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**Health
Development
International**

ebook

visionary
health care leadership
worldwide



Models of Christian Witness in Health Care

An International Study

**by Anne Gewe, Ph.D.,
for Health Development International**

funded by World Vision Taiwan. 1994-1997



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Introduction

This book is intended to be of practical value for the health care practitioner seeking to view professional practice as a wholistic ministry which addresses spiritual, physical, emotional and socio-cultural aspects of health and illness. It is divided into three sections.

Results of Survey Questionnaire

This section summarizes findings from a questionnaire sent to health care practitioners who expressed interest in the integration of spiritual/health care. More than 500 respondents from many parts of the world discussed factors necessary to an integrated ministry, and how to develop expertise in this area. They shared specific ideas on how to "do" integration. The data were also analyzed to look at factors leading to spiritual outcomes and personal satisfaction with integration.

Models of Integration

Since integration was described in this study as multi-faceted, it should be no surprise that ministry projects integrating spiritual/physical health care should be very diverse. The following case studies were selected as models. Each study offers a unique perspective matching the abilities and gifts of the professional with the needs of the surrounding situation, creating a God-honoring ministry.

The Challenge

What can you do? Take these ideas into the "real world" to enhance your ministry.

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Dr. Dean Hirsch, President of World Vision International, believed in the purpose of this study and exerted efforts to look for a source of funding. Dr. Jerry C. L. Chang, Executive Director of World Vision of Taiwan and Vice President at Large of World Vision International, provided the funds for the study.

We deeply appreciate the efforts and openness of all workers in the field who responded to the questionnaires sent out by Ms. Gewe and those who wrote descriptions of their outstanding work on integrating spiritual and physical ministry. We appreciate their willingness to share from their experiences in ministry integration that others may be inspired to adopt or adapt some of their methods for Kingdom building.

Finally, we acknowledge the support and encouragement provided by the HDI Board of Directors during the past four years: Dr. Dale Kietzman, Dr. Edward Neteland, Dr. Rebekah Fleeger, Mr. Lowell Vandervort, Dr. Gordon Buhler, Dr. Don Douglas, Dr. Jean-Paul Heldt, Mr. Frank Kaleb Jansen, Ms. Gladys Jasper, Dr. Richard Johnson, Dr. Gunawan Nugroho, Prof. Konrad Kingshill, Dr. Clydette Powell and Dr. Eric Ram.

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Health Development International

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Survey Results

Introduction

In recent years there has been a call from numerous sources for integrated ministry to both body and spirit. To address this issue, World Vision International/Taiwan, Health Development International and Biola University sponsored a survey. Rather than specify what integration means, two related questions were posed to see if there was a consensus or emergence of themes defining the topic. One asked why individuals considered their particular project to be an integrated spiritual/health care ministry and the other asked "What do you think is essential to an integrated spiritual/health care ministry at an organizational level?"

Further questions centered around the following:

1. What factors lead to spiritual outcomes (such as conversion, discipleship and church growth) in an integrated approach to Christian health care ministry?
2. What factors enable one to integrate personal spiritual and professional health care practice?
3. What factors lead to increased personal satisfaction with integration?

(It is assumed that individuals who are doing a good job of integration will be more satisfied with their performance, than those who are struggling. The assumption held true in a nursing study by Hall and Lanig, 1993, which found a positive correlation with the degree of self-reported integration of Christian beliefs and values in nursing practice, and the degree of comfort in doing spiritual care.)

Sample and Limitations

The sample was developed by asking members of CMDS (Christian Medical & Dental Society), educators from NCF (Nurses Christian Fellowship) and representatives of Christian mission boards in the USA to name individuals whom they thought were involved in integrated approaches to health care. It was felt that the best data would be obtained from people who were using an integrated approach.

However, the sample may also be a limitation of the study because, since participants were recommended, the specific Christian belief or value orientation of each participant is unknown. In addition, more than one individual may be employed by the same institution or mission. So, the study can only speak as to how individuals perceive the work environment and how it has affected them. It cannot talk about organizations per se. One other difficulty is that many organizations do not keep quantitative data on spiritual results, thus statistics related to outcomes represent a much smaller sample size than the total responses of the study.

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Survey Results (part 2)

Demographic Data

A total of 1911 questionnaires was sent to Christian workers involved in some aspect of health care; 1039 were mailed in late 1994 to individuals in the USA and Canada and 872 were sent in January 1995 to a total of 99 other countries. There were 510 usable questionnaires returned.

For convenience in looking at "people groups" the categories of Operation World by Patrick Johnstone were used to group responses.

Africa	145	Middle East	5
Asia	70	North America	212
Caribbean	8	Pacific	5
Eurasia	1	Multiple places	13
Europe	7	10/40 window	1
Latin America	42	Missing data	1

Of the 450 who described the population being served:

*189 (42%) considered the ministry to be rural

*158 (35.1%) were urban ministries

*103 (22.9%) had projects involving both

The majority of respondents, 455 (89.2%) stated they were working in a Christian agency. Only 55 were not. Of the 448 respondents working in Christian agencies who answered the question: "Would you consider this project to be an integrated spiritual/health care ministry?" 422 (94.1%) answered affirmatively.

The length of time which projects had been in existence ranged from less than 1 year to 146 with the median being 10 years. The length of time respondents had been with the projects varied from less than 1 year to 41. The median was 5 years.

The following is a summary of the 390 who listed approx. size of the agencies in which they were working:

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Survey Results (part 3)

The following is a summary of the 390 who listed approx. size of the agencies in which they were working:

<u>Approx. # of clients seen per year</u>	<u># of agencies</u>	<u>Percent</u>
1 - 100	40	10.3
101 - 500	60	15.4
501 - 1000	29	7.5
1001 - 5000	76	19.5
5001 - 9999	25	6.4
10,000 or more	155	39.6
hundreds	1	.3
<u>thousands</u>	<u>4</u>	<u>1.0</u>
	390	100.0

Information about the respondents themselves was solicited. Health care workers from approximately 20 specialties participated, including such diverse areas as pharmacy, psychology, social work, physical therapy, and administration, as well as medicine and nursing.

For ease of handling data, the 507 individuals who gave their titles were categorized as follows:

MD	204 (40.2%)
RN	187 (36.9%)
DDS	18 (3.6%)
*Pastors	19 (3.7%)
Others	<u>79 (15.6%)</u>
Total	507 100.0%

*Pastors included doctors, nurses and dentists who are also pastors.

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Survey Results (part 4)

Missionaries overseas were asked whether or not they had Bible school preparation. Approx. two-thirds (64.7%) answered "yes". This compares favorably with a 1969 study of 158 missionary doctors conducted by MAP which found that less than 50% had formal religious training (Dayton, 1969).

RESULTS AND DISCUSSION

Definition of Integration

Currently, there is no consensus as to what spiritual and professional health care integration is. Holmes (1975) talks of integrating faith and learning in education, and his writing gives a helpful beginning for the discussion of integration. He outlines four approaches which may be adapted to the professional setting.

*First is the attitudinal approach to integration. This involves development of a Christian attitude and motivation. It includes a sense of calling from God for one's vocation and seeing the vocation as worship, stewardship, and a response to God's love.

*The second approach is called the ethical approach. It requires the application of Christian/biblical principles to ethical issues which arise in the course of practice.

*A third approach is entitled foundational. Here, the believer must wrestle with the discipline's foundations of thought and history to be sure current assumptions are Christian.

(For example, western medicine and health care have grown out of philosophic beliefs of Descartes with his mind/body dualism, as well as the dominant 19th century scientific paradigm of a naturalistic/materialistic universe. These foundational beliefs have led to definitions of health as the absence or cure of disease. Unwitting absorption of these and other basic philosophical beliefs which may not necessarily be Christian, seems to have been at the heart of some of the problems of western missionaries trying to minister cross-culturally. Recipients of care may focus only on the western medicine and may miss the spiritual aspects from their cultural viewpoint.)

*Holmes' final approach is called the worldview approach. It is holistic, based upon truly seeing everything in relationship to God, the Creator. It is diverse, involving various perspectives. It is a vision of possibility and an attempt to see all of life from a Christian perspective.

Holmes' integration has been criticized as being a narrow cognitive approach, but it also includes a motivational (attitudinal) perspective. Since actions flow from beliefs, it can be argued that a Christian worldview should result in Christian actions. This creates a wholistic approach to integration involving cognitive, affective and behavioral dimensions.

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Survey Results (part 5)

Integrated Spiritual/Health Ministries

Analysis of why individuals categorized their own projects as integrated, revealed some similarity to the above themes. Answers centered around the following:

1. Spiritual motivation for ministry (attitudinal)
2. A philosophy of health as wholeness (foundational)
3. Actions and interventions which bring Christian values/principles/ethics into the health care setting (ethical)
4. Multidisciplinary approach with collaboration of pastors, churches, evangelists, and various types of agencies with health care workers
5. Support of the organization for a Christian worldview and committed Christian leadership (worldview)

Personal Integration

When asked to give specific ways in which integration takes place, many ideas emerged. Some were concerned about the development of an environment reflecting Christian beliefs and creating opportunities to share about spiritual matters. This involved:

*thinking Christianly about health, and maintaining personal spiritual life and motivation

*excellence in the giving of health care to create credibility with patients/co-workers so that they would be open to the gospel message

*charging reasonable fees as a witness to Christian justice and fairness

*creating an atmosphere of compassion, peace, and acceptance for clients, to show the love of Christ and build up relationships leading to evangelism and ministry. (One health care worker sometimes invites homeless persons for a meal at home, and then invites them to attend church.)

*utilizing Christian music, magazines, and posters with Scripture or other biblical messages in the waiting room to create a Christian atmosphere.

One doctor gives out business cards and calendars with "Assistant to the Great Physician" written on them.

A doctor in a teaching hospital where patient rounds usually involved a large number of health care workers, wrote that she made "solo" rounds in the afternoons, in order to give time alone with patients, providing an atmosphere where they could feel free to focus on concerns and spiritual issues.

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Survey Results (part 6)

The importance of prayer was emphasized in many ways.

1. prayer specifically with patients, focusing on patient-centered concerns
2. prayer asking God for opportunities for evangelism and then, in faith, seeking them
3. prayer before all procedures to ask for God's help and to acknowledge dependence upon Him
4. group prayer meetings and devotions with all staff before work
5. a prayer box, conspicuously placed, made available to clients
6. a centrally located prayer list to which clients could add names
7. use of a "prayer chain" for patient requests, organized often through a local congregation
8. church members who commit to pray specifically for needs of patients and the health care ministry as a whole

One office manager sends out cards to patients with a message like "We're continuing to pray for you." This same manager makes quick calls just to "check up" on patients and remind them that members of the office staff are praying.

Direct spiritual interventions included these ideas:

- *doing a specific spiritual assessment with the physical exam
- *relating Biblical principles to health problems in counseling
- *singing while giving nursing care and reading Scripture passages
- *giving out tracts, books, videos, and Bibles as appropriate
- *using Christian artwork or symbols and attractive bulletin boards located in waiting rooms to begin conversations related to spiritual things
- *giving one's personal testimony (Specific ways included sharing how God helped in some time of crisis, writing an "open letter" to patients, developing a patient newsletter or writing a book.)

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Survey Results (part 7)

Some health care workers discussed ideas for getting the local church involved in health care ministry.

*prayer

*setting aside funds for health care needs for the poor in the local community

*giving shelter or meals to families getting specialized health care who are from out-of-town

*including short articles in the church bulletin on how Scripture relates to health to increase awareness of church members

One nurse tried organizing a "flu shot" clinic in conjunction with a service to anoint the sick for healing. Another suggested combining a prayer meeting with memorial services for those who are grieving. Some mentioned that because they were actively involved with a local church it gave opportunity for patients to see their interest in spiritual things.

Organizational Integration

There are differing opinions as to what is essential for integration at an organizational level. Helen Roseavere (1976), in lamenting the fact that she was so busy with the "health care" aspects of her ministry that she really didn't get to deal with spiritual needs was reminded by a national evangelist that each person had to be a link in the chain that led to salvation. Her specialty in medicine led persons to come to the Christian agency and they were subsequently followed up spiritually by a national "specialist" in spiritual care.

The more recent view of integration is that every health care worker should be able to do Christian health care. This means being proficient in doing health care interventions and in meeting spiritual needs.

Analysis of the question "What do you think is essential to an integrated health care/spiritual ministry at an organizational level?" revealed concern that integration be a major priority in the written mission statement of the agency. Respondents desired that this be combined with a biblical philosophy of health as wholeness in mind, body, and spirit.

Other requirements included creation of an atmosphere of compassion towards clients, as exemplified by Christ, and having a multidisciplinary team spirit with pastors, evangelists and health care workers cooperating with one another. Specific characteristics associated with godly leadership and professionalism were listed.

Factors Affecting Spiritual Outcomes

Statistically, Christian agencies were analyzed for various factors by comparing outcomes in terms of converts, discipling, professional mentoring

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Survey Results (part 8)

and church planting. At an organizational level, there was no statistical difference in outcomes depending upon who in the agency did the majority of spiritual care (health care professional, professional clergy or lay persons).

However, the number of persons being disciplined was significantly higher ($F=3.45$, $df=136$, $p=.01$) when health care professionals, clergy and lay persons shared equally in the spiritual care, than when any one group was mainly responsible. This multidisciplinary approach could represent the importance the organization as a whole placed on the giving of spiritual care with health care.

There were a number of factors which did not affect outcomes. The initial focus of the agency (health care, church, or parachurch organization) made no statistical difference in outcomes. The number of years the agency had been in existence did not correlate significantly with outcomes. Neither health care focus (physical, mental health, teaching, or economic development) nor amount of diversification made any statistical differences. In the USA/Canada, ethnicity was not a factor in outcomes. (Data were analyzed for ethnic diversity in health care givers, recipients of care, and composition of the Board of Directors.)

There were very weak positive correlations ($r=.31$ or less) with outcomes increasing in accordance with increased diversity of organizationally sponsored spiritual interventions, as Bible studies, preaching, and discipling programs, and personal interventions as praying with clients, Biblical counseling or anointing the sick and laying on hands. However, the increased number of interventions, once again, may only be a reflection of the priority given to spiritual care within the organization. Also, one must always keep in mind that number of types of interventions alone is not necessarily a measure of their appropriateness.

Spiritual Interventions and World View

All respondents were asked to designate practices included in the health care delivery of their project/ professional activities which acknowledge the spiritual aspects of disease. Prayer for the client was the intervention most commonly used with 94% stating that they pray with the client present and 92% pray with the client absent.

The following results were obtained on the use of spiritual interventions:

Spiritual Interventions	USA/Canada	Foreign (not short term)	Overall
Counseling related to Biblical life style	72.1%	87.5%	81.1%
Anointing the sick	45.9	20.7	31.1
Laying on of hands	52.7	43.8	48.0
Private confession of sin	55.1	59.0	57.1
Public confession of sin	23.9	21.5	23.0
Exorcism of demons	11.2	25.8	19.5
Spiritual warfare prayer	36.8	48.8	44.8
Celebratory communion	26.0	6.6	15.5

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Survey Results (part 9)

As can be readily seen anointing the sick, laying on of hands, and celebratory communion are used more heavily in the USA/Canada, but exorcism of demons and spiritual warfare prayer have a heavier emphasis in other parts of the world. As one veteran missionary commented, in some areas anointing the sick and the laying on of hands could be construed as magic, rather than Christian spiritual intervention. This reinforces the principle that spiritual care is always given within a cultural context and needs to be culturally appropriate.

A significant finding relates to worldview and seeing spiritual causes of illness. In areas where health care recipients believe in spirits and demons as a cause of illness, both discipling ($t=2.07$, $p<.02$) and new church membership ($t=3.31$, $p<.001$) as a result of the organization's work were significantly greater when the care giver also reported believing in spirits and demons as causing illness. (It must be kept in mind that beliefs were reported by individual health care workers, whereas the outcomes were for the project/agency as a whole.)

This finding, however, is consistent with Pobee (1984, p.248). He writes that the Pentecostal emphasis on the Holy Spirit as a powerful spirit, manifesting Himself in healing and exorcism has been a major force for the growth of African churches. He cites research by K. Appiah-Kubi which asserts that the single most important reason for joining African Pentecostal churches is healing. This may well be true in other areas of the world as well. Failure to adequately integrate spiritual forces into the care giver's worldview for health care may result in failure to adequately deal with spiritual problems for the recipient of that health care.

Obstacles to Integration

Respondents were asked for the greatest difficulty at an organizational level in the integration of spiritual/health care. Answers clustered around:

- *failure of individuals and the organization to view health wholistically
- *lack of educational and material resources (both in terms of the workers' backgrounds for integration and the clients' perception of the agency's role)
- *poor organizational leadership
- *work constraints which make personal integration difficult, including such things as poorly defined roles and expectations.

The difficulties with integration on a personal level were similar.

- *Heavy work loads and time constraints were the most often reported.
- *Seeing health as mainly physical or not seeing the need for personal integration were listed as inhibiting personal beliefs.
- *Conflict with clients' beliefs about the role of the health care worker created an obstacle to integration.

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Survey Results (part 10)

*Lack of knowledge and skills for assessment and appropriate spiritual intervention were acknowledged by some.

*Personal characteristics as fear of "imposing beliefs on others", difficulty with priority setting, and lack of motivation or commitment to doing personal integration were restraints noted.

*A lack of personal supportive networks encouraging integration was also mentioned.

*Organizational factors as viewing health care as business were cited.

*Lack of language fluency was a major issue for health care workers in other countries. Many tasks, especially physical care could be done effectively without mastery of the language, but integration, as evangelism, is not one of them.

Conco (1995) comments that time constraints and lack of formal education in spiritual matters are often given as reasons for failure to integrate spiritual care in nursing, but her study with Christian clients in the U.S. found that typically, spiritual care from the patient's perspective was not time-consuming. Brief comments about God's care, encouraging words or touch, visits of only 5 or 10 minutes, and the caregivers' sharing of personal testimony as to how God helped them cope with some crisis were all viewed by clients as helpful spiritual care.

In this study, "integration" did not differentiate between various aspects of spiritual care as evangelism or spiritual care for Christians. It is quite likely that there were major differences in perspective related to this area of health care for individuals working in the USA/Canada and those ministering in countries where few have heard the gospel.

In spite of all the difficulties, the great majority of respondents (93. 6%) felt that they are able to do personal integration in their professional practice whether or not they work in a Christian agency.

Satisfaction with Personal Integration

Respondents used a likert scale of 1-5 to report satisfaction with personal ability to integrate. A number of factors were studied to see if they increased the feeling of satisfaction with integration. Pastors were significantly more satisfied with their ability to integrate ($F=2.93$, $df=480$ $p=.02$) than other MD's RN's or other health care workers. When parish nurses were compared as a group to all other workers ($t=4.84$, $p<.001$), they also showed a statistically significant greater degree of satisfaction.

