they are sick rather than given priority to witch doctors.

Economy

Buea and the rest of the Southwest region have a rich economic potential. There are vast agro industrial plantations, fertile soils, large plantations of rubber, banana, cocoa, palm trees and tea that extend over several hectares, the University of Buea, and several colleges that were established several decades ago by missionaries. As a consequence of such economic potential, one could expect more facilities in the area of healthcare. Nevertheless, such economy does not allow everyone to easily buy medications in times of disease.

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[6] "Buea - Wikipedia, the Free Encyclopedia," accessed 13 August 2015, about:reader?url=https%3A%2F%2Fen.wikipedia.org%2Fwiki%2FBuea.

[7] "Cameroon | UNDP-ALM - UNDP's Adaptation Learning Mechanism," *Undp-Alm.org*, accessed August 19, 2015, about:reader?url=http%3A%2F%2Fwww.undp-alm.org%2Fexplore%2Fmiddle-africa%2Fcameroon.

[8] "Buea - Wikipedia, the Free Encyclopedia."

Cultural Information

From a cultural perspective, the Bakwerians[9] are the main people in Buea. Though the daily socio-cultural activities are no more deeply immersed into the culture like in a typical African village, there are traits that cannot be undermined. Moreover, there are periodical cultural events that give opportunity to emphasize the cultural trends in Buea. Some sources hold that "The Bakweri are known in Cameroon for their traditional wrestling (Wesuwa), which encompasses all the qualities the Bakweri have inherited from their ancestors: physical endurance, agility, fierce fighting techniques, and a great sense of competition."[10] Essentially, their idea on physical endurance could be useful in bringing enough encouragement to patients who have to fight diseases.

Religious Belief and Affiliations

In Buea, the religious belief from a cultural angle accommodates the idea of God. The dominant group, for instance, ascribes to God the attributes of omniscience, omnipotence, and invisibility. They call Him the Protector, Maeke; the Creator of all things, Iwonde; the Guardian and Keeper of all things, Motateli; the Law-Giver, the Governor, the Source of the Word, Ovase or Lova.[11] Similarly, the idea of God

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[9] Kwekudee, "Trip Down Memory Lane: Bakweri People: Ancient Fierce Fighters, Traditionally Spiritual, Custom-Abiding And Agrarian Bantu People Of Mount Cameroon," *Trip Down Memory Lane*, September 18, 2014, http://kwekudeetripdownmemorylane.blogspot.com/2014/09/ bakweri-people-ancient-fierce-fighters.html.

[10] Ibid.

[11] So deep is their belief in the omniscience and omnipotence of the Supreme Being that one has to understand the thought patterns of the Bakweris to appreciate the part that religious mysticism plays in their day to day affairs. Ibid.

permeates in almost all ethnic and religious groups in Cameroon.[12] Therefore, in dealing with long time health challenges, it should not be a surprise if some family relatives would prefer taking their sick ones to a witch doctor when there is no improvement.

Buea Adventist Hospital

Background of Healthcare in West Cameroon

The National Center for Archives in the town of Buea has historical documents that give a global idea of the health care situation in the 20th century. For instance, Appendix A (p. 3, 1931) shows that while some ethnic groups organized their juju ritual around the fishing activity (ej the seven sea spots of the Bimbians), the Bakweris organized their own djengu[13] societies around sickness and health. Far back in 1919, a native hospital in Buea was reported to be inadequate; even called "bush building" (Appendix B). Later, in 1930, Dr. William is recorded as an example of a medical doctor who worked in Buea upon his arrival on 9 March of the same year (Appendix C). Appendix D gives an example of a native staff composition in a typical hospital in the year 1930. Since 1930, malaria was already reported as being the most prevalent disease (Appendix E).

In 1965, the leading causes of illness, as reported in the Appendix F, included: malaria, helminthiasis, gastrointestinal diseases, skin disorders, respiratory diseases,

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[12] It has been observed that, "While only 47 religious groups are legally registered, hundreds more operated without official government authorization."United Nations High Commissioner for Refugees, "Refworld | 2013 Report on International Religious Freedom - Cameroon," accessed August 19, 2015, about:reader?url=http%3A%2F%2Fwww.refworld.org%2Fdocid%2F53d9079a14.html.

[13] They explain that « djengu » means providential disease which can only be cured through faith by means of sacrifices. Any one affected with it, is owing to some strange habits observed, absent from this world and must be denied of several kinds of privileges. He is confined in a house and must be well fed and differently looked after. Ibid.

accidents and wounds, venereal diseases, rheumatism, eye disease, and scabies. While the State could spend up to 11% of its budget on health (Appendix G), some private companies (like Pamol) put aside up to 12% of its total budget to provide health care to their workers and their families (Appendix G). At that time, when the State formulated the policies for medical care, it regarded subjects as "private medical care, government medical care, public health, social medicine, medical care financing, and related topics" (Appendix H). Obviously, nothing was said about spiritual care. On the contrary, the place of native doctors (i.e. traditional practitioners) in the health system at that time was well established (Appendix I).

The Actual Health Situation in Cameroon

Appendix J is made of different tables taken from the World Health Organization (WHO). They contain a number of data on the WHO statistical health profile for Cameroon. Those tables are included in order to largely support the overall picture of the health situation in Cameroon as well as in Buea.

Description of BAH Before the Project

The study started by a research on ground. The author was able to gather some data that gave him a view of what took place a few months before he arrived to carry on the project. Those data are in three categories: the distribution per occupation for all the patients that came (A), the distribution per occupation for all the patients that were admitted (B), and the distribution per number of days spent in the hospital (C). Data A is important to determine the more frequent social group at BAH. Data B helps to know the type of people who generally stay in the hospital for a period of time, thus presenting an opportunity for spiritual care ministration. Data C gives the number of days when such opportunity is presented to the workers at BAH.

Table 1 below presents the distribution per occupation of all the patients that came to BAH. In Appendix K, Figure 1 graphically expresses the distribution per occupation for all patients that came to BAH between January to March 2015. It appears that the highest percentages of the patients who come to BAH are made of the student population. It amounts to 32.22% or 702 persons. If added to the infants' population (17.62% or 384 persons), it will give a total of 49.84% or 1,086 persons. This is almost half of the whole administered population. In other words, half of the patients that come to BAH belong to the youth group, including children.

Table 1. Distribution per Occupation (Patients Seen)

No.	Occupation	Number	Percentage
1	Students	702	32.22%
2	Business people	426	19.56%
3	Infants	384	17.62%
4	Applicants	193	8.86%
5	Various office workers	138	6.31%
6	House wives	128	5.88%
7	Educators	108	4.96%
8	Retirees	100	4.59%
	Total	2,179	100%

Table 2 shows the distribution per occupation of all the patients that were admitted. In Appendix K, Figure 1 graphically expresses the distribution per occupation for all patients that came to BAH from January to March 2015. It appears that the highest percentages of the patients who come to BAH are made of the student population. It amounts to 32.22% or 702 persons. If added to the infants' population (17.62% or 384 persons), it will give a total of 49.84% or 1,086 persons. This is

almost half of the whole administered population. In other words, half of the patients that come to BAH belong to the youth group, including children.

Table 2. Distribution per Occupation (Admitted Patients)

No.	Occupation	Number	Percentage
1	Students	162	41.43%
2	Infants	91	23.27%
3	Business people	41	10.48%
4	Various office work	28	7.20%
5	House wives	26	6.64%
6	Educators	23	5.88%
7	Applicants	10	2.55%
8	Retirees	10	2.55%
	Total	391	100%

In Appendix K, Figure 2 graphically portrays the distribution per occupation for all patients that were admitted. The study reveals that many people that were admitted belong to the student population (41.43% or 162 of them). That group is immediately followed by infants (23.27% or 91 of them). Altogether, the two groups represent 64.7% or 253 people. In other words, for every 10 patients that are admitted in BAH, almost seven of them are youth or children. The following table provides details on the number of days spent by the patients that were admitted.

Table 3. Distribution per Number of Days Spent in the Hospital Building

No.	Number of days spent	Number of patients	Percentage
1	2 days	192	50.5%
2	3 days	142	37.5%
3	4 days	26	7%
4	5 days	15	4%
5	6 days	3	0.8%
6	11 days	1	0.2%
	Total	379	100%

In Appendix K, Figure 3 gives a graphical view of the number of days of admission of those patients. These figures mean that BAH workers had only two possible days to interact with 192 of their total patients that were admitted. Fifteen of their patients stayed in their structure for five days, three patients for six days, and only one patient up to 11 days. These figures are significant because when patients spent more days in the hospital; it increases the level of possibility to impact them via the ministration of spiritual care. Among the reasons, the literature review has established that friendship must take place as a key stage of the interaction with the patients. Thus, the fact that the highest percentages of admission are two days (50.5%) and three days (37.5%) is noteworthy for this project. As a matter of fact, the total figure here is 88%. In other words, only 12% of the patients can be ministered for four days and above. These two groups of 88 and 12 percentages oblige that the model that will be suggested lays great emphasis on post contact interaction with patients that come to BAH; otherwise, it would be very difficult to lead any patient that has recovered (or a relative) to initial discipleship.

Problem Statement of the Project

As it has been discovered in Chapters 3 and 2 respectively, not only an Adventist hospital is supposed to perform a double ministration to its patients (Chapter 3), but also, the Bible gives instances where wholistic healing happens (Chapter 2). However, one of the crucial problems is that the gospel ministration to patients has always been regarded as the exclusive assignment of pastors or chaplains. Consequently, there have not been intentional plans that exist in BAH in order to relate with former patients (and relatives) at a post contact basis. The main cause is that the attention of the BAH workers has never been drawn to that aspect of the missionary work. Based on the research made by the author of this dissertation and the statement of the problem, the strategy is to work out a research design.

Research Design

This segment of the chapter delineates the research design and methodology. The researcher chooses a descriptive research methodology in order to portray systematically, factually, and accurately the characteristics of the issue of spiritual care in BAH.

Type of Research

In relation to the type of research, the author of this dissertation uses the mixed methods (qualitative and quantitative). Thus, in this study, both methods are used in order to complement each other by providing results that derive from each approach.

Rationale for Selection

The theoretical framework around the issue of spiritual care as a model of medical evangelism demands that people's experience (phenomenology) be explored. It leads to the area of a qualitative type of research. In the course of the study, the

investigation includes numerical data to find out more factual information. That leads to the quantitative type of research. Consequently, the author uses the mixed methods.

Appropriateness to this Study

The mixed methods of research were appropriate for this study for few reasons. First, through the qualitative method, the researcher examined the workers' knowledge, opinions, perceptions, and feelings about the model to experiment. Second, this method also equipped him to analyze the actions, behaviors, activities, and interpersonal interactions of the workers vis-à-vis the patients that came to BAH. Third, the researcher used the quantitative approach in order to consider the frequency at which patients at BAH could agree or disagree with a number of practice in the area of spiritual care. Four, the researcher depended on that approach in order to interpret the reasons why people in the community come to BAH.

Population and Sample of Participants

Generally, a population in a study is the larger group concerned by the project. In this study, there is the workers' population on the one hand and the patients' population on the other hand. A sample referred to those who are selected for a study in a way that they can consistently represent the population from where they are taken. This study looked at the participants as a number of people chosen to be part of the study in a way that does not necessitate representability. Specifically, (1) a short questionnaire was given to 100 outpatients/inpatients to find out the reasons why they came to BAH, (2) a lengthy questionnaire was given to 10 patients (among those admitted) to describe their perspective on spiritual care, (3) open-ended questions for one-to-one interview were asked to seven workers of BAH. In this study, the figures

of the above mentioned people group properly constituted what stood as the data sources.

Criteria of Sampling Procedures and Selection

In order to obtain the sample in this study, the researcher used a different strategy for each of the sources. In regard to the short questionnaire, the researcher made 100 copies of the one-page short questionnaire. He worked with three of the nurses of BAH who are former students of Cosendai University. He instructed them on how to administer the questionnaire. Along with them, they gave the questionnaire to all patients that came (inpatients and outpatients). They made sure they distributed the questionnaires to all until there was no more copy. The specific type of nonprobability sampling here was purposive because the researcher and his former students gave a copy and work only with the patients who were willing to participate in the study. Because the answers were taken on the spot, it was not possible to drop the questionnaire in order to come back and collect it later. The rationale for selection of criteria was twofold. First, the questionnaire was short, thus it could be done in less than five minutes. Second, patients were in a situation where they eventually worried for their health. At times, some were only interested in having their chance to consult with the physician or a nurse.

Concerning the lengthy questionnaire, the researcher was the only one to administer it. The reason was that the material is too technical and could be particularly challenging for a person who has not read the type of material covered in the literature review of this work. He mostly waited for patients that had spent at least two days of admission in the hospital. He did not distribute all copies of the questionnaire on one occasion until they were finished. The rationale was that the researcher's model of spiritual care as a tool for medical evangelism demands enough

time for interaction between the worker and the patient. Friendship had to be developed to become the foundation for post contact relationship. The researcher did the interviews in three periods of time with the condition that the patient satisfies the number of days required for the study. The rationale for this was twofold. First, the researcher could not stay for more than two weeks (because of his teaching assignment). Second, coming at different periods of time allowed him to witness different experiences that could not all happened in a given moment.

In relation to the workers, their selection took into consideration the type of work they do, their years of experience, and their religion. The rationale for such criteria was diverse in nature. Regarding the type of work, it was important to make sure all workers come to know that everyone is expected to administer spiritual care. In relation to the years of experience, the idea was to measure if the practice had been there or if the concept had been neglected. The aspect of the religion allowed arguing whether some workers who are SDA or non SDA were more or less inclined to the double ministration suggested in the researcher's model.

Instrumentation

This is the space where all instruments that were used to collect data are being described. These were: questionnaires, interview schedules, and observation forms. The questionnaires were appropriate for the population here because the majority of them were students. Just like the workers at BAH, they are learned people who could communicate in English. The interview schedules were also appropriate because they took place at the hospital. Since the workers were on duty, scheduling their interviews allowed them to find a replacement for the moment when they met with the researcher. The use of the observation forms in this study helped to take note of (1) little details that were eventually neglected by the sample in responding, (2) live

experiences that enriched the researcher in his familiarity to a hospital setting, and (3) possible inconsistencies between what the participants said and what they did.

The short questionnaire contained five points, and the participants were asked to rank in order of priority the reasons why they came to BAH. The questionnaire gave them the possibility to add more possible reasons and prioritize all. In the last lines of the sheet which they received, they had the possibility to give the single reason that tempts them not to come to BAH in the future if nothing is done to improve the situation. The rationale was not only to allow the participants to indicate possible reasons that the researcher could not foresee, but also to let know what are the possible threats to the healthcare services in BAH.

The lengthy questionnaire included sub parts. The first sub part allowed the patient the possibility to strongly (disagree, and/or, agree) with a number of statements that dealt with the practice of spiritual care by the health personnel vis-à-vis the patient. Along the same line, for the remaining sub parts, the idea was to have the opinion of the patients, and give an idea of what could be their response to the gospel if by God’s grace they recovered from their sickness. The relevancy of that lengthy questionnaire is that spiritual care as seen by the patient must not be assumed; one must measure the patient perspectives on spiritual care.

The open-ended questions for one-to-one interviews to the selected workers were in a semi-structured interview approach. In that, the researcher guided rather than dictated exactly what happened during his encounter with each interviewee. The rationale of such approach was to allow more freedom of analysis on the part of the participant.

Data Analysis

Data Collection Procedures

At this level where the data sources become known (population, sample, and participants), and that the instruments are also identified (questionnaires, interview schedules, and observation forms), this part of the study describes the procedures to collect and analyze the data. First, in order to collect data for the qualitative research, the researcher used his Lenovo tablet to audio record all the workers that were chosen. In relation to the questionnaire and interviews given to the patients, he did not need to do an audio recording. He simply gave out the sheet of paper that contains the formulation of various questions.

Concerning the observations, each time the author went for the field work in BAH, he made sure he spent not less than eight hours during day time in the hospital. He also spent many nights in the hospital. Many a times, he waked up during the nights in order to go round, and go through the same places he saw during the day. If it happened that some emergencies were signaled during the night, he also went and observed. During the whole stay in the hospital, he offered spiritual care not only to patients, but also to the health personnel. In conversation with the local leaders of BAH, he went through some record books and other documents useful for the study. He paid attention to the sign board, to those documents that are posted on walls. He observed what happened in the experience of a patient from the entry to the exit.

Presentation and Description of Findings

The findings are presented in the following order: results of the 100 short questionnaires, 10 lengthy questionnaires, and the open-ended questions to seven workers of BAH. The Table 4 presents the statistics about the reasons why people come to BAH. The top three are: proximity (81% or 75 occurrences), wholistic

healing (80% or 74 occurrences), and expectation on spiritual dimension (76% or 70 occurrences).

Table 4. Reasons Why People Come to BAH

Reasons (prioritized in order of importance)	Number of time each reason is rated in the following order of priority								Total			Order of predominance
	1	2	3	4	5	6	7	8	Forms distributed	Forms collected	% of respondent who mentioned this reason	
Proximity	22	16	2	11	19	2	2	1	100	92	81%	1
Wholistic healing	21	25	14	8	4	2	0	0	100	92	80%	2
Expectation on spiritual dimension	11	15	19	12	13	0	0	0	100	92	76%	3
SDA good reputation	4	9	17	19	11	8	0	0	100	92	73%	4
Cost affordable	11	6	15	14	16	3	2	0	100	92	72%	5
Good care	12	0	0	1	0	1	0	0	100	92	15%	6
Like staff working	8	1	3	1	0	0	0	0	100	92	14%	7
Clean	2	3	0	0	0	1	0	0	100	92	6.5%	8
Easy access	4	1	0	0	0	0	0	0	100	92	5%	9
Obligation to support church institution	1	0	0	0	0	0	0	0	100	92	1%	10

Along the same line, Table 5 describes the threats that can hinder future attendance to BAH.

Table 5. Threats that can Hinder Future Attendance to BAH

Reasons	Number of Times It was mentioned	Percentage	Order of predominance
That BAH is very expensive	16	26.23%	1
That the service is slow	12	19.67%	2
That there is not enough equipment	12	19.67%	3
The absence of good doctors or Specialists	7	11.5%	4
More personnel needed at BAH	6	9.83%	5
Bad behavior of BAH workers	3	4.91%	6
Poor hygiene in rest rooms	3	4.91%	7
If patients do not recover	2	3.28%	8

In Appendix L, Figure 1 expresses the same information in a graphical view. The top three threats were: BAH is very expensive (26.23% or 16 occurrences), the service is slow (19.67% or 12 occurrences), and that there is not enough equipment (19.67% or 12 occurrences). The Table 6 shows the statistics as expressed by patients on their perspectives about spiritual care to them.

Table 6. The Patients' Opinions on Spiritual Care to Them

Please share your opinions	Total Participants	Strongly Disagree	Disagree	Agree	Strongly Agree	Highest choice made for this question	Percentage of the highest choice made
Do you think a health personnel should help you to feel better spiritually as well as physically and emotionally?	10	0	1	4	5	Strongly Agree	50%
Do you think a health personnel should know about your religious beliefs?	10	0	3	6	1	Agree	60%
Should health personnel help you—if you need help, to practice your religion?	10	1	4	4	1	Disagree-Agree	40%
Do you think it is wrong for health personnel to share his or her personal religious beliefs or practices with a patient?	10	1	4	4	1	Disagree-Agree	40%
Do you think a health personnel could harm a patient by sharing his or her personal religious beliefs or practices with a patient?	10	2	6	2	0	Disagree	60%

In the overall result, 60% of the patients (or six of them) agreed with the statements such as: Help me to have quiet times or space, Listen to me talk about my spiritual concerns, Listen to me talk about my spiritual strengths, Tell me about spiritual resources nearby that I can use, Help me laugh (e.g., share a joke), Arrange for my minister or a spiritual mentor to visit me, Arrange for a chaplain to visit me, Offer to talk with me about the difficulties of praying when sick, Offer to pray privately for me (for example, a health personnel, prays for me later while alone).

The following reveals the statistics as expressed by patients on their opinions regarding few issues of spiritual care to them.

Table 7. The Patients' Opinions on Preriquisites for Providing Spiritual Care

When a health personnel cares for my spiritual or religious needs, this worker needs to:	Total participants	Strongly Disagree	Disagree	Agree	Strongly Agree	Highest choice made for this question	Percentage of the highest choice made
Have spiritual beliefs similar to mine	10	0	6	3	0	Disagree	60%
Be from the same religious background as me	10	3	5	2	0	Disagree	50%
Have had personal experiences like I am having	10	3	6	1	0	Disagree	60%
First show me genuine kindness and respect	10	0	1	6	3	Agree	60%
Get to know me first	10	1	4	3	3	Disagree	40%
Have had training about providing spiritual care to ill persons	10	0	1	6	3	Agree	60%
Have had religious training	10	1	1	6	2	Agree	60%

The data on the Table 7 clearly reveals that 60% of them (or six patients) disagreed with the idea that a health personnel could harm a patient by sharing his or her personal religious belief with patients. Six patients (or 60%) disagreed with the idea that the health personnel must first have the same belief before providing spiritual care to patients. In the same line, 60% (or six patients) agreed that the workers must first have genuine kindness and respect before embarking on the ministration of spiritual care. Also, 60% (or six patients) agreed that such workers need a training about spiritual care. The next Table presents the statistics as expressed by patients on their opinions regarding few preriquisites that workers should meet before they provide spiritual care to them.

Table 8. The Patients' Opinions on Medical Evangelism Activities

If by God's grace you recover from your sickness and you are discharged from this hospital, would you like a worker to?	Total participants	Yes	No	It depends	Highest choice made for this question	Percentage of the highest choice made
Keep in touch with you	10	6	0	4	Yes	60%
Invite you to health talks	10	9	0	1	Yes	90%
Give you free religious literature	10	8	1	1	Yes	80%
Conduct personal Bible studies with you	10	7	0	3	Yes	70%
Invite you in the Adventist church when there are special programs for visitors	10	7	1	2	Yes	70%
Give you telephone calls	10	5	0	5	Yes-It Depends	50%
Send you SMS or e-mails(if applicable) to inquire about your health situation	10	9	0	1	Yes	90%
Become your friend in social media (if applicable)	10	6	2	2	Yes	60%
Become a regular visitor as a family friend to you	10	5	2	3	Yes	50%
Encourage you in your decision to be born again through public baptism in the Adventist church	10	5	3	2	Yes	50%

The Table 8 shows the statistics as expressed by patients on their opinions concerning their responses to medical evangelism activities if they eventually recover their health. Eventually, 90% (or nine patients) believe they will accept an invitation to health talk; the same percentage would like to receive some SMSs or emails (if applicable) to inquire about their health situation. Also, 80% (or eight patients) would like to be given free religious literature. Apparently, 70% (or seven patients) are willing to receive Bible studies; the same percentage declares to be available for an invitation to an SDA church for special programs for visitors. It looks as if 50% (or five patients) say they want to be encouraged for new birth through baptism in the SDA church.

Figure 1 in Appendix N discloses the number of respondents for the lengthy questionnaire. There are 10 respondents. Five are between the ages of 17 to 26; three are between 41-67 of age. Two are between 27 and 40. Figure 2 gives their primary diagnosis (reasons for admission). Malaria and typhoid are the top two reasons that are recorded. The following lines give further information about those respondents. First in terms of their religions, there are three Catholic, three Presbyterians, two SDA, one Pentecostal, and one Apostolic. Second, concerning their days of admission, eight of them spent three days, one of them spent four days, and one person spent six days. Third, about the level of sickness; five of them could work without difficulty, and five with difficulty.

This segment presents different summaries of responses from one-to-one interviews to the selected seven workers of BAH. Their responses are related to spiritual care, biblical healing, and medical evangelism. Appendix O is comprised of various tables which give outline views of those responses. Thus, the Table 9

discloses the workers' definition of spiritual care. For the majority, the top summary phrase to define spiritual care was: "Care that brings God in the patient's life."
The next table deals with the question on the workers 'opinion on spiritual care. All of them said it is (very) important. The Table 11 presents the personal meaning of spiritual care for the workers. They chose the statement "bringing the patient to the source of hope" as the number one priority. The one that follows it presents the workers 'actions regarding 'spiritual care' in BAH. In it, the highest workers 'actions regarding spiritual care in BAH were revealed as: "give advice to take medication alongside prayer," "words of encouragement (using the Bible)," "prayer." In the Table 13, the workers' activities with former patients of BAH are summarized. The highest frequency is for "None."

The next segment deals with elements related to biblical healing. The Table 14 gives the statistics about the workers' definition of biblical healing. Their two best summary phrases, that had a frequency of three each, are: "It reminds the healing ministry found in the Bible' and 'Biblical solution to health challenges." The next Table presents the workers 'opinions about 'biblical healing.'

Based on the next table, a view is given on the workers' opinions about 'biblical healing'. Their highest frequency refers to the phrase "It is very important (and needed in our society)". On the Table 16, the statistics in relation to the personal meaning of biblical healing for the workers of BAH are revealed. In their highest expressions, they have two ways of articulating what it means. One is, 'It means a lot to me'; and the second is, 'It is better for us to introduce God in the patient's experience.'

Subsequently, the Table 17 presents the workers actions to patients in need of biblical healing. It appears that their preferred action is to call the attention of the

chaplain that usually comes twice a week when he is in town. The next table deals with workers' personal plan of action for follow-up. It looks as if the highest frequency (5) is to say there is "none" (no personal plan of action to do the follow-up to former patients). After that, the Table 19 summarizes the things done at BAH to mobilize workers as instruments of healing. From all indications, the "morning devotion (8:00-8:15 AM)" has the best frequency (5).

In the succeeding Table 20, statistics concerning the workers 'definition of medical evangelism are provided. The study shows that their best summary phrase has a frequency of 3. The Table 21 that follows presents the workers 'opinion about medical evangelism. Essentially, the largest frequency is 6; it says, 'It is (very) important (and needed). The next table provides details on the workers 'feelings about medical evangelism. Consequently, there are two best summary phrases having the same frequency (2): "It is (very) important," and "It is a good strategy to evangelize."

Behind, the Table 23 portrays the workers 'action in regard to medical evangelism. The most important frequency there is 2. Its summary phrase says, "When possible, be vigilant to see the needs of patient and bring help." The next table is about the workers 'behaviors when a patient is their brother or sister in the faith. The highest frequency there (4) is for "I give them a call, pray for them, and bring support with my resources." In the Table 25, one can see the workers' behaviors in case a patient shares a different faith than theirs. There, the two summary phrases that each has the frequency of 2 are: "Show some concern (and find out how they are responding to the treatment)", and "I explore the aspects of my faith that are similar to theirs."

Details on the workers' personal program for follow-up with former patients are described in the Table 26. The highest frequency (5) is to say, "None." The

ensuing table gives information about the BAH program specifically for former patients. The unique frequency there (7) consists of saying, “None.” In the Table 28, its data shows how people in the community perceive BAH. Their top frequency (4) says, “They believe that we make good impression” (workers use ‘we’ to refer to the Adventist hospital).

This segment provides various details on the interviewees of the open-ended questions. Those details are arranged in three terms. In term of the type of work, three of them are non-medical and four are medical and nurse personnel. In the perspective of their religion, six are from the SDA church while one is non-SDA. In regard to their years of experience, four of them have less than nine years of experience, one has nine years of experience, one has 18 years, and one has 35 years.

Analysis of Data

After presenting and describing the data in the previous segment of this dissertation, the author now analyzes the key information revealed by his findings. His analysis follows the same order of the presentation of findings: (a) 100 short questionnaires, (b) 10 lengthy questionnaires, and (c) the open-ended questions. Nevertheless, in order to give an overall picture of the research, he established some links between a, b, and c. As a reminder in terms of data sources, “a” comes from the population that came to BAH, “b” from patients that were admitted there, and “c” from selected workers of that hospital. During the analysis, the aim of the arguments was to justify the designing of an intervention as he embarks on the program development in his area of study.

From Table 4, it is revealing to see the most important reasons why people come to BAH. Their search for wholistic healing and an expectation on the spiritual dimension have a crucial importance for the intervention that had to be developed. It

appeared that, as an Adventist hospital, people were already prepared to view the Adventist touch in the packaging of the health care they received in this institution. It is true that the questionnaire also revealed that BAH is expensive (Table 4), and such constituted a serious threat; but there is great encouragement in going through the statistics as expressed by patients on their perspectives about spiritual care (Appendix M). Therefore, the following ideas are highly supported: majority of patients agreed that workers at BAH should listen to them talk about their spiritual concerns and needs of spiritual strengths, tell them about spiritual resources that they can use, arrange for their minister's or chaplain's visit, and that workers could pray privately for them. In connection to the designing of the intervention, it meant that the population that came to BAH was somehow prepared to be receptive to the elements of spiritual care mentioned above.

The findings allow seeing a link between such preparedness of receptivity to elements of spiritual care and their opinions concerning their responses to medical evangelism activities. The link is that their logical response is favorable. That is why there is no surprise on the part of patients when some figures are obtained. For instance, 90% (or nine patients) who believe they will accept an invitation to health talk is just obvious. Even 80% of them (or eitght patients) would like to be given free religious literature or 70% (or seven patients) were willing to receive personal Bible study are normal dispositions that could be expected as a result of the program development. Though the intervention does not have an aim to convert the patients into the Adventist Church, the following statistics may be significant for other studies: 70% of patients (or seven of them) declare to be available for an invitation to an SDA church for special programs for visitors, and 50% (or five patients) say they want to be encouraged for new birth through baptism in the SDA church (Table 8).

This analysis cannot bypass two conditions that should allow the ministration of spiritual care at BAH. Based on the study (Table 7), it appears that 60% of the patients (or six of them) agree that the workers must first have genuine kindness and respect before embarking on such ministration. The other condition that also has the same percentage is that workers need a training on the ministration of spiritual care. This is the reason why the intervention should include seminars and a number of lectures that must be given in order to help train the workers at BAH in the field of spiritual care.

Since part of the intervention addresses the cognitive level of the workers at BAH, this analysis can also evaluate and comment their understanding of the notions that will be discussed in the program development. As such, no matter the summary phrases that the workers at BAH used, it appears that they have an acceptable idea in the way they define 'spiritual care' (Table 9), 'biblical healing' (Table 14), and 'medical evangelism' (Table 20). In the same line, their opinion and what those things mean for them are interesting. It can be said in terms of theory: they have very good ideas. Unfortunately, when it comes to the area of practice, there is a lack of it and a lot of weaknesses.

To illustrate some of those lacks, the following results can be used. When asked about their actions regarding 'spiritual care' in the hospital (Table 12), a dialog, singing, paying attention to the patient's countenance, and morning devotion had only 1 in the frequency; prayer had 2, and the words of encouragements using the Bible had 3. In finding out their activities with former patients of BAH (Table 26), it seems that almost nothing was done in the area of spiritual care. For that reason, the greatest challenge in developing the program had to include ways for workers to put in

practice what they already know, because it is very imperative for spiritual care and medical evangelism.

It is essential to connect in one hand what the patients said on their perspectives for spiritual care and on the other hand what workers do in that regard. Whereas 60% of patients (or six of them) agreed that the health personnel should show them genuine kindness and respect in taking care of them (Appendix M, Table 1), there was only one worker out of seven who mentioned "Put on a good countenance" as an action that contributes to biblical healing (Table 17). Moreover, five out of the seven workers do not have a personal plan of action for the follow-up of patients (Table 26); whereas 80% of patients (or eight of them) were ready to receive free religious literature and 70% (or seven patients) were willing that one should conduct Bible studies with them (Appendix M, Table 1). Along the same line, another contrast can be observed from the study. On one hand, there was only one worker who mentioned sending SMSs for encouragement to former patients as his personal program for the follow-up (Table 26). On the other hand, 90% of patients (or nine of them) said "Yes" to the idea of receiving SMSs or emails (if applicable) from the health personnel in order to inquire about their health (Appendix M, Table 1). It could be that such data confirms the existing problem as stipulated in the Statement of the Problem (Chapter 1).

Actually, these few illustrations reveal and confirm that most of the SDA workers in the hospital tend to be reluctant in expressing their Adventist identity. Such reluctance does not represent their mission statement in the hospital. It is as if the idea of shunning to proselytize equals to hindering one's identity as an Adventist. That should not be for at least two reasons: (A) this study has revealed that the population that comes to BAH is highly prepared to receive the Adventist input in

healthcare, (B) the researcher's survey in another faith-based hospital shows that it is just obvious to include religious rituals and activities in taking care of the patients; for example, a morning mass. Some of those Christian hospitals like the Catholic Hospital (in Ngwelle, Douala) even seem to be somehow aggressive and make it compulsory. The author of this dissertation does not intend advocating pressure or compulsion in religion. Nevertheless, a good balance is needed in designing the intervention in view of the development of the program for BAH.

In this analysis, it is also possible to contrast some of the reasons that bring people to BAH and some aspects of what really takes place there on the ground. The analysis of this study examines the importance of embarking in medical evangelism at BAH. As a process of such examination, one could consider three facts. First of all, if one should look at the second and third top reasons that draw patients to this hospital (Table 4), they are: "wholistic healing" (80% or 74 occurrences) and "expectation on the spiritual dimension" (76% or 70 occurrences). Secondly, when admitted to BAH patients were asked the question: "Do you think health personnel could harm a patient by sharing his or her personal religious beliefs or practices with a patient?" 60% (or six patients) choose "Disagree" (Table 6). In other words, they do not see a problem of health personnel sharing their faith with them. Thirdly, the negative answer of "None" provided to the question asked to the selected workers, "List all activities and programs that your health center usually organizes specifically on behalf of all its former patients." (Table27).

It can be assumed that BAH needs to be seriously embarked in medical evangelism in order to achieve the first case scenario about the top reasons why people come to BAH. Nonetheless, the good percentages in that first situation still happened in spite of the answer given for the third case scenario where BAH does not

specifically have a program for post contact with former patients. In order to explain that apparent contrast, the second case scenario can be a strong reason. It reveals the great conviction observed in patients; because majority of them do not think that health personnel could harm them by sharing their personal religious beliefs or practices with them. So, in view of such positive result even in the absence of planned medical evangelism activities in BAH, one is left with two options. The first one is to say that medical evangelism is not important that is why they are still good percentages in attracting patients even in the absence of planned activities with former patients. The second option is to say that the patients' openness to interreligious influences is so strong that those patients can still come to BAH even if there are no organized activities for medical evangelism.

In the opinion of the researcher, the patients' openness to interreligious influences must be seen by the workers at BAH as a motivation to organize and conduct activities pertaining to medical evangelism. Such high involvement can improve the percentages of the top reasons why patients come to BAH more than what they look like now. Moreover, the activities on medical evangelism are not limited to post contacts with former sick people that come to BAH. There are many other good accomplishments related to spiritual care that can also attract patients to BAH. Notwithstanding, the aspect of post contact events with former patients is the one the researcher strongly planned to develop.

Designing of the Intervention

Part of the analysis of the data collected by the researcher revealed some reluctance that workers at BAH have in embarking on medical evangelism. The aim of the intervention designed by the author of this dissertation is to reduce such

observed reluctance. In preparation for the intervention, the following stages were considered:

1. Obtaining of permissions for field work from various Administrations (University, Union, BAH);
2. Contacting an informant at BAH;
3. Sending emails and doing telephone calls to arrange for a working session with the BAH Administration;
4. Traveling to Buea and working with the local administration.

The working session with the administration of BAH also provided details on issues like: the recruitment of the participants, the planning of sessions (how many, and the objectives), the content of the material to cover, and the documents that will be needed. The designing of the intervention relied on what the researcher wrote on the 'Statement of the Purpose.' There, the following was planned to be done: elaborate on spiritual care as the basic component for medical evangelism, develop strategies pertaining to medical missionary work, implement those strategies via seminars and evaluate the impact of those strategies.

Actually, the researcher took a number of steps in designing the intervention to bring about a transformation in BAH. For instance: go through the analysis of the collected data, identify areas where patients need support in relation to spiritual care, and include such in the lectures to cover with the workers. The following are subsequent steps that were taken: identify other patients' expectations and preparedness of receptivity and include them in gathering the material for lectures, identify areas of obvious reluctance on the part of workers at BAH and include such in preparing the material for workshop and capacity building seminars.

Additional steps involved: prepare material for workshops and capacity building seminars, prepare attendance sheets, prepare schedules and list of topics to cover for each session, prepare a list of possible strategies pertaining to medical missionary work while expecting other suggestions from the workers, and prepare few points for brainstorming sessions. The steps in the last stage included: prepare forms that workers could use to report the implementation of various strategies that are suggested, select portions of the literature review that elaborate on spiritual care as the basic component for medical evangelism, and select portions from the Holy Scriptures and Spirit of Prophecy that emphasize the place of spiritual care in SDA hospitals.

Limitations

The major limitation of this study is the relatively small size of patients to whom the researcher gave the lengthy questionnaire. As a matter of fact, ten patients were selected among those admitted in BAH. Such source of information might not totally represent what many more patients might think at a larger scale. It is highly possible that it affects the generalizability of the study to other hospitals and health centers.

Another limitation is the use of the observation method to affirm what happens in other faith-based hospitals. During the analysis of the data, there is a segment of the study that emphasized the reluctance of most workers at BAH. The researcher used the observation method in his visits to other Christian hospitals to assume their aggressiveness (in contrast to the reluctance of workers at BAH) in the area of medical evangelism. It is possible that his observations had some bias when obtaining data.

Concluding Remarks

This chapter has emphasized four essential points. First, it has presented the context of the whole research. Geographical, cultural, and general information were given about the town of Buea and the Adventist hospital there. After telling the history of the project in relation to the institution, some data were used to describe the BAH three months prior to the project. Such description resulted in the problem statement of the dissertation.

Second, the researcher delineated the research design and its methodology. After specifying the mixed methods type of research, the rationale for selection and the appropriateness to this study were explained. The sampling procedures and instrumentation were also described.

Third, concerning the data analysis, the researcher clarified the data collection procedures before presenting and describing the findings. He later analyzed those findings. In a nutshell, it has appeared that the data confirm the existing problem of workers' reluctance in engaging in various activities of medical evangelism in BAH.

Fourth, in line with the program development, the researcher designed an intervention. It is such that allowed him to: (1) elaborate on spiritual care as the basic component for medical evangelism, (2) develop strategies pertaining to medical missionary work, (3) and implement them via seminars and evaluation of their impact. The chapter concludes with the two limitations that permeate in the study. Notwithstanding, this work contains essential material that can give some directions for further research and reflections. The next chapter is going to describe the initiative implementation and its final evaluation.

CHAPTER 5

PROGRAM IMPLEMENTATION

This chapter reveals a thorough description of the initiative implementation. In it, the researcher discloses a step-by-step process of the chosen solution in order to address the problem. Such steps include a schedule of activities for the selected hospital, the strategic activities pertaining to the area of spiritual care per se, and an evaluation of the mixed methods used. Quantitative and qualitative methods were implemented. The first one dealt with the collected and analyzed numerical data after the initiative intervention, while the second one was based on personal interviews of selected individuals chosen from the ex-patients. The results of the evaluation are presented and analyzed in this part of the study.

Activities for the Initiative Implementation

Basic Steps

This segment describes all steps that the researcher took before he actually started to implement the project. He wrote to three different administrations requesting permission for the field work. The first one was written to the administration of Adventist University Cosendai (AUC). The second to the director of the Health Department of the Cameroon Union Mission because BAH belongs to the Union and the head of the Health Department is a member of the administrative council of BAH. He also serves as the technical adviser to the Union President who chairs the council. The third letter was addressed to the administration of the BAH.

Appendix P provides copies of various correspondences. In it, Letter 1 is the recommendation letter that the Rector of AUC gave to the researcher concerning his

fieldwork. The letter bears the name of the researcher and his topic. It also displays the aim of his study. It finally explains that the researcher will need to do some observations, interviews, and any other steps useful for his study. It indicates that the research included Adventist health institutions, non-Adventist that belong to other denominations, public or State hospitals.

In the same appendix, Letter 2 is an email that contains the researcher's request to the Director of the Buea Adventist Hospital via the Union Health Director. He made references to the Cameroon Union Mission President and the West Cameroon Mission President. The request explains the collaboration with their health personnel in order to implement a workable instrument for post contacts with the ex-patients of the BAH. Also, the Rector's recommendation was attached to this request.

In the second page, one can see the response of the Union Health Director sent on the 21 April 2015. In his response, the director attached a copy of the authorization given to the researcher at the Union level of Administration. Actually, Letter 3 of this same Appendix P is all about the permission given by the Union health department. In that letter of authorization, the Director briefly introduced the person of the researcher, the degree he is preparing, the University in which he is doing it, and the topic of his study. He also stated the purpose of the research, the activities that were needed and details about the implementation and the evaluation phases.

Letter 4 discloses the research authorization issued by the BAH on 16 April 2015. In it, the Medical Director indicated that "Action 29/2015" allowed the researcher to carry out his study in their health institution.

Letter 5 is another document that was written to the researcher by the public Kribi district hospital on 23 April 2015. It is one of those few non-SDA hospitals where the researcher did some work in order to ascertain the importance of his model. It appears that

this public hospital has a unit for chaplaincy service. In addition to obtaining permission for field work from the above mentioned administrations, the researcher also contacted his informal, who is the head nurse at BAH and a former graduate of Cosendai University. Before he properly began the implementation phase, the researcher made many telephone calls to arrange for working sessions with the BAH Administration. Ultimately, he had to travel to Buea several times and work on the activities to implement the program which he had designed.

Brainstorming Session

This segment describes the first activity that took place with the BAH workers at the beginning of the intervention. It was on the 28 April 2015, from 7 to 8 am at their Conference room. Appendix Q provides copies of various attendance sheets of all meetings during the intervention. Attendance Sheet 1 shows that 11 workers were present that day in the venue. Among them, one could see the whole administrative team made of the medical doctor, the development officer, and the accountant. The head nurse also attended plus five other nurses. The laboratory unit was represented by one lab technician. In addition to them, a representative of the accounting unit attended the meeting.

Regarding the cost of that activity, the researcher spent 50,000 FRS CFA (about USA $100) for his transportation fare and the four-day-stay in that town. Nothing was spent on the material to use. The informant and the accountant, Mr. Prosper Bias helped to make some calls, remind and gather the workers for the day and hour of the meeting. No refreshment was given to the workers. Nevertheless, the BAH administration later photocopied the list of the workers who were present. An amount of 1,000 FRS CFA (about USA $2) was provided to each attendant for breakfast. That sum was supported by the hospital.

There were three concerns for discussion during that brainstorming session. The first was the mission of SDA hospitals. The second point dealt with the mission statement of the

BAH. The third was the self-evaluation of the worker's ministries: areas of good performance and weak points that needed improvement. During that particular moment, the researcher mostly challenged the thinking of the workers in connection to the three points above-mentioned. He also took note of their suggestions for each aspect. The idea of a double ministration (healthcare and the gospel) on the part of the workers in the hospital was agreed upon. The short SWOT exercise revealed the worker's reluctance as the main hindrance for post contact interactions with ex-patients of BAH. They explained that time could not allow them to be fully engaged in the area of the gospel as they do for healthcare. It appeared to all that more could be done in order to totally reflect what is indicated in their mission statement.

Capacity Building Seminar

This part evokes sessions during which the capacity building seminar was conducted by the researcher. Attendance Sheet 2 in Appendix Q contains various details about the first seminar. It took place just the following day after the brainstorming session, on 29 April 2015. Fifteen workers that were present all came on time. The meeting lasted for one hour, from 7 to 8 am. It was at the usual venue, the BAH Conference room. In addition to the group of workers that attended the meeting on the brainstorming session, the cashier and a nurse/pharmacist joined the group.

There was no specific cost for this meeting, and the hospital provided all what the researcher needed to conduct the seminar. They also paid the little stipend that workers could use later to buy their breakfast. This time, the development officer had joined the informant and the accountant to mobilize the workers.

The list of topics shared during this seminar was: spiritual care, biblical healing, medical evangelism, and the model for implementation and how to apply it. Following are the brief views of the material that was presented during the seminar.

1. Spiritual care. The human body has a physical component as well as a spiritual dimension. When the body is sick, it is not only a physical issue; it has spiritual concerns. The biomedical approach to treat diseases has emphasized the physical component over the years; whereas, the spiritual dimension can also be dynamic in health care. Therefore, the researcher presented spiritual care as a reference to activities that address the spiritual dimension of human beings: prayer, compassionate gestures, kind words, etc. that encourage the sick person to hope for a divine intervention in times of suffering.

2. Biblical healing. The Bible contains fundamental elements to explain the scriptural view of healing. First, healing includes the whole person and every means of healing, whether medical or nonmedical, physical or spiritual. For instance, a medical mean can include the consumption of tablets while a nonmedical can refer to natural laws of health like doing exercise. Second, because God created the body and the mind with limited powers of self-healing, He placed healing agents in the environment. Third, in order to achieve the complete restoration of human well-being, healing on the basis of redemption is required.

3. Medical evangelism. The gospel transforms a person's relationship with God as well as with people. In other words, a person's whose relationship is transformed towards God would also endeavor to cause the same to the people around her/him. Different approaches can be used in this area of spreading the gospel. Thus, medical evangelism would refer to telling the public that God wants to help humankind move towards restoration of the perfection of the perfection of the original health. For all intents and purposes, medical evangelism was presented in terms of being and doing that spread the Word of God through the health ministration to the public. It is a whole person approach.

4. The model for implementation and how to apply it. In talking of a "model," the idea was to present a helpful tool that helps to understand a specific phenomenon. The Bible and some scholars support a phenomenon that should encourage the workers' involvement in

medical evangelism. Usually, when people are sick, they ask existential questions. As a result, a person can come closer to God or apostatize. In other words, conversion and regression can await any sick person. Specifically, if the person recovers from her/his disease, two things can be experienced: coming closer to God via a conversion experience or the strengthening of the faith in God. The researcher highly believes that the ministration of spiritual care activities to a sick person who later recovers from a disease can prepare the way for a conversion experience or the strengthening of someone's faith. That is why this model emphasizes the whole person approach in health care. This model includes practical and simple ways for the ministration of spiritual care.

At the same time, it is important to mention that this model is not designed to be implemented to all patients that come to a hospital. The following conditions are attached to its use: (a) it should be for patients who have spent many days in the hospital, (b) it would be necessary for hospital workers or a chaplain to provide spiritual care to those patients, (c) if by God's grace healing happens, it would be necessary for a worker or chaplain to embark on post contact activities with the patients. There is a list of post contact activities with ex-patients that the researcher has developed. Sincerely, the success of the implementation of this model is not necessarily when baptism could occur; it is when ex-patients give glory to God and are thankful for their experience in the hospital. At the end of that session of the capacity building seminar, the researcher encouraged the workers to start the implementation of the model which was presented to them after entertaining questions. He announced that such implementation had to be done for the next five months.

Appendix Q also includes Attendance Sheet 3. The record shows that 16 workers attended the meeting on 10 June 2015 for another capacity building session. The BAH Conference room was used for the purpose. The meetings run from 7 to 8 am. All unit

services of the hospital were represented: administration, accounting, cashier, laboratory, nurses, etc. As usual, the hospital gave some money for breakfast to all those who attended.

This part of the seminar emphasized only one area of patients 'questions. Following are three main areas that were shared during the presentation:

First of all, it is in a hospital that one usually begins life on earth. This is also where many people complete their earthly pilgrimage. If the time of delivery is viewed as a happy event, the time of death is a very sad one. A life of sickness is often viewed as a very present challenge on earth. There is an element that is unknown to many people today. That is, sickness has the potential to catalyze a profound theological reflection in the person who suffers. When people are sick, they wonder why they exist. They wonder if life has a meaning. Is it worth living? In many typical African societies, one wonders who is behind this disease. Therefore, many people usually consult fetish priests to find answers to those questions.

Secondly, the patient seeks what meaning to give to his/her existence. If life has no meaning, then it is bitter and unpleasant. The spirit of the sick person tries to cling onto anything that can help give meaning to life. This scenario is seen in a lot of victims of accidents that have been traumatized. This is also the case for those who suffer from life-threatening diseases (indeed, any disease can ultimately kill). Questioning is more intense if the diagnosis led to the amputation of a limb or the discovery of cancer.

Thirdly, patients realize that they have lost control over many things and must depend on many others. Fortunately, the reality of the disease is as old as the world. Scriptures depict the case of Daniel who claims to be pining for days of illness (Dan 8:27). Isaiah meanwhile, prophetically saw the city where "no resident will say: 'I am sick'" (Isa 65:19). John, the seer from the island of Patmos also confirms such a prediction (Rev 21:4).

Appendix Q also takes account of the Attendance Sheet 4. In it, the names of 15 workers are mentioned, alongside their positions and signatures. The list of attendants is comprised of two medical doctors, two accountants, one cashier, two lab technicians, the head-nurse plus seven nurses.

Another session of the capacity building seminar took place on 11 June 2015. The venue was also the BAH Conference room; and the time was the same as for the previous sessions: from 7 to 8 am. The reader can find other details of this account in the Appendix.

The researcher equipped the participants on the topic of the interactions with the sick. It was introduced as one of the key areas of empowerment offered to the BAH workers. The main reason is that it is the area that had to determine the way these workers had to apply the implementation of spiritual care to the patients and their relatives. Following are important details that the researcher accentuated during the presentation.

1. Words to patients. To illustrate the power of words, the researcher reminded a popular saying: we do not talk about rope in a house where a man was hanged. Here is the illustration that was used to deal with the case of a certain Mr. Musango. In the story that was narrated, a lady hung herself in that man's house. The idea in using that illustration was that; if any visitor comes and speaks of ropes in that house, it will make the members of the house to feel uncomfortable. The reason is that it would remind them the corpse of the deceased lady. Likewise, a nurse, any family member, and everyone who interacts with the sick person must be aware of the inevitable impact of every word said to the patient.

2. Another element that was incorporated in the presentation was the fact that sometimes sick people appear to be too demanding. They do it almost naturally because of their fragile situation (worse still if the person is naturally complicated and difficult when in good health). God created humans to live and support one another as parts of the same body. There is some sort of equilibrium in society when they are all in good health. This equilibrium

is broken when someone gets sick. As an illustration, Fouda, a young lady gets sick. Such a situation creates a downward pull (with respect to the equilibrium that keeps people of a community together). She will therefore unconsciously try to hang on those around her in order to return to the equilibrium position. Other people can be tempted to consider Fouda as being too demanding. However, that lady does not necessarily know that she is behaving as such. It is true that she may be a capricious person; but the sick condition creates expectations and one naturally looks up to those around self to meet up with these expectations.

3. Gestures towards the patient. Just like words, gestures have the ability to send a message that can either pull up the sick person who is down to a high level; or push low further toward the bottom so that illness eventually crushes the person down. So every gesture should be carefully chosen. By the way, the cultural background of an area should determine what gesture may be accepted somewhere and rejected elsewhere. Other items that will be of spiritual help to the patients providing them with the support they need while on their sick bed, include: the therapeutic touch, attentive and compassionate looks, smiles, a listening ear; these are all in addition to mere presence.

4. Specific actions towards the patient. Generally, there are actions which, if properly carried out, allow those around the sick to shine in the life of the patient. For example, fasting, prayer (Matt 17:21), and generosity (Prov 3:27, 19:17; Matt 25:40) are concomitant, and complementary actions to the spiritual care of the patient. Much is usually said about prayer. Also, there could be numerous ways to fast, not necessarily only one to avoid food. Yet, the fasting that refers to avoiding food should be for healthy persons. It is self-denial in order to be better disposed to prayer. Fasting prepares the heart through self-imposed sacrifices that is needed in order to be more sensitive to God’s voice in prayer and meditation. This therefore requires the person to be “strong” in order to be humbled (“weakened”). It requires the person to be “balanced” in order to take the risk of becoming “imbalanced.” It requires that the

person should have accumulated calories to be burned. A patient does not have the physical balance required in order to do that type of fasting. Instead, a patient has the obligation to take his or her medication in order to recover. Studies attest quite well the therapeutic nature of fasting but amalgam should be avoided. When a drug prescription requires that the patient eats, he or she should be permitted to eat; because at that moment, and in that case, food is part of medication. Recommending fasting (abstinence from food) to patients is synonymous to leading them to death. Taking into consideration all of these aspects means total practical generosity towards the patient.

At the close of that particular session, the researcher insisted that, even though some patients are often quite stubborn, and madden, he advocated a society where people should accompany the sick ones cherishingly; reserving reproaches and health education when those patients are clinically out of danger.

In Sheet 5 of this same Appendix Q, the researcher took note of the key details about the gathering held on the 12 June 2015. It was the third consecutive day of meetings started on 10 June 2015. Fourteen workers attended to that session of the capacity building seminar that lasted for one hour: from 7 to 8 am. They all met with the researcher at the Conference room of that institution. In the coming lines, the writer of this dissertation briefly summarizes the material that was covered.

First of all, he alludes to the reasons for establishing health centers. Following are key points to take into consideration:

1. The researcher cited E. G. White writings where she gives specific guidance concerning health centers. As an illustration, she insists that sanitariums should be near important cities, but in suitable places away from the cities. Although E. G. White does not say directly what is a “suitable place,” her other publications allow assuming what it refers to. Most certainly, the idea behind is to ensure an environment for rest far from the noise of big

cities. From this point, one can imply that health centers are created in order to provide a suitable place that will contribute for the recovering of patients.

2. The essence of E. White's arguments is that health centers are established to be used as a possible channel to help sick people. It should be a place suitable to impress their minds with the Word of God. It is also an opportunity to impress minds out of what the Word of God has done for those who work in the hospital.

3. Along the same line, the researcher also referred to some authors; for instance, Sorajjakool and Seyle.[268] They suggest that sick people come to the hospital because it is a place of hospitality; a place that offers the embrace of illness in the presence of care. In other words, they explain that the hospital is a place where the stranger can find rest, protection, and care.

Secondly, regarding the additional topic of that day, it dealt with the model for experiment and how to go about it. Since details on that model have already been provided in this part of the work, the following lines highlight Sheet 6 of the same Appendix Q under study. That sheet comprises the list of the post contact activities that are linked to the implementation of the researcher's model. Before coming back to those activities, the author of this study draws the attention of the reader on the two notes that preceded the list of those strategic activities. The first note explained that the workers' participation in this initiative was not part of the contract between BAH and the workers. Therefore, it was a free will contribution for the purpose of an academic research. The aim of that note was to remove the suspicion of any compulsion about the double ministration promoted by the researcher; especially because they are non-SDA workers in that institution.

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[268] S. Sorajjakool, and B. Seyle, "Faith, Illness, and Meaning," *Spirituality, Health, and Wholeness*, eds. Siroj Sorajjakool and H. Lamberton (Binghamton, NY: Haworth Press, 2004), 89.

The second note on that sheet of paper clarified the final goal of medical evangelism as expected by the researcher in the life of ex-patients of BAH. In that remark, the researcher insisted that the aim was not a necessary baptism into the Adventist church, but an opportunity/encouragement to be/remain in a right relation with God. In adding that note, the author of this study tried to avoid any confusion between his model and the practice of proselytizing when some people talk of taking care of the spiritual needs of patients. The list of the post contact activities as suggested by the researcher had 13 items and it allowed the workers to add possible activities that were not eventually taught by the researcher.

The implementation of this model started after the capacity building seminar held on 29 April 2015 and lasted for five months. Other sessions of the seminar took place during evaluation on the fifth month. They mainly emphasized the model under experiment. Then, another period of two months was added to continue the implementation prior to another evaluation on the seventh month.

Evaluation of the Initiative Implementation

First Evaluation (September 2015)

After the first period of implementation of the model that took place from April to September 2015, an activity known as focus group discussion was organized. Actually, that was the first evaluation of the project implementation. It took place during the last days of September. In line with it in Appendix P, Letter 6 is a correspondence. In that one page email, one can see that the researcher wrote to BAH on 18 September 2015. The email shows the response of the Development officer on behalf of the Medical Doctor. Also, in her response, she agrees that the researcher should start with devotional and then follow by small group discussions.

Along the same line, Appendix R is made of Focus Group Discussion (FGD) Sheets. In it, FGD Sheet 1, FGD Sheet 2, FGD Sheet 3, and FGD Sheet 4 are provided. Respectively,

they list the names of the members of group 1 (four members), group 2 (five members), group 3 (three members), and group 4 (five members). Group one activity took place on the 29 September 2015, from 7 to 8 pm. The remaining groups met on the following day, 30 September 2015. Each group members gathered in the Conference room for one hour with the researcher from 8:30 to 11:30 am.

Consequently, following are some statistics pertaining to the first evaluation that gave a view on the worker's involvement to that program. Still in Appendix R, the FGD Sheet 5 is the schedule for those group discussions. It was prepared and signed by the Head Nurse. It shows that there are 20 workers in the hospital. That figure differs from the information BAH administration gave back in 2013, where they talked of 15 workers. The explanation given to the researcher is that they usually receive nurses for internship. Therefore, the figure of 20 included such nurses and not only regular workers of BAH. During that first evaluation, the main idea was mostly to see the level of involvement of all the workers and the interest on implementing the model. Selected ex-patients were not evaluated at all. Their evaluation has been planned during the second period at the end of the initiative implementation. In that basis, it appeared that 17 out of 20 workers (85%) took part to the implementation of the model. Among the 17, seven (41%) returned their form containing the post contact activities with former patients. Ten (59%) did not returned their form or said they had misplaced it.

There was one topic for all FGD. It was about the model for experiment and how the group members went about: achievements, challenges, and suggestions. In relation to the achievements, less emphasis was put on the aspect of figures in relation to each activity. The researcher's focus was essentially on the workers' challenges and their suggestions at that level of the study. The following details express the most important challenges raised by the workers who participated to the implementation of the model:

- It is difficult to have time after work hours to get involved in the medical evangelism activities
- The reduced number of personnel at BAH and the high level of outpatients and in patients make it difficult for workers to function with an organized program for evangelism per se.

The following details express the main suggestions that came from almost all the group discussions:

- There is need of organizing a regular and always available chaplaincy unit for BAH
- It is necessary for BAH to recruit workers/chaplains who will concentrate only on the follow-up activities with former patients.

The general feeling after the first evaluation was that:

- Those of the workers who were involved in the implementation of the model said it is a necessity
- Many confessed the lack of time, but insisted that they liked the idea
- All said more time was needed to go through another period of implementation
- The overall understanding was that it will take time for such a program to become a culture and a mindset in BAH.

Second Evaluation (December 2015)

The first week of December was the period for the second evaluation. It came two months after the first one and seven months after the beginning of the fieldwork for this study. Appendix P, Letter 7 is the email that the researcher sent on 28 November 2015 to announce his arrival for the second evaluation. In Appendix R, FGD Sheet 6, FGD Sheet 7, and FGD Sheet 8 give various details on the workers who took part at that evaluation. The conditions were quite the same as for the previous meetings for evaluation. Even the challenges and

suggestions from the workers did not differ from what they had said two months earlier. In effect, the discussions with various groups of workers confirmed the qualitative data provided during the first evaluation.

Besides the workers' population that was evaluated, there was also a need of getting a feed-back from the patients' population. The researcher put in place two different instruments to evaluate the patients' population.

The first was a questionnaire given to 50 people (patients and their relatives) which was conducted from 2 to 4 December 2015. The questionnaire found out their level of satisfaction regarding the services that are provided in the selected Adventist hospital. Moreover, in the form given to each person who was willing to participate in this study, everyone was asked to use the appropriate space to mark each item. Appendix Q, Sheet 7 provides a copy of the questionnaire given to each person who was willing to fill the form. At the end of the survey, the researcher calculated each mark given by each participant for each item. Each total was now divided into 50 to find the average. The following table presents the average mark over 10 that the 50 patients (and/or relatives) gave to express their level of satisfaction regarding the services at BAH.

Table 9. Level of Satisfaction of Patients after the Project

No.	Description of the experiences taking place in this hospital	Average mark/10
1	Workers show compassion to patients	8.1
2	Workers use words that encourage patients	8.21
3	Prayers are offered in wards	2.62
4	Workers pray personally with patients	2.38
5	One can feel the presence of God in this hospital	7.72
6	Workers really represent God in this Christian hospital	6.68
7	People are kind, smiling, and welcoming in this hospital	9.54
8	This hospital does everything to keep in touch with former patients	4.36
9	I feel encouraged to recommend this hospital to other people	8.11

From the table, it appears that the best mark is for item 7. It talks of BAH workers ’attitude of kindness, smile, and welcoming in the hospital. The worst mark is for item 4 which talks of workers ’personal prayer with patients. The model for implementation included actions such as kind gestures, smiling, and a good facial expression as possible means for the ministration of spiritual care. Hence, such mark is seen as a positive outcome from the implementation of the model.