(The parish nurse movement is of relatively recent origins and these nurses are responsible for health care needs for specific churches/synagogues. It is expected that they will integrate spiritual/health care, and most work closely with pastors/priests/rabbis.)

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Survey Results (part 11)

As expected, those working in Christian agencies reported a higher level of satisfaction than those in non-Christian agencies ($t=1.61$ $p<.01$). Another factor which positively influenced satisfaction included attendance at a Christian professional school ($t=2.14$, $p<.01$). Individuals working in the USA/Canada reported more satisfaction with integration than those working in other countries ($t=3.98$, $p=.05$).

Anecdotal reports in literature seem to indicate that health care workers who go as missionaries and then spend most of their time giving only physical health care without the spiritual component are not satisfied. For Christian agencies, satisfaction was significantly greater for individuals in agencies which showed a greater emphasis on spiritual care and teaching, than those which had the major emphasis on physical care ($F=3.22$, $df=414$, $p=.01$). However, there were no differences in reported satisfaction, based upon who in the agency was perceived as doing the majority of spiritual care (health care professional, clergy, or lay persons).

There were no significant correlations between personal satisfaction and several other factors. The number of years the agency had been in existence, the number of years the respondent had been involved in the particular project, the number of years of Bible school preparation or the number of units of Bible courses taken made no difference. No statistically significant difference was found in personal satisfaction between individuals in an organization which began as a health care work, or as a church, or as a parachurch organization. Diversity of health care activities made no statistically significant difference in reported satisfaction. Whether or not the health care worker in a Christian agency considered a project to be an integrated ministry, did not affect the level of reported satisfaction.

Developing the Ability to Integrate: the Role of Experience

In order to understand the development of personal integration, respondents were asked to prioritize several factors affecting their ability to personally integrate spiritual/health care: professional school preparation, Bible school preparation, agency orientation, on-the-job services, the mentoring process and experience. Close to 1/4 th of the 482 respondents (23%) listed experience as being the number 1 priority, having the greatest impact on their ability to integrate and only 17% did not include it as a priority at all.

Experiences listed which aided integration were in areas related to health care practice and personal faith development. Some specifically improved clinical/vocational practice and others led to spiritual development/ personal relationship with God and the ability to do personal evangelism.

*Bible study

*growing up in a Christian home

*a feeling of being called to health care

*academic learning

*networking, support and discipleship of others

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Survey Results (part 12)

*A number recounted that growth in the ability to integrate came especially from having to work through difficulties or crises, where medicine/health care was not enough and it was only God's power that enabled the individual to cope.

*A few mentioned miraculous healings which resulted in a change of attitude.

The Role of Mentors

The role of mentors was also explored. It centered around the following: personal example as a model, imparting a vision or philosophy for health care as ministry, personal support and nurturing of the health care worker, and educating in the areas of skills training and staff development.

The mentor acted as teacher in the areas of increasing proficiency in professional practice, and learning to give spiritual care appropriately, as well as learning how to integrate the two. Mentors aided with personal spiritual development. In cross-cultural situations they were particularly helpful in instructing how culture affects integration.

Educational Preparation for Integration

Individuals working in countries other than the US or Canada were asked how their Bible/Christian education did or did not prepare them for medical missions. It was interesting that the major areas in which some individuals felt prepared, were basically the same areas which others felt were missing in their programs. Positives included:

- *education in personal Christian growth and leadership
- *missions exposure and training in cross-cultural principles
- *solid theology and evangelism techniques
- *practical application of Biblical knowledge to living
- *discussion of healing ministry.

Those who felt unprepared complained of a lack of education for leadership, lack of cross-cultural preparation, not enough emphasis on evangelism and discipling, insufficient practical application of Biblical principles and lack of a focus on health care as a ministry. It appears that a comprehensive missions program needs to include all the above elements to truly prepare individuals for their roles as cross-cultural missionaries.

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Survey Results (part 13)

Nationalization of Health Care Projects

An often stated goal of missions is nationalization of the ministry. Results from questionnaires sent to places other than the USA and Canada, supported that trend. The following percentages of national workers were reported for the agencies in the study:

<u>Percentage National Workers</u>	<u>Frequency</u>	<u>Percent</u>
25% or less	11	4.6%
26-50%	23	9.7%
51-75%	35	4.7%
76-100%	<u>169</u>	<u>71.0%</u>
	238	100.0%

<u>Percentage National Leadership</u>	<u>Frequency</u>	<u>Percent</u>
25% or less	45	18.9%
26-50%	25	10.5%
51-75%	37	15.5%
76-100%	<u>131</u>	<u>55.0%</u>
	238	99.9%

<u>Project Director</u>	<u>Frequency</u>	<u>Percent</u>
National	125	53.4%
Expatriate	<u>109</u>	<u>46.6%</u>
	234	100.0%

Over 60% of respondents outside of the USA and Canada, stated that they were satisfied with current levels of national involvement. Those who were not, described the following barriers to nationalization: lack of education with not enough qualified personnel, financial barriers, cultural values not necessarily congruent with "mission values" and political restraints.

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Survey Results (part 14)

Although community-based care is gaining support, many of the respondents in this survey are connected with agencies involved in the more traditional mission hospital model. The following percentages were given for community-based care.

<u>Percentage of Community Based Care</u>	<u>Frequency</u>	<u>Percent</u>
25% or less	99	42.1%
26-50%	34	14.5%
51-75%	24	10.2%
76-100%	<u>78</u>	<u>33.2%</u>
	235	100.0%

Lessons Learned from this Survey

The goal of this study is to help individuals improve in their ministries of integrated spiritual/health care. Therefore, instead of conclusions, some lessons learned and their applications to potential future health care ministry will be outlined.

- 1. Because there are so many ways of doing integration, aspects of personal spiritual/health care integration can be done by any Christian whether or not he/she works in a Christian agency.*
- 2. The category of health care worker (the who) giving "spiritual care" is not as important as the fact that giving spiritual care is seen as a priority.*

When everyone was involved, more discipleship resulted than when any one particular group was responsible. This is congruent with the view of all those respondents who felt that a multidisciplinary team approach is essential to Christian integration within a project.

- 3. Personal spiritual/health care integration is wholistic ministry.*

It involves the *cognitive*, trying to bring Scripture to bear on every area of knowledge within the discipline. It is *affective* in that Christianity gives perspectives. *God's compassion and forgiveness must lead the Christian health care worker to a response of compassion and love for fellow humans.* The power of God gives hope and His love gives motivation for seeing the work as a ministry. Integration is also active as beliefs and attitudes are embodied in specific actions of caring.

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Survey Results (part 15)

4. Any program seeking to educate Christian health care practitioners who are skilled in integration for cross-cultural ministry should provide for personal Christian growth and leadership.

Practical application of biblical knowledge to general living along with missions exposure and cross-cultural principles should be emphasized. Solid theology and evangelism strategies, as well as discussion of health as a ministry are needed to form a firm foundation for future practice.

5. In cross-cultural evangelism, the expatriate should be careful that the ministry is Biblical health care, not western medicine.

The reality of spiritual forces must not be underestimated. Dr Cynthia Hale (1989) writes that missionaries miss out on opportunities for evangelism by not giving credence to supernatural explanations for illness, suffering, and natural disasters. Consider that Jonah's disobedience led to a storm, there were supernatural forces at work in the testing of Job, and Ananias and Saphira died because they tried to lie to the Holy Spirit. Supernatural forces were, indeed, at work in these situations.

The good news is that Christ is greater than any spiritual force of evil. This study supported the need to include the concept of both good and evil spiritual forces in a wholistic health perspective. Spiritual warfare is one of the tools to be utilized in the ministry of integrated spiritual/health care.

6. Since experience was considered so crucial to the ability to integrate spiritual/health care, training programs should include experiential learning or practicums in the curriculum.

Christian agencies should inquire about an applicant's comfort with integration and provide experiences with integration, not just informational on-the-job training. Mentorship may be very helpful in modeling the skills of integration, guiding the experiences of the novice and aiding with post-experience reflection to discover better ways to accomplish the ministry.

7. More creative problem-solving needs to be done in the area of overcoming barriers to the nationalization of health care ministry in countries beyond the USA/Canada.

More study is needed to look at issues of lack of qualified national personnel in terms of education and finances. More attention is needed to propose creative ways to work within political restraints. There must be thoughtful assessment as to how Christianity can change cultural values which are not congruent with it after determining which "missionary Christian" values are "western" and which are truly biblical.

Some work has already been done in these areas. Health care personnel are aiding communities to set up gardens, agricultural projects and sustainable cottage industries. Partnering is being done between more affluent churches in the USA and Canada and those in other countries. There is a new awareness on the part of many for the need for cultural sensitivity. But, more is needed in order to truly further God's kingdom on earth.

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Survey Results (part 16)

Conclusion

It can be concluded from this research, that the Christian health care practitioner has a pivotal role in helping people everywhere to see health wholistically. Making integration of spiritual and physical health a priority, each professional has a major part to play in bringing the message of salvation to the lost, and facilitating healing for those who are suffering.

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Model # 1: Combining Nutrition & Evangelism in Bolivia

This presents non-traditional teaching strategies focusing on experience. Cooking classes designed in a culturally-sensitive manner become the vehicle for developing relationships and Bible study.

How it began

Saturday evening, and finally it was quiet. All day long the loudspeaker had given out the gospel message in Spanish to people waiting on crowded benches to see the missionary nurse, but finally each had been seen and was gone. There were now a myriad of daily tasks to complete; sweeping the floor, counting the money, ordering supplies, and preparing for Sunday's patient care needs.

The stillness was broken by an insistent shaking of the outside gate which gave the missionary compound protection and privacy. Someone was shouting "Doctora, Doctora." "It's off-hours," I thought. "I hope it's something important because otherwise I can't let them in. Eventually they will learn that we have hours for care and only emergencies are treated after hours."

The couple at the gate simply asked for medication for their baby with diarrhea. Leaving them standing at the gate, I quickly fulfilled their request and without my questioning further, they left. I returned to my chores. Two days later the baby was dead. (1)

It was experiences like this which led Sharon Soper, RN to question her traditional missionary nurse role. She began to wonder if she should do more, and whether or not people were being effectively reached for Jesus Christ through her witness.

Reflection made her realize that the clinic was structured according to North American values. Time was important as hours were posted and enforced. The tasks to be accomplished were of first priority after hours, and missionaries were frustrated that the people were accustomed to waiting until someone was seriously ill before coming for care. They didn't seem to understand prevention and planning ahead. Generally speaking, specific roles were assigned to the missionary health care worker and the pastor. The spiritual needs were cared for mostly through the recorded gospel message or the activities of the pastor, as the nurses focused their time on meeting physical needs, feeling there was insufficient time for both.

She felt frustrated and ineffective. People wanted medicines and vitamins, but she knew it was changed behaviors which truly improve health. She didn't have time for "spiritual work" and yet that was her purpose for being in Bolivia.

For her, the way out of this dilemma came through a better understanding of the holistic nature of the gospel. Jesus was concerned with both physical and spiritual health. These are two aspects of one ministry, bringing the Kingdom of God to earth. Christianity should bring changes to the whole person in physical, cognitive, social, spiritual, and emotional dimensions as each area is transformed through the power of the Holy Spirit. Changes within the individual have the potential to change the culture and society. Leaving the clinic, Sharon began a ministry of development. She's convinced that her current ministry is not only more culturally appropriate and congruent with values of the local people, but it also ministers to the whole person.

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Model # 1: Combining Nutrition & Evangelism in Bolivia (part 2)

A new idea

She stumbled (almost literally) onto an idea. After rain, she noticed scattered soybeans sprouting along the roadside. Trucks carrying the beans would get stuck in the mud and anyone helping to dig them out would receive a sackful of beans in return. Many were thrown away because the people didn't know what to do with them. Gradually the idea began to take root that she could help individuals become healthier through promoting good nutrition, emphasizing the use of soybean foods in cooking classes.

There are 3 main offshoots of this project. First, the cooking classes have been a vehicle for the development of relationships with women so that they are open to the presentation of the gospel. Second, others are trained to adapt the methods for teaching their own classes, and third, personal discipling/ mentoring has occurred with Sharon's national co-worker who now can support herself through a small business producing Super-Flour. This is a nutritious mixture of soy, corn, and rice which creates a complete protein with as much or more nutritional value than red meat.

Methods

From the beginning, Sharon had to learn much about the technical processing of Super-Flour. It consists of 1/2 toasted soybeans, 1/4 toasted rice and 1/4 toasted corn. Each ingredient is separately toasted before mixing and grinding. She tried meat and grain grinders before deciding that the traditional Bolivian "batan" which is a football-sized 5 to 10 pound stone with a curved edge was best. Placing the grains on a second flat stone and rocking the "batan" back and forth was an efficient means to produce flour. Thus, she discovered it was the inexpensive and familiar item to the women that was really the best to use.

The next job was to persuade the people to use this flour, and the soybean classes began. The course now takes place one afternoon a week, for seven weeks. "Crash courses" are avoided because they would decrease the personal contact which is so important to building relationships. The classes are an "event", and held in the natural context of a home whenever possible. "Official" starting time is around 2 o'clock, but they actually start when it looks like not many more people are going to come, usually around 2:30 PM. They end at about dusk, rather than any specific time. This makes for flexibility which is compatible with local values related to time.

Informal teaching strategies are emphasized. Group solidarity is strengthened through working and eating together. Each week one or two soybean foods are prepared, involving the use of local seasonings to imitate the flavors and textures of traditional dishes as closely as possible. Recipes are memorized by watching and participating, just as most women would learn in their homes. The only measuring tools are a regular coffee cup and a teaspoon, items which all would have at home. Much informal teaching is accomplished as women feel free to interact during the preparation time.

Further teaching takes place through varied activities. One week a drama is performed by volunteers in the class, "The World Competition between Miss Meat and Miss Soybean". There is a script to compare the nutritional value of meat and

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Model # 1: Combining Nutrition & Evangelism in Bolivia (part 3)

soybeans, but participants can, and often do adapt the script to local events. One time Miss Meat draped a string of link sausages around her neck and Miss Soybean adorned herself with a necklace and earrings made from soybeans. The class loved it.

Music and pictures are used. Sharon wrote a song about soybeans, set to a traditional well-known tune and each week the class learns a new verse. The women may bring instruments. Another activity is coloring posters. Each week in class one of the basic food groups for good nutrition is discussed and every woman receives a drawing to color which can be taken home. Sharon also has developed a file of enlarged, poster sized pictures to show the use of soybeans in Japan, China or the U.S.A. creating the image that they are not just a food for the poor, but they are a progressive and prestigious food as well.

Storytelling is an integral part of this curriculum. Women are encouraged to tell stories of personal experiences with soy foods. If this is new to them, Sharon may give dramatic case studies from her experiences. In one case a child with a very swollen body was brought to the doctor who prescribed a drink made from Super-Flour. The child was so improved after one week that the parents continued with the treatment afterwards. This is also the time when Sharon includes Biblical stories such as Daniel eating legumes or Mary and Martha, stories which reflect the interests of women.

One week features a kitchen apron fashion show complete with photos being taken and prizes. The winner makes an acceptance speech and takes a "victory walk". Sometimes, community leaders are invited to be the fashion show judges as the time when four men from World Vision breakfast projects did the judging. This gave prestige to the event and helped the men understand the project better.

The last week there is a "show and tell" exhibition. The only stipulation is that exhibits must be soybean related. Entries have included poems, songs, skits, paintings, greeting cards, musical instruments, and one lady even brought her 3 year old in a two-piece outfit made with soybeans. A Super-Flour cake is baked and eaten to celebrate graduation day.

The final exam is given orally and it helps the group remember the recipes and major points. It is a group effort and if someone doesn't remember an answer, anyone else may answer, or an easier question is selected. Everyone passes and receives a certificate as a tangible means to show accomplishment.

Results

The classes have been an open door to other ministries. The concept is flexible enough to adapt to many evangelistic strategies. It focuses on development of relationships. At times, as mentioned, Bible studies can actually be planned into the afternoon's activities.

At other times, because of religious and political opposition, Sharon just makes it clear to the women that if they are interested she will gladly talk to them individually about the God who cares about people as both physical and spiritual beings. This has led to many opportunities to share with women personally.

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Model # 1: Combining Nutrition & Evangelism in Bolivia (part 4)

Some women who graduate from the classes feel motivated to go out and teach on their own. One day a former participant who was teaching her own "barrio" class came to Sharon and exclaimed: "You won't believe what happened! My neighbor accepted the Lord right there in class!"

Sharon has also been able to teach the principles to other missionary women seeking to enhance their community outreach. She received a letter from one missionary who has implemented this

methodology in an anti-evangelical area. It stated that three cooks from a nearby religious institution attended the classes and their priest came to the graduation ceremony. That same course stimulated two other Christian nationals to start soybean classes of their own.

Sharon's Bolivian co-worker, worked side by side with her in the development of this project and now has the ability to support herself through Super-Flour production. In January of one year she and Sharon were desperately preparing to deliver 44 tons of Super-Flour by the end of the month. (Part of this has been as a result of a Food for the Hungry decision to change from powdered milk to Super-Flour in their school feeding programs in Bolivia.) But, more importantly, through the hours spent together they shared spiritual growth leading to reconciliation with family members whom her co-worker had not seen for years.

During a furlough Sharon received a letter stating that her co-worker had been invited to preach three Saturdays in a new out-reach area. In conjunction with her Bolivian church she spends Sunday afternoons helping with church planting as well as leading a weekly women's Bible study. This ongoing apprentice-type relationship has resulted in spiritual maturity. A former maid, functionally illiterate woman and member of a religious sect, is now literate, runs her own Super-Flour business, and is actively involved in the ministry of the local Christian church.

Resources

This teaching ministry is relationship-intensive and low-budget in terms of material resources needed. The major necessities are motivation and creativity to use local technologies. Sharon charges for the foods to be cooked in the classes but uses different methods. Sometimes a set price is charged, but in rural settings she has found it is better to let each person volunteer to bring some ingredient. Those who are poorer may volunteer for something less expensive, but the fact that they have volunteered means that they are committed to attending. Payment also enhances perceived value.

Lessons Learned

1. Sharon learned that clinics based upon Western values of time efficiency, schedules and priorities did not meet the needs of the local population.

She needed to focus on personal relationships and the use of time as understood by the people to whom she was trying to minister. So, through the years, she has made many changes in an effort to become more culturally appropriate and to focus on those relationships. For example, instead of dividing up the food to take home, she

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Model # 1: Combining Nutrition & Evangelism in Bolivia (part 5)

always has the class eat together. She sees eating as a way to evangelize and points to the Scriptural example of Christ sharing meals with various people.

2 When serving in an area of poverty, the physical needs of patients coming to a clinic may be so intense that their urgency seems to squeeze out the time needed for the important spiritual care.

Taking the developmental approach and giving women the skills to teach their own classes has enabled them to better meet their own needs without being overly dependent upon her.