Unfortunately, the least mark shows that much still have to be done in the area of medical evangelism. Not only the average note (2.38) is for the personal prayers with patients, but even prayers in the wards (2.62) are not too effective. It brings back the issue of workers’ reluctance on activities pertaining to the area of medical evangelism. Nevertheless, on a more global perspective, those 50 patients (and/or relatives) said they feel encouraged to recommend BAH to other people (8.11). Based on the fact that the idea of God is the key component for what should happen in the life of a patient or relative, the result on item 5 cannot be undermined. That item talks of feeling the presence of God in BAH. The average note from the data source gave 7.72. It also reveals some positive traits in the aspect of medical evangelism. It appears that almost eight people out of 10 (80%) think that there is God in BAH. They would not say it if the workers were not doing their best about medical evangelism activities.

The second instrument put in place by the researcher to evaluate the patients’ population was a questionnaire to selected ex-patients of BAH. Based on the brainstorming session held on 28 April 2015, the capacity building seminar conducted on 29 April 2015, and 10 -12 June 2015, the researcher had assumed that workers could have used the rest of the month of June to master what was discussed. So he decided to take into consideration patients that came starting 1 July 2015. Also, based on the fact that 30 November 2015 was the end of the period for the second evaluation, the researcher decided that the patients to be selected

should all belong to those who came within that segment of time (1 July 2015-30 November 2015).

Grounded on the fact that the model for the implementation suggests a maximum of days of admission in the hospital, the decision was made to take all those that spent more than two days because observations from the Nurses' Recording book show that majority of patients spent two days in the hospital. A patient that fulfilled all other conditions also needed to have a phone number in order to be taken among the participants to receive a phone call. If the phone number of a patient that fulfilled other conditions was not properly recorded, the name was skipped and someone else taken into consideration. But if during the call, the ex-patient's number was not going through or the person could not pick the phone, no replacement took place. Such person was considered as one who has not responded or who was unavailable for the interview.

Though participants were selected as described above, their participation was still at a voluntary basis. The reason is that, when each one of them was called, the caller (researcher) introduced himself and said a word about the study; after that, his question to each former patient was: 'are you willing to participate to this study in answering few questions?' It is only if the person indicated her willingness that the researcher started with the questions for the interview. In the record book, one could see that some of those former patients were children or aged people. The names of their next of kin and contacts allowed interviewing their relatives on their behalf. In an instance where a contact had more than one person admitted in the same period, it was still just one copy of the questionnaire that was used for the participant.

Appendix Q, Sheet 8 is the list of the 100 ex-patients of BAH. The following detailed information are given there: names, phone numbers, days of admission, date of admission, disease, remarks on availability, and time spent on interview. Out of the 100 patients selected

and whose phone numbers were taken, 57 were available (YES), 38 were not reachable (NR), two were revealed as false numbers (FN), and three fall on a wrong person (WP).

In that list, NR means not reachable. It was for numbers not going through or those calls that were not picked. It also includes one case where the person picked but the communication was too bad because of a network problem. The large number of NR (38) can be explained by a few reasons. The researcher lives in a town where the network is constantly disturbed. Moreover, it could happen that the hours at which calls were made were not convenient for those who missed their calls.

In the same list, FN signifies false number. When the researcher called, the person said she/he is not the one (neither a relative of the name) that is mentioned in the list. It could also be a number that was mistakenly written either by the nurse or the researcher himself. Along the same line, WP means wrong person. It is for cases where the family gave the number of a relative who did not attend the sick person at all in the hospital. YES is for the ex-patients who effectively answered the researcher's calls. They were 57 in total; they constituted the data source for the second evaluation on the perspective of the ex-patients.

After given some details about the selection of the ex-patients, this study now considers the questionnaire which the 57 former patients had to fill. Appendix Q, Sheet 9 is a copy of that questionnaire. After summarizing the choices of those former patients, the author of this dissertation presents the following two tables. The discussion of their results comes just after.

Table 10. The Ex-patients' Experience while at BAH

No.	Experiences	Yes	No	NA
1	At least one prayer was offered in my ward	27	30	0
2	At least one health personnel prayed personally with me	21	36	0
3	I received words of encouragement from the health personnel	57	0	0
4	The health personnel referred to God as the Healer in taking care of me	44	23	0
5	The workers tried to know about my faith before taking care of me	30	27	0
6	The health personnel helped me to feel better spiritually as well as physically, and emotionally	48	9	0
7	I felt frustrated when a worker decided to pray for me without my consent	4	17	36
8	I felt very grateful when a worker prayed for me	21	0	36
9	I was given religious literature	12	45	0

Table 11. The Ex-patients' Experience after they Left BAH

No.	Experiences	Yes	No	NA
1	I have received at least one invitation to health talks organized by the hospital	10	47	0
2	I have received at least one invitation to a health talk organized by a worker	6	51	0
3	I have received at least one telephone call from one of the workers	8	49	0
4	I have received sms or emails from a worker showing concerns for my health situation	6	51	0
5	I have been visited at home by one of the workers who is a friend	5	52	0
6	I have received at least one invitation for a special program in the SDA church	3	54	0
7	I have received Bible studies lessons to fill given to me by a worker	5	52	0
8	I have sat for a Bible discussion with one of the workers	5	52	0
9	I have had an opportunity to share a meal with one the workers	9	48	0

As a matter of fact, the former table is mostly about some spiritual care activities on the patients' perspective. According to item 3, all 57 ex-patients remember and all agree that they received words of encouragement from the BAH personnel. Forty eight of them said the

health personnel helped them to feel better spiritually as well as physically, and emotionally. Forty four also referred to God as the Healer in taking care of them. Nevertheless, the workers' involvement in activities that are strategic to medical evangelism is weak in some points and moderate in others. Take for instance the distribution of religious literature. Only 12 (21%) of those ex-patients received a booklet or magazine dealing with faith. Along the same line, 21 (36%) former patients had the opportunity to be approached for a personal prayer with a worker. Also, based on item 7, nobody negated the idea of being grateful when a worker prayed for him/her.

The latter table insisted on strategic activities for medical evangelism. The results about the experience of those patients after they have left BAH are crucial to determine whether the researcher's goals were met. The following lines describe those results. A rapid view on those figures reveals that all statistics below the "YES" column do not exceed 10. It means that out of the 57 ex-patients who participated to the telephone call interview, not more than 10 (17.5 %) were involved in any of the nine activities pertaining to medical evangelism.

As a matter of fact, the three top achievements of BAH workers are:

1. Activity one - inviting ex-patients to health talks organized by the hospital. Ten patients (17.5 %) mentioned it.
2. Activity nine - sharing a meal with ex-patients. Nine patients (15.7 %) had that experience with BAH workers.
3. Activity three - making at least one telephone call to ex-patients. Eight patients (14.03 %) received such calls from the workers.

In a numerical perspective, those percentages are very weak. Even, item 6 is the area where the lowest figure was obtained. Its activity is about extending at least one invitation for a special program in the SDA church. Only three former patients (0.05 %) received such solicitation.

At the same time, the researcher's model for implementation had encouraged the workers of BAH to be personally involved in the strategic activities pertaining to the area of medical evangelism. The idea was all about to shun proselytizing. It is possible that most workers of BAH understood the model up to a level where less had to be said about churching. Apparently, the researcher succeeded in letting them know that the priority in doing medical evangelism is not about preaching the church or seeking for church goers. In that perspective, to invite three former patients to the SDA church is totally a good result that falls in line with the researcher's model. His idea is that the issue of church should even be discussed as a consequence of a former patient's curiosity in talking to health personnel of BAH. Therefore, though that figure is the lowest, it indicates that the model under experiment achieved the expectation of the researcher.

Critics can be tempted to explain that such lowest figure is an obvious consequence of the BAH workers' reluctance. The researcher's answer to such a critic is to draw the attention on activities 5, 7, and 8. The fifth item talks of former patients who were visited at home by BAH workers who are friends. Five ex-patients (0.08 %) had such experience. The seventh item is related to Bible studies lessons given to ex-patients. Five of them (0.08 %) received lessons from BAH workers. The eight activity is sitting with former patients to conduct Bible studies. There are also five patients (0.08 %) who had that experience after leaving the Adventist hospital.

Once more, it is true that those figures and percentages are not higher enough as compared to the 57 former patients who were called on the phone. The fact that BAH workers involved themselves in the variety of activities during the seven months of implementation of the model cannot be undermined. An indicator for the success of the program is the willingness to run an activity, and be continually running it. The results depend on the way God would use a worker as an instrument to extend the message of restoration to sick people

and their relatives. Thus, a failure of the model would be that nothing is done in relation to medical evangelism activities. Success is that, something is done; and spiritual curates should depend on God for the outcomes.

Project Report

After the second evaluation of the project that was conducted in December 2015, the researcher took two months (January and February 2016) to analyze the results and prepare a research report. In Appendix P, Letters 8 and 9 are emails sent by the researcher to various administrators.

Letter 8 is the correspondence sent on 2 March 2016. There, it is possible to identify the email addresses of the following administrations to which the researcher sent his academic research report:

1. On behalf of BAH and the West Cameroon Mission:
   - the Development Officer who is the wife of the Medical Doctor and handles his correspondences
   - the Treasurer
   - the Head Nurse who is also the informant of the researcher
   - the President of the West Cameroon Mission
2. On behalf of the Union and the University where the researcher works:
   - the Vice Rector in charge of Academics
   - the University Rector
   - the Director of the Health Department at the Union
   - the President of the Cameroon Union Mission
   - the Executive Secretary of the Union
3. On behalf of the Adventist Health International (AHI):
   - the Project Manager-AHI

- the Chancellor of Loma Linda University and President of AHI

Letter 9 ascertains that the project manager, forwarded a copy of the research report to the President of Loma Linda University, because there was a failure delivery after the researcher sent him an email. In the correspondence sent by the researcher (Letter 8 above mentioned), he reminds that his proposal was accepted far back in 2013. He adds that, the expectations as mentioned in his proposal, he would send his recommendations at the end of the study. Moreover, he hoped that his suggestions could be used as a roadmap in the managing of the ministration of spiritual care to the patients in Adventist hospitals in Cameroon. Thus, the following lines give an overview of the research report that was sent and examined the rationale for reporting to each level of administration.

The 12-page research report includes the following elements in the very order: dissertation title, delimitation, definition of terms, model for implementation, activities conducted, results and brief analysis, recommendations. Essentially, the material enclosed in each subhead is made of portions or comments/summaries of what is provided in various chapters of this work. Following are the nine suggestions that he gave to those administrations at the end of the study:

1. BAH should recruit three more nurses and a minimum of two chaplains in order to organize the chaplaincy unit service on a more effective way.
2. The Administration should assign to those chaplains the follow-up of the medical evangelism activities.
3. The human resource should organize things in a way that workers can have two days per month in order to do their personal follow-up to specific ex-patients.
4. The administrative council of the hospital should ensure that the proper percentage of the hospital budget is made available for medical evangelism activities.

5. Under the coordination and recommendation of the chaplaincy, the hospital board should allocate funds to workers willing to conduct any of the 13 specific activities pertaining to medical evangelism.
6. Organize quarterly meetings on the double ministration gospel and healthcare, and how to avoid proselytizing. Paste posters and fix signboards on different places of the hospital; they should comprise messages of hope from the Bible and the book *The Ministry of Healing*.
7. The Administrative council of the hospital should allow the use of a special amount for the writing, printing, and distribution of booklets, leaflets, and devotionals that contain such messages. The booklets and leaflets could be given to patients who are admitted, while the devotionals can be sold and constitute a source of revenue to the institution.
8. Dealing with future recruitment at BAH, it should not be automatic to put SDA workers on the church scale of remuneration. That status should be given after three to five years to those who would have demonstrated a commitment to the double ministration model.
9. The hospital administration should reconsider the church policy on "Operating principles for Health-care Institutions." For instance, the second principle declares, "Health-care institutions function as an integral part of the total ministry of the church and follow church standards including maintaining the sacredness of the Sabbath by promoting a Sabbath atmosphere for staff and patients, avoiding routine business, elective diagnostic services, and elective therapies on Sabbath."[269]

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[269] General Conference of Seventh-day Adventists, *Statements, Guidelines and Other Documents* (Washington, DC: General Conference of Seventh-day Adventists, 1988), 53.

There is a rationale for reporting to each level of administration. As it can be seen from earlier indications to those to whom the report was sent, the researcher touched five levels of administration:

1. Adventist University Cosendai. He sent them the report for the following reasons:
    - It is his employing organization
    - It partially sponsors his study
    - It trains nurses and accountants that can be employed by hospitals
    - It trains pastors that can be introduced to the field of hospital chaplaincy
    - It can use the material in that report to run its habitual seminars on value based education
2. Buea Adventist Hospital. The researcher sent them a copy with the following hope in mind:
    - They can use the material during capacity building seminars
    - The report provides material that shows the necessity of putting in place a chaplaincy unit
    - It provides ideas for post contacts with former patients
    - It provides suggestions to run medical evangelism activities
    - It has a lot also to do with ethical issues in the general managing of patients by the medical personnel
3. West Cameroon Mission. The motives for sending them a copy are:
    - BAH is in their territory
    - It is good for them to be informed of what takes place in the hospital because all the Adventist workers there are members of a church belonging to the Mission

- The pastor who occasionally offers some chaplaincy services at BAH is paid by the Mission
- The Mission has a project of creating health centers as it endeavors to reach the status of a Conference
- Ideas on medical evangelism can be explored by the Mission as an unprecedented approach on health evangelism in their territory

4. Cameroon Union Mission (CUM). Here are the reasons why the researcher thought of sending them a copy of the report:
   - BAH belongs to CUM
   - CUM recruits the personnel and appoints local leaders at BAH
   - CUM defines the highlights of evangelism in the whole territory including at BAH
5. Adventist Health International (AHI). The following points explains why it was also necessary to send a copy of the report to them:
   - They have been the funding organization to erect the main building and equip the hospital to make it reach standard
   - They supervise the running and managing of all Adventist hospitals in Cameroon, including BAH
   - They regularly send volunteers and even recommend qualified medical personnel in order to reinforce the human resources in all Adventist hospitals in Cameroon, including at BAH
   - They have a greater expertise in the ministration of spiritual care because Loma Linda University can even support Adventist University Cosendai in that area.

Closing Remarks

This chapter mainly presented three points: the activities for the initiative implementation, the evaluations of those activities, and the project report. First, some basic steps were considered before mentioning the brainstorming session and the capacity building seminars that the researcher conducted. Second, two evaluations were made in September and December 2015. Third, the researcher wrote a 12-pages document that contained his academic research report which was sent to five different administrations: the University where he works, the hospital where he implemented the initiative, the Mission where BAH is located, the Union and AHI that supervise all leadership decisions in the selected hospital.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

This chapter starts with the summary of the material covered in various chapters (2 to 5). Next is the final evaluation of the study. After that, the researcher provides the following points: his learnings, the final conclusion of the study, and the recommendations for future studies in the same area.

Summary

It is essentially a recap of various conclusions of the different chapters of the study. The research question for the spiritual and theological foundation chapter consisted in finding what could be the importance of the ministration of spiritual care in connection to healing? The study revealed that the ministration of spiritual care is a mere human contribution that can serve as channels for God to intervene and heal the sick person. God can probably do without the human agent if He wants. Not all instances of the human contribution would lead to healing. Nevertheless, almost all instances of healing include the human contribution through the ministration of spiritual care. For the biblical instances where divine healing has happened alongside the ministration of spiritual care, there is an evidence of entrance, restoration, or progress in a relationship of discipleship with God, the Great Healer. Hence, the ministration of spiritual care is important and connected to healing from two angles: the pre-healing stage and the post-healing experience. This provided a foundation for the researcher to develop a model for medical evangelism based on the post contact dimension of interaction with former sick people who have attended the BAH in Cameroon. Before arriving at that, the next chapter developed the literature review of the dissertation.

To sum up that literature review chapter, it appeared that various authors have explored the fields of medical evangelism, biblical healing, and spiritual care. The researcher discovered key ideas that brought new insights. Medical evangelism is part of a big picture called evangelism. It implies using the field of health to help humankind move to a complete restoration of their original state of health. Biblical healing includes a whole person approach. God is supreme in deciding whether He brings recovery from a physical ailment or not. Also, He gave limited self-healing power to humans through the use of simple health principles. The most important is that complete healing must include redemption through the acceptance of Jesus as Savior and Physician. It is this third view of healing (as supported by Ferguson and Packer) that explains why some healed patients in health centers can possibly either be converted or grow to (initial) discipleship. It happens only if proper ways are followed to minister to those patients. Therefore, spiritual care is understood as a reference to activities that address the spiritual dimension of human beings.

In regard to the research question in that chapter, the author of this dissertation provided an answer which is informed by the insight gained from the review. It is when spiritual curates respect the patients' faith, accept their theology, do not impose their religious concerns to them, and correctly use the nouthetic approach of counseling that the ministration of spiritual care can achieve expected results.

Ultimately, the researcher found a relationship between the literature review and the central topic of the research. Many authors had explored the possibility of making converts from a ministration of spiritual care to sick people. They all insisted that a proper methodology should be followed in doing that. In the best case scenario, this perspective of medical evangelism can easily lead to initial discipleship (or continual growth in it). The condition is that the patients themselves should be the ones seeking meaning for unanswered existential questions that allow using their spiritual resources.

The fourth chapter has emphasized four essential points. First, it has presented the context of the whole research. Geographical, cultural, and general information were given about the town of Buea and the Adventist hospital there. After telling the history of the project in relation to the institution, some data were used to describe the BAH three months prior to the project. Such description resulted in the problem statement of the dissertation.

Second, the researcher delineated the research design and its methodology. After specifying the mixed methods type of research, the rationale for selection and the appropriateness to this study were explained. The sampling procedures and instrumentation were also described.

Third, concerning the data analysis, the researcher clarified the data collection procedures before presenting and describing the findings. He later analyzed those findings. In a nutshell, it has appeared that the data confirm the existing problem of workers' reluctance in engaging to various activities of medical evangelism in BAH.

Fourth, in line with the program development, the researcher designed an intervention. It is such that allowed him to: elaborate on spiritual care as the basic component for medical evangelism, develop strategies pertaining to medical missionary work, and implement them via seminars and evaluation of their impact. The chapter concluded with the two limitations that permeate in the study. Notwithstanding, the work contains essential material that can give some directions for further research and reflections.

Thus, the fifth chapter revealed a thorough description of the initiative implementation. In it, the researcher disclosed a step-by-step process of the chosen solution in order to address the problem. The chapter mainly presented three points: the activities for the initiative implementation, the evaluations of those activities, and the project report. First, some basic steps were considered before mentioning the brainstorming session and the capacity building seminars that the researcher conducted. Second, two evaluations were made,

in September and December 2015. Third, the researcher wrote a 12-pages document that contained his academic research report which was sent to five different administrations: the University where he works, the hospital where he implemented the initiative, the Mission where BAH is located, the Union and AHI that supervise all leadership decisions in the selected hospital.

Final Evaluation

There are three stages in this section. (1) It begins with a summary of what the initiative was all about. (2) Then, it reminds the evaluation method that was used, the interpretation of data, and the conclusion drawn from them. (3) It ends by providing an answer on whether the researcher found out the solution to the problem statement or not; and how does he know.

First of all, in this in-ministry dissertation, the initiative was all about the development of a spiritual care model for medical evangelism in BAH, Cameroon. The idea was to put in place a model that uses the ministration of spiritual care as a ground for medical evangelism. Technically, spiritual care to patients is not about efforts for proselytizing nor churching them. It is about adding intentionality when using the habitual efforts to accompany sick people. That intentionality has to do with a willingness to bring about wholistic health to the sick.

Following the understanding of the researcher, the medical personnel, friends and relatives of the sick are only instruments that play a key role if the sick person should receive total health. In the model put in place in the selected hospital, the health workers were supposed to provide spiritual care services in a way that prepares the ground for medical evangelism activities. Still in the logic of the model for experiment, such activities were strictly to be conducted at a post contact basis when patients leave the hospital after more than two days of admission. The initiative worked out the involvement of BAH workers in order to reach former patients of their hospital through specific evangelistic interactions. The

expectation was that those ex-patients would have a good level of satisfaction on the basis of their experience at BAH.

Secondly, the researcher used the impact evaluation method which measures the impact of the program effectiveness up to six months after its completion. In this study, the first evaluation was made five months after the beginning of the implementation of the initiative. A second evaluation took place two months after (or at the seventh month). The data collected took into consideration the workers' population as well as the patients' population.

Thirdly, from the interpretation of the data, the researcher assumes that he found out the solution to the problem statement. In what concerns the workers' population, the initiative served as a catalyst to awake and encourage their involvement to medical evangelism activities. Although numerical information seems to minimize the success of the initiative for the workers at BAH, qualitative data portray their unprecedented involvement in that particular branch of the missionary work. In relation to the patients' population, the phone calls interviews to 57 ex-patients revealed a good level of satisfaction that they have expressed. It is important to explain why the research found the solution to the problem. It is in the basis of a comparison between the situations that he discovered at the beginning of the study and what was achieved at the end of the initiative implementation. Basically, Tables 4, 6, and 8 respectively talk about the reasons why people come to BAH, the patients' opinion on spiritual care to them, and the patients 'opinion on medical evangelism activities. They all deal with the situation at BAH prior to the time of the study. The people who were coming to BAH (76%, see Table 4) said they had expectation on the spiritual dimension. In that table, 15% said they come because they usually received good care at BAH. In Table 6, 50% of patients who were admitted said they strongly agreed that health personnel should help them feel better spiritually as well as physically and emotionally.

After the implementation of the program, Tables 30 and 31 are related respectively to the ex-patients' experience while at BAH and when they left the hospital. Table 30 revealed the following: 57 ex-patients (100%) said they have received words of encouragement from the health personnel, 44 (77%) said the health personnel had referred to God as the Healer in taking care of them, 48 (84%) testified that the health personnel helped them to feel better spiritually as well as physically and emotionally. Table 31 presents the following: ten of the ex-patients (17.5%) said they have received at least one invitation to health talks organized by the hospital, five (0.08 %) said they have been visited at home by one of the workers who is a friend, another five (0.08 %) said they sat for a Bible discussion with one of the workers, and nine (15.7%) said they have had an opportunity to share a meal with one of the workers. In linking the obtained figures, it can be observed that they revealed an effort to address the initial situation and an improvement on what was already on ground.

Learnings

This course of study was very educational. Many things can be classified in two categories: some results (facts) that could not be imagined before and some miscellaneous discoveries. At first, here are some facts that could not be imagined except through a study. For example, the Table 8 reveals that 70% of the patients who come to the Adventist hospital (after being discharged) are also willing to be invited to the Adventist church when there are special programs for visitors. Likewise, 70% are also willing that Bible studies be conducted with them. At the same time, Table 31shows a real discovery to see that nine (out of 57 ex-patients that were called on the phone) said they have had an opportunity to share a meal with one of the workers of BAH. Also, Table 29 presents the average mark of 9.54 out of 10 that was given to health personnel by 50 ex-patients of BAH as they expressed their level of satisfaction regarding the kindness, smiling attitude and welcoming habit in the hospital of

BAH workers. In the same table, those ex-patients also gave 7.72 out of 10 to the item, 'One can feel the presence of God in this hospital'.

Secondly, here are some miscellaneous data that are not directly linked to the topic of study. After reading extensively about the place of singing and dancing in the African rituals for healing, it was discovered that mission in Africa should be sensitive to the fact that most Africans have singing and dancing in their genes. Therefore, instead of prohibiting such things (alongside with the instruments that are used, eg. drums), it is better to suggest ways of worship that would be guided by principles derivable from the Bible.

Also, researching on cultures, the impact of names was noticeable. In fact, it was discovered that names were given in lines with an attribute or some general traits that characterized the people bearing those names. Therefore, in ministry, it would be important to encourage the members to know what is behind their names. A prayer should be offered to break any evil spirit attached to an evil practice performed by the forefathers of those who bear the names. Thus, it becomes important to encourage newborn Christians to see the importance of living harmoniously with the new name they bear. Finally, at a personal level, it was revealed that the forefathers of the researcher were not only the kings, but also they functioned as healers in the community. Since that discovering, he is left with a passion: a strong interest for the double ministration in the healing ministry (not only the spiritual dimension but even the physical one through the use of natural remedies). Thus, he is determined to make such health education an obvious duty to carry continually.

Final Conclusion

In going beyond the facts revealed in this study, one can make a higher level of interpretation, analysis, and synthesis of the results provided above. On that foundation, an overall conclusion can be drawn which is that when a church invests well in hospital care, it turns to be an effective means of making disciples. The quality of services provided to

patients in such hospitals demarcates them from other ones that neglect that area of their profession. The population coming to these health facilities becomes well acquainted with the double ministration of health and the gospel. If more awareness is created around it, it can emphasize the aspect of the health reform message among the church members who work in such hospitals. When there is a regular use of spiritual care as a component of medical evangelism in hospitals that belong to faith-based movements, the understanding of a church as a center of health becomes obvious and contagious.

Recommendations

The recommendations here are addressed to future researchers in this field of study. They are provided with the hope that this in-ministry dissertation has raised interest in the aspect of using spiritual care as a model for medical evangelism. In view of the betterment of future studies in this same area, the following three points would be helpful:

1. Find and use a similar study made in other faith-based hospitals in order to compare the issue of workers' reluctance towards medical evangelism activities. In effect, this study tackled the reluctance that the workers at BAH had concerning their involvement on post contact activities with ex-patients. Such reluctance was assumed in comparison to the zeal that the researcher observed while visiting other faith-based hospitals. Therefore, it would be interesting to ascertain such reluctance if a study reveals that workers in other hospitals of the same kind have a better commitment to medical evangelism activities.
2. Use a greater size of in-patients in order to improve the generalizability of the study to other hospitals and health centers. As a matter of fact, the data source for the patients' population that provided their opinions on spiritual care and medical evangelism was made of ten patients that were admitted at BAH. It could be interesting to increase

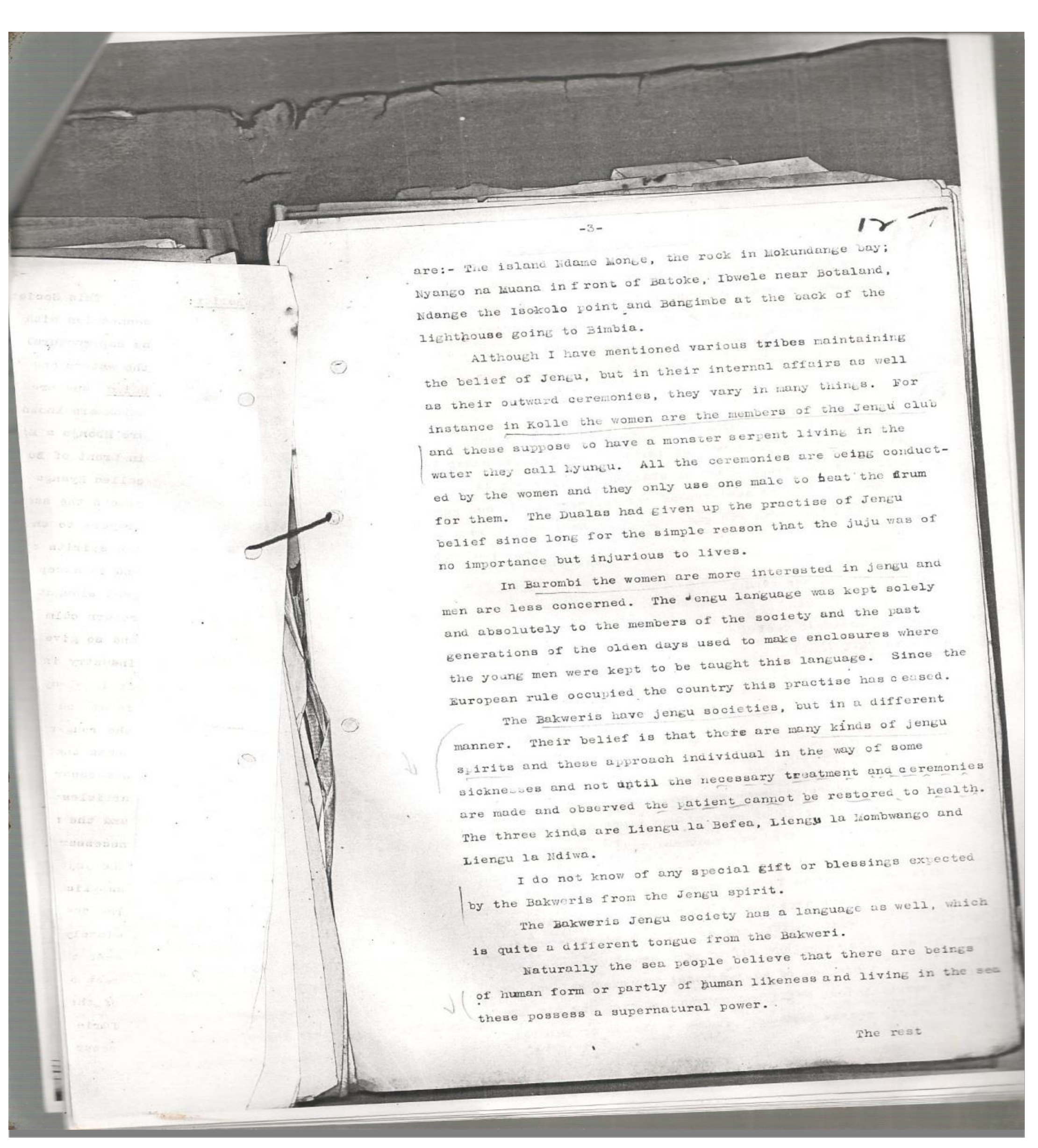
such source of information to a higher number in order to possibly improve the obtained results.

3. Chose to stay in the place where the study is conducted during the months of implementation of the proposed model. Actually, the researcher was living about 500 km away from the hospital where the research was taking place. He indicated that part of his source of information was made of observations in the selected hospital. It would be preferable for the next researcher to rather stay the town of Buea during the months where the study is conducted. In doing so, that could improve the researcher's understanding of the environment in which the workers endeavor to apply the double ministration of health and gospel.

APPENDIXES

APPENDIX A

MEMORANDUM



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17

are:- The island Ndame Monge, the rock in Mokundange bay; Nyango na Muana in front of Batoke, Ibwele near Botaland, Ndange the Isokolo point and Bengimbe at the back of the lighthouse going to Bimbia.

Although I have mentioned various tribes maintaining the belief of Jengu, but in their internal affairs as well as their outward ceremonies, they vary in many things. For instance in Kolle the women are the members of the Jengu club and these suppose to have a monster serpent living in the water they call Nyungu. All the ceremonies are being conducted by the women and they only use one male to beat the drum for them. The Dualas had given up the practise of Jengu belief since long for the simple reason that the juju was of no importance but injurious to lives.

In Barombi the women are more interested in jengu and men are less concerned. The Jengu language was kept solely and absolutely to the members of the society and the past generations of the olden days used to make enclosures where the young men were kept to be taught this language. Since the European rule occupied the country this practise has ceased.

The Bakweris have jengu societies, but in a different manner. Their belief is that there are many kinds of jengu spirits and these approach individual in the way of some sicknesses and not until the necessary treatment and ceremonies are made and observed the patient cannot be restored to health. The three kinds are Liengu la Befea, Liengu la Mombwango and Liengu la Ndiwa.

I do not know of any special gift or blessings expected by the Bakweris from the Jengu spirit.

The Bakweris Jengu society has a language as well, which is quite a different tongue from the Bakweri.

Naturally the sea people believe that there are beings of human form or partly of human likeness and living in the sea these possess a supernatural power.

The rest

APPENDIX B

TELEGRAM 1919

(1) 7

CAMEROONS

NO 59/19

RESIDENT'S OFFICE
BUEA,
CAMEROONS.

15th March 1919

SIR,

I have to confirm the telegram of which a copy is given below sent you from this Office to-day.

I have the honour to be,
Sir,
Your obedient Servant,

W J Ambrose

Resident, Cameroons Province.

To The Medical Officer
Chang

COPY

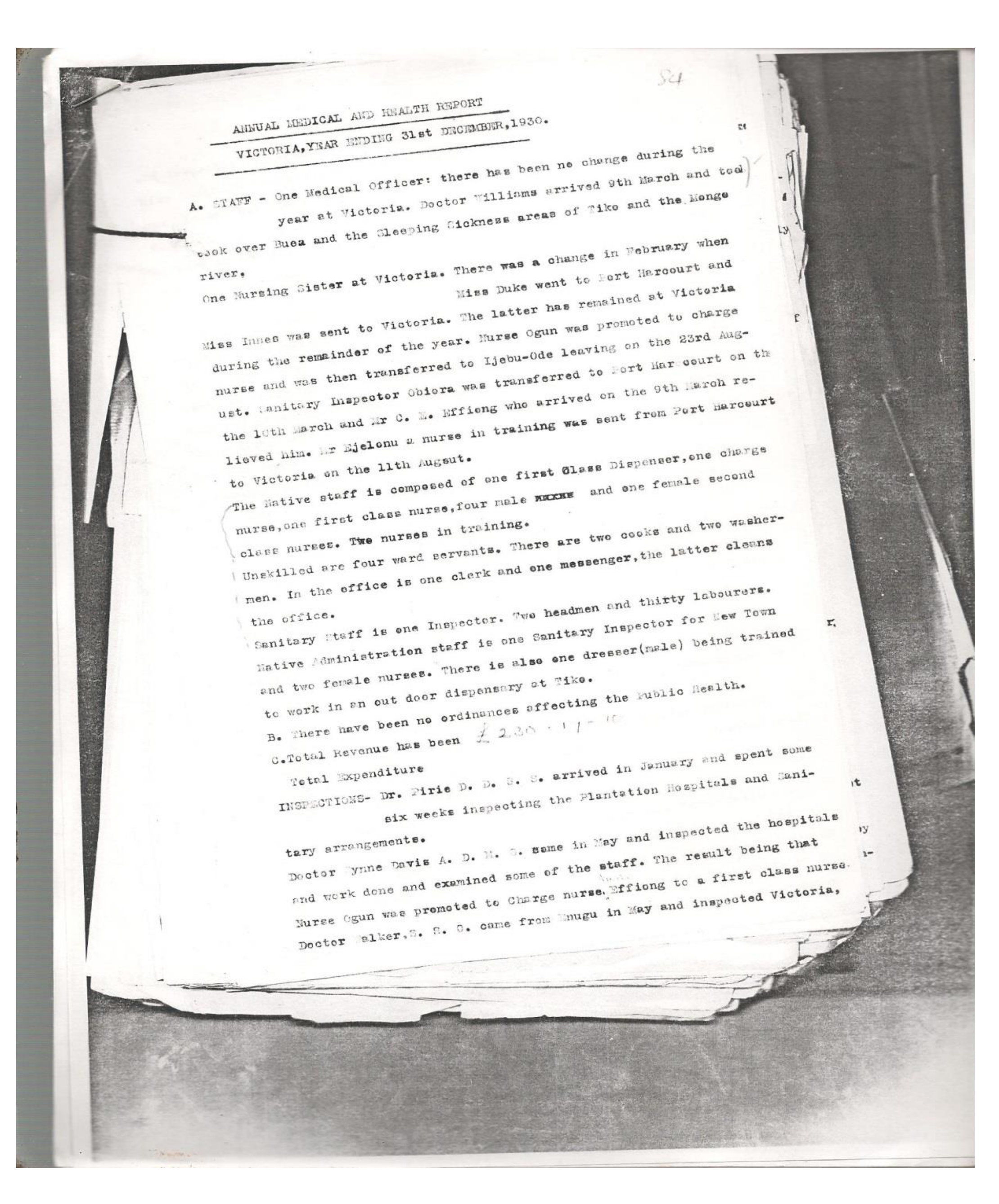
Priority.
M. O. Chang
422. D. O. reports Native Hospital inadequa[illegible]
What do you recommend. An entirely new hospital or merely additions. It is I presume a bush building.

Ambrose - Resident
15/3/19.

Printed by the Printing Office Buea 7. 4. 19. 1000 (374)

APPENDIX C

HEALTH REPORT 1930



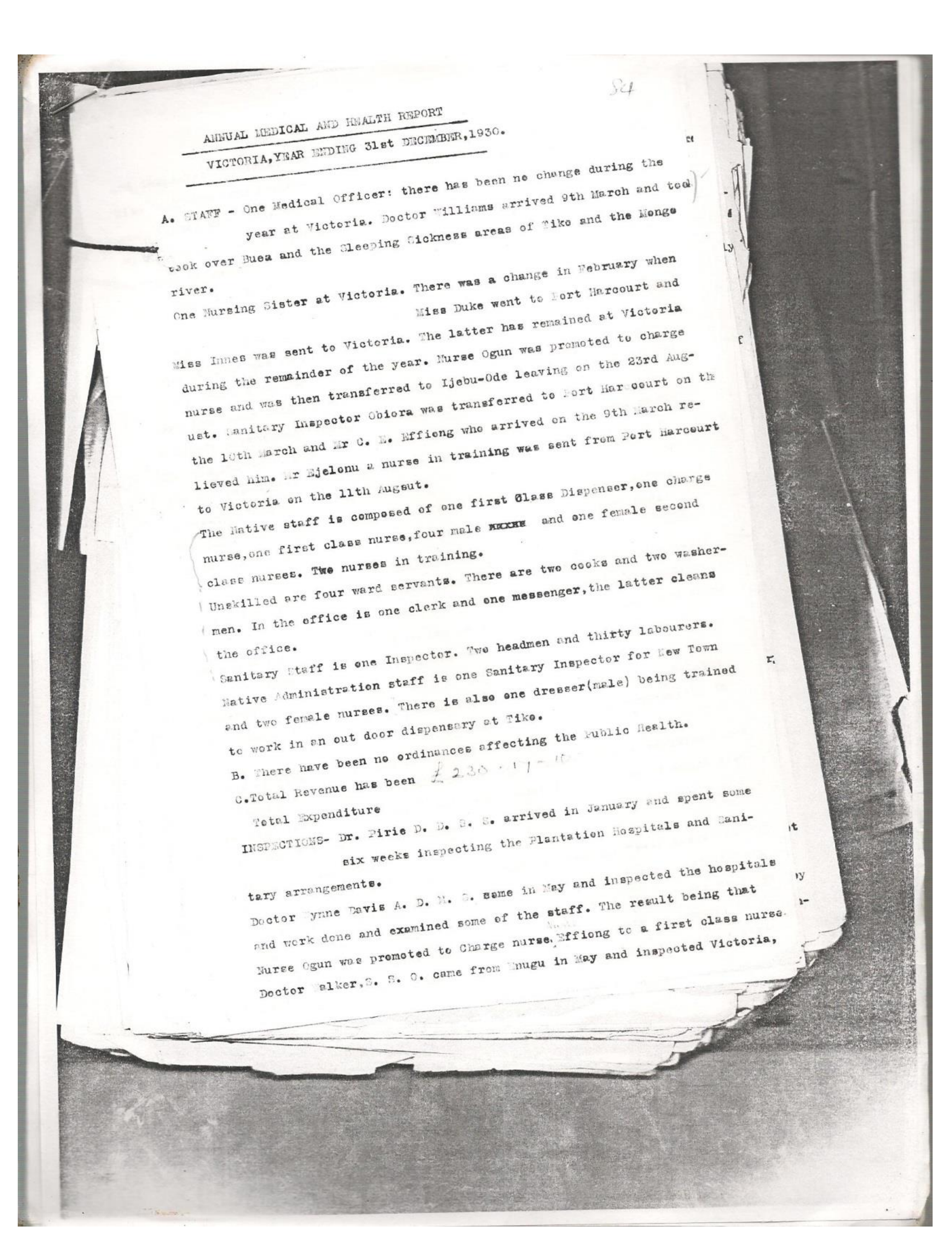
ANNUAL MEDICAL AND HEALTH REPORT

VICTORIA, YEAR ENDING 31st DECEMBER, 1930.

A. STAFF - One Medical Officer: there has been no change during the
year at Victoria. Doctor Williams arrived 9th March and took
took over Buea and the Sleeping Sickness areas of Tiko and the Mongo
river.
One Nursing Sister at Victoria. There was a change in February when
Miss Duke went to Port Harcourt and
Miss Innes was sent to Victoria. The latter has remained at Victoria
during the remainder of the year. Nurse Ogun was promoted to charge
nurse and was then transferred to Ijebu-Ode leaving on the 23rd Aug-
ust. Sanitary Inspector Obiora was transferred to Port Harcourt on the
the 10th March and Mr C. E. Effiong who arrived on the 9th March re-
lieved him. Mr Ejelonu a nurse in training was sent from Port Harcourt
to Victoria on the 11th Augsut.
The Native staff is composed of one first Class Dispenser, one charge
nurse, one first class nurse, four male XXXXX and one female second
class nurses. Two nurses in training.
Unskilled are four ward servants. There are two cooks and two washer-
men. In the office is one clerk and one messenger, the latter cleans
the office.
Sanitary Staff is one Inspector. Two headmen and thirty labourers.
Native Administration staff is one Sanitary Inspector for New Town
and two female nurses. There is also one dresser(male) being trained
to work in an out door dispensary at Tiko.
B. There have been no ordinances affecting the Public Health.
C. Total Revenue has been £ 2.20 - 1 / - 10
Total Expenditure
INSPECTIONS- Dr. Pirie D. D. S. S. arrived in January and spent some
six weeks inspecting the Plantation Hospitals and Sani-
tary arrangements.
Doctor Wynne Davis A. D. M. S. came in May and inspected the hospitals
and work done and examined some of the staff. The result being that
Nurse Ogun was promoted to Charge nurse. Effiong to a first class nurse.
Doctor Walker, S. S. O. came from Enugu in May and inspected Victoria,

APPENDIX D

NATIVE STAFF 1930



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ANNUAL MEDICAL AND HEALTH REPORT

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Native Administration staff is one Sanitary Inspector for New Town
and two female nurses. There is also one dresser(male) being trained
to work in an out door dispensary at Tiko.

B. There have been no ordinances affecting the Public Health.

C. Total Revenue has been £230 - 17 - 10

Total Expenditure

INSPECTIONS- Dr. Pirie D. D. S. S. arrived in January and spent some
six weeks inspecting the Plantation Hospitals and Sani-
tary arrangements.

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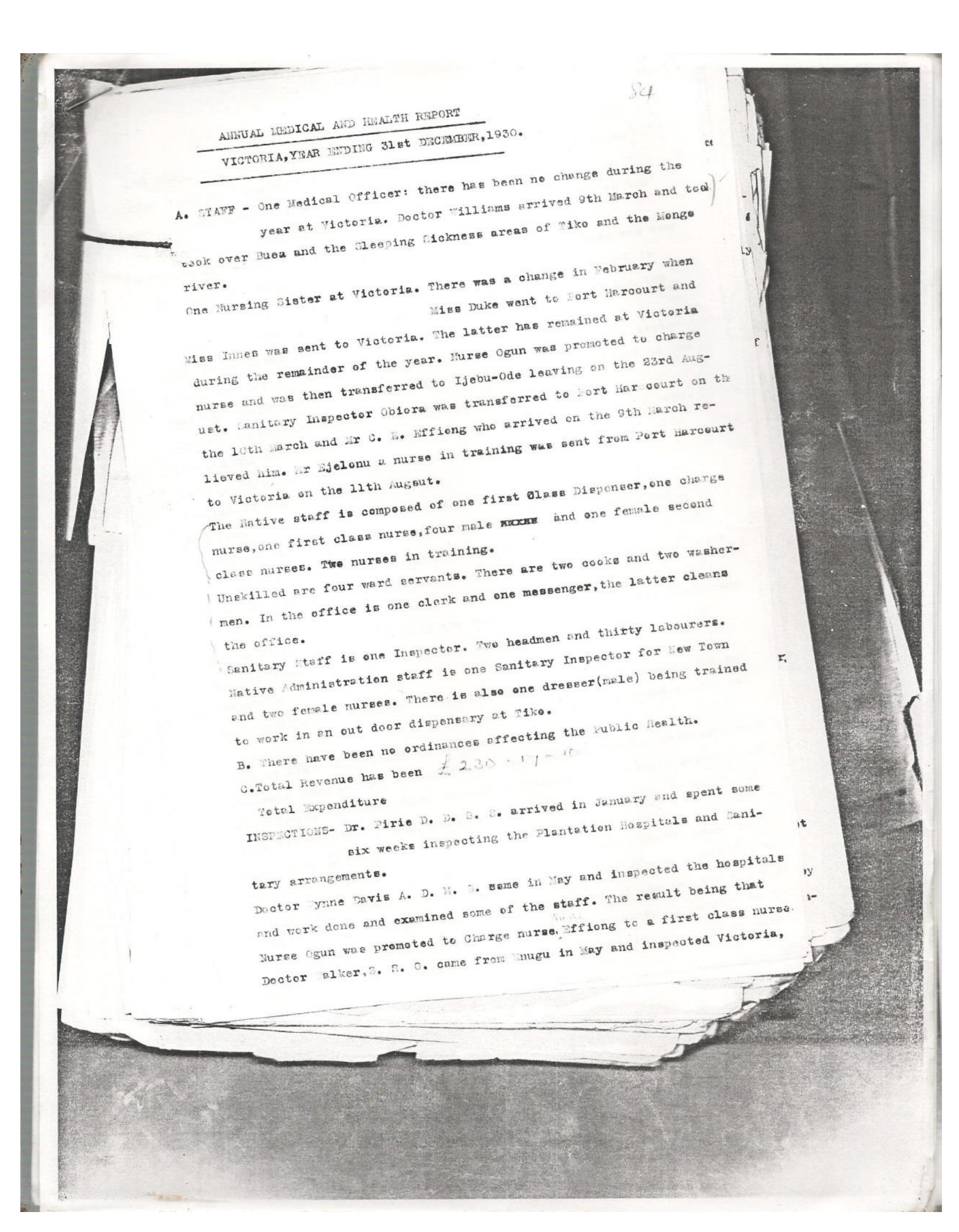
APPENDIX E

MALARIA IN 1930



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ANNUAL MEDICAL AND HEALTH REPORT

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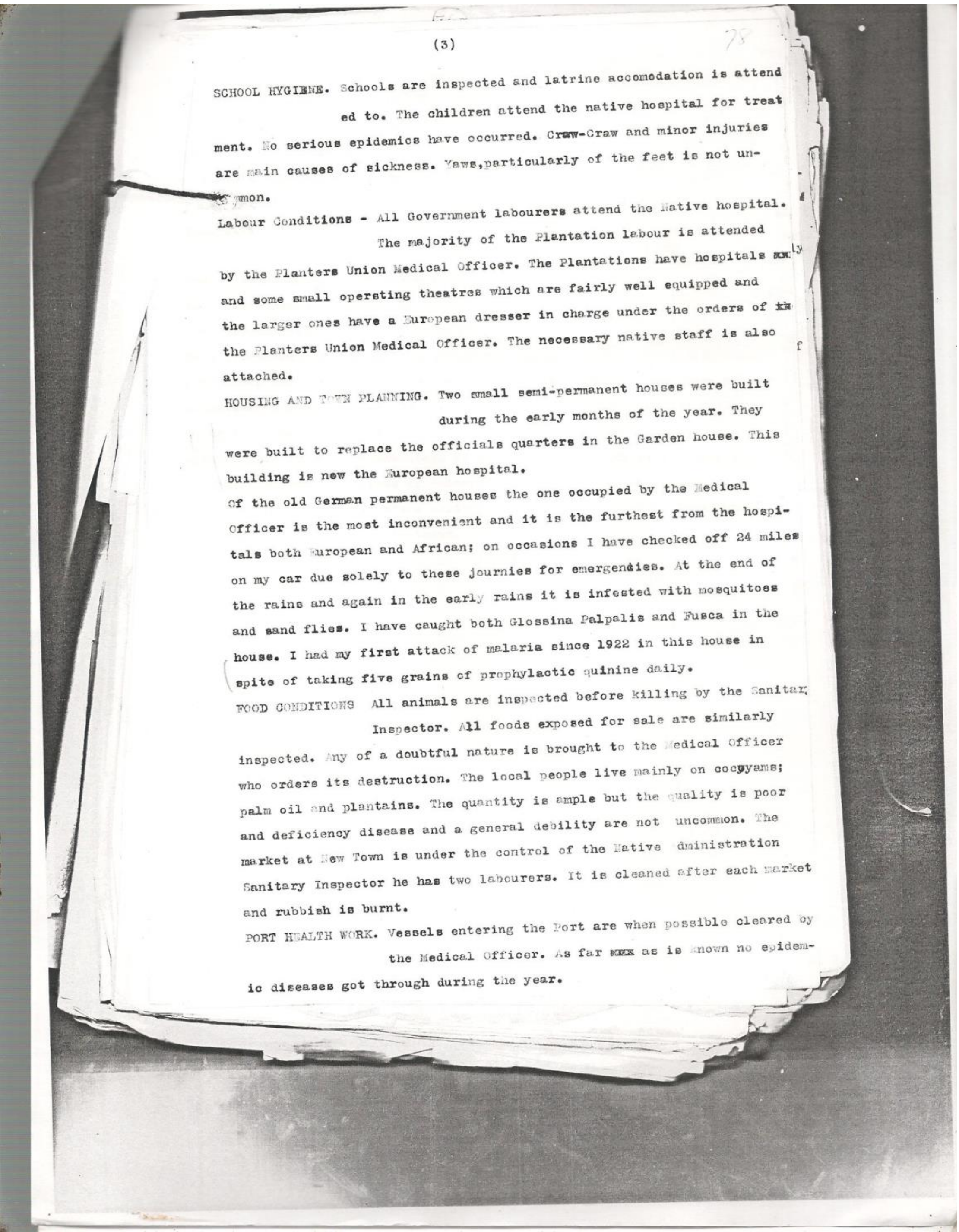


(3)

SCHOOL HYGIENE. Schools are inspected and latrine accomodation is attended to. The children attend the native hospital for treatment. No serious epidemics have occurred. Craw-Craw and minor injuries are main causes of sickness. Yaws, particularly of the feet is not uncommon.

Labour Conditions - All Government labourers attend the Native hospital. The majority of the Plantation labour is attended by the Planters Union Medical Officer. The Plantations have hospitals and some small operating theatres which are fairly well equipped and the larger ones have a European dresser in charge under the orders of the Planters Union Medical Officer. The necessary native staff is also attached.

HOUSING AND TOWN PLANNING. Two small semi-permanent houses were built during the early months of the year. They were built to replace the officials quarters in the Garden house. This building is now the European hospital.

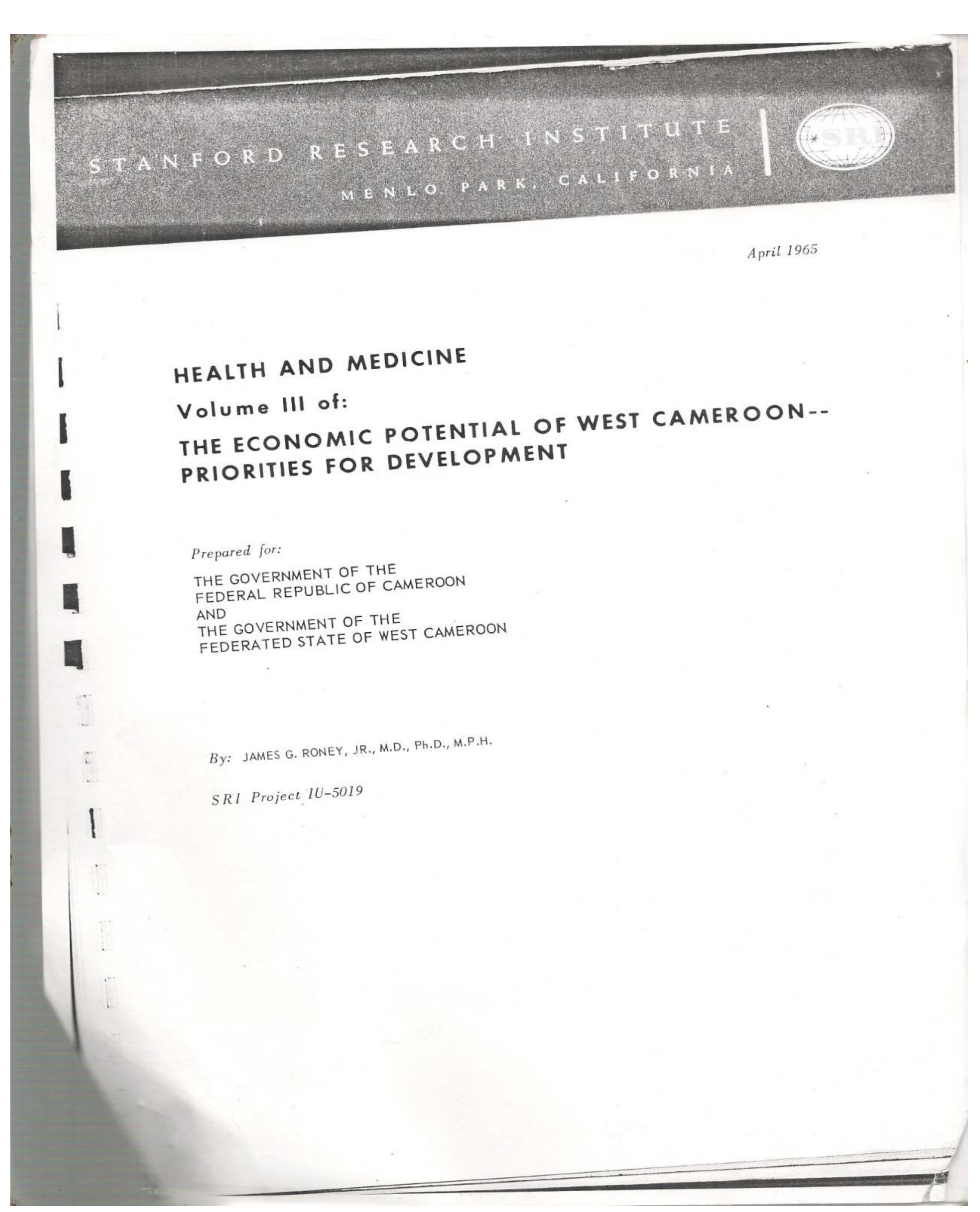
Of the old German permanent houses the one occupied by the Medical Officer is the most inconvenient and it is the furthest from the hospitals both European and African; on occasions I have checked off 24 miles on my car due solely to these journies for emergencies. At the end of the rains and again in the early rains it is infested with mosquitoes and sand flies. I have caught both Glossina Palpalis and Fusca in the house. I had my first attack of malaria since 1922 in this house in spite of taking five grains of prophylactic quinine daily.

FOOD CONDITIONS All animals are inspected before killing by the Sanitary Inspector. All foods exposed for sale are similarly inspected. Any of a doubtful nature is brought to the Medical Officer who orders its destruction. The local people live mainly on cocoyams; palm oil and plantains. The quantity is ample but the quality is poor and deficiency disease and a general debility are not uncommon. The market at New Town is under the control of the Native Administration Sanitary Inspector he has two labourers. It is cleaned after each market and rubbish is burnt.

PORT HEALTH WORK. Vessels entering the Port are when possible cleared by the Medical Officer. As far as is known no epidemic diseases got through during the year.

APPENDIX F

CAUSES OF ILLNESS IN 1965



STANFORD RESEARCH INSTITUTE
MENLO PARK, CALIFORNIA

SRI

April 1965

HEALTH AND MEDICINE

Volume III of:

THE ECONOMIC POTENTIAL OF WEST CAMEROON--
PRIORITIES FOR DEVELOPMENT

Prepared for:

THE GOVERNMENT OF THE
FEDERAL REPUBLIC OF CAMEROON
AND
THE GOVERNMENT OF THE
FEDERATED STATE OF WEST CAMEROON

By: JAMES G. RONEY, JR., M.D., Ph.D., M.P.H.

SRI Project IU-5019

Chapter 2

SUMMARY

Public Health Conditions

Public health in West Cameroon is at an intermediate stage of development; widespread epidemics are not a threat, but some groups of diseases are still uncontrolled and continue to sap the vitality of the populace.

A number of chronic infections and infestations cause debilitation and some are the direct or indirect causes of death. Due to the incomplete reporting, the leading causes of death are not fully known. However, of the reported deaths, the leading causes are: complications of pregnancy, malaria, tetanus, dysentery, and infections stemming from wounds, intestinal obstruction and hernia, and measles.

The leading causes of illness, as reported, are: malaria, helminthiasis, gastrointestinal diseases, skin disorders, respiratory diseases, accidents and wounds, venereal disease, rheumatism, eye disease, and scabies.

Present Health Programs and Facilities

Activities to lessen the danger of these diseases are being conducted in West Cameroon by government agencies at Federal, State, and local levels, by plantation companies such as the Cameroons Development Corporation, by missionary groups, and private individuals. The private individuals include chemists (commercial pharmaceutical firms), patent medicine stores, 263 licensed native doctors, and many more native doctors who are unlicensed.

There are 22 general hospitals, 2 leprosaria, and 26 maternity hospitals, having a total of 1,874 beds. This means one bed for every 565 inhabitants, assuming 1964 population to be 1,058,000 persons. There are 33 physicians, or one physician for every 32,061 inhabitants. These ratios are thought to be worse than similar ratios for East Cameroon, but slightly better than those for Nigeria. The number of inhabitants per nurse is 3,861 and the number of persons per dentist is over 500,000. There are only two dentists in the territory.

APPENDIX G

HEALTH CARE BUDGET 1965

water is improperly drained. This seems to reflect partly the interest of the camp manager in these matters and partly the degree of orientation of the workers about the proper use and maintenance of their facilities.

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The medical care systems of the corporations in West Cameroon provide 547 hospital beds, or 29 percent of the total number of beds in the State. These facilities are located in the southern part--the Kumba and Victoria Divisions.

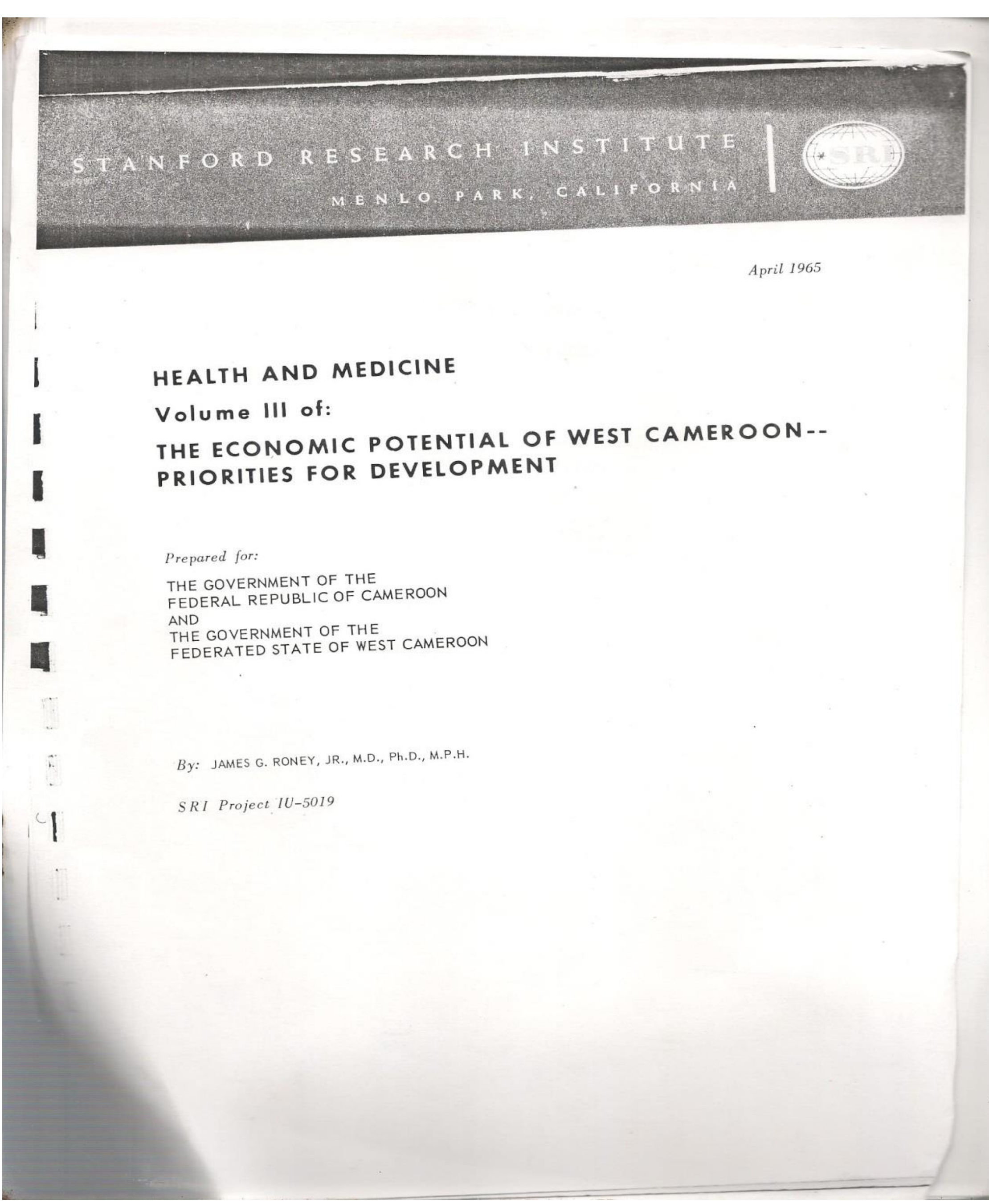
Missionary Groups

There are a number of religious denominations in West Cameroon, Moslem, Seventh Day Adventist, Jehovah's Witnesses, Church of Christ, Apostolic Church, Presbyterian, Baptist and Roman Catholic. The Basel Mission (Presbyterian), Cameroon Baptist Mission and Roman Catholic Mission are the only ones which give health and medical services. These missions provide a substantial portion of medical care in West Cameroon including 29 percent of the hospital beds.