3. Protein-calorie deficiency is the most common cause of serious malnutrition in developing countries.

Soy is as nutritious as meat and yet costs a fraction of the price. Creative use of local and familiar items as seasonings, tools (the batan), and mixing the soy with the well-known corn and rice follows a sound principle of education in that people learn more quickly by combining the unfamiliar with what is already known.

4. Using non-traditional methods of teaching which focus upon experience rather than cognitive content has increased the effectiveness of Sharon's classes.

This style allows the content to be enjoyable and easily learned by both educated women and those with almost no formal education alike.

This holistic ministry has certainly led to opportunities for evangelism and discipleship. It has also led to decreasing personal tension and an increasing sense of effectiveness in sharing the God who is concerned with whole people in physical, cognitive, emotional, social and spiritual dimensions.

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Model # 2: Integrated Community Health & Development in Ecuador

by Calvin L. Wilson MD

This 5-year project in Ecuador utilized the development of a national team of Christian health care professionals. They actively sought local resources and demonstrated that it is possible to achieve significant improvements in both spiritual and physical health within a very basic health infrastructure.

How it began

The Onzole River area in the northern province of Esmeraldas, Ecuador has, for many years, contained a very isolated and needy population of both blacks and Chachi Indians.

A community survey completed in the late 1980's revealed the extent of this need. Results showed that no effective medical/dental services were available within a two-day canoe trip. There were no preventative services for children or pregnant women, and malaria, parasites, wounds, skin infections, and back problems were abundant. There was a very high incidence of dental caries in both children and adults, resulting in too many totally decayed teeth. Approx. 50-55% of the adult population was involved in tobacco and/or alcohol use, and there was a substantial incidence of drug abuse.

In terms of public health concerns, only 20% of the population used a latrine regularly and even less, (10%) treated water prior to use or used safe drinking water. The average diet was lacking in iron, zinc, and B vitamins. Only 30% of households had a small vegetable garden for supplementing diet, and the communities had little expertise in dealing with governmental or nongovernmental organizations which could potentially benefit them.

Spiritually, while most professed to be Catholic, very few were practicing their religion and only one or two active believers were identified in the villages. Thus, children received only sporadic religious instruction and sexual promiscuity was rampant. Relational conflict was the norm.

Committed to an integrated bio-psycho-social-spiritual approach to medical care, I took on the challenge to develop a project in Ecuador which would reflect that philosophy. I had been previously privileged to practice family medicine in a group of 4 believers in Lakewood, Colorado. We sponsored one member to take up to 3 months every 4 years for a short term mission. Both myself and my wife had been committed to mission work for years, working in Guatemala, Peru, and Zaire for short stays of 2-3 months. Thus, God had prepared me to understand health care needs in cultural settings outside of the United States.

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Model # 2:

Integrated Community Health & Development in Ecuador (part 2)

People and Organizations Involved

This project emphasized the use of national professionals and administration, in conjunction with two Ecuadorian non-profit organizations, National Evangelical Group of Help and Development (CENAD) and Medical Assistance Programs (MAP). The initial team was multidisciplinary, consisting of a doctor, nurse, dentist, social worker, and boatman. A nurse midwife was on the team for about a year to facilitate Pap testing and family planning counseling. (Unfortunately, after she left, there was a decrease in women asking for these services, perhaps, because the local nurse practitioner who was added by the Ministry of Health was male and many women would prefer to confer with another woman on these matters.)

At the beginning of the third year, the Ministry of Health requested that the project be expanded from four main communities to include eight more. A Ministry rural doctor and the above- mentioned nurse were assigned to the largest additional village, San Francisco. A second team was added to the project made up of a dentist and part time social worker. Periodic help in agriculture and with family planning were also arranged.

As project developer and coordinator, I had visited the Onzole River approx. every 2-3 months of the year prior to the initiation of the project. During short-term medical and evangelistic visits, I made contacts and discussed with village leaders the components of a more extended effort. When funds were offered for development of a full project, the national team was recruited through CENAD, the first sponsoring institution. Our initial team consisted entirely of strong believers, especially the doctor and nurse, who were very active from the start in discipling and evangelistic work as well as the medical work.

The team also looked for ways to collaborate in projects sponsored by other agencies. They helped with a UNICEF project involving construction of latrines. They worked with the Ecuadorian Ministry of Health to facilitate the building of a clinic in San Francisco. They worked towards the designation of the clinic in Santo Domingo as a Ministry of Health Clinic so that the village would be entitled to a Ministry (governmental-supported) rural doctor and nurse.

Through collaborative arrangements, all the health promoters have been included in the Ministry of Health program of continuing health education and are receiving a small stipend from the government. The project partially funded living expenses for a nurse practitioner for the fiscal year of 1994. This was continued until the lengthy process of contracting with the Ministry of Health was completed. He is now funded completely by the government. All of these strategies have made the projects self-sustainable, without reliance on outside sources of funding.

Methods

A major goal of this comprehensive project was to give time-limited help (5 years) which would foster community self-sufficiency and limit dependence on outside resources. The target area consisted of a portion of the Onzole River containing four main communities. Completing a community survey by means of house to house visits and broad-based interviews in the four primary villages was the method chosen to introduce members of the team to the area. (A copy of the community development assessment tool and a sample village profile can be found at the end of this article.)

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Model # 2:

Integrated Community Health & Development in Ecuador (part 3)

A family chart was drawn up for every household, leading to the creation of an area diagnostic profile. The data became the basis for planning specific activities to operationalize the goals summarized below:

- Improve the general standard of health with an emphasis on prevention and early detection of the most serious and common medical/dental problems.
- Train local community workers (supported by community and government funding) in detection and management of the most common medical/dental problems.
- Help develop economic self-sufficiency, and a more healthy style of living.
- Present the gospel of Jesus Christ in a natural manner, with the goal of seeing believers built up and formed into a strong and self-sustaining Christian community.

Once the village of Santo Domingo was chosen as the base of operations, the community expressed its support by joining in with team members to build a clinic with living quarters for the team. The project team worked on the river for 15 days each month, following a preestablished schedule of activities and programmed visits to the other communities so that all were visited monthly.

In the area of physical health maintenance, general medical care was provided with a total of approx. 25% of visits being logged for preventive activities as well-child and pre-natal care.

- There were bimonthly immunizations of children and pregnant women, with regular review of immunization schedules.
- An intensive malarial control program was instituted including eradication of mosquito breeding sites, biweekly universal prophylaxis with chloroquine/ primaquine for a period of 12 months followed by selective family prophylaxis and early treatment of those with symptoms.
- The team worked in collaboration with area wide governmental programs for the control of onchocercosis, malaria, tuberculosis and cholera, and initiated an intensive campaign to promote chlorination of water.
- Dental care included filling of caries and restoration of damaged teeth as well as fluoride treatments yearly to all children of school age.

Research gave data for evaluation. There was one study of nutritional status. Treatment for parasitic infections was analyzed by comparing the efficacy of two local herbal remedies to standard anti-parasitic medication. There was an investigation into types of malaria manifested in river areas, and clinical resistance to standard treatment. IUD use, acceptance and complications in women was a subject of inquiry. A demographic study of prevalence of dental disease on the upper river was published. Data were utilized to improve the health care delivered in the project.

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Model # 2: Integrated Community Health & Development in Ecuador (part 4)

Community development called for the formation of an active Health Committee in each village and participation in local inter-institutional committees to coordinate health activities for the area. Two village pharmacies, managed by locally trained villagers were established. Two villages began libraries, managed by local librarians. Both family and multi-family latrines were constructed (some of this done in conjunction with UNICEF). There was formation of a bank of tools for village projects and local handicrafts.

An agronomist helped introduce new vegetables and seeds with improved agricultural techniques and a small tree farm was established for reforestation. Household vegetable gardens were promoted. Assistance was provided in draining a swamp and building a permanent drainage ditch.

Teaching/training was a major priority to enhance knowledge and skills and increase self-sufficiency:

- Seminars and training in community organization, accounting, and leadership skills for community leaders helped to increase independence.
- There was regular teaching in the schools related to brushing teeth and each child was given a toothbrush.
- Bimonthly meetings with local village midwives focused on an exchange of ideas and teaching about prenatal and postpartum care.
- Mothers were trained in each village in improved hygiene skills, protection of food from contamination and spoiling, recognition and home management of common childhood illnesses and prenatal care.
- Village health workers were trained in prevention and management of common illnesses, health education, appropriate use of medications and natural remedies, and emergency treatment of dental problems.

Spiritual care included regular Bible studies for interested young people and adults, and weekly Bible classes for school-age children. Spiritual mentoring of the team was a top priority for me, both during team meetings and while on site in the villages. Team members thus were enabled to counsel patients regarding personal problems from a Bible-centered perspective.

There were special village-wide seminars on topics of interest such as family life, marriage, and child-rearing according to biblical principles, and by the final year of the project, quarterly spiritual retreats were held. I taught many of the seminars, but also had help from one of the downriver pastors, the first doctor who joined us for short visits from time to time, and other visitors.

Programmed correspondence courses were made available and there was an emphasis on youth. Two young men were sponsored in their desire to attend Bible School in Argentina. Approx. 6 young people per year received scholarships to attend Bible conferences or camps. Sports clubs were a means of reaching out to young people. The dentist in Santo Domingo took a major role with the team doctor in working with village soccer teams in coaching and leading in devotions, and planned activities during training and after major tournaments.

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Model # 2:

Integrated Community Health & Development in Ecuador (part 5)

Results

Medically speaking, within the five year period, the results showed significant improvement. The overall incidence of malaria was reduced by 75% on the upper river. In the last year, there were no cases of cholera found, in spite of the fact that it was still high in areas surrounding other jungle rivers. The incidence of symptomatic parasitic infections decreased by 50%. There was significant improvement in acceptance of preventive health care, especially in the areas of well-child and prenatal care and family planning.

Total preventive care visits increased by 54% between the first and fifth year of the project. Approx. 80% of all children on the upper river completed or were current with the recommended vaccination schedule when the project concluded. There has been increased awareness of the need for regular brushing of teeth and dental prophylaxis and a significant drop in the number of tooth extractions from the first to the fifth year of the project.

Health auxiliaries (similar to physician assistants) and promotors (trained in village sanitation, hygiene and first aid) have been well-taught on how to manage emergency toothaches and routine cleaning. There are now government paid health auxiliaries and health promotors in every major village along the river and two functioning pharmacies, supplied by governmental sources. An agreement has been negotiated with the Ministry of Health to continue to provide medical and dental care to the river population, resulting in the assurance that care will continue into the future. Regular health education classes with young mothers and schoolchildren were taken over by health promotors and the nurse practitioner. The team had trained them well.

By the fifth year it was found that household gardens had increased, especially in Santo Domingo where they increased from 30% to 70%. Some new crops introduced by the team were being produced as pumpkin, sunflowers, and yucca. Economically, there was increased awareness of outside markets and strategy for marketing handicrafts. The team primarily helped by transporting crafts to a consignment store in Quito, distributing the proceeds of sales and returning unsold goods to the owners. There was a well functioning library in San Francisco. The Ministry of Health allotted increased budget, as it became more aware of the complex needs of the area.

In relation to the spiritual needs of the communities, the project saw the development of two active evangelical churches in the lower river areas of San Francisco and Anchayacu, both led by capable local pastors. These pastors also helped periodically with the upriver work. As a result of the evangelistic and discipling outreach, there are now two new groups meeting regularly in Colon and Santo Domingo. Each group has at least one man who is well grounded in biblical truths, and following programmed seminary studies by correspondence.

Shortly after the project ended, each of the villages constructed a church and they are continuing to meet and develop on their own with local leadership. The Santo Domingo and Anchayacu groups are also in the process of constructing church buildings. Three area-wide retreats were held in the last year of the project with the final one being organized and led totally by local believers. They did everything from arranging for speakers to providing for meals. About 90 believers shared in this time of Bible teaching, testimonies, and enthusiastic singing.

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Model # 2:

Integrated Community Health & Development in Ecuador (part 6)

Interdependence among believers on the river is increasing as the pastors of San Francisco and Anchayacu both make occasional trips to visit upriver congregations. Two men were trained in Bible School with the plan of returning to the river as Bible teachers and church leaders.

The Challenge of Termination

Terminating any aid project can be traumatic, and all too often in the past, the termination has resulted in the demise of the program. However, this project had stressed self-sufficiency from the beginning so that communities were able to proceed on their own with the resources and knowledge gained over the previous years.

Perhaps the most difficult part was the termination of close relationships which had been forged over many difficult situations. An entire week was devoted to farewell dinners, meetings, and ceremonies in the various associated communities. One village discussed giving a live pig to the team, but finally settled for an engraved plaque of thanks.

Assets also had to be carefully distributed and arrangements were reached in collaboration with community representatives and the Ministry of Health. Most medical and dental equipment was donated to the Ministry with the stipulation that it not be used outside of the area. The canoe and functioning outboard motor were given to the community of Santo Domingo, under the supervision of the nurse practitioner, primarily to be used for medically-related purposes.

Local law was carefully followed in relationship to termination of the team members. By always keeping in mind the time-limitations and after careful planning, all elements of the project were released to the nationals.

Lessons Learned

1. The collaboration with governmental and other agencies has made it possible for this comprehensive project to be self-sustainable, rather than dependent on outside funding.

2. Using an entire working team composed of Ecuadorian professionals, allowed them to serve as models to their own peers of an integrated, team-oriented and spiritually focused approach to meeting complex community needs in an isolated setting.

As Ecuadorians, they could identify with the local people, and most of them desired to continue working in the same area after the project was to be terminated.

3. The total cost of the five year project was \$212,883 and it ended with a small surplus in the budget.

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Model # 2:

Integrated Community Health & Development in Ecuador (part 7)

It involved over 58,000 man-hours of work. Although the cost may be seen as high, it showed that a time-limited, project can be started in an isolated area lacking any basic services and difficult to access, and it can be terminated with a good sense that the work will be carried on by the communities of those who will ultimately benefit.

For more information:

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Sample Village Diagnostic Profile (used to establish health care goals)

Village: Colon
Total population: 588

men	women	1-4	5-14	15-45	>45
305	283	135	185	211	57
52.0%	48.0%	23%	31%	36%	9.7%

- Use mosquito net: 79%
- Knowledge of malaria: 14%
- Symptoms of malaria: 17%
- Use alcohol: 66%
- Use drugs: 54%
- Animals in house: 71%
- Use latrine: 65%
- Garden: 57%
- Boil water: 2%
- Chlorinate water: 0%
- Use rain water: 7%
- No water treatment: 84%
- Family problems: 30%

Illiterate	1-2 grade	3-6 grade	high school	Schooling unknown
20%	15%	19%	4%	41%

- Malnourished children: 7%
- Dental caries: 14%
- Gum inflammation: 34%

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Model # 3: Community Analysis & Church Planting in Zimbabwe

by Gisela Roth, MD, MABC

A traditional model of integration resulted in the planting of 5 churches and a preaching point within 6 years. Although the health care workers were instrumental in helping communities to recognize their spiritual needs, it was the cooperation of many different groups (chaplains, AIDS counselors, pastors, church youth, and health care personnel) which the Holy Spirit used to produce the results.

This is not really a model of integrated care as the term is currently being used, but the story of how God, in His grace, used some missionaries in the health care field in an amazing way to build churches in northeastern Zimbabwe. There was a close cooperation between "medical" and "spiritual" care people, both having a common concern for the wholistic care of the patient and all being convinced that it does not help a person, if he/she gains the whole world, yet loses his/her soul. To gain good health, be fully immunized etc. is important, but spiritual health is even more important. *The integration really occurred, not at an individual/project level, but in the working together of many different groups at the Karanda Mission Hospital: chaplains, AIDS-counselors, the Karanda Fellowship pastor and youth, home-based care staff, community nurses, and doctors.* The majority were nationals and a few expatriate missionaries gave support and encouragement as needed.

How it began

It all started in 1990 with Lorraine Waite, a community nurse and member of the Karanda Mission Hospital staff, a ministry of TEAM (The Evangelical Alliance Mission). As part of her regular outreaches she did village analyses. In an analysis, village members get together to discuss their problems. Anything that worries them can be brought up, so cattle diseases, access to water and lack of food came up frequently. After hearing the problems, Lorraine Waite and her community team would try to link up the village with available resources, either governmental or non-governmental organizations (NGO).

One village decided beer drinking was their worst problem and being drunk was preventing the community members from attempting change. It also was keeping them from attending to their children's nutritional needs and other critical issues. From the insight gained through discussion and the linking with appropriate resources, village members were enabled to change and after a time the village prospered.

Another village, Date, named lack of knowledge of spiritual truth as their main problem. They wanted someone to come and teach them the Bible. In response to the request, Lorraine Waite mobilized the youth of her local church at the hospital, Karanda Fellowship. They went with her every Saturday to hold women's and youth's meetings, evangelizing in the area. One young man, Thomas Zongoro, was discipled by Sr. Waite. As he learned the Scriptures, he began to preach in Date.

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Model # 3: Community Analysis & Church Planting in Zimbabwe (part 2)

Changes took place as villagers became believers and then had a vision to share the gospel with their neighbors also. Mr. Kariwo, a believer from Date, joined Mr. Zongoro and they moved further afield across the river to Gwashure. Studying TEE lessons in Karanda, Mr. Zongoro was able to teach them in the villages of Date and Gwashure. Then a family from another village, Chitsato wrote a letter to Karanda asking for help. Once again, Thomas Zongoro responded to the needs of this third village with

some of the Karanda youth, supported and transported by missionaries. Gradually churches were planted and began to grow in all three areas.

In 1992, the father of a sick child attended morning devotions for outpatients at the Karanda Mission Hospital. He came forward to repent, as he had been challenged by the words of the hospital chaplain, Pastor Chisara. The chaplain introduced him to Thomas Zongoro and another outreach came into being. Together they started to evangelize in the father's home area, Muzemba. Another church was planted.

A fifth church was added to the group through a church split in another area, and the Karanda Fellowship became like a mother church for all these new growing congregations, holding baptisms, supporting area meetings financially and with teachers, and encouraging the believers through planning revival meetings, Easter meetings, women's and youth meetings. For most of this time the fellowship was led by hospital nurses due to the lack of a pastor.

Finally, in 1993 a seventh church was added after Mr. Kariwo, who had since become a church leader at Date visited his relatives in Sosera and witnessed to them. Some became Christians and he began discipling them with assistance from the Karanda Fellowship.

Problems Encountered

In 1991, Sister Waite retired and Thomas Zongoro and his wife went to Bible College to train for 3 years. Although they spent all of their holidays encouraging the young churches, attendance dwindled. The churches were too far away from Karanda to be reached easily by bike and bus connections were difficult. Nevertheless, Christian employees of the hospital rose to the challenge and preached in area churches to support the believers and keep the churches alive.

A new hospital chaplain, Pastor Valente, and the new pastor of Karanda Fellowship, K. Kayawah, felt that God was leading them to do an evangelistic outreach with the "Jesus Film". They showed it in five of the churches for two nights each, drawing large crowds. Many indicated making decisions for Christ, but follow-up was slow and there was a decline in interest by the time a joint team of the Karanda Fellowship pastor, youth and local believers got organized to respond to the need.