The Basel Mission is responsible for 2 general hospitals, 1 leprosy hospital, and 2 maternity hospitals, with a total of 186 beds; all the hospitals are located in Bamenda, Mamfe, and Kumba Divisions. In addition, at Manyamen near Kumba, there is a leprosy settlement for 450 patients; the medical officer also visits 100 out-clinics.

APPENDIX H

POLICIES FOR MEDICAL CARE



STANFORD RESEARCH INSTITUTE
MENLO PARK, CALIFORNIA

SRI

April 1965

HEALTH AND MEDICINE

Volume III of:

THE ECONOMIC POTENTIAL OF WEST CAMEROON--
PRIORITIES FOR DEVELOPMENT

Prepared for:

THE GOVERNMENT OF THE
FEDERAL REPUBLIC OF CAMEROON
AND
THE GOVERNMENT OF THE
FEDERATED STATE OF WEST CAMEROON

By: JAMES G. RONEY, JR., M.D., Ph.D., M.P.H.

SRI Project IU-5019

Related to these research activities is the periodic assessment of progress and the comparing of the health status in West Cameroon with that of other populations. For this type of study, it is essential to have a uniform system of nomenclature of disease, efficient record-keeping systems and facilities for analysis. The adoption of an international system for the classification of diseases is suggested as a basis for standardizing nomenclature, and record-keeping systems for surveillance. Two useful publications can be cited in this connection, Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, Vols. I and II, World Health Organization, Geneva, Switzerland, 1957, and International Classification of Diseases, U.S. Public Health Service, Washington, D.C., 1959. The record-keeping system should be designed so that it can eventually be used on punch cards for computer storage and analysis.

The Medical Research Unit at Kumba is an existing research facility of great value which deserves the support of the Federal Republic of Cameroon. In its present study of onchocerciasis, the Medical Research Unit is using the chimpanzee as a laboratory animal. The study is handicapped by the absence of up-to-date, escape-proof, hygienic housing for its animals.

Medical Care

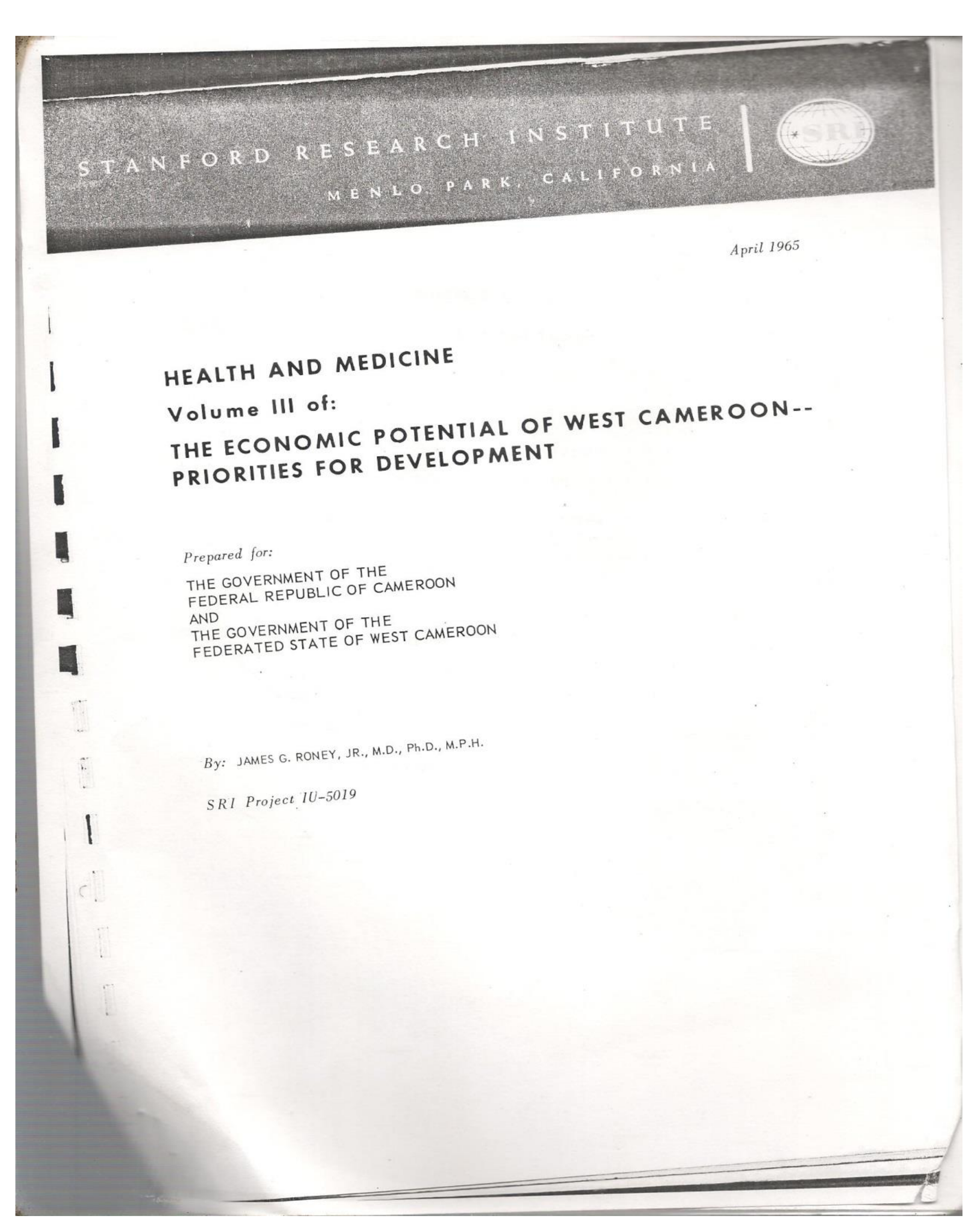
nothing as spiritual care!

The policies for medical care in West Cameroon have not yet been formulated. There are widely divergent opinions regarding such subjects as private medical care, government medical care, public health, social medicine, medical care financing, and related topics. This diversity of opinion is due in part to the different training backgrounds of Cameroonians and foreigners serving in the medical and health fields. There is, perhaps, more policy uniformity in East Cameroon. At any rate, there is a need for a clearer statement of policies for medical care appropriate to the Federal Republic as a whole. To help formulate policies, more frequent meetings of the medical associations are recommended for the purpose of gaining a thorough understanding of medical care problems. Increased communication between East and West Cameroon might be achieved through the appointment of East Cameroonian physicians to fill positions in West Cameroon and vice versa.

The basic issue is the extent and manner in which the Government can provide medical care. Problems of transport, staffing, and finance will impede the widespread extension of care to rural areas for years to come. Care for urban populations, concentrated as they are in a limited

APPENDIX I

THE PLACE OF NATIVE DOCTORS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Chapter 3

PUBLIC HEALTH AND CULTURAL CHANGES

The total process of improving public health in West Cameroon will involve collaboration between the authorities of government, the physicians, nurses, health inspectors, school teachers, vendors of medicines, the traditional practitioners--called native doctors--and above all parents and children. Hopefully, health standards can be raised in large measure by efforts of the inhabitants to take care of themselves, supported by professionals in the health field.

If improvements are brought about in this way, individuals will need to abandon some traditional *mores* and to adopt new practices, for example, to pay something extra for treated water, to dispose of sewage in a new manner, or to substitute new medicines for traditional remedies. Acceptance of such changes can contribute to general health and thus is as much a part of a public health program as the construction of new hospitals or the training of physicians. This comment does not argue against new hospitals or training; the point is that public willingness to depart from the practices of prior generations will be critical in the success of the total health programs.

Some parts of the territory have already changed rapidly, and for the better. In urban areas such as Victoria, Bamenda, and Kumba the inhabitants have begun to adjust their behavior patterns for health reasons; household cleanliness, public water supplies, and vaccinations are becoming normal to their way of life.

In the more remote regions, however, traditional behavior patterns still tend to persist; and in some of these regions protective footwear has come to be regarded as essential only within recent years. But even in the more modernized regions, some behavior patterns still reveal a reluctance to depart from tradition; for example, some of the labor camps are littered, sewage disposal systems remain unrepaired for long periods of time, diets deficient in protein are still preferred, and household pit latrines continue to be used. In part, these shortcomings are attributable to low levels of income, but in a larger sense they stem from adherence to habit patterns of the past and from the absence of a tradition of urban living.

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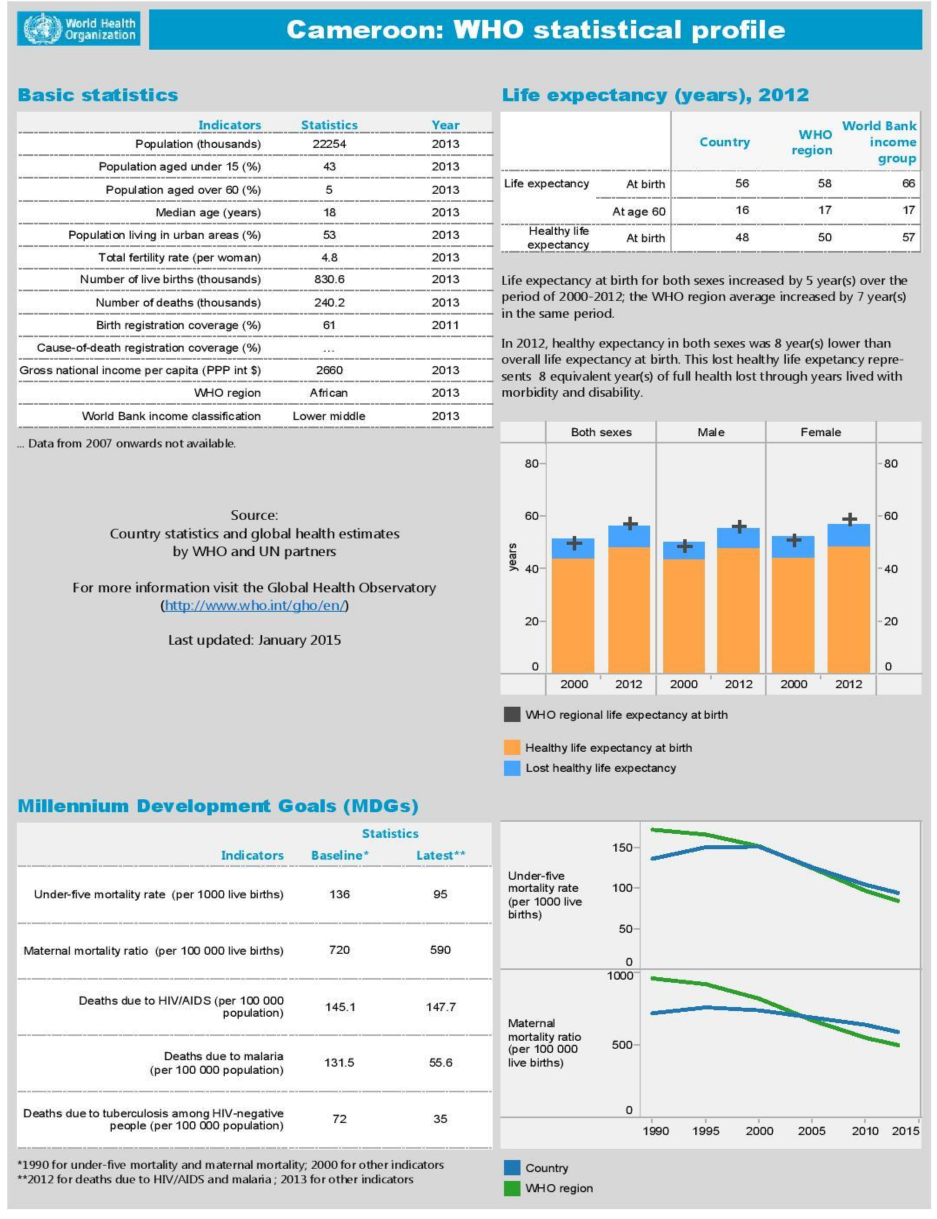
APPENDIX J

CAMEROON HEALTH PROFILE



World Health Organization

Cameroon: WHO statistical profile

Basic statistics

Indicators	Statistics	Year
Population (thousands)	22254	2013
Population aged under 15 (%)	43	2013
Population aged over 60 (%)	5	2013
Median age (years)	18	2013
Population living in urban areas (%)	53	2013
Total fertility rate (per woman)	4.8	2013
Number of live births (thousands)	830.6	2013
Number of deaths (thousands)	240.2	2013
Birth registration coverage (%)	61	2011
Cause-of-death registration coverage (%)	...	
Gross national income per capita (PPP int $)	2660	2013
WHO region	African	2013
World Bank income classification	Lower middle	2013

... Data from 2007 onwards not available.

Source:
Country statistics and global health estimates
by WHO and UN partners

For more information visit the Global Health Observatory
(http://www.who.int/gho/en/)

Last updated: January 2015

Life expectancy (years), 2012

		Country	WHO region	World Bank income group
Life expectancy	At birth	56	58	66
	At age 60	16	17	17
Healthy life expectancy	At birth	48	50	57

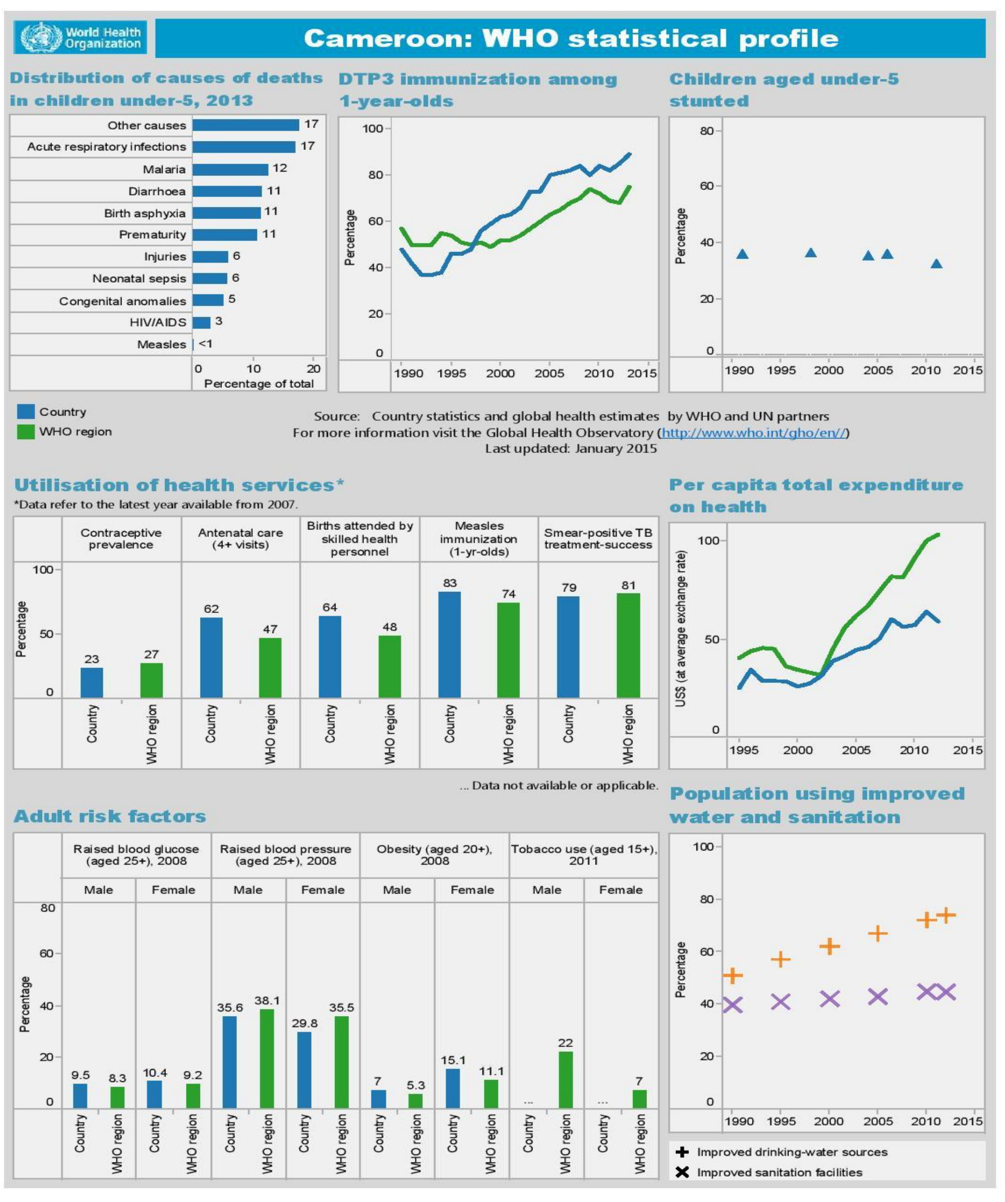
Life expectancy at birth for both sexes increased by 5 year(s) over the period of 2000-2012; the WHO region average increased by 7 year(s) in the same period.

In 2012, healthy expectancy in both sexes was 8 year(s) lower than overall life expectancy at birth. This lost healthy life expetancy represents 8 equivalent year(s) of full health lost through years lived with morbidity and disability.

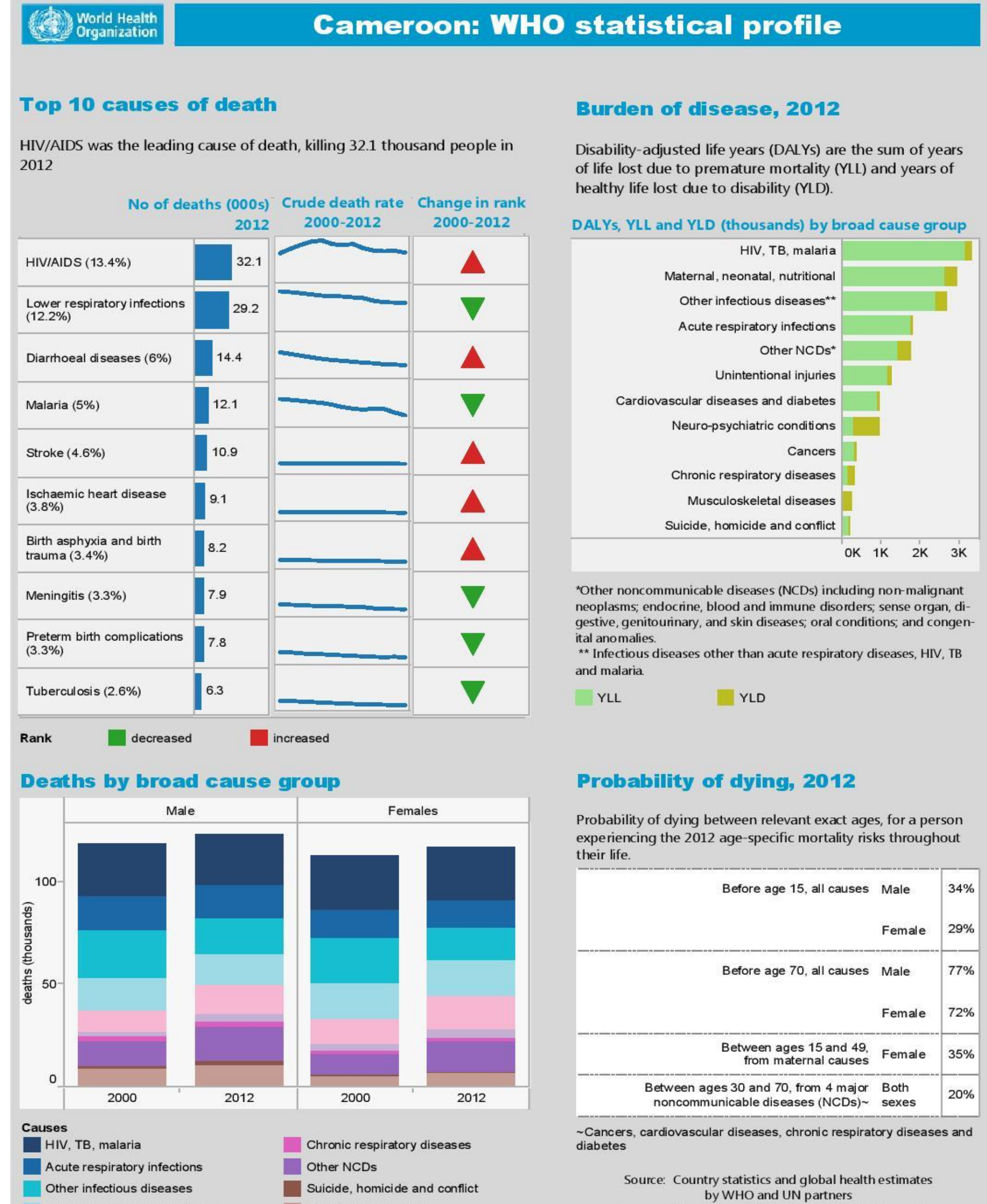
Millennium Development Goals (MDGs)

Indicators	Statistics Baseline*	Statistics Latest**
Under-five mortality rate (per 1000 live births)	136	95
Maternal mortality ratio (per 100 000 live births)	720	590
Deaths due to HIV/AIDS (per 100 000 population)	145.1	147.7
Deaths due to malaria (per 100 000 population)	131.5	55.6
Deaths due to tuberculosis among HIV-negative people (per 100 000 population)	72	35

*1990 for under-five mortality and maternal mortality; 2000 for other indicators
**2012 for deaths due to HIV/AIDS and malaria; 2013 for other indicators



World Health Organization
Cameroon: WHO statistical profile
Distribution of causes of deaths in children under-5, 2013
Other causes 17
Acute respiratory infections 17
Malaria 12
Diarrhoea 11
Birth asphyxia 11
Prematurity 11
Injuries 6
Neonatal sepsis 6
Congenital anomalies 5
HIV/AIDS 3
Measles <1
Percentage of total
DTP3 immunization among 1-year-olds
Children aged under-5 stunted
Percentage
Country
WHO region
Source: Country statistics and global health estimates by WHO and UN partners
For more information visit the Global Health Observatory (http://www.who.int/gho/en/)
Last updated: January 2015
Utilisation of health services*
*Data refer to the latest year available from 2007.
Contraceptive prevalence 23 27
Antenatal care (4+ visits) 62 47
Births attended by skilled health personnel 64 48
Measles immunization (1-yr-olds) 83 74
Smear-positive TB treatment-success 79 81
Per capita total expenditure on health
US$ (at average exchange rate)
... Data not available or applicable.
Adult risk factors
Raised blood glucose (aged 25+), 2008
Raised blood pressure (aged 25+), 2008
Obesity (aged 20+), 2008
Tobacco use (aged 15+), 2011
Male
Female
9.5 8.3 10.4 9.2 35.6 38.1 29.8 35.5 7 5.3 15.1 11.1 ... 22 ... 7
Population using improved water and sanitation
Improved drinking-water sources
Improved sanitation facilities



World Health Organization
Cameroon: WHO statistical profile
Top 10 causes of death
HIV/AIDS was the leading cause of death, killing 32.1 thousand people in 2012
No of deaths (000s) 2012
Crude death rate 2000-2012
Change in rank 2000-2012
HIV/AIDS (13.4%) 32.1
Lower respiratory infections (12.2%) 29.2
Diarrhoeal diseases (6%) 14.4
Malaria (5%) 12.1
Stroke (4.6%) 10.9
Ischaemic heart disease (3.8%) 9.1
Birth asphyxia and birth trauma (3.4%) 8.2
Meningitis (3.3%) 7.9
Preterm birth complications (3.3%) 7.8
Tuberculosis (2.6%) 6.3
Rank
decreased
increased
Burden of disease, 2012
Disability-adjusted life years (DALYs) are the sum of years of life lost due to premature mortality (YLL) and years of healthy life lost due to disability (YLD).
DALYs, YLL and YLD (thousands) by broad cause group
HIV, TB, malaria
Maternal, neonatal, nutritional
Other infectious diseases**
Acute respiratory infections
Other NCDs*
Unintentional injuries
Cardiovascular diseases and diabetes
Neuro-psychiatric conditions
Cancers
Chronic respiratory diseases
Musculoskeletal diseases
Suicide, homicide and conflict
0K 1K 2K 3K
*Other noncommunicable diseases (NCDs) including non-malignant neoplasms; endocrine, blood and immune disorders; sense organ, digestive, genitourinary, and skin diseases; oral conditions; and congenital anomalies.
** Infectious diseases other than acute respiratory diseases, HIV, TB and malaria.
YLL
YLD
Deaths by broad cause group
Male
Females
deaths (thousands)
100
50
0
2000
2012
2000
2012
Causes
HIV, TB, malaria
Acute respiratory infections
Other infectious diseases
Maternal, neonatal, nutritional
Cardiovascular diseases and diabetes
Cancers
Chronic respiratory diseases
Other NCDs
Suicide, homicide and conflict
Unintentional injuries
Probability of dying, 2012
Probability of dying between relevant exact ages, for a person experiencing the 2012 age-specific mortality risks throughout their life.
Before age 15, all causes Male 34%
Female 29%
Before age 70, all causes Male 77%
Female 72%
Between ages 15 and 49, from maternal causes Female 35%
Between ages 30 and 70, from 4 major noncommunicable diseases (NCDs)~ Both sexes 20%
~Cancers, cardiovascular diseases, chronic respiratory diseases and diabetes
Source: Country statistics and global health estimates by WHO and UN partners
For more information visit the Global Health Observatory (http://who.int/gho/mortality_burden_disease/en/)
Last updated: January 2015

APPENDIX K

FIGURES ON BAH PATIENTS

Figure K1 graphically expresses the distribution per occupation for all the patients that came to BAH between January to March 2015.

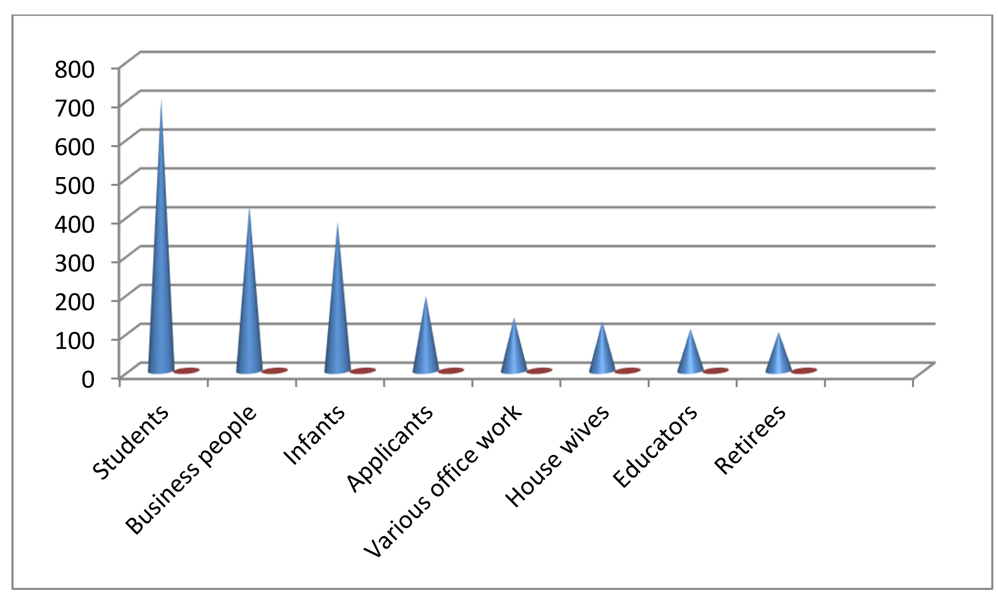


Figure K2 portrays the distribution per occupation for all the patients that were admitted.

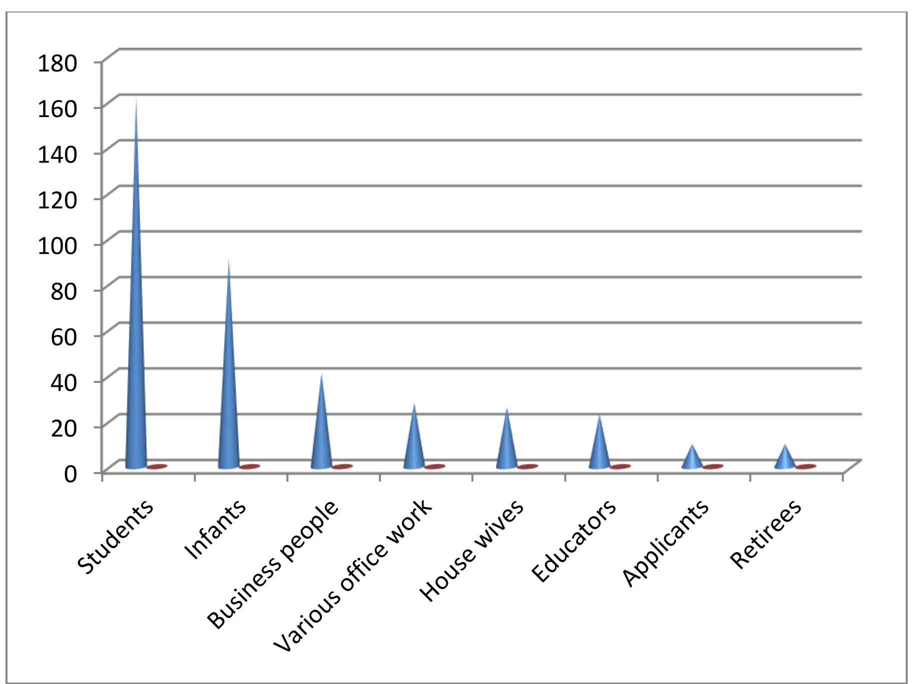
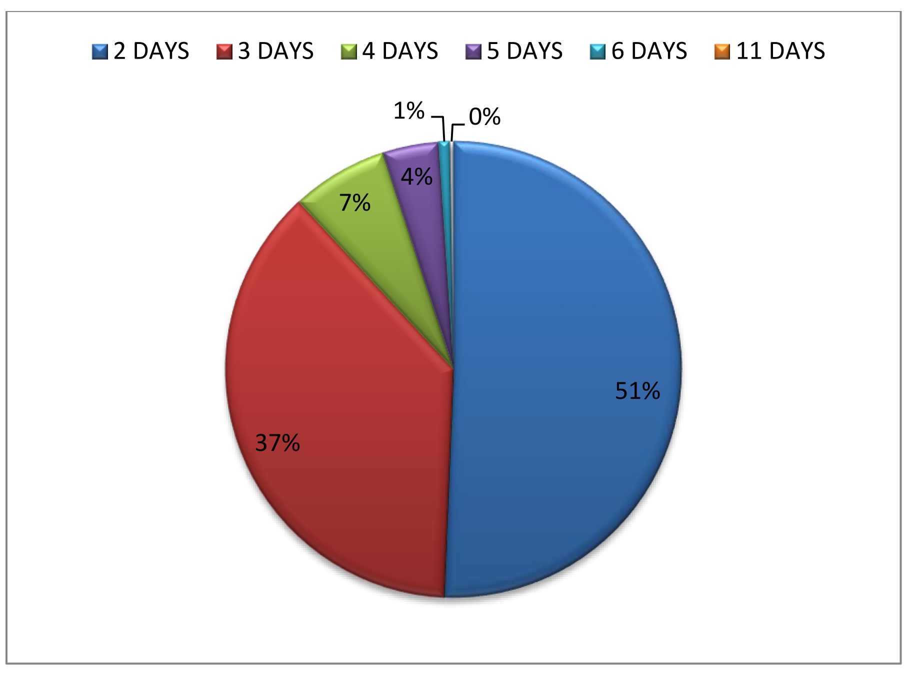


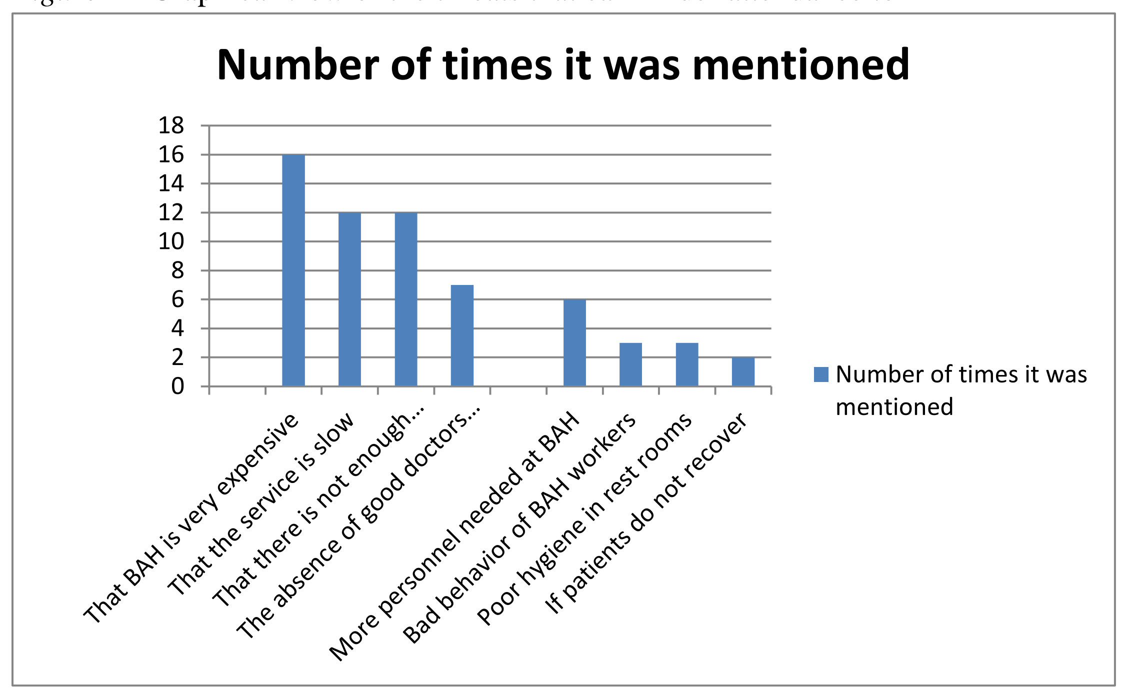
Figure K3 shows the number of days of admission in the hospital



APPENDIX L

THREATS BAH ATTENDANCE

Figure L1 Graphical view of the threats that can hinder attendance to BAH



APPENDIX M

SPIRITUAL CARE VIEWED BY PATIENTS

Table M1. Statistics about the patients perspectives about spiritual care to them

Item: "In general, I would like health personnel to:"	Total participants	Strongly Disagree	Disagree	Agree	Strongly Agree	Highest choice made for this question	Percentage of the highest choice made
Help me to have quiet times or space	10	0	1	6	3	Agree	60%
Listen to me talk about my spiritual concerns	10	0	2	6	2	Agree	60%
Listen to me talk about my spiritual strengths	10	0	3	6	1	Agree	60%
Teach me about ways to draw or write about my spirituality	10	1	1	4	4	Agree-Str Agre	40%
Listen to the stories of my life	10	2	5	2	2	Disagree	50%
Tell me about spiritual resources nearby that I can use	10	0	1	6	2	Agree	60%
Help me to think about my dreams	10	1	3	4	2	Agree	40%
Bring me humorous things	10	0	4	2	4	Disgr-Str Agree	40%
Help me laugh (e.g., share a joke)	10	0	0	6	4	Agree	60%
Help me, if I needed, with my religious practices	10	1	1	5	2	Agree	50%
Arrange for my minister or a spiritual mentor to visit me	10	1	0	6	2	Agree	60%
Arrange for a chaplain to visit me	10	0	2	6	3	Agree	60%

(table continues)

Table1(continued). Statistics about the patients perspectives about spiritual care to them

Item: "In general, I would like health personnel to:"	Total participants	Strongly Disagree	Disagree	Agree	Strongly Agree	Highest choice made for this question	Percentage of the highest choice made
Offer to talk with me about meditation	10	0	1	5	4	Agree	50%
Offer to talk with me about the difficulties of praying when sick	10	0	1	6	2	Agree	60%
Offer to pray privately for me (for example, a health personnel prays for me later while alone)	10	0	0	6	4	Agree	60%
Offer to pray with me	10	0	0	4	5	Str Agre	50%
Ask me about my spiritual beliefs	10	1	2	5	2	Agree	50%
Ask me about what gives my life meaning	10	1	3	4	2	Agree	40%
Ask me about how I relate to God (or whatever is that Ultimate Other)	10	0	3	5	2	Agree	50%
Ask me about religious practices	10	0	3	5	2	Agree	50%

APPENDIX N

RESPONDENTS OF THE LENGTHY QUESTIONNAIRE

Figure N1 shows the number of respondents for the lengthy questionnaire

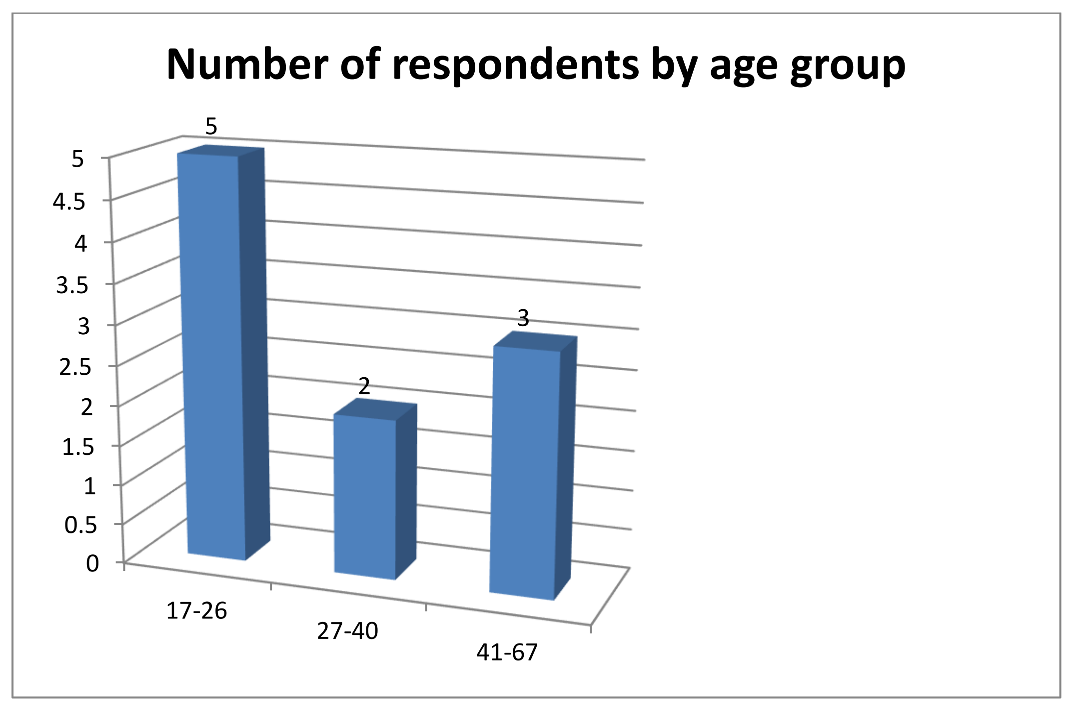
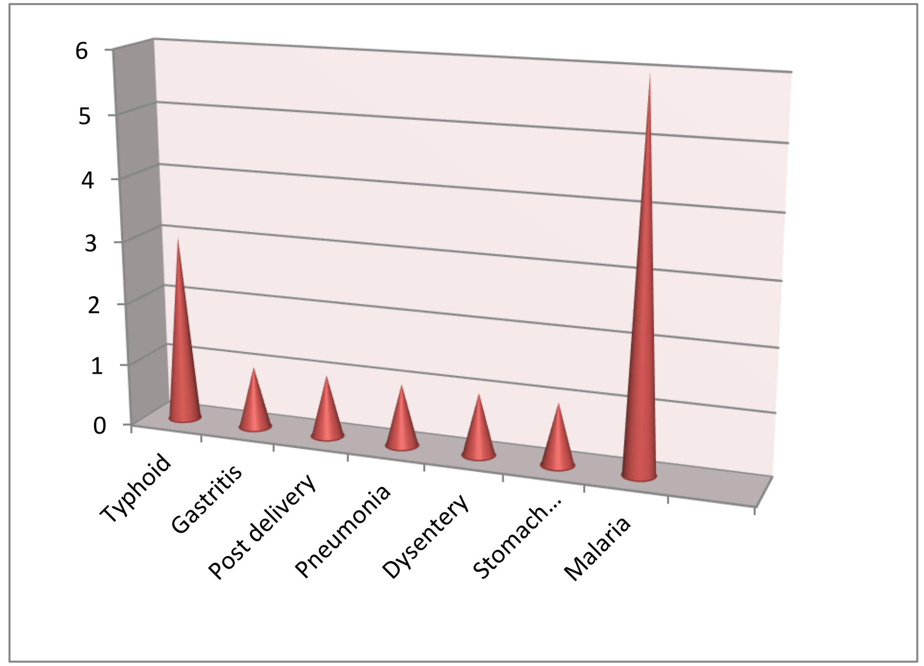


Figure N2 gives the primary reasons for their admission



APPENDIX O

INTERVIEWS TO BAH WORKERS

Table O1. The workers 'definition of spiritual care'

Interview Question	Summary Phrase	Frequency
In health centers, what does the term 'spiritual care' mean?	Care that brings God in the patient's life	3
	Care for the spiritual life	2
	Wholistic care	2
	Care that includes the patient's beliefs	1
	Starting the day with prayer	1

Table O2. The workers 'opinion on spiritual care

Interview Question	Summary Phrase	Frequency
What is your opinion about it?	It is (very) important	7
	It helps for wholistic management of patients	1
	It is mostly for elderly people and those Suffering of chronic diseases	1
	It has to be integrated in taking care of the patients	1
	It is an aspect that should not be left out	1
	It has a positive connotation	1

Table O3. The personal meaning of spiritual care for the workers

Interview Question	Summary Phrase	Frequency
What does 'spiritual care' mean to you personally?	It brings the patient to the source of hope	3
	We also need it	2
	It helps in caring for the sick	2
	It is a way to talk about God	1
	It connects the patient back to God	1

Table O4. The workers 'actions regarding 'spiritual care' in BAH

Interview Question	Summary Phrase	Frequency
What are some of your actions regarding 'spiritual care' in this health center?	Give advice to take medication alongside prayer	4
	Words of encouragement (using Bible)	3
	Prayer	2
	Dialog with patients	1
	Singing with patients	1
	Pays attention to the patient's countenance	1
	There is morning devotion	1
	Does health education	1

Table O5. The workers 'activities with former patients of BAH

Interview Question	Summary Phrase	Frequency
What are some of the activities you engage in with former patients of this health center?	None	4
	Appointment to come back for check up	2
	Rare visitations to one who is a friend	1

Table O6. The workers 'opinions on what 'biblical healing' refers to

Interview Question	Summary Phrase	Frequency
Tell me what 'biblical healing' refers to	It reminds the healing ministry found In the Bible	3
	Biblical solution to health challenges	3
	To take care of patients	2
	A therapy whose prescription is in the Bible	1
	That we are just instruments, God is the Healer	1

Table O7. The workers 'opinions about 'biblical healing'

Interview Question	Summary Phrase	Frequency
What is your opinion about it?	It is very important (and needed in our society)	5
	It is superior (but not exclusive of) to medical prescriptions and products	3
	Insists that it is mostly for diseases for which medicine has no solution	1

Table O8. The personal meaning of 'biblical healing' for the workers at BAH

Interview Question	Summary Phrase	Frequency
What does 'biblical healing' mean to you personally?	It means a lot to me	2
	It is better for us to introduce God in the patient's experience	2
	It means that no matter the disease, God has the answer	1
	It reminds that the doctor and nurses treat, but only God heals	1
	It is taking the approaches that are in the Bible related to healing and imitate	1

Table O9. The workers actions to patients in need of biblical healing

Interview Question	Summary Phrase	Frequency
What are some of your actions that can make sense to a patient in need of biblical healing?	Call the attention of the chaplain that comes twice a week	2
	Send the patient to counselling unit	1
	Give advice	1
	Dialog in showing concern	1
	Prayer, visitations, singing, and reading of the Bible	1
	Hold the hands of the sick when support is needed	1
	Bring God to the person	1
	Put on a good countenance	1

Table O10. The workers' personal plan of action for follow-up

Interview Question	Summary Phrase	Frequency
What personal plan of action do you follow up, if any?	None	5
	Scarce visitations	1
	Weekly Bible study program with friends that includes a few long time former patients	1

Table O11. Things done at BAH to mobilize workers as instruments of healing

Interview Question	Summary Phrase	Frequency
What corporate things are done in this health center that can mobilize workers as instruments of healing?	Morning devotion (8:00-8:15 AM)	5
	A week of prayer recently organized	2
	Health fare for health education	1

Table O12. The workers ‘definition of ‘medical evangelism

Interview Question	Summary Phrase	Frequency
What is ‘medical evangelism’?	Spreading the word of God through the medical field	3
	Health personnel help the population to have a good life	1
	Health personnel teach health principles	1
	Giving free medication to people	1
	Going out to evangelize as medical personnel and nurses	1

Table O13. The workers ‘opinion about medical evangelism

Interview Question	Summary Phrase	Frequency
What is your opinion about it?	It is (very) important (and needed)	6
	It helps to attach spiritual meaning to the work of health personnel	1
	It will be good to do it once in a while	1
	Medical personnel have to incorporate Christ in carrying their duties	1

Table O14. The workers ‘feelings about medical evangelism

Interview Question	Summary Phrase	Frequency
Share with me your feelings about medical evangelism	It is (very) important	2
	It is a good strategy to evangelize	2
	It is a simple approach	1
	I agree with the idea of having everyone involved in doing it	1
	Disappointed that the State does not address the issue	1

Table O15. The workers ‘actions in regard to medical evangelism

Interview Question	Summary Phrase	Frequency
What are some of your actions in regard to medical evangelism?	When possible, be vigilant to see the needs of patient and bring help	2
	Encourage patients to take medications with trust in God	1
	None	1
	Avoid shouting at patients	1
	Being kind so that they will enjoy their stay	1
	Tell the person about God without using the church etiquette	1

Table O16. Workers ‘behaviors when a patient is a brother/sister in the faith

Interview Question	Summary Phrase	Frequency
How do you behave when a sick person is your brother/sister in the faith?	I give them a call, pray for them, and bring support with my resources	4
	I sing songs, and read the Bible to encourage them	2
	I feel more concerned	1
	I educate the person right there because she knows the principles	1

Table O17. Workers ‘behaviors when a patient shares a different faith

Interview Question	Summary Phrase	Frequency
What about when the person does not share your faith (is not of the same church with you)?	Show some concern (and find out how they are responding to the treatment)	2
	I explore the aspects of my faith that are similar to theirs	2
	I avoid talking about what is contrary to their belief	1
	I ask how does their source of hope instruct about coping with their situation	1
	I avoid given the impression that I want to convert her to SDA	1

Table O18. Workers ‘personal program for follow-up with former patients

Interview Question	Summary Phrase	Frequency
List some of the activities or programs that you personally handle with former patients from your health center?	None	5
	Send SMS for encouragement to a few of them	1
	Bible studies, share gifts with a few who are co-members in the same social gathering where they used to attend	1

Table O19. The BAH program specifically for former patients

Interview Question	Summary Phrase	Frequency
List all activities and programs that your health center usually organizes specifically on behalf of all its former patients	None	7

Table O20. How people in the community perceive BAH

Interview Question	Summary Phrase	Frequency
How do people in the community perceive this health institution?	They believe that we make good impression	4
	Many complaints that we are expensive	2
	Their satisfaction depends on the type of experience they make (positive or negative)	1

APPENDIX P

LETTERS DURING FIELDWORK

Letter 1 From the Rector

UNIVERSITE ADVENTISTE COSENDAI
Nanga-Eboko
BP 401 Yaoundé, Cameroun
Tél. : (+237) 677 79 90 32/ 50 03 65 46
Courriel :
cosendai_rectorat@yahoo.fr/rachelntyam@yahoo.fr
RECTORAT

ADVENTIST UNIVERSITY COSENDAI
Nanga-Eboko
PO BOX 401 Yaoundé, Cameroon
Tél. : (+237) 677 79 90 32/ 50 03 65 46
E-mail :
cosendai_rectorat@yahoo.fr/rachelntyam@yahoo.fr
RECTORATE

Le Recteur

TO WHOM IT MAY CONCERNS

Objet: *A request for the purpose of research.*

Pastor NGANING MBENDE JACQUES YVES is a Lecturer in the Theology Department of University Adventiste Cosendai, Nanga-Eboko. As a Doctor of Minitry Candidate, his research topic is: DEVELOPMENT OF SPIRITUAL CARE MODEL OF MEDICAL EVANGELISM IN BUEA ADVENTIST HEALTH CENTER, CAMEROON.

His aim is to suggest an instrument for the betterment of the care giving to sick people in the perspective of the ultimate healing that derives from a living connection with God.

He needs to do some observations, interviews, and take any other steps useful for his study. His research includes Adventist health institutions, non-Adventist, and public hospitals.

We will appreciate your sincere collaboration to his study for the sake of academic.

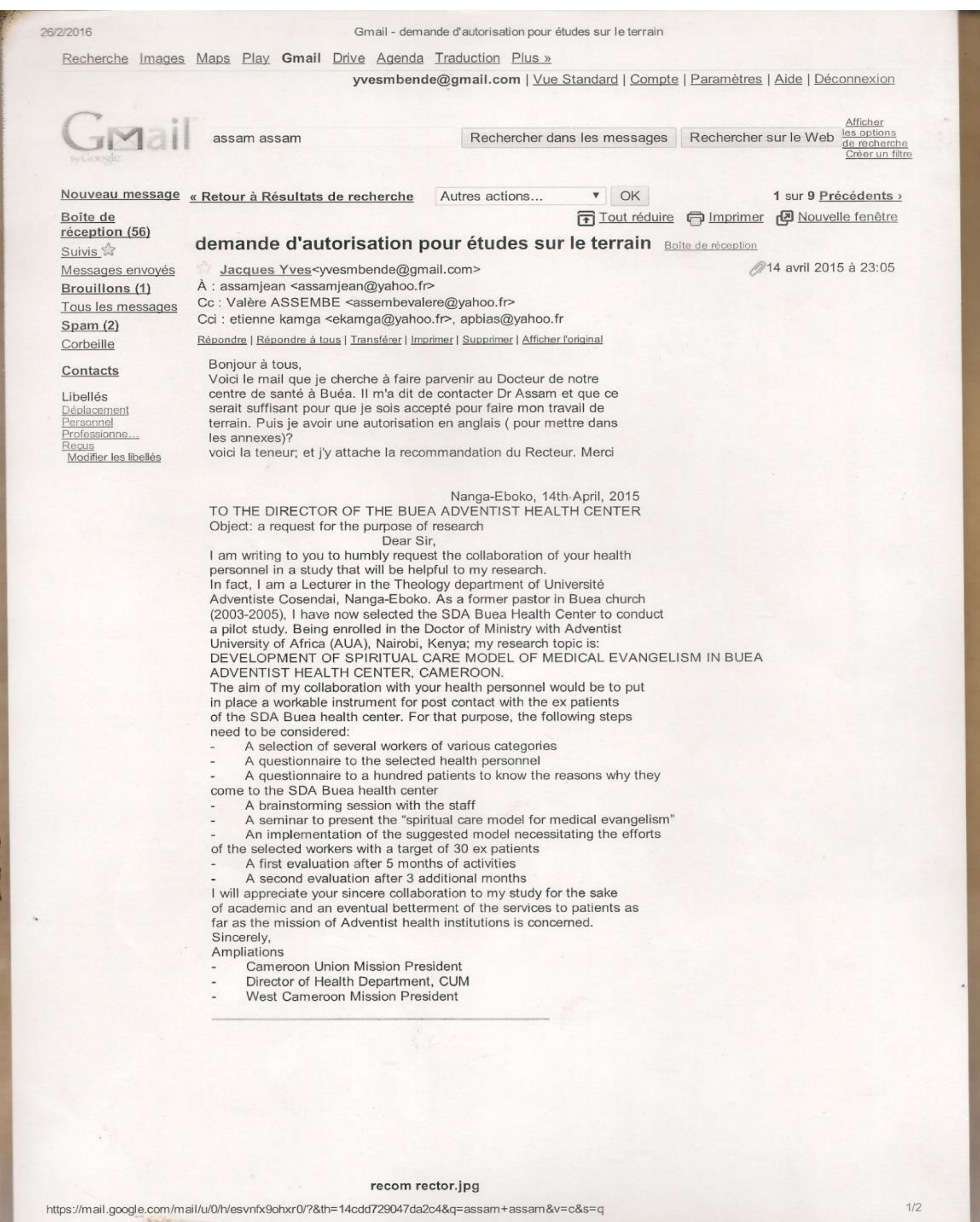
Sincerely.

Nanga – Eboko, 14-04-2015

UNIVERSITE ADVENTISTE COSENDAI – Le Recteur – NANGA EBOKO-CAMEROUN

Professeur Joseph G. Nkou
Docteur ès Sciences de l'Education

Letter 2 For authorization


26/2/2016 Gmail - demande d'autorisation pour études sur le terrain

Recherche Images Maps Play Gmail Drive Agenda Traduction Plus »

yvesmbende@gmail.com | Vue Standard | Compte | Paramètres | Aide | Déconnexion

Gmail assam assam Rechercher dans les messages Rechercher sur le Web Afficher les options de recherche Créer un filtre

Nouveau message « Retour à Résultats de recherche Autres actions... OK 1 sur 9 Précédents ›

Boîte de réception (56) Tout réduire Imprimer Nouvelle fenêtre

Suivis

Messages envoyés

Brouillons (1)

Tous les messages

Spam (2)

Corbeille

Contacts

Libellés: Déplacement, Personnel, Professionne..., Reçus, Modifier les libellés

demande d'autorisation pour études sur le terrain Boîte de réception

Jacques Yves<yvesmbende@gmail.com> 14 avril 2015 à 23:05
À : assamjean <assamjean@yahoo.fr>
Cc : Valère ASSEMBE <assembevalere@yahoo.fr>
Cci : etienne kamga <ekamga@yahoo.fr>, apbias@yahoo.fr

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Bonjour à tous,
Voici le mail que je cherche à faire parvenir au Docteur de notre centre de santé à Buéa. Il m'a dit de contacter Dr Assam et que ce serait suffisant pour que je sois accepté pour faire mon travail de terrain. Puis je avoir une autorisation en anglais (pour mettre dans les annexes)?
voici la teneur; et j'y attache la recommandation du Recteur. Merci

Nanga-Eboko, 14th April, 2015

TO THE DIRECTOR OF THE BUEA ADVENTIST HEALTH CENTER
Object: a request for the purpose of research

Dear Sir,

I am writing to you to humbly request the collaboration of your health personnel in a study that will be helpful to my research.
In fact, I am a Lecturer in the Theology department of Université Adventiste Cosendai, Nanga-Eboko. As a former pastor in Buea church (2003-2005), I have now selected the SDA Buea Health Center to conduct a pilot study. Being enrolled in the Doctor of Ministry with Adventist University of Africa (AUA), Nairobi, Kenya; my research topic is: DEVELOPMENT OF SPIRITUAL CARE MODEL OF MEDICAL EVANGELISM IN BUEA ADVENTIST HEALTH CENTER, CAMEROON.
The aim of my collaboration with your health personnel would be to put in place a workable instrument for post contact with the ex patients of the SDA Buea health center. For that purpose, the following steps need to be considered:

- A selection of several workers of various categories
- A questionnaire to the selected health personnel
- A questionnaire to a hundred patients to know the reasons why they come to the SDA Buea health center
- A brainstorming session with the staff
- A seminar to present the "spiritual care model for medical evangelism"
- An implementation of the suggested model necessitating the efforts of the selected workers with a target of 30 ex patients
- A first evaluation after 5 months of activities
- A second evaluation after 3 additional months

I will appreciate your sincere collaboration to my study for the sake of academic and an eventual betterment of the services to patients as far as the mission of Adventist health institutions is concerned.
Sincerely,
Ampliations

- Cameroon Union Mission President
- Director of Health Department, CUM
- West Cameroon Mission President

recom rector.jpg

https://mail.google.com/mail/u/0/h/esvnfx9ohxr0/?&th=14cdd729047da2c4&q=assam+assam&v=c&s=q 1/2

191K Afficher Analyser et télécharger

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Assam Assam Jean Paul<assamjean@yahoo.fr> 21 avril 2015 à 20:26
À : Jacques Yves <yvesmbende@gmail.com>
Cc : VALERE ASSEMBE <assembevalere@yahoo.fr>

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Hi Pastor
Your authorization for research at Buea Adventiste Health Center
Thanks

Dr. Jean Paul Assam Assam
PhD
(DEA) in Biochemistry,Fac.Sc.
Msc.in Biomedical Science, FMBS
lecturer, University of Douala, Cameroon.
Tel: (237) 99 86 74 54
Email: assamjean@yahoo.fr

En date de : Mer 15.4.15, Jacques Yves <yvesmbende@gmail.com> a écrit :

Objet: demande d'autorisation pour études sur le terrain
À: "assamjean" <assamjean@yahoo.fr>
Cc: "Valère ASSEMBE" <assembevalere@yahoo.fr>
Date: Mercredi 15 avril 2015, 0h05
- Afficher le texte des messages précédents -

---

authorization letter for pastor yves.docx
147K Afficher au format HTML Analyser et télécharger

Réponse rapide
À : Assam Assam Jean Paul <assamjean@yahoo.fr>
À tous : Assam Assam Jean Paul <assamjean@yahoo.fr>, VALERE ASSEMBE <assembevalere@yahoo.fr> Autres options de réponse

Envoyer Enregistrer un brouillon ✓ Inclure le texte des messages précédents dans la réponse

« Retour à Résultats de recherche Autres actions... OK 1 sur 9 Précédents ›

Utilisez le champ de recherche ou les **options de recherche** pour retrouver rapidement des messages.
Vous utilisez actuellement 762 Mo (4 %) sur les 15360 Mo dont vous disposez.
Dernière activité sur le compte : il y a 2 minutes depuis l'adresse IP 52.91.242.98 Détails

Affichage de Gmail : version standard | **version HTML simplifiée** En savoir plus

Conditions - Confidentialité - Accueil Google

Letter 3 From the Union Health director

CAMEROUN UNION MISSION

HEALTH DEPARTMENT

Letter of Authorization *for* Pastor YVES MBENDE for the purpose of research at Buea Adventist Health Center

To whom it may concern

I have the honor most respectfully to give an authorization to Pastor Yves MBENDE Doctorate of Ministry student at Adventist University of Africa (AUA), Nairobi, Kenya; and Lecturer in the Theology department at *Université Adventiste Cosendai*, Nanga-Eboko to collect data for his research program on topic «***DEVELOPMENT OF SPIRITUAL CARE MODEL OF MEDICAL EVANGELISM IN BUEA ADVENTIST HEALTH CENTER, CAMEROON***»

The aim of this research in collaboration with health personnel would be to put in place a workable instrument for post contact with the ex patients of the SDA Buea health center. the following steps need to be considered:

- A selection of several workers of various categories
- A questionnaire to the selected health personnel
- A questionnaire to a hundred patients to know the reasons why they come to the SDA Buea health center
- A brainstorming session with the staff
- A seminar to present the "spiritual care model for medical evangelism"
- An implementation of the suggested model necessitating the efforts of the selected workers with a target of 30 ex patients
- A first evaluation after 5 months of activities
- A second evaluation after 3 additional months

As Head of the Health Department, I do not foresee any potential conflicts to the principles of scientific ethics. Based on his current and past achievements, i believe Pastor Yves MBENDE is full of excellent scientific and personal aptitude to perform research at our institute with a clear vision. If I can be of any further assistance, or provide you with any further information, please do not hesitate to contact me.