Another major concern has been "baby dumping" of new converts. They learn of the gospel while being hospitalized and then lack follow-up once they leave. The home-based care team has been able to provide some help in this area as team members work to establish new converts in local churches.

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Model # 3: Community Analysis & Church Planting in Zimbabwe (part 3)

Current Methods of Spiritual and Health Care

The Zongoros completed their Bible training and came back to the Karanda area, bringing a renewed enthusiasm for spiritual things. At first they tried staying with each church for several weeks at a time. However, it was difficult for the church members to house and feed the whole family which included two children by now. It was also very hard on their family life to keep moving around. So, a new plan for church development was devised.

Leadership training was felt to be the greatest need for each of the area churches since none had a pastor, and in mid-1996, the Karanda Bible School was born. Negotiations with the Karanda hospital's administration began in order to provide for accommodations and food for the potential leaders. The curriculum was formulated around a modular form, similar to that used by many health promotor programs. A module of study was designed to take 2 to 4 weeks. Then the trainees would practice what they learned in their local churches.

Under the direction of Thomas Zongoro, the first training course of 9 months is now finished. To feed themselves, earn bus fare and money for books, the students worked 2 1/2 hours each day at the hospital doing various jobs like cleaning, collecting trash, pruning trees, etc., that often were set aside due to labour shortage. The students were encouraged to witness to patients and relatives in the Karanda area, as well as in their home areas.

Another hospital ministry is the home-based care team headed by Pastor Chisara and coordinated by Dr. Gisela Roth. A chaplain and a nurse make visits together, seeing chronically ill patients in their homes monthly. Often they are accompanied by a national driver who is also a Christian and who will witness and pray with the family as a part of the team. All the needs of the patients and their families are acknowledged. Most of the patients have AIDS, although some have other conditions like cancer.

Many AIDS orphans are also visited and supported. It came to the attention of the home-based care team that one of their patients had died. When the team visited the home, none of the four children were there. Although three were between the ages of 8 and 14, they had all been sent to work full time on local farms. None of them were in school anymore.

Through intervention of the home-based care team, an uncle finally agreed to take the children into his home and send them to school, if they could be financially supported. He already had two children of his own and two children from another sick relative to look after. Adding four more would make a family of ten.

The headmaster of the local school was approached about waiving the school fees to allow the orphans to come back to school. He supported the plan and pushed it through the school board, and now hopes to start a self-help project at the school to help other orphans as well. The family has since started raising chickens as a means to earn money and become independent of mission help. The uncle and children have begun to attend the church in Gwashure.

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Model # 3: Community Analysis & Church Planting in Zimbabwe (part 4)

Finances for the orphan program have purposely been raised within Zimbabwe. The hope is that there would be more longevity to the support, it would be more personal, and it would increase the awareness of local Christians to their responsibility to be involved with the AIDS disaster in Zimbabwe. Several churches in more affluent areas of Zimbabwe are now giving monthly financial support to AIDS orphans, collecting clothes and supplying other help as needed.

As AIDS ministries coordinator, Dr. Roth is also involved in the training of AIDS counselors and teaching in churches and schools about AIDS, including spiritual aspects. A difficult part of this ministry is potential "burnout" due to the number of HIV counseling sessions needed and the deaths encountered. (The adult population has a staggering HIV infection rate of about 25% and approx. 10% of all babies born are HIV positive.) So, the need is great. The doctor and chaplains meet together to problem-solve and pray for these difficult situations.

The good name of the hospital opens doors in evangelism and all the area churches help in linking up patients who have become Christians in the hospital to local Christian groups. The home-based care team tries to establish new converts in any solid church in their home area. Many members of the area churches also get help with medical needs at the hospital, and appreciate the caring atmosphere. The Mafait family was instrumental in the original request for Bible teaching in the village of Date. After many miscarriages, Mrs. Mafait recently stayed for several months at the hospital while pregnant, and everyone shared in the couple's joy when she went home with a healthy young one.

Results

The daily devotions and active visitation of hospital chaplains are resulting in new believers among both patients and their families. New converts from the various hospital outreaches are being integrated into churches in their areas.

Not only have churches been planted, but recently a patient from Kanyoka heard the gospel while in the hospital. He became a Christian and upon discharge began attending the Chitsato church, which was the nearest to him. However, a Karanda Bible School student from the Chitsato church mobilized others to go with him to witness in the Kanyoka area, and a new group has begun meeting in the former patient's home area.

The Karanda Bible School and the hospital are finding ways to work together to provide jobs, medical care, evangelism, and leadership training to build up local churches.

Lessons Learned

1. *The village analyses helped to determine where the people were aware of their spiritual needs and open to the gospel.*

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Model # 3: Community Analysis & Church Planting in Zimbabwe (part 5)

2. Persistence is essential in the face of obstacles.

There were times when there was dwindling attendance as church leaders were unable to consistently visit the churches or follow-up evangelism was too late (weeks after decisions were made), but God has rewarded faithfulness.

3. Never underestimate the value of discipleship.

One missionary saw the potential in a youth, Thomas Zongoro. Through discipleship, and study in a TEE program, he developed into an effective evangelist. Later he graduated from Bible College and now he heads a Bible school with great enthusiasm for God. He and his family are acting as a model for godly family living. Other youth have caught the enthusiasm. Two more are in Bible school and one is planning to begin soon.

For more information:

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Model # 4: Schools as an Entry Point for Health & Evangelism in Tanzania

The work of Community Health Evangelists in Tanzania is featured in this model. Here, free health screening is done for school children. Through follow-up meetings with parents, local community health committees are formed and community health evangelists are trained to become active in solving local problems.

How it began

Dr. Eben Mwash's life is a testimony to the fact that no experiences are wasted in God's economy, as He prepares individuals for service. Dr. Mwash received his schooling and medical degree in his own country, Tanzania, and then became a district medical officer which gave him a broad variety of experiences in health care. He was promoted to regional officer which increased his knowledge of

the health care problems faced by the entire region. An MPH from Loma Linda Medical School in the USA gave him theoretical concepts for practice in the field of public health and deepened his vision for healthy communities, as well as giving him helpful contacts within the field of public health. Upon his return to his native country, he became the personal physician to the first president of the United Republic of Tanzania.

Being known in governmental circles led to opportunities such as becoming an official delegate to the 32nd and 33rd World Health Assemblies in Geneva, Switzerland where the topic was primary health care. Networking led to advisory jobs with WHO (World Health Organization) and AMREF (African Medical and Research Foundation) where he interacted with others having a like vision for health of African peoples, and taught a course on Primary Health for Developing Countries. In 1991 he began working with AMREF on the HESAWA School Health and Sanitation programme with the goal of getting local communities to participate actively in clean water and sanitation activities.

As he was gradually developing his own philosophy of health as a state of being in harmony with God, self, others and the environment, God brought him in contact with Stan Rowland of Medical Ambassadors International (MAI), and they found they had much in common. Both desired to use physical health as the entry point for transforming individuals spiritually and physically, and for changing their communities.

The purpose of MAI is to support nationals at the point of need in local communities, so the partnership led to development of the inter-denominational Christian service oriented Primary Health Care Ambassadors Foundation in Tanzania. It works with local churches to establish Community Health Evangelism (CHE) programs.

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Model # 4:

Schools as an Entry Point for Health & Evangelism in Tanzania (part 2)

The People Involved

***Church leaders:** have a vision and sponsor CHE programs.

***Trainers:** learn through Training of the Trainers (TOT) Seminars. There are 3 classes spread over one year. Each lasts one week and emphasizes a different stage of the development of the CHE program. TOT1 and 2 are very practical in nature and TOT3 emphasizes planning and evaluation of projects. The trainers in turn teach CHE's at the community level. These trainers are the models for integrating a spiritual ministry into a community health program. They model home visits and each teaches in areas of physical and spiritual care. For example, when teaching about a foreign body, the truth may be taught that the foreign body must be removed or the human body will fester and become infected. In the same way, unconfessed sin festers and infects the life with ungodly attitudes and actions. It must be confessed.

***Community Health Committee:** has 7-11 members and does the administrative oversight for each individual project. It writes its own constitution, decides how it should be governed and selects the CHE's for the community.

***CHE:** Community Health Evangelists are those who actually do the work, integrating spiritual and physical health care. They become involved in various community projects.

Methods

Community Health Evangelism projects emphasize transformation of individual lives. One person changes and affects others who in turn reach out to the community in ever-widening circles until the whole community is changed from the inside out. Viewing health as restoration of relationships between individuals and God, self, others, and the environment, the proper perspective on health is maintained. Without Christ, only the symptoms of underlying spiritual problems are assuaged and the basic sickness remains.

Christian development is helping people become all that God intends them to be. The usual CHE strategy begins by training local nationals who are mature Christians and capable of teaching others. A team of trainers, one of whom usually has a medical background, enters a cluster of villages where the CHE program is introduced.

The villages then elect their own committee to oversee the program and their own CHE's (Community Health Evangelists). Both the committee and CHE's are trained over six months. Content includes:

1. Recognition of signs/symptoms of common diseases of the area
2. Simple, locally available methods of cure
3. Disease prevention through protection of water sources and building latrines

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Model # 4:

Schools as an Entry Point for Health & Evangelism in Tanzania (part 3)

4. Using information learned at home
5. Teaching neighbors what has been learned
6. Knowing Christ as personal Savior and growing in the Christian faith
7. Sharing Christ with neighbors
8. Follow-up and discipleship of new believers.

(Stan Rowland notes that during the training, since the CHE's and committee members are volunteers and this means commitment, any which were not Christians at the beginning either come to faith in Christ or lose motivation and quit. So, the program which was community-selected at the onset now becomes community-based and Christian.)

The CHE's learn to use 21 picture books on physical and spiritual topics when they teach in homes. They have Bible study as part of their course, so they can later lead their own Bible studies using the same materials. "The Four Laws Picture Book" is an easy method to use in sharing their faith. They have also been involved with clean water projects, gardening, vaccinations, and much more, but one of the beautiful things about this type of program is that it can be adapted to meet local community needs.

In Tanzania, preparation begins with a 3-day vision seminar for church leaders to share the concept of health as wholeness and to create a desire to have such a project in their area. It is essential that the churches see this as a way to reach out to their non-Christian neighbors.

When support has been ascertained, the program is initiated through health screening done in the local schools. A meeting with teaching staff is held to discuss the advantages of screening all the children in order to identify health problems. The head teacher then introduces the team to village government officials to obtain their approval and support, and a meeting to gain parental support is also held.

Once support is assured, a team of trainers with the help of local medical personnel such as a nurse and laboratory technician screen for the following:

1. Urine for parasites (including Schistosomiasis)
2. Stool for parasites
3. Blood for malaria parasites (optional)
4. Hemoglobin
5. Weight, height, age, and sex
6. Short nutritional history of eating habits, episodes of diarrhea, etc.

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Model # 4:

Schools as an Entry Point for Health & Evangelism in Tanzania (part 4)

7. General physical assessment for skin, intestinal, and respiratory diseases, cardiovascular abnormalities and abdominal masses etc.

Approximately 100 children can be screened in one day. An additional day is needed to finalize the individual student reports and summarize major problems for the parents' meeting.

At the parents' meeting, each parent is given a personal report for his/her children) with appropriate medical advice. Then the leader facilitates a discussion, utilizing a problem-based learning approach to ask parents to identify underlying causes of the main health problems affecting their children. Motivation is high because they are discussing actual felt problems along with actions to decrease or eliminate them. Parents are helped to plan and begin to implement a solution to one identified problem during this initial meeting. So, there is a feeling of accomplishment. The idea of a CHE program is presented as one way to help facilitate better health and at the end of the meeting a community CHE Committee is elected.

The Committee members receive 18 hours of training, spread over six days. By completion, they thoroughly understand the role of a committee and CHE's. They write their own constitution and determine how they will govern themselves. Then the Committee selects 20-25 local people to become CHE's.

The CHE's are prepared with training in both spiritual and physical health truths. Trainers model home visits and hold follow-up discussions of problems encountered. Later the CHE's will do their own home visits, teaching the concepts which they have learned. Teaching methods are participatory and group oriented. They include role plays, demonstrations, visuals, stories, songs, and group discussions. Learning focuses on problems, not just abstract concepts for general knowledge which are likely to be quickly forgotten. This type of learning is retained through continued practical use. The training consists of 40-50 sessions, lasting from 3 to 6 months as needed.

After the initial training, CHE's receive additional training of two to three days per month for the next twelve months. This reinforces the learning and improves their problem-solving skills.

After one year, a major evaluation is carried out. This leads to identification of strengths and weaknesses of the actions taken, and new goals/strategies may be planned. The community feels that it owns the project, because it is through community discussion that specific projects are formulated. Furthermore, CHE's are prepared to deal with local needs and problems.

Problems Encountered

The main problem encountered so far has been the lack of enthusiasm on the part of church leaders to get involved and support this work. Unfortunately, many judge the effectiveness of projects by the amount of external donor money available. But, these are not expensive and do not need a lot of donor money. They are sustainable because they are community "owned". Dr. Mwasha's main intervention for this problem is to hold vision seminars to change the way Christians think, and to get them motivated to action for Christ.

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Model # 4:

Schools as an Entry Point for Health & Evangelism in Tanzania (part 5)

Results

Results include many new born-again believers, church planting and tremendous improvement in physical health within a year or two. There are currently two pilot CHE projects in Tanzania. The Mwanza project started in 1993 and by 1995, there was a new church planted under the Africa Inland Church with hundreds of people coming to know Jesus as personal saviour. The use of Ventilated Improved Pit latrines (VIP) had increased from 0% to 30% and intestinal worm infection had decreased. In the second project in Moshi, over 50% of the children screened in February of 1995 had ascariasis and/or hookworm. Many had low hemoglobin values. By June, 1996, the worm infestation had been decreased to 30% and mean hemoglobin values had risen. This is a method of reaching people in a wholistic manner to meet both physical and spiritual needs. It is both replicable and sustainable.

Lessons Learned

1. Problem based learning states that *adults learn better and faster when they have a sensitive problem to solve.*

This approach is an effective tool for sensitizing and mobilizing communities for action and taking responsibility for their own health.

2. *Start small and expand slowly* always bearing in mind that physical and spiritual health are equally important.

3. *Once properly motivated, small communities can do much more than what most development workers could imagine.*

4. The message of II Timothy 2:2 (*entrusting the truth to reliable men who are qualified to teach*) is meant for both physical and spiritual truth.

Our CHE projects must be based on this verse. We must teach in such a way that those who learn from us are able to communicate the same message to others effectively. This is the concept of multiplication as opposed to addition.

For More Information:

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Model # 5: Life Abundant Programme in Cameroon

Cameroon Baptist Convention Health Board working in partnership with the North American Baptist Conference)

Daphne Dunger, RN, MA and Anne Gewe, RN, MSN

It began as the vision of a missionary nurse. It's purpose is to enable underserved communities through their local Cameroon Baptist Convention churches to share abundant life (wholistic well-being) within the context of their environment, culture and Christian beliefs.

How it began

As the director of Nursing Services of our major mission hospital and simultaneously a tutor in the School of Nursing in past years, I often reflected on why patients, their care-givers, and national hospital staff and students did not practice better levels of hygiene and sanitation after many years of teaching. Having lived as an "MK" in the same area as a child, and knowing that healthful living had been modeled on an every-day basis by missionaries as well as taught in the schools and churches, it was frustrating to realize that the impact had been limited. While some were clean, well-dressed people who bathed frequently, it seemed that there was at the same time evidence that toilets were few and/or often not used or poorly maintained. Handwashing, done by passing a basin of water around from person to person at times of group meals, was performed as a token symbol of fellowship, but otherwise was often not practiced. It was clear that real understanding was lacking and basic attitudes had not been truly changed, resulting in inadequately changed practice.

Furthermore, patients were brought to the hospital too late, only to die on arrival. This was done not only by those living great distances but those living a stone's throw from the hospital doors. Patients absconded from the wards (usually in the night) to get further treatment from witch doctors when their healing seemed too slow. To see students "freeze" in the middle of a role-play on the first aid care of a convulsing epileptic patient, fearful that touching the foaming saliva would give them the disease (even though the pathophysiology had already been discussed), showed the reality of unchanged worldviews and the need for culturally sensitive teaching within the context of daily living.

On weekends when there was opportunity to visit outlying churches, especially the small ones in remote villages, my heart would ache as I saw that though Christ was named and God was worshipped, most often other gods were also included and invoked for their blessings and protection. Most of these small churches had only well-meaning church helpers (laymen with little or no Bible training) serving as pastors. The people had not been able to learn adequately and just could not understand.

In this situation, I strongly believed that sincere, committed Christians had the highest potential for being the healthiest of human beings as well as being the most effective healers...simply because Christ is in them. So, as all of these realities pressed on my heart and mind, it is not surprising that God gave me a vision of the local church being the ideal place from which streams of healing could flow to the surrounding community.

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Model # 5: Life Abundant Programme in Cameroon (part 2)

For the majority of churches this would mean enabling them through discipleship, leadership development beginning with awareness training, and resources so that they could become the

"spearheads" bringing true health to their own people. Though highly skilled and specialized treatment of physical illness such as surgery could not be done in the church, the vast majority of sickness and health problems could be more comprehensively and appropriately addressed than in a traditional missionary hospital.

Program Organization

The Life Abundant Program (LAP) in Cameroon began in 1979 with one missionary nurse (myself) assisted by a national male interpreter working in 4 villages about 3-4 hours apart when traveling by foot. It now assists 44 villages in an area of approx. 8500 sq. miles, including remote areas accessible only by 4-wheel drive vehicles, foot or helicopter. About 20 different tribes and languages are included. The overall purpose is to enable underserved communities through their local Cameroon Baptist Convention churches to share abundant life (wholistic well-being) within the context of their environment, culture, and Christian beliefs.

There are 2 levels of responsibility in LAP although they are cross-trained to do each other's tasks when necessary. (See appendix A for diagram of relationships)

1. Central administrative staff

2. Area staff who are decentralized and include area coordinators, field assistants, and staff of Integrated Health Centres

Both of these levels relate to village workers who are not truly "staff" of LAP, but are workers helping their respective villages and receiving minimal remuneration from the village. These workers include the village health committee, Life Abundant Promoters (VHW's) and Trained Birth Attendants (TBA's).

The central level has the primary responsibility for overall administration, educational planning and allocation of resources for appropriate utilization. As humanly possible and with the help of the Holy Spirit, anyone hired as a LAP staff person is a committed, growing Christian and his or her immediate family is also. All participate as role models and consistently support the work in prayer.

Area staff members are hard working, faithful and committed persons. For cost and work effectiveness, they live in their geographical work areas because they are the ones who directly interact with and enable the communities to "get the work done". In matters of major program planning and decision making, both levels meet together in person or by use of the radio communication system.

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Model # 5: Life Abundant Programme in Cameroon (part 3)

The Area Coordinators and their Field Assistants function where the "tire meets the tarmac". They are nationals and know the culture "from the inside out". They are often away from their families for long stretches of time in order to spend time with villagers, whom they routinely visit every three months. Three of them are in areas which mean days of trekking in difficult terrain to reach respective villages. Tribal differences, food availability, and economic factors require these individuals to be very adaptable.

Each Area Coordinator is a special and unique individual with a commitment to spiritual and physical health. SG is an example. He's a short, stocky but agile, "up-beat" man with a grown family. After completing primary school he was accepted into ward auxiliary in-service training in our Baptist general/leprosy hospital in 1965, learning injections and sterile procedures. Being a quick learner and efficient worker, he was soon moved into the Operating Room where he worked for 18 years, becoming skilled to give spinal anesthesia and to close abdominal cases. During this time he became an active Boys Brigade leader in the local area. He then did three years of Bible College, followed by qualifying as a Nurse Aide (LPN + equivalent).

Since coming to LAP he has taken a 2-year community health course in Nigeria. His wife is an RN and is Chief of Post (COP) of one of our Integrated Health Centres. He has a gift of evangelism, an "African Billy Graham". The couple have been a strong model of Christian marriage and family life. Having come through some hurdles themselves, they have held staff and church weekly seminars in their home on Christian family life.

For the past 10 years, working in a predominantly Islamic area, he has effectively and steadily worked with integrity and love, ministering to, teaching, and challenging the people around him. Seven villages in the area where he is presently working can testify to his role in enabling them to have more abundant life...physically and spiritually.

Approach to Integration

LAP staff workers make no apologies for who they are, and give the people an honest description of their beliefs and commitments before starting village work whether in a Christian, Muslim or pagan village. They are available to be of help, but make it very clear in a non-Christian village that if the people do not want to accept them "as they are", they had better find someone else to help. LAP workers do not only come to bring medicines, but to better health in a much broader way.

Village activities are chosen in accordance with village life style, cognitive thinking styles and educational levels. They are done as a part of outreach by the local church. A Bible Reading Schedule and an easy-to-learn inductive question outline has been designed by a staff member for semi-literate people. With no more than 3 or 4 verses each day, the interested person can realistically commit to daily Bible reading and to leading an inductive Bible Study Discussion group using these tools. Bible reading schedules may be sold at a small cost.

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Model # 5: Life Abundant Programme in Cameroon (part 4)

Other activities include the Bible Study/Prayer groups which have been started, structured around the inductive Bible study question outline. Short seminars titled after Bible characters (Barnabas, Abraham, and Andrew) are held on Sundays and fit into the usual Sunday morning schedule. The Area Coordinator or Field Assistant may be the guest preacher in the local church. Films are sometimes shown in the market square, or at school and may be accompanied by preaching.

Yearly village health fairs are arranged and coordinated by the Village Health Committee with the local church utilizing the opportunity for evangelism as well as being involved in the health and life of the community. (LAP staff demonstrate, involving the community for the first one, and thereafter the community does its own.) It is usually a day long event during which blood pressures may be checked. Demonstrations may be included on such subjects as nutrition, oral rehydration drink (ORT) and handwashing. Dramas and games are often included and lead to discussion on such topics as AIDS, alcoholism, and family life.

To meet the spiritual needs of staff members, a LAP prayer calendar is distributed every 6 months, noting needs of individual LAP Health Centres, Staff members, Village Health Workers, Village LAP committees, administrative needs, Cameroon Baptist Convention needs, national and world concerns. All staff as well as local pastors receive these. Prayer days with Bible study are scheduled twice a year for central and area staff. The health centres are encouraged to have their own. Central and area staff members have prayer partners and make needs known on a weekly LAP radio communication time. Frequent audible prayer is a part of all activities. It serves as a constant reminder that God is in charge and helps keep words and life congruent.

Problems Encountered

As expatriates, we often do not know the best way to solve interpersonal relationship conflicts and may even cause problems. To avoid problems, the national Area Coordinators and Field Assistants take the lead in 98% of the dialogue involved in working with communities while ex-patriate personnel provide support, over-all guidelines and encouragement

Spiritual follow-up in the villages after films, seminars, and preaching is sometimes difficult due to the distances which staff members must travel and the fact that so many pastors are untrained lay people. LAP would like to teach more local pastors in counseling and discipleship.

Transportation costs and salaries of area coordinators initially were funded by the Cameroon Baptist Convention Health Board. The salaries have gradually become the responsibility of the Integrated Health Centres in each area where the coordinator serves. Transportation costs still receive assistance from external funding (by Bread for the World) and a portion of these may also be included in the Integrated Health Centres' budgets, where appropriate. However, the villages are becoming more self-sufficient. Ignorance and misunderstanding have been a problem. Sometimes the funds at hand (intended for purchase of re-supply of medicines) become diverted to personal needs. LAP has been strengthening its efforts for adequate conscientization of each village so that true community-determined health care happens.

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Model # 5: Life Abundant Programme in Cameroon (part 5)

Results

Although the present-day description of the LAP is somewhat different than that of the original proposal, the basic purpose, beliefs and philosophy of ministry have not changed. One exception is that today ministry may be carried out in a village where no church exists, but where it can be identified as an outreach of a nearby local church or of the larger Christian community in Cameroon. Even Muslim villages are seeking to be involved in the program.

There have been both positive spiritual and physical outcomes. Local churches have been strengthened, often coming to renewed life and maturing. Local Christians have recognized spiritual illness, repented and recommitted themselves to the Lord, bringing unity to the local congregation. Nationals have been brought to Christ and there is discipleship taking place through inductive Bible study and prayer groups. Several Muslim communities have welcomed LAP because of the reputation for having medicine that really works because God is behind it.

Village people are gradually experiencing changes in their attitudes and beliefs as they actively initiate and participate in health care for themselves, enabling them to solve their real health problems, not just symptoms. Several existing Dispensary/Maternities have become Integrated Health Centres, meaning that they go out into the immediate community with immunizations, "under-fives" care for children and programs for community sanitation. They may extend outreach to other villages.

Contagious diseases have decreased with the immunizations. Some villages show marked changes in the cleanliness, happiness and vitality of babies and toddlers, their mothers and their families. A decrease in IMR and MMR is documented as well.

Another result is in the lives of national health care/medical workers. Change has been seen as curative oriented medical staff have developed preventative, culturally sensitive, and spiritually concerned attitudes and practice.

Lessons Learned

1. Prayer is important!

Just as personal Bible study and prayer are vital for the individual, so prayer is essential for ministry. The "tyranny of the urgent" is alive and well and although it may be easy to work in the spirit of prayer, we have learned to take time for audible prayer. We have learned to stop, literally, before entering a new, Muslim, pagan or problematic village to ask God for insight, discernment, wisdom as we relate to people and for His blessing on them. We bathe in prayer individuals, families, villages, workers and staff, and church and government leaders on all levels, as well as problems.

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Model # 5: Life Abundant Programme in Cameroon (part 6)

2. Participative management creates real teamwork and joint ownership of values, beliefs, goals and objectives.

It may be difficult for some to do administration in this way, but team involvement means that the task is truly shared.

3. "Practice what you preach" is more than mere words.

The LAP central and area staff teach by word, demonstration, and lifestyle! We and our families, based on proven experience and belief, use mosquito nets, boil our water, and wash our hands frequently.

4. The work will be only as successful as the quality of the workers, whether on the top, middle or lower levels of responsibility.

For example, when individuals are chosen to be Village Health Workers who do not meet at least 90% of the qualifications, it is almost prognostic that there will be failure of health care efforts in that village.

5. Decentralization means each village can focus on its own needs, facilitating local sustainability and meaningfulness.

The needs are real, and the people respond and actively participate in a partnership with LAP staff as they begin to live more abundant lives.

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Model # 6: The Power of Prayer in Health Care in Ghana

Dr. John Boateng is actively involved in spiritual warfare and evangelistic crusades, as well as surgery and community health. Under his direction, 22 community health centers have been founded. Working with the Luke Society, he has seen 24 churches planted in Ghana within 5 years.

How it began

In 1989 when Dr. John Oduro Boateng became the first director of the Luke Society work in Ghana, the Ejura Sekyeredumasi District, Ashanti Province, was one of the most deprived districts in Ashanti, with World Bank figures for 1987 showing that 36% of all Ghanaians fell below the poverty line. There were only 2 health centers for the entire region of about 100,000 people and no doctors. Mud and rock roads were rough and there was no electricity. The people, primarily farmers, needed their children to work with them in the fields, so many were unable even to take advantage of the meager school resources which existed. Water was scarce, especially when shallow wells dried up. Malaria, diarrhea and intestinal parasites were rampant and infant mortality was very high (approx. 30 per 1000 live births).

There were only 5 Christian churches in the whole area. Traditional religious practices promoted idolatry and demonic bondage, and encouraged spending income on construction of shrines rather than using it to support economic development. These spiritual beliefs included animism, and ancestral and fetish worship. Witches, wizards and fetish priests and priestesses inspired fear in the people. Many who claimed to be healers were equally proficient in curing or casting curses. Thus an environment was created where people were not likely to quickly trust modern medical care.

The Vision

After two years of prayer and planning, Dr. Boateng moved into this context with a vision to reach the poor through health care and evangelism. He began a clinic in a five-room house in Kasei with no electricity. Clinic personnel consisted of himself, his wife and one helper. The focus was a Primary Health Care Program, providing basic medical services and training community health workers to teach sanitation, hygiene and disease prevention in the villages. In the evenings open-air evangelistic meetings were held. He recognized that in this type of environment, it was impossible to address physical needs adequately without giving attention to the spiritual. He made the salvation of souls the central focus of all his projects/activities.

Dr Boateng is well aware of the oppression of Satan and demonic strongholds, having been born in Ghana. He has seen first-hand the power of fetish priests and magic done through the power of demons. So he, too, claims power, but it is the power of the Holy Spirit. He begins each day with prayer at around 4 am. He and his staff have devotions and prayer at 5 am and by 6 he is ready to start surgery. He has a desire to do much for the Kingdom of God and works not through his own strength, but in the power of the Holy Spirit.

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Model # 6:

The Power of Prayer in Health Care in Ghana (part 2)

He is not alone in the spiritual battle. He works closely with Joseph Mintah, the Luke Society's evangelism coordinator. Joseph often prays for about 6 hours a day and fasts at least once a week. Before conducting frequent evangelistic crusades he coordinates Christians coming together for a week or two of fasting and prayer, and all night prayer vigils. These men have power with God and they emphasize to the people that the Holy Spirit's power is greater than any other: demons, fetishes, curses, or magic. The result of their working by faith is that they have seen 24 churches planted within 5 years.

Activities of the Health Care Program

The Kasei Clinic is now a base clinic which works in association with 22 village centers in remote areas. It has a compound which covers 30 acres, featuring a newly-constructed medical clinic, the Boateng's home, a hostel for inpatients, a canteen and a bath house. The rest of the land is used for growing crops such as corn, cowpeas, plantains, pineapples and fruits, and for grazing of sheep and goats. This not only helps to feed staff members and patients, but profits from produce sold help support the work and a portion is tithed into other ministries.

After early morning devotions, Dr. Boateng does hernia repairs. He averages about 120 surgeries per month. (Hernias are a common injury in the area due to the heavy lifting which is a part of the daily routine of farming.) He utilizes a local anesthetic for the surgery rather than general anesthesia so the patients are awake during the operation. Then while he works, clinic staff play Christian music, and Bible teaching tapes or he and staff members talk with the patient about spiritual things. Many become Christians on the operating table just like Emma, a gentleman who had traveled about 3 hours for his hernia operation. During surgery he heard the Gospel for the first time and accepted Christ. He renounced fetish practices and currently is a missionary to his own people, having been involved in the planting of 3 churches.

Another medical officer at the Kasei clinic sees patients with a variety of medical complaints and nurse assistants help with dispensing medications. Many of the medications are donated and dispensed at a very low cost to the poor.

The clinic has a reputation for quality care, so wealthy businessmen from as far away as Ivory Coast and Burkina Faso are just as likely to be patients as the poor from the surrounding area. A sliding fee is charged, based upon what the patient can afford. The wealthy help finance surgery for the poor. As witnesses for Christ, staff strive for excellence in use of equipment and surgical techniques. Infections are rare, and recurrent hernias are few.

The poor are the focus of service, so they can be seen throughout the compound, sitting under trees or resting on benches. They may spend several weeks recovering from various illnesses, eating at the canteen and sleeping in the hostel, continuing to be ministered to by Christians there. Some eventually find work on the compound.

Often the people who need medical care the most cannot come to the Kasei clinic, so under Dr. Boateng's direction, 22 community health centers have been founded. Each has one or more trained community health workers and a dispensary. Five of the centers also employ nurse midwives. In order to create a sense of ownership by the local community, the village people must donate the land and help build the clinic structure. Each has a health committee involved in oversight of the work.

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Model # 6:

The Power of Prayer in Health Care in Ghana (part 3)

In every area, prayer is paramount. In one village a chief was ill. He had claimed to have black powers but none of them availed to cure him of his illness. As a last resort, he came to the Christians. Through their prayer, he was healed, and became a believer. A church has now been planted in that village.

Evangelism

Although evangelism is thoroughly incorporated with the health care ministry, additionally, Dr. Boateng is involved with both major crusades and church planting, working with other members of the Luke Society in Ghana. The four or five day crusades strive to unite existing Christian churches to work together to win their towns for Christ. Because many who come to Christ have been involved with prior demonic worship, deliverance sessions are an important component of the crusades. The purpose of these are to bind spirits, cast out demons and set people free from satanic and ancestral covenants to engage in new covenants with God through Christ. After each crusade there is follow-up on how to live a life pleasing to God. Crusades may result in church planting.

A typical church planting might begin with showing the Jesus film after a week or two of prior prayer and fasting. A portable PA system announces the arrival of the team. They first go to the house of the village chief chairman to show respect for his leadership. Christians from a local church come on a tractor trailer to help setting up benches and drums. The worship service is totally African in nature. There is dancing and singing in worship to God, and women from the target village are encouraged to join with the Christians. As the women dance, men clap and play the drums.

After the showing of the Jesus film, viewers are challenged to give their lives to Jesus as Savior and Lord. Before the team leaves, a lay leader from a nearby church is appointed to help guide the new church. Members from previously planted churches commit to discipling new believers. The church will also receive regular visits from Luke Society staff members.

The village of Dauda, primarily a Muslim village, was the focus of a recent evangelistic outreach. In one night, 38 adults and about 75 children became Christians after seeing the Jesus film. Quickly a new church was planted.

Resources

Dr. Boateng sees the building of supportive relationships with government and non-governmental organizations, and local leaders as key in the ability to gain the needed resources for successful village projects. For example, support of the District Assembly in the Ashanti Region provided a means of networking to present projects to village leaders. Support of village leaders then led to actions as donating land for a health clinic or church. UNICEF has provided assistance with medical supplies and health education materials. Partnerships with World Vision have led to founding of Christian schools and provision of clean water. Current projects include a cooperative farming project and a banking project in which help has been provided by Sinapi Aba, a Ghanaian micro-enterprise organization and Opportunity International.

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Model # 6: The Power of Prayer in Health Care in Ghana (part 4)

Results

Individual conversions have already been mentioned. They are a common occurrence within this ministry where all Luke Society members are expected to be involved in sharing the Gospel. Also, as previously mentioned, church planting is occurring at a rapid rate and new members are being disciplined. But, holistic development is also taking place within communities.

The story of the Asubuasau village is representative of this trend. It is located in a remote area, inaccessible even by tractor during the rainy season. Five years ago, there was no church, no potable water, very poor sanitation and the only school was in a dilapidated thatched grass house. The village chief was a fetish priest, strongly opposed to Christianity.

The strategy for reaching the village first called for believers to gather together in regular prayer for it. Then the program of health education was introduced to leaders. The chief was openly opposed to the work, but persistence established the reputation of a caring presence. Today the village has potable water, a new school, a growing church and a health clinic.

Lessons Learned

The following key principles have been found to be critical to the implementation of the projects in Ghana.

- 1. People need both physical care and release from spiritual bondage in order to become the individuals which God intends them to be. Spiritual powers must be confronted and bound.*
- 2. Prayer, fasting, good planning and participation of staff members and local church leaders is key to discipling, growth in church membership, and church planting.*
- 3. Development of collaborative partnering relationships allows for networking and access to needed resources.*
- 4. Funding will be accepted only from organizations which permit the sharing of the Gospel.*

God will take care of needs if He is honored, and it is His truth which sets people free. As people trust God with the little resources they have, they will see them multiplied.
- 5. Staff should be drawn from local communities and should live within them whenever possible.*
- 6. Programs should not be created just because funding is available. Projects must meet real needs.*

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Model # 6:

The Power of Prayer in Health Care in Ghana (part 5)

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Model # 7: AIDS Care as an Avenue of Ministry in Zaire

Dr. Daniel E. Fountain

None of the current expensive specialized medications for AIDS are available in the Vanga Hospital of Zaire. However, research has shown the power of emotions in affecting the immune system both positively and negatively. The pastoral counseling staff and health care personnel work closely to strengthen emotional/spiritual healing in AIDS patients which may lead to remission and increased quality of life.

How it began

All through medical training, I was aware that an important ingredient of healing was missing from the classical biomedical model. I could not see how medicine and the Bible could be put together. However, in the early 1960's God began showing me how He does work to bring about healing, what is the importance of prayer, and how to communicate with Him for guidance and help.

Then during 1987-1988 I was privileged to be the missionary scholar in residence at the Billy Graham Center at Wheaton College. Studying the Scriptures and other writings intensively, I was able to put thoughts together in the monograph entitled, Health, the Bible and the Church. Some conclusions were:

- 1.Churches must support healing through a ministry of counseling, reconciliation, correction, and creating a caring community, bringing together individuals of various backgrounds.
- 2.Church members must be willing to help the sick through prayer, support and sharing fellowship.
- 3.All dimensions of health must be integrated: education, agriculture, economy, protection of the environment, and community awareness in order to really promote effective development. (1)

These thoughts were not formulated only through thinking in a sort of "ivory tower" experience, but additionally they were the result of experience on the mission field in the country of Zaire, working in conjunction with the Vanga Hospital. The Vanga Hospital was established in 1920 by the American Baptist Foreign Mission Society in a rural area of west-central Zaire. The location was in the Bandundu Region about 500 km east of Kinshasa, the capital. It was mainly a bush curative hospital until 1961 when my wife Miriam, who is an RN, and I arrived.

Miriam had served as a nursing instructor prior to coming to Zaire and together we were able to institute training programs for various levels of health workers. We also helped with the establishment of rural health centers in the surrounding needy area with a population of about a quarter million. In 1967, working through community churches, we began a community health outreach, the first such in Zaire.