Yours Sincerely,

Dr Jean Paul Assam Assam; PhD
Senior Lecturer
Email: assamjean@yahoo.fr

Letter 4 The Research Authorization

SEVENTH-DAY ADVENTIST HEALTH CENTRE
PO BOX 33
BUEA, REPUBLIC OF CAMEROON

Clinic: 237- 33.32.22.70
Wards: 237- 33.32.20.60
bueaadventisthospital@yahoo.com

April 16, 2015

RESEARCH AUTHORIZATION

Pastor NGANING MBENDE Jacques Yves, lecturer in the Theology Department of the Adventist University Consendai, Nanga Eboko, has been authorized, following **Action #29/2015** to carry out his research on the theme "**Development of Spiritual care model for medical evangelism in Buea Adventist Hospital, Cameroon".**

In testimony, this present document is issued to serve only the purpose for which it is intended.

Medical Director

Letter 5 Authorization From A Non SDA Hospital

REPUBLIQUE DU CAMEROUN
PAIX – TRAVAIL – PATRIE
MINISTERE DE LA SANTE PUBLIQUE
SECRETARIAT GENERAL
DELEGATION REGIONALE DE LA SANTE DU SUD
DISTRICT DE SANTE DE KRIBI

REPUBLIC OF CAMEROON
PEACE – WORK – FATHERLAND
MINISTRY OF PUBLIC HEALTH
SECRATARIAT GENERAL
PUBLIC HEALTH REGIONAL DELEGATION
HEALTH DISTRICT SERVICE

HÔPITAL DE DISTRICT DE KRIBI

Directeur
Dr J.G. TSIAGADIGUI
Conseiller Médical
Dr François A. ONDOA
Surveillante Générale
Mme ZANGA BELINGA

Services :
URGENCES
MEDECINE
CHIRURGIE
GYNECO-OBSTETRIQUE
PEDIATRIE
ORTHOPEDIE-TRAUMATOLOGIE
KINESITHERAPIE
ODONTOSTOMATOLOGIE
U.P.E.C.
C.D.T.T.
S.M.C.S.
IMAGERIE MEDICALE
LABORATOIRE
PHARMACIE

N°168/AR/MINSANTE/SG/DRS/DSK/HDK/CM

AUTORISATION DE RECHERCHE

Pastor NGANING MBENDE Jacques Yves, Lecturer in the Theology Department of University Adventiste Consendai, Nanga-Eboko, est autorisée à effectuer une recherche sur le thème : « ***Development of spiritual care model of medical evangelism in Buea adventist health center, Cameroon*** », sous la supervision du **Pasteur René NKAE**, Pasteur, Chef Service de l'Aumonerie de l'Hôpital de District de Kribi.

En foi de quoi la présente Autorisation de Recherche est délivrée pour servir et valoir ce que de droit.

Kribi, le 23 AVR 2015

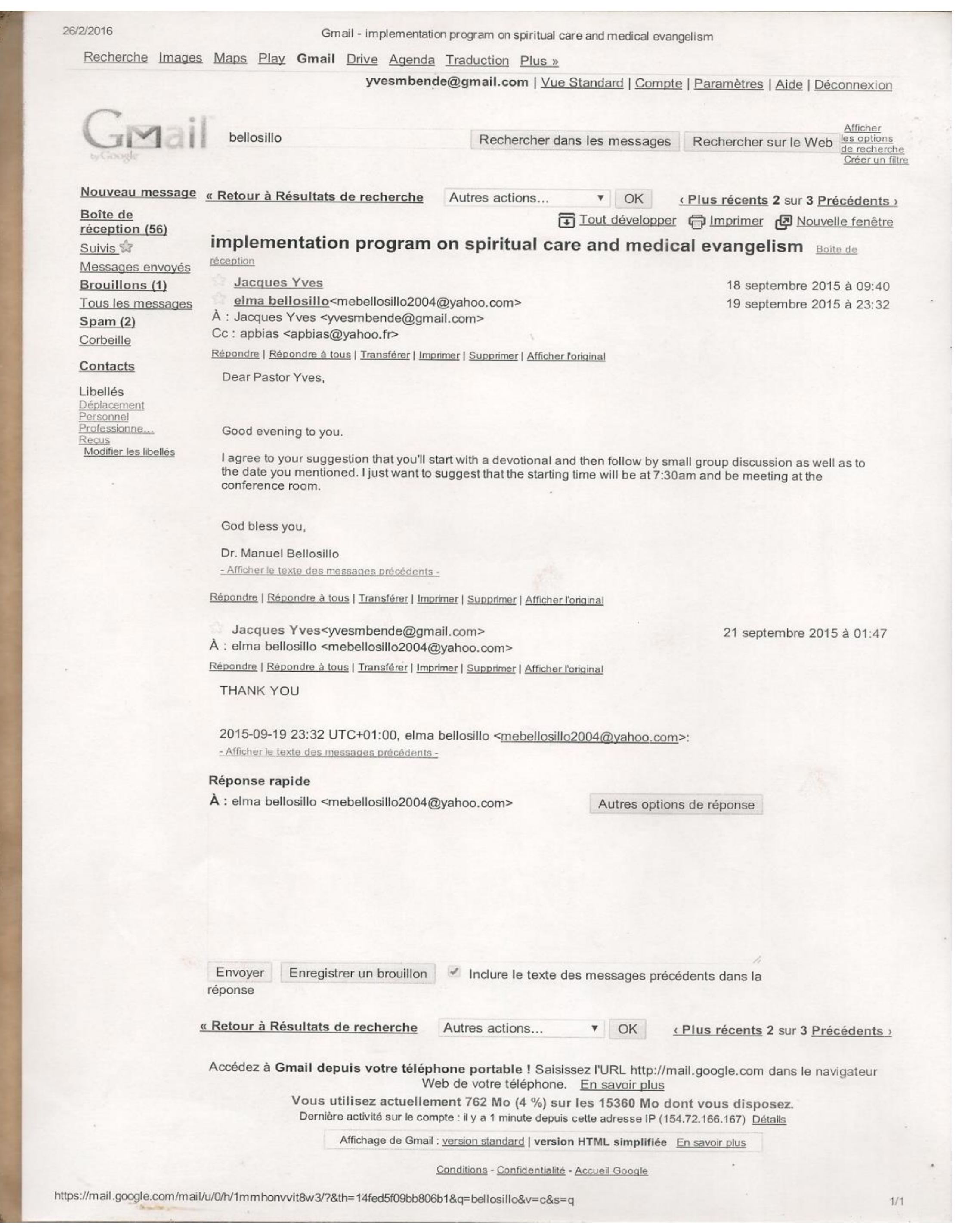
Le Directeur de l'Hôpital de District de Kribi,

Dr TSIAGADIGUI Jean Gustave

Ampliations :
- CM
- SG
- ECO
- Coordo
- Superviseur
- Majors
- Intéressé
- Chrono/Archives

Tel : 33 46 14 86 / 33 46 10 51 / 33 46 19 46
Email : hdk1935@hotmail.com
BP : 52 Kribi

Letter 6 Email for 1st Evaluation


26/2/2016 Gmail - implementation program on spiritual care and medical evangelism

Recherche Images Maps Play **Gmail** Drive Agenda Traduction Plus »

yvesmbende@gmail.com | Vue Standard | Compte | Paramètres | Aide | Déconnexion

Gmail bellosillo Rechercher dans les messages Rechercher sur le Web Afficher les options de recherche Créer un filtre

Nouveau message **« Retour à Résultats de recherche** Autres actions... OK **‹ Plus récents 2** sur **3 Précédents ›**

Boîte de réception (56) Tout développer Imprimer Nouvelle fenêtre

Suivis

Messages envoyés

Brouillons (1)

Tous les messages

Spam (2)

Corbeille

Contacts

Libellés
Déplacement
Personnel
Professionne...
Reçus
Modifier les libellés

implementation program on spiritual care and medical evangelism Boîte de réception

Jacques Yves — 18 septembre 2015 à 09:40

elma bellosillo<mebellosillo2004@yahoo.com> — 19 septembre 2015 à 23:32

À : Jacques Yves <yvesmbende@gmail.com>

Cc : apbias <apbias@yahoo.fr>

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Dear Pastor Yves,

Good evening to you.

I agree to your suggestion that you'll start with a devotional and then follow by small group discussion as well as to the date you mentioned. I just want to suggest that the starting time will be at 7:30am and be meeting at the conference room.

God bless you,

Dr. Manuel Bellosillo

- Afficher le texte des messages précédents -

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Jacques Yves<yvesmbende@gmail.com> — 21 septembre 2015 à 01:47

À : elma bellosillo <mebellosillo2004@yahoo.com>

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

THANK YOU

2015-09-19 23:32 UTC+01:00, elma bellosillo <mebellosillo2004@yahoo.com>:

- Afficher le texte des messages précédents -

Réponse rapide

À : elma bellosillo <mebellosillo2004@yahoo.com> Autres options de réponse

Envoyer Enregistrer un brouillon Inclure le texte des messages précédents dans la réponse

« Retour à Résultats de recherche Autres actions... OK **‹ Plus récents 2** sur **3 Précédents ›**

Accédez à **Gmail depuis votre téléphone portable !** Saisissez l'URL http://mail.google.com dans le navigateur Web de votre téléphone. En savoir plus

Vous utilisez actuellement 762 Mo (4 %) sur les 15360 Mo dont vous disposez.

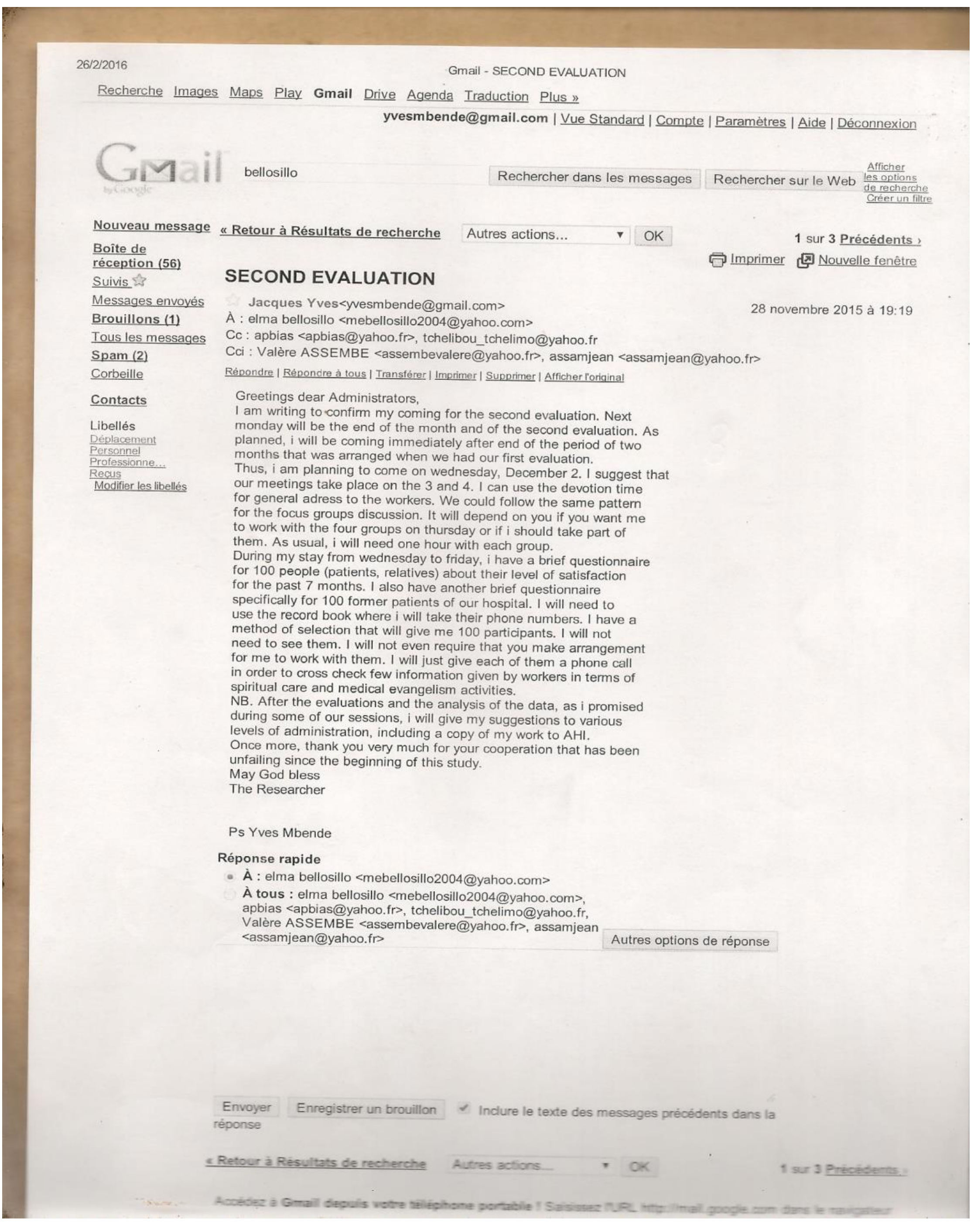
Dernière activité sur le compte : il y a 1 minute depuis cette adresse IP (154.72.166.167) Détails

Affichage de Gmail : version standard | **version HTML simplifiée** En savoir plus

Conditions - Confidentialité - Accueil Google

https://mail.google.com/mail/u/0/h/1mmhonvvit8w3/?&th=14fed5f09bb806b1&q=bellosillo&v=c&s=q 1/1

Letter 7 Email For 2nd Evaluation



26/2/2016 Gmail - SECOND EVALUATION

Recherche Images Maps Play **Gmail** Drive Agenda Traduction Plus »

yvesmbende@gmail.com | Vue Standard | Compte | Paramètres | Aide | Déconnexion

bellosillo — Rechercher dans les messages — Rechercher sur le Web — Afficher les options de recherche — Créer un filtre

Nouveau message — « Retour à Résultats de recherche — Autres actions... — OK — 1 sur 3 Précédents ›

Boîte de réception (56) — Suivis — Messages envoyés — Brouillons (1) — Tous les messages — Spam (2) — Corbeille — Contacts — Libellés: Déplacement, Personnel, Professionne..., Reçus, Modifier les libellés

Imprimer — Nouvelle fenêtre

SECOND EVALUATION

Jacques Yves<yvesmbende@gmail.com> — 28 novembre 2015 à 19:19

À : elma bellosillo <mebellosillo2004@yahoo.com>

Cc : apbias <apbias@yahoo.fr>, tchelibou_tchelimo@yahoo.fr

Cci : Valère ASSEMBE <assembevalere@yahoo.fr>, assamjean <assamjean@yahoo.fr>

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Greetings dear Administrators,
I am writing to confirm my coming for the second evaluation. Next monday will be the end of the month and of the second evaluation. As planned, i will be coming immediately after end of the period of two months that was arranged when we had our first evaluation.
Thus, i am planning to come on wednesday, December 2. I suggest that our meetings take place on the 3 and 4. I can use the devotion time for general adress to the workers. We could follow the same pattern for the focus groups discussion. It will depend on you if you want me to work with the four groups on thursday or if i should take part of them. As usual, i will need one hour with each group.
During my stay from wednesday to friday, i have a brief questionnaire for 100 people (patients, relatives) about their level of satisfaction for the past 7 months. I also have another brief questionnaire specifically for 100 former patients of our hospital. I will need to use the record book where i will take their phone numbers. I have a method of selection that will give me 100 participants. I will not need to see them. I will not even require that you make arrangement for me to work with them. I will just give each of them a phone call in order to cross check few information given by workers in terms of spiritual care and medical evangelism activities.
NB. After the evaluations and the analysis of the data, as i promised during some of our sessions, i will give my suggestions to various levels of administration, including a copy of my work to AHI.
Once more, thank you very much for your cooperation that has been unfailing since the beginning of this study.
May God bless
The Researcher

Ps Yves Mbende

Réponse rapide

À : elma bellosillo <mebellosillo2004@yahoo.com>

À tous : elma bellosillo <mebellosillo2004@yahoo.com>, apbias <apbias@yahoo.fr>, tchelibou_tchelimo@yahoo.fr, Valère ASSEMBE <assembevalere@yahoo.fr>, assamjean <assamjean@yahoo.fr>

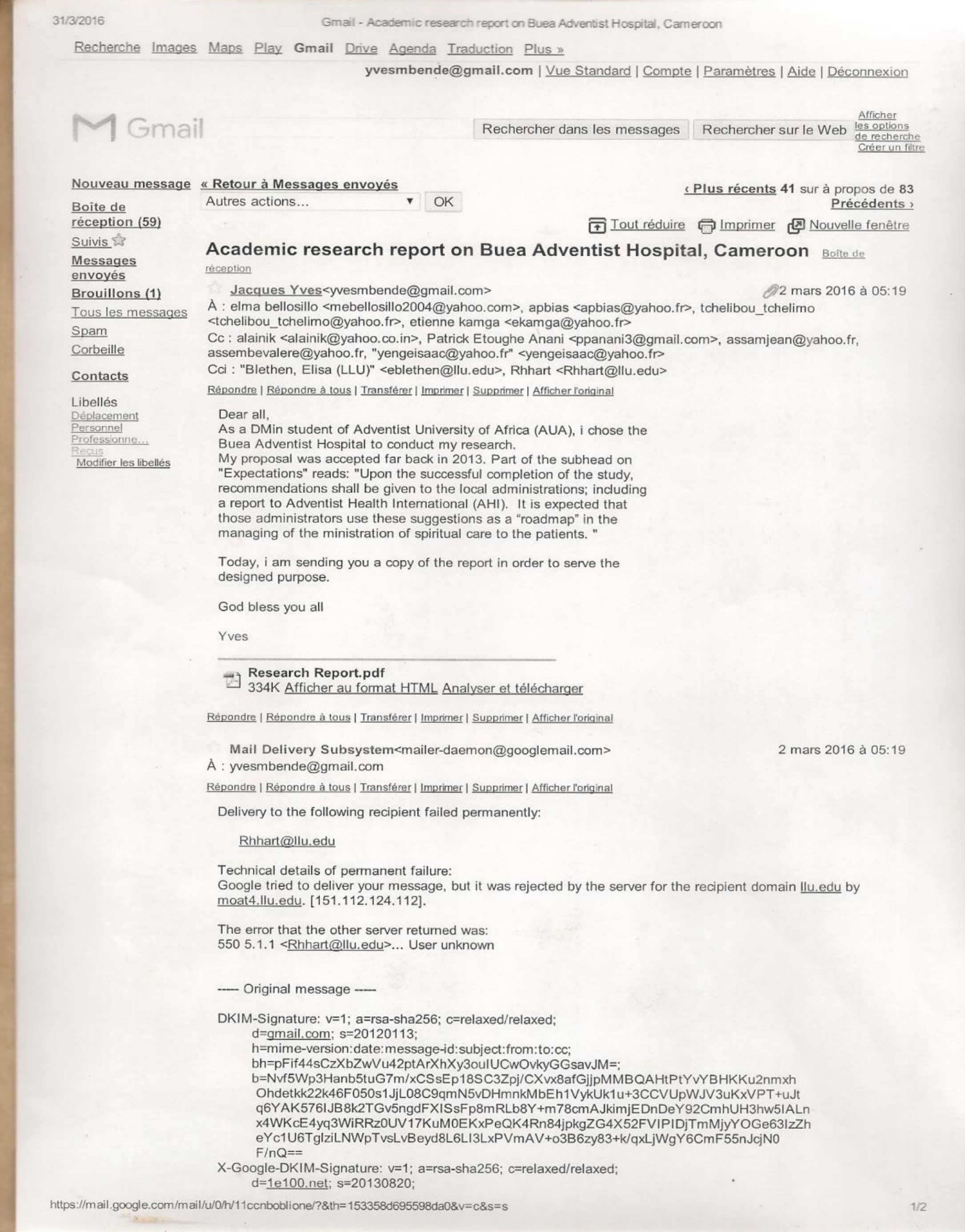
Autres options de réponse

Envoyer — Enregistrer un brouillon — Inclure le texte des messages précédents dans la réponse

« Retour à Résultats de recherche — Autres actions... — OK — 1 sur 3 Précédents ›

Accédez à Gmail depuis votre téléphone portable ! Saisissez l'URL http://mail.google.com dans le navigateur

Letter 8 Email For Research Reporting



31/3/2016 Gmail - Academic research report on Buea Adventist Hospital, Cameroon

Recherche Images Maps Play **Gmail** Drive Agenda Traduction Plus »

yvesmbende@gmail.com | Vue Standard | Compte | Paramètres | Aide | Déconnexion

Gmail

Rechercher dans les messages | Rechercher sur le Web | Afficher les options de recherche | Créer un filtre

Nouveau message | **« Retour à Messages envoyés** | **‹ Plus récents** **41** sur à propos de **83** **Précédents ›**

Autres actions... OK

Boîte de réception (59)
Suivis
Messages envoyés
Brouillons (1)
Tous les messages
Spam
Corbeille
Contacts
Libellés
Déplacement
Personnel
Professionne...
Reçus
Modifier les libellés

Tout réduire | Imprimer | Nouvelle fenêtre

Academic research report on Buea Adventist Hospital, Cameroon Boîte de réception

Jacques Yves<yvesmbende@gmail.com> 2 mars 2016 à 05:19
À : elma bellosillo <mebellosillo2004@yahoo.com>, apbias <apbias@yahoo.fr>, tchelibou_tchelimo <tchelibou_tchelimo@yahoo.fr>, etienne kamga <ekamga@yahoo.fr>
Cc : alainik <alainik@yahoo.co.in>, Patrick Etoughe Anani <ppanani3@gmail.com>, assamjean@yahoo.fr, assembevalere@yahoo.fr, "yengeisaac@yahoo.fr" <yengeisaac@yahoo.fr>
Cci : "Blethen, Elisa (LLU)" <eblethen@llu.edu>, Rhhart <Rhhart@llu.edu>

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Dear all,
As a DMin student of Adventist University of Africa (AUA), i chose the Buea Adventist Hospital to conduct my research.
My proposal was accepted far back in 2013. Part of the subhead on "Expectations" reads: "Upon the successful completion of the study, recommendations shall be given to the local administrations; including a report to Adventist Health International (AHI). It is expected that those administrators use these suggestions as a "roadmap" in the managing of the ministration of spiritual care to the patients. "

Today, i am sending you a copy of the report in order to serve the designed purpose.

God bless you all

Yves

Research Report.pdf
334K Afficher au format HTML Analyser et télécharger

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Mail Delivery Subsystem<mailer-daemon@googlemail.com> 2 mars 2016 à 05:19
À : yvesmbende@gmail.com

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Delivery to the following recipient failed permanently:

Rhhart@llu.edu

Technical details of permanent failure:
Google tried to deliver your message, but it was rejected by the server for the recipient domain llu.edu by moat4.llu.edu. [151.112.124.112].

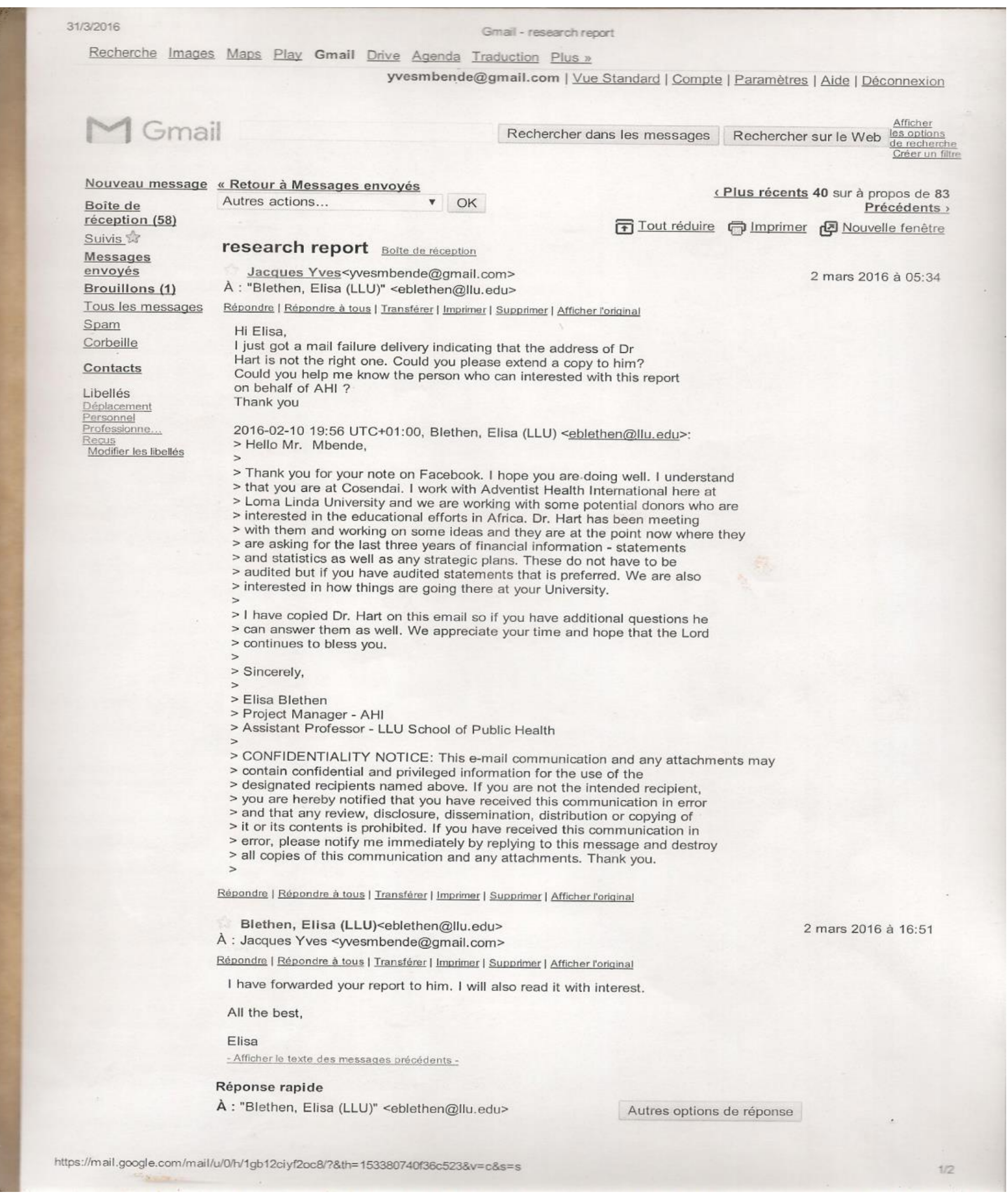
The error that the other server returned was:
550 5.1.1 <Rhhart@llu.edu>... User unknown

----- Original message -----

DKIM-Signature: v=1; a=rsa-sha256; c=relaxed/relaxed;
d=gmail.com; s=20120113;
h=mime-version:date:message-id:subject:from:to:cc;
bh=pFif44sCzXbZwVu42ptArXhXy3ouIUCwOvkyGGsavJM=;
b=Nvf5Wp3Hanb5tuG7m/xCSsEp18SC3Zpj/CXvx8afGjjpMMBQAHtPtYvYBHKKu2nmxh
Ohdetkk22k46F050s1JjL08C9qmN5vDHmnkMbEh1VykUk1u+3CCVUpWJV3uKxVPT+uJt
q6YAK576IJB8k2TGv5ngdFXISsFp8mRLb8Y+m78cmAJkimjEDnDeY92CmhUH3hw5IALn
x4WKcE4yq3WiRRz0UV17KuM0EKxPeQK4Rn84jpkgZG4X52FVIPIDjTmMjyYOGe63IzZh
eYc1U6TglziLNWpTvsLvBeyd8L6LI3LxPVmAV+o3B6zy83+k/qxLjWgY6CmF55nJcjN0
F/nQ==
X-Google-DKIM-Signature: v=1; a=rsa-sha256; c=relaxed/relaxed;
d=1e100.net; s=20130820;

https://mail.google.com/mail/u/0/h/11ccnboblione/?&th=153358d695598da0&v=c&s=s 1/2

Letter 9 Research Report


31/3/2016 Gmail - research report

Recherche Images Maps Play **Gmail** Drive Agenda Traduction Plus »

yvesmbende@gmail.com | Vue Standard | Compte | Paramètres | Aide | Déconnexion

Gmail — Rechercher dans les messages — Rechercher sur le Web — Afficher les options de recherche — Créer un filtre

Nouveau message — **« Retour à Messages envoyés** — Autres actions... OK — **‹ Plus récents 40** sur à propos de 83 **Précédents ›**

Boîte de réception (58) — Suivis — **Messages envoyés** — **Brouillons (1)** — Tous les messages — Spam — Corbeille — **Contacts** — Libellés: Déplacement, Personnel, Professionne..., Reçus, Modifier les libellés

Tout réduire | Imprimer | Nouvelle fenêtre

research report Boîte de réception

Jacques Yves<yvesmbende@gmail.com> — 2 mars 2016 à 05:34
À : "Blethen, Elisa (LLU)" <eblethen@llu.edu>
Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Hi Elisa,
I just got a mail failure delivery indicating that the address of Dr Hart is not the right one. Could you please extend a copy to him?
Could you help me know the person who can interested with this report on behalf of AHI ?
Thank you

2016-02-10 19:56 UTC+01:00, Blethen, Elisa (LLU) <eblethen@llu.edu>:
> Hello Mr. Mbende,
>
> Thank you for your note on Facebook. I hope you are doing well. I understand
> that you are at Cosendai. I work with Adventist Health International here at
> Loma Linda University and we are working with some potential donors who are
> interested in the educational efforts in Africa. Dr. Hart has been meeting
> with them and working on some ideas and they are at the point now where they
> are asking for the last three years of financial information - statements
> and statistics as well as any strategic plans. These do not have to be
> audited but if you have audited statements that is preferred. We are also
> interested in how things are going there at your University.
>
> I have copied Dr. Hart on this email so if you have additional questions he
> can answer them as well. We appreciate your time and hope that the Lord
> continues to bless you.
>
> Sincerely,
>
> Elisa Blethen
> Project Manager - AHI
> Assistant Professor - LLU School of Public Health
>
> CONFIDENTIALITY NOTICE: This e-mail communication and any attachments may
> contain confidential and privileged information for the use of the
> designated recipients named above. If you are not the intended recipient,
> you are hereby notified that you have received this communication in error
> and that any review, disclosure, dissemination, distribution or copying of
> it or its contents is prohibited. If you have received this communication in
> error, please notify me immediately by replying to this message and destroy
> all copies of this communication and any attachments. Thank you.
>

Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

Blethen, Elisa (LLU)<eblethen@llu.edu> — 2 mars 2016 à 16:51
À : Jacques Yves <yvesmbende@gmail.com>
Répondre | Répondre à tous | Transférer | Imprimer | Supprimer | Afficher l'original

I have forwarded your report to him. I will also read it with interest.