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Model # 7:

AIDS Care as an Avenue of Ministry in Zaire (part 2)

Combining the spiritual/pastoral care and medical care began in the Vanga Hospital in 1984. This was when Rev. Mrs. Matala, a native of Zaire, joined the staff, after graduating from seminary with specialized training in hospital pastoral counseling. Patients with psycho-somatic complaints and others with so-called incurable illnesses were directed to her. Soon afterward she began to deal with HIV+ persons. By 1992, the number of HIV+ persons had grown to almost one new person per day and the intensive spiritual and psychological counseling ministry for AIDS patients was started.

A team of seven members of the hospital staff assists Mrs. Matala in the counseling program. They received a short period of training in counseling from her and one of the attending physicians, to prepare them to facilitate individual and group dialogue, and in understanding medical and spiritual aspects of chronic illness, especially HIV infection. A spirit of unity exists among the entire hospital staff, and both physicians and nurses refer patients to the pastoral service.

The Context and Components of Caring for AIDS Patients

Currently the gender distribution for the AIDS infection is almost equal in males and females. The principal route of transmission is through heterosexual relationships as homosexual relations and IV drug use are almost unknown. The spread of the virus by transfusions, however, is also an issue.

The care of HIV+ persons in the Vanga Hospital has five aspects:

1. An open welcome to the sick person. There is no isolation or separation of those who are HIV+. They receive the same treatment and care as other patients, as well as respect for confidentiality.
2. Appropriate medical care, which includes treatment for co-existing infections and other conditions. None of the current specialized medicines for HIV are available. Careful disinfection and protection of staff and patients against viral transmission are assured.
3. Social support. The cost of care is kept to a minimum and is subsidized for those who cannot pay.
4. Pastoral care including counseling, instruction and group dialogue in the medical and spiritual aspects of chronic illness and especially HIV infection.
5. A ministry of prayer. Consultations, group meetings and planning sessions start and end with prayer. However, in individual consultations, prayer is offered, but never imposed. Special times of prayer are organized to focus on specific needs and concerns for those who desire it.

The Caring Process for HIV+ Persons: Physical Testing

The hospital cares for patients either as out-patients or as in-patients. An RN does the initial examination and triage and requests the appropriate lab studies. Most patients are then referred to an attending physician. If the physician suspects the possibility of HIV infection, the SERODIA-Fujirebio test will be ordered to detect HIV antibodies.

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Model # 7: AIDS Care as an Avenue of Ministry in Zaire (part 3)

In the laboratory, all specimens are anonymous. Only the two technicians doing the tests know the patient identity of each numbered specimen. The register of numbers and names is kept locked and only the attending physician is advised of the results.

When the physician receives a positive result, he begins the counseling process and then recommends a referral to the pastoral service. The objectives of counseling focus on awareness and handling of negative emotional burdens through Christ, and the development of positive thoughts and attitudes, in addition to finding a support system. Confession and request for forgiveness, pardon of others, reconciliation and release of destructive emotions like anger, resentment, hatred, and jealousy may all be recommended as a part of the process for healing.

Emotional/Spiritual Assessment

The assessment by the counselor begins with questions of a general nature about the illness. This helps establish a relationship for caring, without causing the patient to be ill at ease. Then specific assessment is done for the following:

1. Particular concerns and worries.
2. Dreams, especially painful or disturbing ones, as these often have much significance to sick persons in Africa.
3. Important conflicts and tensions in the family or clan.
4. Painful or difficult events in the past: fear, grief, resentment or anger, abuse, rejection etc.
5. Past behavior causing discomfort or guilt.
6. Fear of sorcery or of being cursed.
7. Belief about God. The counselor inquires about the faith and beliefs of the sick person, seeking to identify spiritual resources which can be mobilized to strengthen the immune system and also to determine if spiritual problems exist.

These questions reveal important socio-cultural and spiritual values of the patients. Individuals are free to answer or not, but the counselor does encourage reflection on each question. Confidentiality is assured, and if the patient wishes, the counselor will end with prayer. A counselor may encourage the patient to accept Christ if he/she seems open to the suggestion. However, no pressure or attempts at manipulation are made.

Christ is available to all who want Him, but it is a personal decision. The team never rejects anyone who does not wish to become a Christian, but continues to treat him/her with respect as did Christ. He healed sick people because He had compassion on them and many did not accept Him.

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Model # 7:

AIDS Care as an Avenue of Ministry in Zaire (part 4)

Although he did not have AIDS, the story of JM, a teenager, illustrates the importance of this whole-person assessment and the giving of culturally-sensitive care. He was admitted to the hospital with a six month's history of progressive pain in the right hip, fever, and weight loss. He could no longer support weight on his right leg. Clinical and x-ray examinations were compatible with tuberculosis of the right hip, so the doctor ordered the standard treatment for tuberculosis.

After a month of treatment, he had made no improvement. In fact, his condition was worse. Doctors presumed the bacilli were resistant to standard treatment, and began a course of second- line therapy. However, the pain, fever, and weight loss continued and JM appeared to be dying.

At that time a young student nurse, Denise, who was caring for JM, did an in-depth assessment. In order to pay for his school fees, his parents had to borrow money from an uncle. Some months later, the uncle demanded reimbursement, but the parents had no money. The uncle became angry and put a curse on JM. In the presence of JM, the uncle said that he would become seriously ill and, in spite of all the doctors would do, he would die. That appeared to be happening.

The student nurse, together with the pastoral team, talked to JM about the Lord Jesus Christ and he became a Christian. Using the Gospels, the team showed JM that Jesus, who healed the sick, raised the dead, and Himself arose from death was more powerful than his uncle. When he accepted this, the fear of his uncle disappeared. The next step was to help JM forgive the uncle for the evil brought on him. With forgiveness, the hatred toward the uncle was healed and within a few days, JM's fever disappeared. He began to eat and gain weight. A few months later he was completely healed physically.

Revealing the Diagnosis of HIV/AIDS

In most cases, when the counselor feels that the HIV+ person has been adequately prepared psychologically, then the attending physician and counselor meet together with him/her to reveal the diagnosis. The doctor explains that the patient has a serious chronic illness which is diminishing resistance to infections. It is caused by a virus for which no cure is yet known. It is only after this initial discussion that the doctor does verify that the virus is indeed, AIDS. Up to this point, the team does not use the term AIDS unless the patient asks about it.

The patient is assured that there is real hope that improvements will occur and a remission may take place. By telling the truth about the diagnosis, the patient can better understand the illness and learn behavior patterns to follow to improve health, as well as to protect the spouse and family. The individual can also pray specifically in terms of his/her own symptoms, immune system and healing process. The team leaves time for questions, answering all as honestly as possible. The therapeutic aspect of tears is recognized and concern, sympathy and hope are expressed with encouragement to continue with counseling and physical care.

The counselor makes contact again within 24 hours to follow up. This provides further opportunity for expression of feelings, asking questions and emphasizing hope. The counselor encourages the patient to continue with regular sessions of counseling and prayer.

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Model # 7: AIDS Care as an Avenue of Ministry in Zaire (part 5)

Group Meetings

Regular group meetings are organized with sufferers of various chronic illnesses. Persons with HIV are invited, but the identity of their illness is not revealed unless they themselves speak of it. The group meetings are a time to share concerns and gain ideas on how to cope. A sense of community is fostered for mutual caring and encouragement. Thankfulness is expressed for positive things which God is doing such as improvement in health, relief from worries, and joy in knowledge of acceptance by God. Prayer concerns are shared and patients pray for each other. The team encourages patients to organize their own spontaneous sessions of prayer at other times.

Every Sunday morning, a special service is held in the hospital for Bible teaching on healing, and prayer for healing. Through the counseling and the group meetings, culturally-sensitive spiritual care is brought to patients as they work through the many social, cultural and spiritual issues associated with AIDS.

The necessity of dealing with these socio-cultural values and spiritual aspects of HIV/AIDS is well-illustrated in the story of EM. She was a 27-year-old woman, hospitalized in the Vanga Hospital. She had felt God's call on her life to become a Catholic sister and at the age of 14 she began preparation for entering a convent. When she finished high school she was already a novitiate, and she began teaching.

Visiting her parents during a summer holiday, she met a young man. He invited her to spend the night with him, but she refused. After she returned to school, the young man gave gifts to her parents and said that he wanted to marry her. They strongly encouraged her to marry him, but she continued to refuse. So, he went to the school where EM was teaching and told the school director she was his fiancée. EM denied this and repeated her desire to continue preparing to enter the convent. However, the director took her job away, telling her to return home and obey her parents. Once home, she continued to refuse the marriage, but finally in response to intimidation by her parents, she accepted.

Shortly thereafter she became pregnant, and during the pregnancy, her husband left her and ran away with another woman. The baby, healthy at birth, began to experience repeated infections and died of AIDS at the age of one and a half. Later, EM began experiencing night sweats, fever, weight loss, and pain in the chest and abdomen. A serological test confirmed that she had AIDS.

She had been a Christian for several years, but that did not make her immune from spiritual problems: bitterness toward her parents; hatred toward the young man who deceived her, infected her and then abandoned her; guilt for having left her calling and accepting the marriage. To help her with the emotional battle going on inside, she needed the multidisciplinary approach from individuals who could understand the surrounding cultural and social values. She needed culturally sensitive care in order for her to reestablish peace in her soul.

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Model # 7: AIDS Care as an Avenue of Ministry in Zaire (part 6)

The Results

Numerous factors contribute to the results of this program. Physicians, nurses and pastoral counselors all have a dedicated commitment to Jesus Christ. There is a strong support group of intercessors and a spirit of unity among medical and pastoral staff. There is also an acute awareness of the spiritual dimension of this ministry. Spiritual means are essential in overcoming the powers of darkness trying to destroy persons and the works of God. God has graciously granted positive outcomes.

The rate of participation of HIV+ persons in the counseling process is above 90% and more than two-thirds of counselees with HIV profess having or entering into a personal relationship with Jesus Christ. They express joy, a sense of peace, and improved well-being.

More than 90% of HIV+ persons to whom the diagnosis has been revealed have accepted it with tranquillity and fortitude. No major reactions of anger, despair or suicidal tendencies have been encountered. Furthermore, the majority of persons with HIV disease experience improvement in their general condition. A few who come with far advanced HIV disease succumb rapidly, but usually with peace and gratitude for the help received.

The majority of persons with HIV disease are discharged after treatment of their other infections and the counseling process. The team encourages them to continue self-examination and committing all concerns to God in prayer. In order to have social and spiritual help, the team also recommends that they become part of a spiritual support group wherever they go. They are asked to return on a monthly basis if possible.

Problems Encountered

A major problem at the beginning was strong opposition from church leaders, especially local pastors. They feared having persons with AIDS come to the center. They were also jealous of the large numbers coming to the hospital for spiritual ministry and not coming to the local church. God helped work through these conflicts, as Christian medical people took the initiative first of all, in helping persons with AIDS to cope with their problems, secondly in designing biblically-based educational programs and third, in encouraging Christian lay people to do home visitation of sick persons. Thus the churches are becoming more active in facing the challenge of HIV/AIDS.

A second problem occurred during the Ebola epidemic in nearby Kikwit. With members of the Vanga Hospital, I had been holding seminars and workshops for Catholics and Protestants both in the city of Kikwit and at the hospital, teaching about AIDS and educating for its prevention. There was opposition from those who profit from the exploitation of women and commercial sex.

When the Ebola epidemic appeared, I was accused of having cursed the city and causing many deaths. Undercurrents of antagonism still continue in parts of the city even though we at the Vanga Hospital were able to play an important role in helping to stop the spread of the Ebola virus. These accusations, once again demonstrate the importance of understanding and dealing with the spiritual and cultural components of disease, in general, and with AIDS/HIV, in particular.

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Model # 7: AIDS Care as an Avenue of Ministry in Zaire (part 7)

Lessons Learned

- 1. There must be a strong, clear, biblical foundation underlying all aspects of health care with Christ at the center.*
- 2. Evangelism does not necessarily have to be overt. Perhaps the most effective evangelism is that of compassionate care, sacrificial service and a quiet presence.*
- 3. Health care must embrace physical, social, emotional, psychological, and spiritual concerns.*
- 4. Building and maintaining unity among believers in the Body of Christ must have a high priority.*
- 5. Regular and intense prayer is essential, both individually and in groups.*

1. Fountain, Daniel E. (1989) Health, the Bible and the Church. Wheaton, IL: Billy Graham Center, Wheaton College.

For more information:

*Fountain, Daniel E. (1995) "Care of Persons with AIDS in a Christian Hospital". Vanga Hospital.

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Model # 8: Living as a Christian Expatriate in a "Closed" Country

Anonymous

This will be helpful to health care professionals desiring a ministry in a country closed to traditional missionary endeavors. The author shares ways in which she is able to live as a Christian doctor in a society which forbids proselytizing.

How it began

I am writing anonymously because my work has been in a country which, in many ways, is anti-Christian. However, my experiences demonstrate how personal Christian integration can be done by individuals, even in a country which forbids proselytizing. It is also a testimony to Paul's assertion that each Christian has a role in God's economy. Some plant the seed, others water, but God gives the increase.

My experiences are typical of many Christian doctors working outside of the U.S.A. and being involved with a variety of aspects of health care. I have spent the majority of my time in-hospital, but in recent years, I have been more closely associated with community health and development.

The projects with which I have been associated grew out of the vision of a Christian pioneer medical expatriate, who began well-baby clinics in rural villages. When this pioneer doctor arrived in 1951 there were no schools, no government offices, no medical care, no electricity, and no plumbing in the villages. She was not discouraged. Eventually a hospital was established, and Mobile Health Services were begun to reach out into communities. Volunteers in each community created awareness of health needs, did health teaching, and mobilized community involvement in providing space for clinics. By the 1970's expatriate nurses were training nationals to take over the clinic work and teach their own village health workers.

Over the years, other services were added such as tuberculosis control activities including sputum examination and advisory services in sanitation, nutrition, and clean drinking water. Gradually, rural developmental activities such as drinking water supply, sanitation, horticulture, forest conservation, mill construction, nonformal education, income generation, and cottage industries were found helpful in raising the standard of living and thus improving health. By the mid 1980's a medical insurance program was introduced and village leaders trained to manage it. The original vision has grown to provide in-service training for medical, nursing and public health students.

The oversight of all these activities is being turned over to local communities and government health services. The Christian team of expatriates and nationals is turning its efforts to even more remote and needy districts. While being very careful to honor agreements not to proselytize, each Christian is able to live out a personal life which demonstrates Christian caring, and is free to share his/her spiritual motivation when asked.

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Model # 8: Living as a Christian Expatriate in a "Closed" Country (part 2)

Personal Integration

Because of working agreements with the government, project activities have never overtly integrated components of spiritual and physical health. However, I have discovered numerous ways in which to integrate my faith into my personal medical practice.

First, I have developed a prayer base of individuals who are committed to praying for myself and my husband, also an M.D., and for the country in which I am working. After a time, I learned that the national culture is very spiritual in nature, and nationals actually welcomed prayer as an important spiritual component of the healing process. As a result, interactions with patients, villagers, and staff often included prayer as a key activity.

Privately, I specifically prayed for opportunities to share verbally about Christ with those whose hearts God prepared. Knowing that God answers prayer, I then was alert for such opportunities to meet people at their point of spiritual need.

For example, while on a field trip with a public health student, the conversation turned to a long-standing personal conflict between two high-level officials in the Ministry of Health. I asked the student why they didn't just forgive each other and go on with the business of providing health care in the best way possible. The student answered, "But they would never do that. There is no forgiveness in our religion." That led to an opportunity for me to share about my own father who had been orphaned at age 16 during the Armenian genocide in Turkey. Three months later he had the opportunity to kill the murderer, but he chose to forgive him because of his Christian faith. That conversation led to other student-initiated interactions and the opportunity to pray with the student asking God to help her write her thesis. Meeting the student at her point of need led to an openness to the gospel.

I was challenged as a young person by a former medical missionary to China to help meet both physical and spiritual needs. My motivation was, and is, to obey Christ's commands: love God; love your neighbor as yourself; Go into all the world ...; and lose your life for my sake and the gospel's.

I have tried to live out the truth of my conviction that Christ is the answer to everyone's need for salvation and abundant life, and I want to communicate love, caring, honor and respect for all the people I meet, regardless of their interest in the gospel. I believe this life style allows patients to both see and hear a convincing testimony.

For example, it was the end of a long day at the clinic when an older woman with leprosy came to be seen. I mentioned that I would be soon returning to the USA for home leave. The patient then called me "bhagavan" (god) for leaving the luxuries of America to serve in a poor country. I replied that I'm not a god, and that the Almighty God is the source of any good deeds which I may have carried out. Furthermore I know this God for myself.

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Model # 8: Living as a Christian Expatriate in a "Closed" Country (part 3)

The needy woman then remarked, "So, you are a guru as well as a doctor! Can you tell me how to find peace? I have been on innumerable pilgrimages to erase my sin for having allowed my husband to die at a young age, but I have not received peace." This gave me the opportunity to tell the woman of Jesus, the Prince of Peace, and to invite her to stay in the village with a local Christian family with whom she had much in common. She bought a New Testament.

In my personal life, I try to make sure that spiritual needs/values and activities play a role. My husband and I have led Bible Study sessions for anyone desiring to come. I have also, at times, been able to join staff for Bible study. Once a young woman who had previously received treatment for TB and was twice non-compliant with the medical regime, came again to see me. She was dying from hemoptysis and pneumonia. Responding to the husband's pleas, I gladly paid for the medication myself, since agency policy did not allow the giving of free drugs to non-compliant patients and the patient was too poor to be able to buy them.

The situation gave the opportunity to draw a parallel between all of us who are undeserving sinners who can receive the free gift of eternal life through Christ because of God's love and grace. The husband had already purchased a Bible and had been studying it with a Christian teacher in his village. In time, both were baptized elsewhere and became the first Christians from their tribe in that particular area.

I value being a member of a team of Christians, giving honor to all members and making sure that someone is available to address spiritual matters. One young man came to the clinic complaining that the pills he had previously been given only took away his symptoms, headaches. They didn't deal with the cause of his illness. He wondered if my "religion" could help him. I told him that Jesus could help, but felt we would need to talk at greater length to learn about the cause of the headaches. So, I invited him home to lunch.

In time, the man became a Christian but it was through the influence of various Christians. He had a neighbor who was a Christian or he might never have asked about my "religion". That friend and he traveled about 3 hours weekly to attend a Bible class taught by my husband. He also attended a local church from time to time. God worked through a number of people, not just one.

The idea of sharing one's home just to talk or enjoy a meal together is illustrated by the above example, but it is only one way in which to integrate one's faith and personal lifestyle. Not being fluent in the language is an obstacle, but while learning the language, it is helpful to live more or less at the economic level of those to whom one wants to minister. Dressing appropriately to "fit in" with nationals of the same age and gender, and having an attitude of "teachableness" enhance the development of genuine friendships and future sharing.

One area in which "westerners" miss out on opportunities for witness through medical care is in failing to give credence to the supernatural explanations offered by non-westerners for illness, suffering, and disasters. Being trained in the modern empirical model of science, expatriates often look for natural explanations, forgetting that Scripture gives supernatural explanations for earthly events. One can point to Job's suffering, or the storm at sea which was caused by Jonah's disobedience.

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Model # 8: Living as a Christian Expatriate in a "Closed" Country (part 4)

In the New Testament, Jesus stated that a man was born blind in order to show the glory of God, and Ananias and Sapphira died trying to lie to the Holy Spirit. Often the church grows rapidly where Jesus Christ is shown to be more powerful than locally recognized spirits, gods, or demons. Christians need to be aware of spiritual warfare and communicate the power of God in Christ, not just the love (which is emphasized in so many "western" churches) when ministering in many non-western cultures.

Problems Encountered

Not having enough time to do everything considered important is a problem that looms large in any health care situation. I learned to "stretch" my time through delegation and teamwork, sharing the workload with nurses and paramedics. Morning rounds tend to be concerned with physical needs and a variety of health care workers (doctors, students, nurses, etc.) may attend them. Often efficiency is emphasized so that other responsibilities such as clinic assignments, teaching, or surgery can be done afterwards. So, I scheduled my own "solo" hospital round in the late afternoon. This allowed me to take more time to interact with patients and families, and to address spiritual and social concerns.

I found that bringing an inquirer into contact with local national Christians was an effective way to avoid a "rice Christian convert". If there was a strong motive on the seeker's part for external gain by association with an expatriate, lessening the expatriate's in-depth involvement would allow the true motive to become apparent if the seeker lost interest.

Follow-up of patients coming to the hospital has been a concern. At the beginning, I encouraged Christians from the hospital to go into the nearby district to locate these people to follow up on their spiritual well-being. Now, Christians from local churches make tours of the districts to give individuals additional opportunity to hear about Christ.

Results

Although there has never been a formal spiritual component in these activities, all expatriate staff and a few national staff have been Christians and have tried to evidence their faith through excellence in health care delivery. Compassionate caring for physical needs has often led patients to question "why?" Since the culture is essentially religious, workers have been free to talk about their Christian faith on a one-to-one basis.

Non-Christian patients and co-workers appreciate prayer for their needs. Expatriate workers have lived among the people rather than on compounds and have developed close personal relationships, opening their homes to meet needs of local people.

As a result, in spite of the restrictions, many nationals have become believers and churches have emerged. Furthermore, these churches are national churches. Expatriates may have informal leadership roles such as teaching, serving on committees, or helping with Bible studies, but the churches are national in leadership, name, and character. Cultural preferences in worship such as sitting on the floor and the use of traditional music are evident.

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Model # 8: Living as a Christian Expatriate in a "Closed" Country (part 5)

Lessons Learned

1. The health care worker must remember that obvious needs for physical health, clothing, and education are not the only needs.

Jesus said "Seek first the Kingdom of God and his righteousness, and all these things will be added unto you." One should pray specifically for opportunities to meet spiritual needs, and not be so "wholistic" that the spiritual is no longer a priority.

2. Christians should not attempt to be "Lone Rangers". Nationals provide many resources.

Where there are significant social and emotional needs, it is important to get an inquirer in touch with a local Christian group, so that the group can pray and meet needs.

3. Hospitality in one's own home or home visits make for an informal environment in which to meet with people and make them feel comfortable about getting to know an expatriate.

Jesus can be naturally shared in the context of personal experiences.

4. The Christian's responsibility is to obey God's call to ministry and service, and leave the results to Him.

One Christian expatriate nurse has testified that she worked for 18 years delivering babies in this country. She could not give a verbal witness, but she prayed for each baby at the time of delivery. Many years later, she was appointed as a Community Health Nurse. Making home visits, she came in contact with young adults whom she had delivered and for whom she had prayed. The political atmosphere had changed and with increased religious freedom, many were eager to hear about the Lord Jesus. She had numerous opportunities to share the gospel and saw God's blessing because she was faithful.

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Model # 9:

A Caring Community for the Whole Person in New Hampshire

His Mansion Ministries focus on care for individuals struggling with chemical addiction, eating disorders, sexual and physical abuse, and other dysfunctional behaviors as suicidal tendencies. The original community is located in New Hampshire, but it has been the model for treatment programs in other countries.

Past Influences

Creating "community", in every sense of the word, has been the dream of hundreds of people throughout the ages. The Israelite community was identified as God's chosen people, bound together by common religious values and a promised land. Early Christians "had everything in common" as they shared both materially and spiritually to meet the needs of one another. In the 1970's, when His Mansion Ministries was formed, members of the Jesus People Movement, many of whom came from the "drug scene", yearned for communities of physical and emotional healing, where all could share in the benefits of Christian beliefs. It is within community that the deepest human needs are met for love, belonging, nurturance, identity, a sense of purpose, safety and security.

So, it is not surprising that community became the vehicle for ministry to emotionally and physically hurting men and women when God moved the hearts of Joseph Wagner, Hal Moore and Stan Farmer to establish His Mansion Ministries. These men were also greatly influenced by the book, Mueller of Bristol by A.T. Pierson.

George Mueller established orphanages by faith, not having the wealth to support them. He wanted individuals to be able to see that God is worthy of trust in providing for needs. His aim for the children was that they be healthy and comfortable, content with the necessities of life, and growing both spiritually and physically in order to become useful members of society. Each orphanage was a community with structure and a regular schedule, so children participated in work, play, school, exercise and devotional services. This was care for the whole child. Mueller's philosophy has influenced the sense of community which has been carefully nurtured by His Mansion Ministries over the years.

His Mansion Ministries is now located on 361 acres near Clarke Summit, New Hampshire. This peak was named for a chaplain who was a Christian. He drowned after surrendering his lifejacket to save the life of a fellow seaman during World War II. In the same spirit of service, the community of His Mansion gives new life to individuals who need help to break free from chemical addictions, eating disorders, sexual and physical abuse or other dysfunctional behaviors such as suicidal tendencies. There is also a program for pregnant women in crisis. Spiritual healing is the key to emotional and physical healing, and being part of a community allows caring to take place in the whole being: body, soul and spirit.

People Involved

The residential-care programs are Christ-centered, one year programs for men and women between the ages of 18 and 30, who have expressed a desire for help and recognize the need to change behaviors. In the community, needs for food and shelter, transportation, safety and security are met. Residents are called "students", which emphasizes a learning role. Members of the community work hard to create a

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Model # 9:

A Caring Community for the Whole Person in New Hampshire (part 2)

sense of belonging for every student. For the first 6 to 9 months, each student has a daily routine of work projects, evaluation, education, development and study of Scripture. Then for 3 to 6 months, he/she participates in a re-entry program, obtaining a job in the "real world" but returning to the caring community at the end of the day for nurturing, accountability, and encouragement.

Interns are short-term missionaries who raise their own support and assume the roles of older brothers/ sisters, friends, and sometimes parental figures for the students. They should be at least 21 and serve for a maximum of 2 years. The role calls for modeling the love of Christ, so it is essential that each has a genuine Christian commitment and is actively involved in a church. Strong recommendations from pastors or church leaders are a must. As with other mission opportunities, it is requested that those who are in debt remain employed until such time as those debts have been paid. Each intern takes a 6 week in-house training course with a curriculum based upon the Bible and experience of veteran missionaries. Nearly one-fourth of His Mansion Ministries' Interns are former students. This community allows for growth and maturation and then investment in the lives of others who are less mature, just like the model of discipleship given in Scripture.

Each intern is nurtured, supported and disciplined by a Discipleship Supervisor (men with men and women with women) who has previously served as an intern. These Supervisors are encouraged to develop knowledge and leadership skills and may serve for 2 or 3 year terms. The positions of discipleship supervisors are filled by missionaries who have made long-term commitments. Often they are married couples with children, adding the dimension of a stable family model to the community. They must be "commended" by home churches and have a solid base of prayer support to make their financial needs known to God.

A Director of Counseling oversees the Disciples, providing the accountability necessary for a caring community to function well. Accountability on all levels is modeled for the students.

Finally, the community has a "Program Director" who has administrative responsibility for all activities and physical aspects.

Short-term volunteers, either as individuals or with organized groups, give of their time and talents for the building up of the community in various ways. Some have completed specific physical building projects. Others help with physical labor of harvesting crops. All work to build relationships with students and to share their faith and the love of God.

Generally each student has a sponsor who is not part of the community. The sponsor is not financially responsible but is encouraged to provide a small monthly stipend to meet the student's personal needs. The sponsor's major role is to be responsible for the student's arrival and eventual re-entry into the outside world again.

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Model # 9:

A Caring Community for the Whole Person in New Hampshire (part 3)

Program Methods

Not all candidates can be accepted to become students in the community. Potential candidates receive a packet which contains mutual expectations and regulations. Authority and accountability are important in building security and discipline within any community. They also provide for structure, a component which is often lacking in the lives of those suffering emotionally. Therefore, the candidate must agree to live by the rules and guidelines. Then he/she personally contacts the Director of Discipleship for an interview and takes responsibility for being present. (His Mansion Ministries does not provide transportation.)

After completion of the interview and a tour of the facilities, the Director of Discipleship and the Discipleship Supervisors share the decision of whether or not the community experience will be an appropriate method for helping with healing in the life of the prospective student. In some cases, the problem is too serious to be handled in this type of community. If a student is not accepted, every effort is made to provide alternate referrals. Even after acceptance there is a probationary period in which both parties can evaluate whether or not the student is benefiting from the participation and should continue.

Positive peer pressure helps students adjust, as most want to be accepted. The first few days are of vital importance in community adjustment. Staff members must exercise "tough love" at this time to help individuals develop the internal discipline to obey the rules necessary to the smooth functioning of the community. "Veteran students" are given responsibility to help new students adjust. This aids in developing the sense of concern for one another necessary to development of maturity.

A well balanced diet is an essential ingredient to the physical well-being of members of the community and much of the food is home-grown. A healthy diet combined with a vigorous daily work schedule enhances physical health which in turn affects emotional, mental and spiritual well-being.

Because of the centrality of caring to the healing process, staff members are key to the success of this program. There is nearly a one-to-one staff-to-student ratio. A ratio which was too low could allow students to attempt to establish a "street mentality" and prevent the sense of caring from pervading the

atmosphere. A ratio which was too high could result in an institutional "we/they" mentality which would equally destroy the desired quality of caring.

A daily routine begins with students and interns having a time for devotional reading. Early morning chores are completed before breakfast. Depending upon the program, staff members and students go to prearranged jobs in the community, gather for work assignments or attend classes. Each student has some time during the week for attendance in classes when he/she is excused from work assignments. Classes are tailored for special needs and may include practical education, industrial arts, occupational skills, high school equivalency and basic Bible or individual discipleship. They alternate throughout the week with times of physical work which allows for healthy coping with frustrations.

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Model # 9:

A Caring Community for the Whole Person in New Hampshire (part 4)

The whole schedule reinforces the Biblical concept that all of life is of spiritual significance and Christian principles, values and actions modeled by staff pervade the atmosphere. Consequences for tardiness and poor workmanship help to maintain structure and develop motivation for productive living.

Mealtimes further the sense of community as men and women from varying backgrounds sit together to converse, sharing experiences and increasing social skills. Visitors are welcome and dispersed among the tables whenever possible. Notices of coming events and pertinent news are announced at the end of each meal. Immediately after supper, everyone is encouraged to watch international news and then the TV is turned off. Students and staff discuss the news and pray concerning the issues raised.

Evenings have both structure and flexibility with choices for active games as ping pong, basketball, volleyball, and floor hockey. There is a library and a music program. Students and staff are encouraged to play instruments, join the chorale or participate in drama. Interns join students during evenings to model healthy creativity and structure. Special "family nights" are scheduled as game nights, family movies, and outings. At 9:00 PM official activities end and interns and students return to dorms for Bible-centered devotions and discussion before going to bed.

There are qualified educators on the staff to do teaching. Practical education covers reading, writing and arithmetic. Reentry classes focus on skills as safety, job search and interview techniques, social skills development and dating relationships. Special classes teach how to keep a checkbook, follow a budget or

fill out applications. There is on-the-job training to help develop motivation and attitudes to be successful in such activities as caring for animals, using machinery, and cooking. Every student participates in classes in Christian living. Each room discipler is responsible to make sure scripture reading, discussion and homework are part of his/her relationships with assigned students.

Pregnant women in crisis may be part of the New Beginnings Program. Each mother-to-be participates in classes on motherhood and parenting taught by experienced mothers and mature women. Before the baby is born, the mother is made aware of alternatives regarding the future of the baby. Mothers-to-be also experience the same discipleship and structure as other students to help them prepare for eventual reentry into the outside world.

Prayer and Share is held several days a week and lasts for about 45 minutes. Much of the community gathers for praise and thanksgiving to God in a large group. Time is spent in petitioning God for ongoing needs which may be spiritual, physical, financial or material. Seeing God answer prayers in concrete ways helps many to trust Him for spiritual healing and forgiveness of sin as well as for emotional and physical healing.

An important aspect of any ministry is funding. His Mansion Ministries does not accept any state or federal aid. No student, parent, or church is required to pay for a student's care. Through the years, God has supplied their needs without resorting to heavy-handed financial appeals or soliciting of funds. Staff members raise their own support, and the ministry has developed a prayer army within the greater Christian community to intercede before the Father for the ministries.

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Model # 9:

A Caring Community for the Whole Person in New Hampshire (part 5)

Every person who helps His Mansion Ministries financially or materially receives a handwritten "thank you" from a student or intern. This links the smaller physical community to the larger caring community of the Christian Church. It helps prevent a sense of isolation which can occur within small communities.

His Mansion Ministries has speakers whose primary concern is to stimulate other believers through example. Seminars to churches on how to deal with drugs, alcohol, parenting, or developing support groups help to develop caring within the church community. Pressing Onward is a program designed to prepare churches to meet the needs of dysfunctional people, and to link student graduates with churches

which are willing and able to encourage them "in the real world."

Problems Overcome

As with any ministry, problems have arisen. In the area of healing, creating the proper balance between the spiritual and practical/physical aspects of health of the community has been difficult. A holistic philosophy deals with this dilemma by acknowledging that everything done within the daily routine has a spiritual dimension because of the inter-relationship of the physical, mental, emotional and spiritual dimensions of humans. Every activity contains an opportunity to build healthy perceptions and form essential skills needed for life in general. As interns understand this concept, conflicts between things labeled "spiritual" and those labeled "physical" decrease.

Size of a community can be a problem as growth may lead to de-personalization and less effectiveness. Smaller regional programs are preferable to larger organizations which take on an institutional flavor, so, His Mansion Ministries has been multiplying itself in other locations through the concept of "mini-Mansions". A four or five unit apartment house is purchased and a set of "house parents" lives in one of the units. Each of the other units will have an intern and two or three students. Students are required to hold down a daytime job with "therapeutic" interventions taking place during evenings and weekends. This adaptation shows the versatility of the concept of community. A community does not have to be large to be effective.

Program Results

His Mansion Ministries in New Hampshire serves approximately 40 individuals in a year. It is not at all uncommon for 2 or 3 individuals each year to be hearing the gospel for the first time and for them to make decisions for Christ. Every one of the 40 students is disciplined by a more mature believer and all the interns are mentored in their roles as well. Networking is established between the community and churches in order to further emotional and spiritual healing.

His Mansion Ministries has been in the business of replication. New Hampshire remains the training center, but another residential program for care is flourishing in Prospect Heights, IL, a suburban area of Chicago. It has been the model for treatment programs in Prince Edward Island, South Africa, The Bahamas, and Ontario. Groups in India, Hungary, Kenya and Jamaica have expressed interest. As mentioned previously, the idea of community is adaptable to many settings, whether rural, suburban or urban.

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Model # 9:

A Caring Community for the Whole Person in New Hampshire (part 6)

Lessons Learned (shared by Stan Farmer, Executive Director)

1. It is essential to have a clearly defined vision and goals statement with a clear process for achieving them, and a team of co-laborers who "buy-in" to that vision.

2. An organization should take advantage of organizational development tools already available

(Myers Griggs and/or Team Management Systems).

Evaluation conducted by an impartial consultant can help to develop high efficiency teams, keep personnel longer and greatly decrease burnout.

3. Staff members must not be so "spiritually minded" that they are no earthly good.

There must be a balance. Ministries are also businesses and must be run with legal contracts. Evaluation is essential. Accountability is a Biblical principle and is demonstrated both internally and externally through evaluation. Christian caring is not simply a feeling. It is demonstrated through emotional support and also through excellence with well thought-out, intellectual/factual decisions based upon realities of the "secular" world.

4. Networking as much as possible to give away valuable insights furthers the kingdom of God.

It is needful to cooperate with senior's research efforts to increase in excellence and to remain fiscally conservative. Good stewardship is required of every Christian, as the parable of the talents shows.

Major Source: Farmer, Stan. "His Mansion Ministries: A Brief Description". (unpublished document).

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Model # 10: Church Health Services & Utilization of Nurse Case Managers in Wisconsin

by Lois Augustson, RN, MSN

The clinic opened in the educational wing of a church in 1993. A team approach is used to deliver whole person health care. A pastor participates with the nurse in the initial assessment of all new patients. The nurse, as the case-manager, then becomes the client advocate to access needed resources.

How it Began

Although there are many programs, both public and private to provide health care to Americans, thousands still "fall through the cracks." This underserved population tends to have greater severity of illness for most diagnoses and survival rates are often lower. They may also have insufficient support systems to aid them in recovering from illness or the family, under conditions of poverty and the strain of disease, may actually become a destructive force.

In his own life, Dr. Michael Augustson experienced the destructive effects of illness. When he was 14, his father experienced a major illness. Although he recovered physiologically, the illness took a significant toll, creating personal and family disruption. From this experience, Dr. Augustson made a commitment that when he became a physician he would care for his patients in a manner that prevented or minimized these destructive effects as much as possible.

It was recognition of this lack of attention paid to the psycho-social-spiritual dimensions of health and illness, along with a burden for the poor which motivated Dr. Augustson to share his vision of health care for the medically underserved with his pastor. Thus began Church Health Services (CHS), an ecumenical health care ministry, located in Beaver Dam, Wisconsin. As a non-profit organization, CHS became the first and only free medical clinic within the service area of Beaver Dam Community Hospitals.

It opened in 1993, in the educational wing of a local church, offering clinic hours one day per month. The initial volunteer staff included one family physician, five nurses, one nurse practitioner, one pastor and two office-support staff members. It has since expanded to include three general medical clinics per month, and one monthly clinic operated in conjunction with the Wisconsin Women's Cancer Control Program, offering breast and cervical cancer screening. The latter is administered through the local health department.

Staff now includes one part-time clinic coordinator (paid) and over 40 volunteers including 3 family physicians, one nurse practitioner, 20 registered nurses, 6 pastors, 1 dietitian, 1 psychologist and 8 support staff. Volunteers logged over 1100 hours of service in 1995 alone. In addition, CHS receives professional support from a comprehensive network of community physician specialists and other health care providers.