All the best,

Elisa

- Afficher le texte des messages précédents -

Réponse rapide
À : "Blethen, Elisa (LLU)" <eblethen@llu.edu> — Autres options de réponse

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APPENDIX Q

ATTENDANCE SHEETS

Sheet 1 On 28-04-2015 From 7 Am-8 Am

Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Brainstorming session

Date: 28-04-2015 Venue: Buea Adventist Hospital, Conference Room Time: 7 A.M- 8 A.M

Concerns for discussions: The mission of SDA Hospitals

The mission statement of this Buea Adventist Hospital

Self evaluation of the workers' ministries: areas of good performance and weak points that need improvement (kind of SWOT)

Attendance sheet

No.	Name of the worker	Position	Signature
1	Participant A	M.D	
2	Participant B	Development Off	
3	Participant C	Head Nurse	
4	Participant D	Nurse	
5	Participant E	Accountant	
6	Participant F	Adm. Staff	
7	Participant G	Nurse	
8	Participant H	Laboratory	
9	Participant I	Nurse	
10	Participant J	Nurse	
11	Participant K	Nurse	
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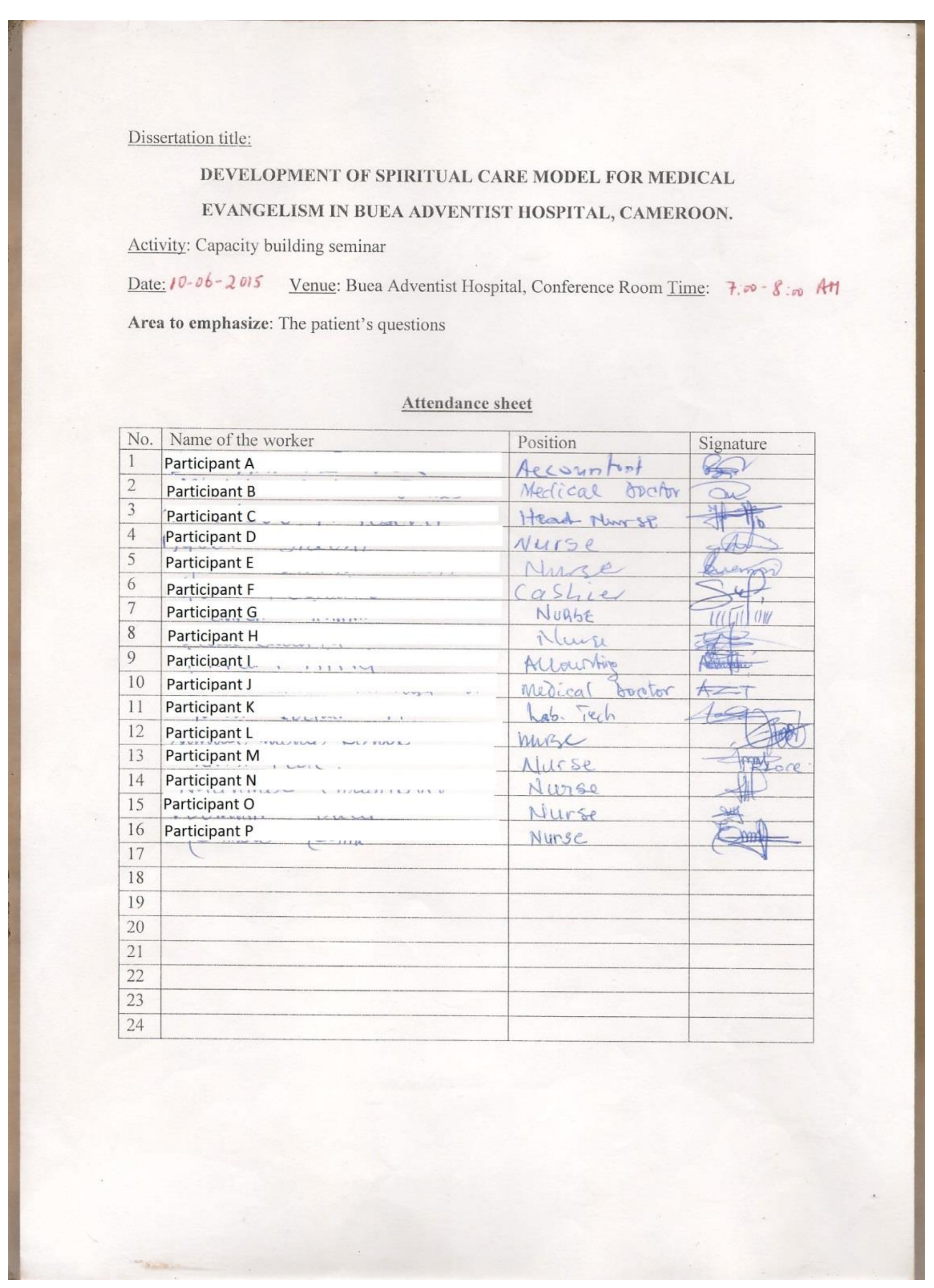
Sheet 2 On 29-04-2015 From 7 Am-8 Am



Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Capacity building seminar

Date: 10-06-2015 Venue: Buea Adventist Hospital, Conference Room Time: 7:00 - 8:00 AM

Area to emphasize: The patient's questions

Attendance sheet

No.	Name of the worker	Position	Signature
1	Participant A	Accountant	[signature]
2	Participant B	Medical Doctor	[signature]
3	Participant C	Head Nurse	[signature]
4	Participant D	Nurse	[signature]
5	Participant E	Nurse	[signature]
6	Participant F	Cashier	[signature]
7	Participant G	Nurse	[signature]
8	Participant H	Nurse	[signature]
9	Participant I	Accounting	[signature]
10	Participant J	Medical Doctor	[signature]
11	Participant K	Lab. Tech	[signature]
12	Participant L	Nurse	[signature]
13	Participant M	Nurse	[signature]
14	Participant N	Nurse	[signature]
15	Participant O	Nurse	[signature]
16	Participant P	Nurse	[signature]
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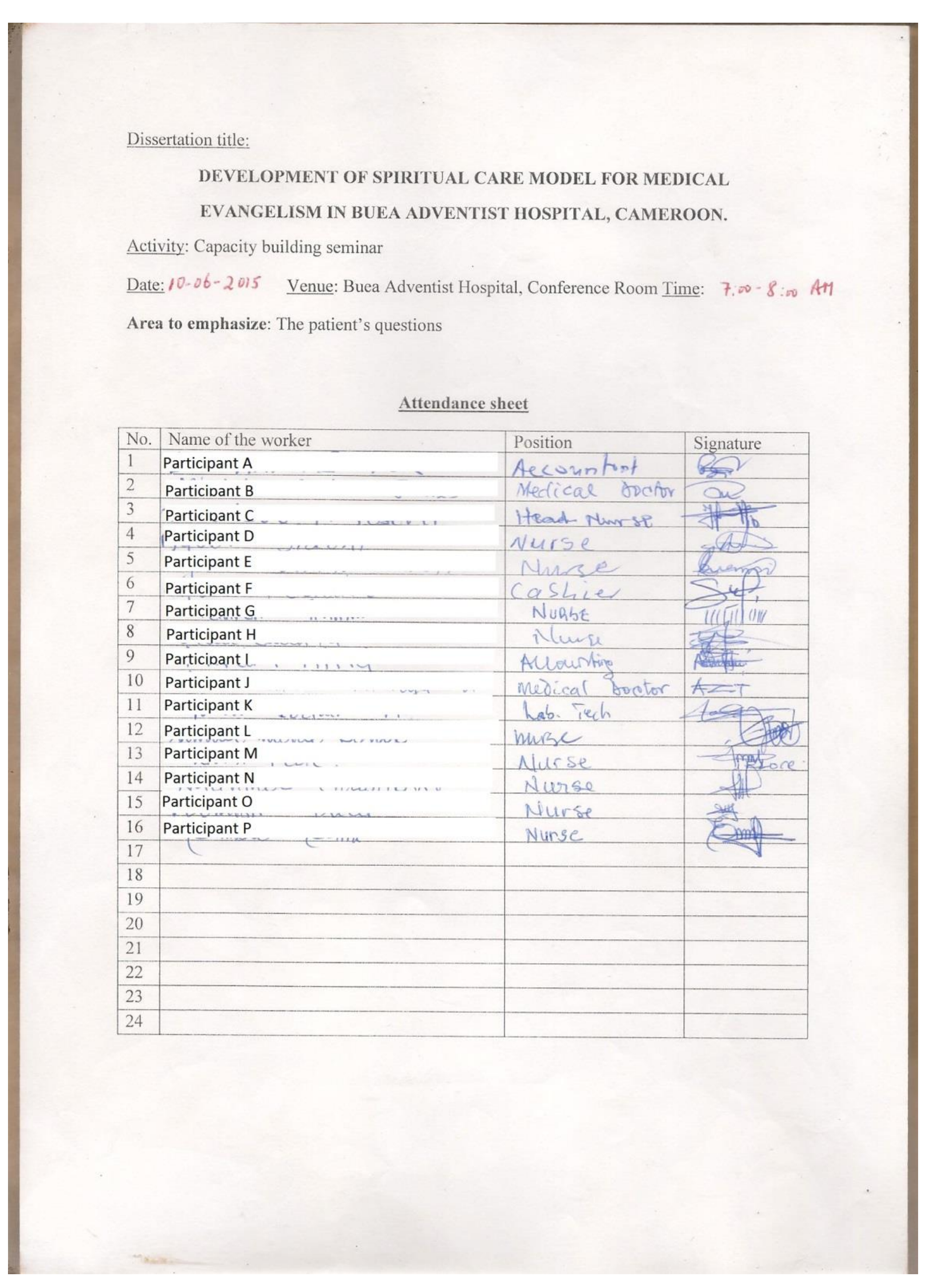
Sheet 3 On 10-06-2015 From 7 Am-8 Am



Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Capacity building seminar

Date: 10-06-2015 Venue: Buea Adventist Hospital, Conference Room Time: 7:00 - 8:00 AM

Area to emphasize: The patient's questions

Attendance sheet

No.	Name of the worker	Position	Signature
1	Participant A	Accountant	
2	Participant B	Medical doctor	
3	Participant C	Head Nurse	
4	Participant D	Nurse	
5	Participant E	Nurse	
6	Participant F	Cashier	
7	Participant G	Nurse	
8	Participant H	Nurse	
9	Participant I	Accounting	
10	Participant J	Medical doctor	
11	Participant K	Lab. Tech	
12	Participant L	Nurse	
13	Participant M	Nurse	
14	Participant N	Nurse	
15	Participant O	Nurse	
16	Participant P	Nurse	
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Sheet 4 On 11-06-2015 From 7 Am-8 Am

Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Capacity building seminar

Date: 11 june 2015 Venue: Buea Adventist Hospital, Conference Room Time: 7:00 - 8:00 Am

Area to emphasize: Interactions with the sick

Attendance sheet

No.	Name of the worker	Position	Signature
1	Participant A	Medical doctor	[signature]
2	Participant B	Nurse	[signature]
3	Participant C	Lab	[signature]
4	Participant D	Head Nurse	[signature]
5	Participant E	Accountant	[signature]
6	Participant F	Nurse	[signature]
7	Participant G	Cashier	[signature]
8	Participant H	Nurse	[signature]
9	Participant I	Nurse	[signature]
10	Participant J	Medical Doctor	[signature]
11	Participant K	Accounting	[signature]
12	Participant L	Nurse	[signature]
13	Participant M	Laboratory	[signature]
14	Participant N	Nurse	[signature]
15	Participant O	Nurse	[signature]
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Sheet 5 On 12-06-2015 From 7 Am-8 Am

Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Capacity building seminar

Date: 12 June 2015 Venue: Buea Adventist Hospital, Conference Room Time: 7:00 -8:00 AM

Areas to cover: Reasons for establishing health centers

The model for experiment and how to go about

Attendance sheet

No.	Name of the worker	Position	Signature
1	Participant A	Nurse	[illegible]
2	Participant B	Nurse	[illegible]
3	Participant C	Nurse	[illegible]
4	Participant D	Head-Nurse	[illegible]
5	Participant E	Nurse	[illegible]
6	Participant F	Laboratory	[illegible]
7	Participant G	Medical Doctor	[illegible]
8	Participant H	Nurse	[illegible]
9	Participant I	Security	[illegible]
10	Participant J	Nurse	[illegible]
11	Participant K	Lab	[illegible]
12	Participant L	Nurse	[illegible]
13	Participant M	Cashier	[illegible]
14	Participant N	Accounting	[illegible]
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Sheet 6 Activities on Medical Evangelism

The Medical Evangelism initiative in the Buea Adventist Hospital

The worker's report for the follow-up activities with ex patients

NB and reminder: The participation to this initiative is not part of the *contract* with the workers; so no one is bound to participate. It is a free will contribution for the purpose of an academic research.

Remark. The final goal of medical evangelism as expected by the researcher in the life of ex patients of the Buea Adventist Hospital is not a necessary baptism into the Adventist church, but an opportunity/encouragement to be/remain in a right relation with God.

List of the post contact activities and the total figures for the 5 months experiment

No.	Possible activities with the ex patients (and family members) targeted by the worker	Cumulative figure
1	Prayers offered on their behalf	
2	Instances of prayer with them	
3	Invitation to health talks organized personally in a small group setting	
4	Invitation to all sorts of health programs organized by the B.A.H.	
5	Instances of sms or emails (if applicable) sent to inquire about their health situation or do a follow up of health lectures	
6	Instances of sms or emails (if applicable) sent to give some encouragement from Bible passages	
7	Instances of telephone calls just for friendship inter action finding out about the whole family	
8	Number of free religious literature distributed to them	
9	Number of home visitations	
10	Number of invitations into the Adventist church when there are special programs for visitors	
11	Number of Bible studies lessons given to them that they should fill	
12	Number of Bible studies lessons conducted with them	
13	Instances to share meals together	
14		
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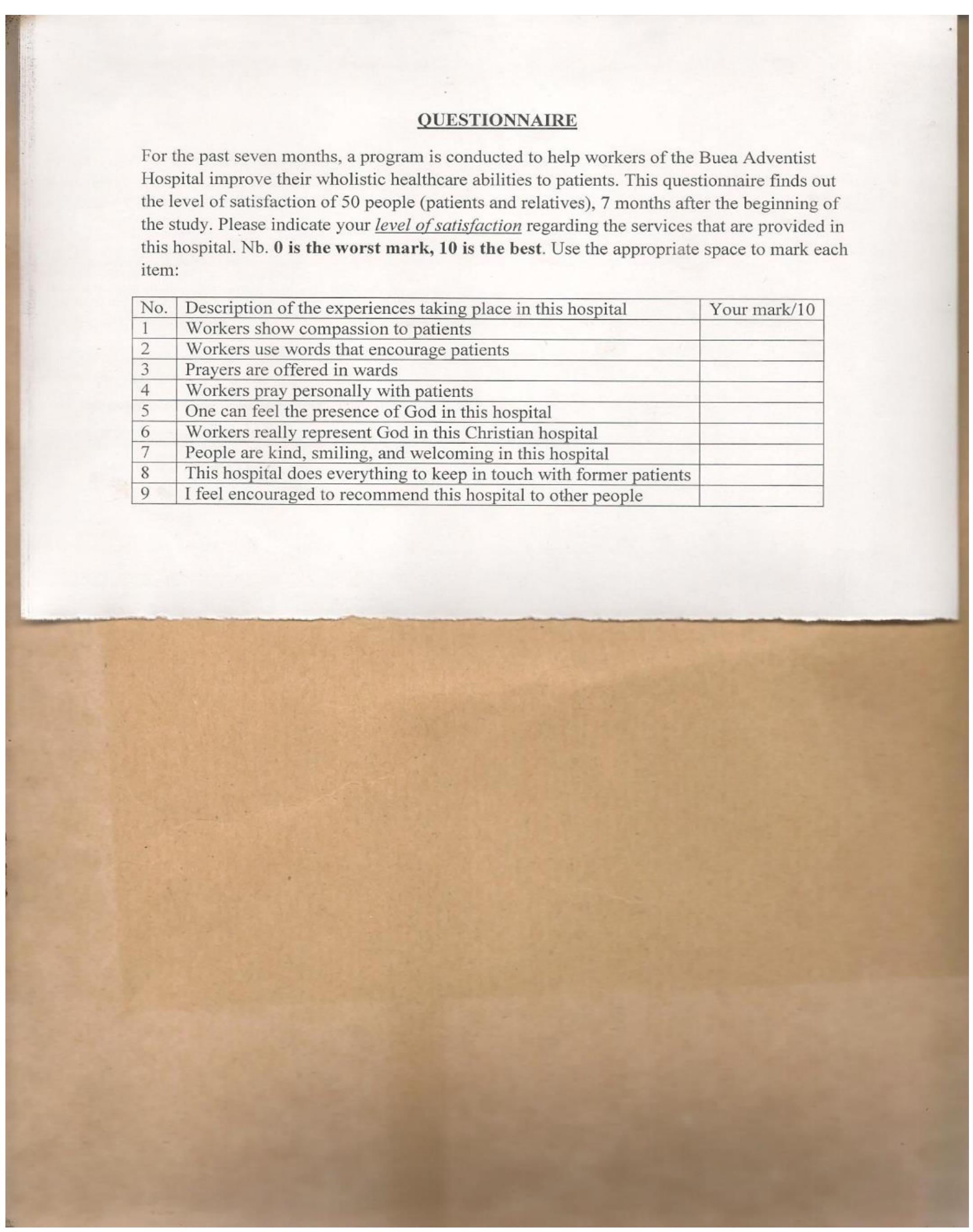
Last segment of the report:

State in a few points, the impact of the model under experiment in your life, the life of your hospital, and the life of the ex patients you are engage in the follow up with (use the space in the back of this sheet).

Worker's Name:

Sheet 7 Questionnaire for Level of Satisfaction



QUESTIONNAIRE

For the past seven months, a program is conducted to help workers of the Buea Adventist Hospital improve their wholistic healthcare abilities to patients. This questionnaire finds out the level of satisfaction of 50 people (patients and relatives), 7 months after the beginning of the study. Please indicate your *level of satisfaction* regarding the services that are provided in this hospital. Nb. **0 is the worst mark, 10 is the best**. Use the appropriate space to mark each item:

No.	Description of the experiences taking place in this hospital	Your mark/10
1	Workers show compassion to patients	
2	Workers use words that encourage patients	
3	Prayers are offered in wards	
4	Workers pray personally with patients	
5	One can feel the presence of God in this hospital	
6	Workers really represent God in this Christian hospital	
7	People are kind, smiling, and welcoming in this hospital	
8	This hospital does everything to keep in touch with former patients	
9	I feel encouraged to recommend this hospital to other people	

Sheet 8 A List of the 100 Ex-Patients

All ex-patients were selected according to admission dates as specified in the inclusion criteria. Exact admission dates are not reported here to protect patient identity. In the same line, their names, as seen here are each coded.

Sheet 8 B List of The 100 Ex-Patients

Sheet 8 C List of The 100 Ex-Patients

Sheet 8 D List of the 100 Ex-Patients

Sheet 9 Questionnaire through Phone Calls

QUESTIONNAIRE THROUGH TELEPHONE CALLS

For the past seven months, a program is conducted to help workers of the Buea Adventist Hospital improve their wholistic healthcare abilities to patients. This questionnaire helps to crosscheck their services to former patients during their stay in the hospital and after they left the hospital. Please, as much as you can remember, indicate by choosing between **Yes** or **No** the experiences that can be applied to you.

A- During your stay at the hospital

No.	Experiences	Yes	No
1	At least one prayer was offered in my ward		
2	At least one health personnel prayed personally with me		
3	I received words of encouragement from the health personnel		
4	The health personnel referred to God as the Healer in taking care of me		
5	The workers tried to know about my faith before taking care of me		
6	The health personnel helped me to feel better spiritually as well as physically, and emotionally		
7	I felt frustrated when a worker decided to pray for me without my consent		
8	I felt very grateful when a worker prayed for me		
9	I was given religious literature		

B- After you left the hospital

No.	Experiences	Yes	No
1	I have received at least one invitation to health talks organized by the hospital		
2	I have received at least one invitation to a health talk organized by a worker		
3	I have received at least one telephone call from one of the workers		
4	I have received sms or emails from a worker showing concerns for my health situation		
5	I have been visited at home by one of the workers who is a friend		
6	I have received at least one invitation for a special program in the SDA church		
7	I have received Bible studies lessons to fill given to me by a worker		
8	I have sat for a Bible discussion with one of the workers		
9	I have had an opportunity to share a meal with one the workers		

APPENDIX R

FOCUS GROUP DISCUSSIONS (FGD)

FGD 1 on 29-09-2015 From 7 Pm-8 Pm

Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Focus Group Discussion

Date: 29/09/2015 Venue: Buea Adventist Hospital, Conference Room Time: 7pm - 8pm

Areas to cover: The model for experiment and how they went about: achievements, challenges, suggestions

Group: 1

Attendance sheet

NAME	POSITION	SIGNATURE	Forms returned
Participant A	Med. Dir.		No misplaced
Participant B	Nurse		No misplaced
Participant C	Accountant		Not found returning later
Participant D	COUNSELLING		Yes

FGD 2 on 30-09-2015 From 8:30 Am- 9:30 Am

Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Focus Group Discussion

Date: 30/09/2015 Venue: Buea Adventist Hospital, Conference Room Time: 8:30- 9:30 Am

Areas to cover: The model for experiment and how they went about: achievements, challenges, suggestions

Group: 2

Attendance sheet

NAME	POSITION	SIGNATURE	Returned
Participant A	Head- Nurse	[signature]	yes
Participant B	Lab. Head	[signature]	yes
Participant C	Nurse	[signature]	(later)
Participant D	Dep. Dir	[signature]	(No)
Participant E	medical doctor	[signature]	No

FGD 3 on 30-09-2015 From 9:30 Am- 10:30 Am

Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Focus Group Discussion

Date: 30/09/2015 Venue: Buea Adventist Hospital, Conference Room Time: 9:30 - 10:30 AM

Areas to cover: The model for experiment and how they went about: achievements, challenges, suggestions

Group: 3

Attendance sheet

NAME	POSITION	SIGNATURE	Returned
Participant A	Nurse	[signature]	yes
Participant B	Lab Tech	[signature]	yes
Participant C	Nétoiteur	[signature]	No

FGD 4 On 30-09-2015 From 10:30 Am- 11:30 Am

Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Focus Group Discussion

Date: 30/09/2015 Venue: Buea Adventist Hospital, Conference Room Time: 10:30 - 11:30 Am

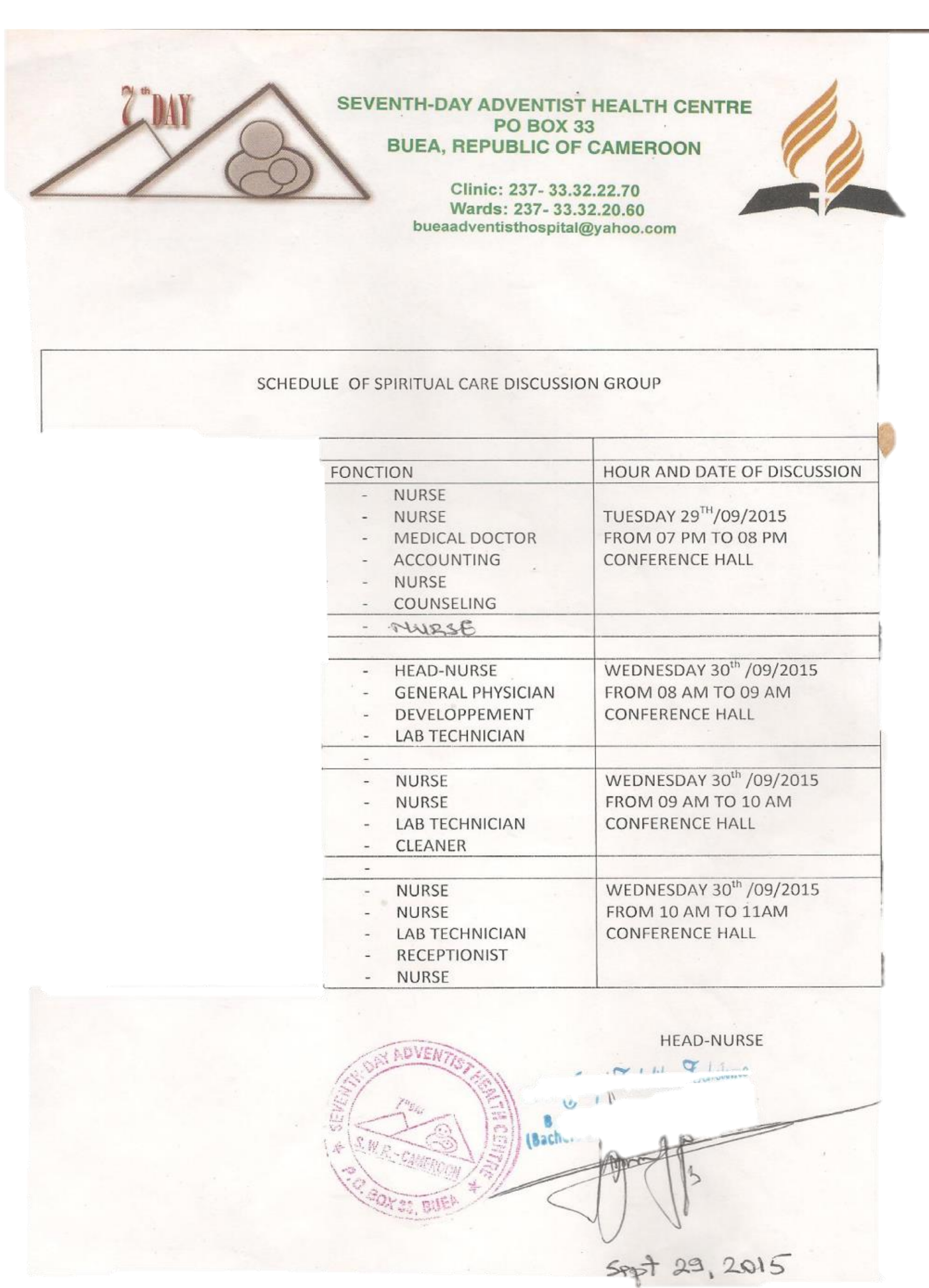
Areas to cover: The model for experiment and how they went about: achievements, challenges, suggestions

Group: 4

Attendance sheet

NAME	POSITION	SIGNATURE
Participant A	Receptionist	[illegible]
Participant B	Lab.	[illegible]
Participant C	Nurse	[illegible]
Participant D	Nurse	[illegible]
Participant E	Accounting	[illegible]

FGD 5 Schedule For fgd



SEVENTH-DAY ADVENTIST HEALTH CENTRE
PO BOX 33
BUEA, REPUBLIC OF CAMEROON

Clinic: 237- 33.32.22.70
Wards: 237- 33.32.20.60
bueaadventisthospital@yahoo.com

SCHEDULE OF SPIRITUAL CARE DISCUSSION GROUP

FONCTION	HOUR AND DATE OF DISCUSSION
- NURSE - NURSE - MEDICAL DOCTOR - ACCOUNTING - NURSE - COUNSELING	TUESDAY 29TH/09/2015 FROM 07 PM TO 08 PM CONFERENCE HALL
- NURSE	
- HEAD-NURSE - GENERAL PHYSICIAN - DEVELOPPEMENT - LAB TECHNICIAN	WEDNESDAY 30th /09/2015 FROM 08 AM TO 09 AM CONFERENCE HALL
-	
- NURSE - NURSE - LAB TECHNICIAN - CLEANER	WEDNESDAY 30th /09/2015 FROM 09 AM TO 10 AM CONFERENCE HALL
-	
- NURSE - NURSE - LAB TECHNICIAN - RECEPTIONIST - NURSE	WEDNESDAY 30th /09/2015 FROM 10 AM TO 11AM CONFERENCE HALL

HEAD-NURSE

SEVENTH-DAY ADVENTIST HEALTH CENTRE S.W.R.-CAMEROON P.O. BOX 33, BUEA

Sept 29, 2015

FGD 6 on 04-12-2015 From 10 Am- 11 Am

Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Focus Group Discussion

Date: 04 Dec 2015 Venue: Buea Adventist Hospital, Conference Room Time: 10:00- 11:00 AM

Areas to cover: The model for experiment and how they went about: achievements, challenges, suggestions

Group: 1

Attendance sheet

NAME	POSITION	SIGNATURE
Participant A	Nurse	[signature]
Participant B	Nurse	[signature]
Participant C	Receptionist	[signature]

FGD 7 on 04-12-2015 From 8 Am- 9 Am

Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Focus Group Discussion

Date: 04 Dec 2015 Venue: Buea Adventist Hospital, Conference Room Time: 8:00-9:00 AM

Areas to cover: The model for experiment and how they went about: achievements, challenges, suggestions

Group: 2

Attendance sheet

NAME	POSITION	SIGNATURE
Participant A	Nurse	
Participant B	HEALTH COUNSELLOR	
Participant C	Nurse	

FGD 8 on 04-12-2015 From 9 Am- 10 Am

Dissertation title:

DEVELOPMENT OF SPIRITUAL CARE MODEL FOR MEDICAL EVANGELISM IN BUEA ADVENTIST HOSPITAL, CAMEROON.

Activity: Focus Group Discussion

Date: 04 Dec 2015 Venue: Buea Adventist Hospital, Conference Room Time: 9:00-10:00 AM

Areas to cover: The model for experiment and how they went about: achievements, challenges, suggestions

Group: 3

Attendance sheet

NAME	POSITION	SIGNATURE
Participant A	Head Nurse	[signature]
Participant B	Lab head	[signature]
Participant C	Accountant	[signature]

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Ordination to the pastoral ministry: 6 September 2008

Degrees:

BAC A4 ESP, 1998: Lycée bilingue de Ngaoundere.
BTh, 2002: Université Adventiste Cosendai de Nanga-Eboko, Cameroun.
M.A. Pastoral Theology, 2009: Adventist University of Africa, Kenya.
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Other trainings

-First Aid. Cameroon Red Cross.
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Professional Experience:

September 2002-July 2009: Church and district pastor in various fields: Buéa, Kumba, Douala, Dschang.
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August 2009- To present: Teacher in the Theology Department of Adventist University Cosendai, Cameroon
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List of Publications

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