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Model # 10:

Church Health Services & Utilization of Nurse Case Managers in Wisconsin (part 2)

The foundational principle underlying the establishment of the CHS ministry is found in Luke 9:2. "He [Jesus] sent the apostles out to tell about God's kingdom and to heal the sick." Recognizing the role of the church in promoting the health of people, CHS attempts to respond to the needs of the medically underserved in a way that encompasses the whole person. Four dimensions of health and illness are included: physical, psychological, social and spiritual. These are inseparable and share a synergistic relationship with each other. Each is important and key to the state of health of the entire person.

CHS seeks to restore the role of the church in health care, a role often forgotten. Gallup polls consistently describe a close affinity between the American people and church, and Baker, in an article in JAMA (Oct. 26, 1994) includes the church as one of the community institutions that should be a part of the integration of community resources to have a major impact on the health of the public (1). CHS is becoming one of these resources, making certain that the spiritual dimension is integrated into whole person health.

The Method

A team approach is used to deliver whole person health care. Clergy are important members of the health care team. They assist patients and staff through the provision of spiritual assessment and intervention, clinic devotions, and prayer.

The pastor meets with the staff for a time of devotion and prayer prior to the opening of each clinic session. He or she participates with the nurse in the initial assessment of all new patients. Patients are requested to complete a *Whole Person Self-Assessment (Appendix A)* which is then utilized in an interview format with team members to assist in assessment of the individual's physical, emotional, social and spiritual aspects of health and illness. This allows all health concerns to be addressed. Faith links staff and patients on a deeper level than merely addressing physical needs could ever do.

Clergy provide pastoral care, respond to spiritual needs presented in each visit and share their overall assessment with team members and the client. The pastor provides encouragement and support to staff members as they seek to understand and care for the spiritual dimensions of each individual.

The story of Linda, a 14 year old daughter of an Hispanic migrant worker, beautifully illustrates how this team approach works in real life. She was referred to the clinic by a high school counselor because of abdominal pain and vomiting. Plagued with physical complaints resulting in poor school attendance and falling grades, Linda's initial visit focused on addressing the immediate physical complaints as well as establishing a trusting relationship.

A second visit incorporated increased focus on the emotional, social and spiritual facets of her life and resulted in a more integrated plan of care. The doctor-nurse-clergy team learned that she was the oldest of four children. Since her father was a migrant worker, it had been the pattern for several years for the family to live in Wisconsin for four months and then to go to Texas for eight months. She admitted

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Model # 10: Church Health Services & Utilization of Nurse Case Managers in Wisconsin (part 3)

that she had often wished to die and two years previously had taken an overdose of forty or fifty pills. Five months earlier, a boy she had a crush on was killed in an auto accident. She told of crying daily. In the past, she had earned A's in school, but now she was getting B's and C's. She said there was no hope for her, and during the interview, she often appeared to be near tears. She only attended church about once a month.

The team listened to her and affirmed her as a person, specifically in regard to her intelligence, communication skills, physical beauty, and for being a child of God. She was helped to see that grieving over her dead friend was a normal reaction, as the story of how Jesus wept over the death of his friend Lazarus was related. The visit concluded with prayer, a brief discussion with her mother and a decision to order some diagnostic studies.

The tests revealed essentially normal results, and her case was reviewed with a specialist in psychiatry. A third visit occurred, just days before the family's scheduled departure for Texas. A plan of care was explained. It included a discussion of diet. She was to continue her histamine-blocking medication for her stomach and was started on an anti-depressant. She was advised to follow up with a physician in Texas. She was asked to seek out a mental health counselor and to become active in her church, with the benefits of church and a youth group that were interested in personal relationships being emphasized. She received the hot-line number to a national Christian-based counseling center for teens. She was again affirmed as a person and was given two self-addressed, stamped envelopes to send back to the clinic with an update on how she was doing. Her mother's questions were addressed. At the close of the visit, this plan was put into writing and agreed upon.

Hearing no response from her, after six weeks, a note of inquiry was sent from CHS. Two weeks later a Christmas card was received with the following note:

Sorry I haven't written any sooner. I've been somewhat busy lately. You know, studying for exams and all that. But it's better late than never. My family and I want to wish you and your family a Christmas filled with joy. Thank you for everything you have helped us with. You showed me that there is hope to whatever problems we might have, as long as we turn to God. I wish more people could be able to realize this. With people like you, willing to help us, I'm sure they will.....Sincerely, Linda

From the standpoint of the doctor-nurse-clergy team, these three office visits were very time intensive and a real challenge to orchestrate, but also highly rewarding. This kind of person-oriented health care creates a win-win situation for both patient and provider.

Collaborative Relationships

Networking with professional health care givers and organizations has been crucial to the continuation of the comprehensive services which CHS is able to offer. Formalized agreements with community physicians allow patients to see primary care physicians or specialists for free or reduced rates.

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Model # 10:

Church Health Services & Utilization of Nurse Case Managers in Wisconsin (part 4)

Four area pharmacies provide their lowest discounted rate on pharmaceuticals for CHS patients. Pharmaceutical representatives frequently provide large supplies of samples and the local St. Vincent DePaul group has agreed to pay for other medications and supplies as needed.

Several groups provide other services.

*Although CHS is able to do simple labs, most of the lab work is referred to consultant physicians who have provided the services at no charge.

*Area radiologists volunteer to do x-ray interpretation at no charge.

*The hospital provides virtually any service available for outpatients or inpatients at no charge or reduced rates.

*A protocol has been developed with the local dental society, and mental health consultation is available through the Lutheran Social Services and Psychiatric Association.

*Two board members are also members of the County Human Service and Health Department. In addition to working with the Health Department to establish the Wisconsin Women's Cancer Control Program, the CHS clinic is one of their satellite immunization clinics. Health Department staff refer clients who are in need but do not qualify for governmental assistance to CHS.

A major collaborative relationship exists with area churches. Three pastors serve on the board of CHS and six pastors work in the clinics. Many congregations are a source of financial and volunteer support. There is interest in utilizing CHS to help in the training of lay health workers for local churches, and a parish nurse program has been proposed to bring together clients, churches, the clinic, and the larger community.

To insure ongoing support and involvement, CHS volunteers and Board members have engaged in a public information campaign which has included many presentations to local and regional groups as well as news releases through local radio, TV, newspaper, and church denominational news services. CHS has also successfully lobbied for laws to provide state-sponsored malpractice insurance for health professionals working in free clinics.

A close working relationship also exists with area schools through their counselors and psychologists. Service clubs promote presentations at meetings and then contribute financially.

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Model # 10:

Church Health Services & Utilization of Nurse Case Managers in Wisconsin (part 5)

Patient Care Providers

A CHS clinic is similar to a general medical clinic in appearance and equipment available. However, a significant difference is in the utilization of the "nurse as case manager" approach to the delivery of health care. The nurse is the advocate who helps the client to understand care available at CHS and to access needed resources of the larger health care system outside.

*Patients who receive care at CHS are assigned to one nurse to manage their clinic visits. The nurse is the coordinator for the team. A patient may have contact with several team members at a visit, but the constant is the nurse manager. On the first visit, the patient meets with the nurse, pastor, and many times a physician or nurse practitioner (NP). On the second visit the nurse, pastor, physician/nurse practitioner and patient meet to review the Whole Person Self-Assessment and to begin to develop a Personal Health Plan together. Subsequent visits might be similarly structured or might include patient education with the nurse, pastoral care, dietary counseling, psychological assessment, alcohol and drug assessment or referral to a consulting specialist. Outside referral services are managed by the Clinic Coordinator who is a nurse. *The nurse is central to this process of delivering whole-person centered care.**

Challenges

The developing ministry of CHS has not been without its challenges! There are few existing office systems which accomplish whole person health care. Changing the way Americans think about health, and partnering with health care providers is no small task. Discerning the best way to truly help the poor has similar difficulties. Developing the concept of the nurse as case manager is a new and unique approach.

When the CHS ministry planning began, health care centers throughout the country were contacted. Few systems were found to be adaptable to accomplishing the desired goal of providing person-oriented health care. Therefore, considerable time and energy have been, and continue to be devoted towards developing and refining intake tools and procedures, clinic and staff protocols and effective documentation systems.

The Board of Directors is actively pursuing innovative ways to purposefully and completely communicate all the dimensions of health and illness to patients. Position statements have been drafted and are being reviewed. The current intake process will be expanded to include a clear presentation of the establishment of a health care partnership with patients, resulting in increased responsibility of the patient for his/her health and illness.

Full implementation of the concept of nurse as case manager has been limited, due to lack of availability of consistent volunteer staff. Many volunteer nurses cannot commit to more than one 4-hr. clinic shift per quarter. Consideration is being given to developing a paid parish/clinic nurse position. This nurse would be responsible for providing consistent staffing of the clinics, as well as sharing in parish nurse responsibilities for area churches.

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Model # 10:

Church Health Services & Utilization of Nurse Case Managers in Wisconsin (part 6)

Results

During three years of operation, 790 office visits were provided for 200 under- or uninsured patients. Their presenting medical concerns were similar to those seen by the average primary care physician. However, at CHS these concerns were addressed by a team of health care professionals which addressed both medical and non-medical concerns affecting the overall health status of the individuals. There has been a significant spiritual impact on individual clients, as illustrated previously by the story of Linda.

There have been positive outcomes for staff members as well as patients, as one nurse writes:

Working with patients and staff at CHS has impacted my jobs as a surgical staff nurse and as an occupational health nurse in very positive ways. This experience has reinforced for me that we are always treating the 'whole person', not just a fracture or abdominal pain. Each person is a spiritual, emotional, and physical being, with needs associated likewise. Working with the CHS staff has helped me to see how much better care we can deliver when we treat people with love, dignity, and concern, always looking to God for our strength and example.

Lessons Learned

Providing whole person care to the medically underserved continues to be a great joy and challenge. L. James Wylie has written, "Health is the property of, or better the responsibility of each of us." (2) It is this premise linked with faith that sustains the vision. *The past three years have shown that the most important ingredients necessary to the success of the CHS ministry are people, prayer, patience, and perseverance.*

1. It is God's people who must answer the call to serve using their unique gifts to help His people. We must stay God focused!

2. Pray without ceasing. Prayer works.

Recently much has been written connecting prayer and health. Heart patients who are prayed for heal more rapidly with fewer complications. Many people reportedly would like their health care practitioners to pray with them. Few refuse the offer of prayer. Prayer is a continual source of encouragement to both patients and staff.

3. Patience is needed to do things in God's time, not ours.

There are times when we feel frustrated with a seeming lack of progress, maybe with a patient, maybe with a project. Whatever the case, when we eventually have the opportunity to look back, His handiwork is quite evident. So, persist we must, as we faithfully trust Him to finish the good work which He has begun!

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Church Health Services & Utilization of Nurse Case Managers in Wisconsin (part 7)

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2. Wylie, L. James. (1990) "The Mission of Health and the Congregation." In Parish Nursing: the Developing Practice. Ann Solari-Twadell, Anne Marie Djupe and Mary Ann McDermott, eds. Park Ridge, IL: National Parish Nurse Resource Center. P. 18.

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Model # 11:

The Luke Society: Developing Domestic Ministries in the USA

Grace Tazelaar

This illustrates how experiences and principles of cross-cultural ministry world-wide can be translated into ministry in the USA. Lay persons can be trained for appropriate roles in giving culturally-sensitive care, promoting health in the context of ministry.

History

The Domestic Missions of the Luke Society was based for many years at Cary Christian Center. Cary was founded by Dr. Peter Boelens who moved to Mississippi following a term in Korea as a missionary and having completed his MPH and pediatric residency in Minnesota. Someone challenged him about working overseas when people in the United States were also in need of health care. He researched and found that the poorest area in the U.S. was the rural Delta region of Mississippi and determined to begin a health outreach in this area. An elaboration of these humble beginnings has been written in a book, *Delta Doctor*.

The Lord blessed the work in the Delta which caught the attention of other Christian health professionals in foreign countries. Soon the Luke Society expanded to include work in ten foreign countries. From his time in Korea, through the founding of Cary Christian Center, and in the development of the foreign programs, Dr. Boelens believed that training lay people to provide basic health care was a strategy that could be useful in promoting not only health but also the gospel of Jesus Christ.

When I joined the Luke Society in 1991, a project aimed at training lay health advisors and lay home visitors had been started at Cary Christian Center by Sonja Kerlen, a nurse practitioner, and Carolyn (Care) Newhof, the director of the parent and child program at Cary Christian Center. The program collected data that demonstrated the value of the lay home visitor program, a program that had trained women from the community to visit regularly the mothers enrolled in the parent and child classes. The five year average infant mortality among the target non-white population was cut nearly in half after the home visiting program had been in place three years. A Bible study was begun for the mothers and the message of Jesus Christ was being presented in a culturally appropriate way.

After 21 years, the Luke Society decided that Cary Christian Center had come of age and should become independent. The challenge put to me was to redefine the domestic work of the Luke Society based on the experience of Cary. I had just returned to the United States from Uganda, East Africa where I had spent six years assisting the Church of Uganda and the Uganda Protestant Medical Bureau to develop community-based health care programs. Dr. Boelens had challenged me with the same challenge he had been given. "There are needy people in the United States who can benefit from what you are doing in Uganda. Why don't you try to do this in the US?"

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Model # 11:

The Luke Society: Developing Domestic Ministries in the USA (part 2)

Reentering the health care delivery system in 1991, I found a lot of talk about health care reform. I avidly read all the latest proposals. It became clear to me that whatever reforms would take place, two areas were probably not going to be adequately addressed. First, health promotion was going to be pushed onto the back burner when the demands of and funding for curative health services were so high. Some preventive care would be provided, for example immunizations and screenings for cancer and hypertension. But preventing long term health problems such as substance abuse and violence that have their roots in emotional and social issues were probably going to be dealt with cursorily. Second, the separation of church and state would mean that spiritual care would not be addressed. Health care professionals are taught about the spiritual dimension of patients but are given very little instruction or time as to how to provide this kind of care.

Motivation

As a Christian, I felt that these were two areas that the Church of Jesus Christ could and should be addressing. Promoting healthy lifestyles is Biblical. The Biblical term *shalom*, often translated as peace, may also appropriately be interpreted as health. "For the Jews ... health was essentially a positive quality that derived from the fact that people existed in total harmony -- total peace -- with their world. This harmony includes one's relationship to nature and to one's fellows. It was internal ('peace of mind,' as we would say) but most of all harmony with God." (1) Christians should be leading the way in promoting this kind of health and in the process they could provide spiritual care.

I also believed that Jesus Christ is the answer to the root cause of some of the more problematic health issues such as substance abuse. In Uganda when I was doing health teaching about AIDS, we talked about God's plan of marriage and "loving faithfully," i.e., limiting sex to the person with whom you are committed to spending the rest of your life. The common response was that it was impossible or unnatural to limit oneself in this way. I was grateful to the Apostle Paul when he wrote in Romans 7:14-24 that he found himself doing the evil he abhorred rather than the good that he knew to do. Paul answers his rhetorical question "Who will rescue me from this body of death?" with "Thanks be to God -- through Jesus Christ our Lord." In and of ourselves it is impossible to live as God has designed and taught us because of our sin. It is only by appropriating God's power given to us as a gift through the Holy Spirit when we accept Jesus as our Savior that we can begin to make the changes necessary to be living in godly ways and enjoying the *shalom* that God intended at creation.

The strategy of training lay (non-health professionals) people to promote health and the gospel that had been successful in the program at Cary and in the foreign programs seemed to be a natural for the Domestic Missions program. What had been successful there needed to be replicated elsewhere in the United States. A coinciding philosophy of the Luke Society has been to invest in people whom God has called into this type of ministry. Thus we began to seek people whom God had called within the United States to promote health and the gospel of Jesus Christ.

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Model # 11:

The Luke Society: Developing Domestic Ministries in the USA (part 3)

Results of Integrating Faith and Health

Over the past four years the Lord has led us to work with ten different programs in the United States. They vary depending on the vision and God-given abilities of the program leaders, the needs of the community, and the resources available. (See the list of programs and descriptions.)

The programs which have been in existence longer have provided the base for my learning and have enabled me to provide advice to the newer programs about approaches that work or may be questionable. We are all teaming together. Over the past three years, it has become clear that two factors have contributed to the success of the program and the integration of spiritual care.

1 Atkins, Tony. "What is Health?" in A New Agenda for Medical Missions, edited by D. Merrill Ewert. MAP International Monograph, 1990, p. 11.

The first is the calling and commitment of the program leader. The leader must be committed to serving God in the training of others. For example, Jodi Pyper the nurse who heads the Teen Treasures program in Cary does more than hold meetings once a week for the girls. She has them sleep over at her home, takes them shopping with her, and involves them in service projects within the community. She gets them involved in her life so that she is able to teach by example as well as by didactic classroom teaching. One of the Teens recently wrote:

I shared a message about abstinence and God's way with two of my classmates who happened to be pregnant. One of the girls was planning on having an abortion so I talked to her. Then I asked Jodi for some pamphlets and gave them to the girl and let her know that if she needed anybody to talk to that she could talk to me or any of the other Teen Treasures and we would try to help her. Two years ago I wouldn't have talked to anyone at school about abortion, sex or what God says because I didn't know about it and didn't have the courage. Now that I've been in Teen Treasures I have learned and experienced what it means to be a servant of God and help His people. Teen Treasures has taught me a lot and has given me the courage to stand up for what is right.

Another important factor is prayer. Cindy Cook-Dew knows the importance of prayer in ministry. I remember as Cindy was getting ready to pair the Resource Moms she had trained in the Baby LUV program with the pregnant teenagers she told me that she was a bit anxious about how this would work. So she did what she had done all along in developing the Baby LUV program; she prayed. God perfectly matched the Resource Moms with the teenagers. One of the resource moms who had recently had a baby wore a size 3 dress. When she met her teen mom, the teenager did not have any maternity clothes and was a size 3. The resource mom was thrilled to be able to help this teenager with some of her maternity clothes. That helped them to bond immediately.

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Model # 11:

The Luke Society: Developing Domestic Ministries in the USA (part 4)

Approach

Domestic Missions in the Luke Society approaches health with a broad definition. It doesn't limit programs to disease orientation or curative medicine. This has allowed us to begin programs that may not overtly be considered health programs such as the Male Image program at Vicksburg Family Development Service (VFDS).

Male Image is a male mentoring program for adolescent boys who come from single parent homes headed by women. It grew out of a big sister program that VFDS began to present teen pregnancy among the female siblings of pregnant teenagers. The big sister program was successful but received its funding from United Way which did not allow for Bible instruction. The big sisters came back and said that while they enjoyed the interaction with the girls, the little brothers of the pregnant teenagers were not being targeted. They understood that it took two people to get pregnant and felt something needed to be done for the boys. The staff at VFDS agreed and approached the Luke Society about beginning the Male Image program. Timidly they told us that they wanted to include a Bible study as a part of the Male Image program. We encouraged them and told them we would not support the program if it did not include a Bible study.

People ask me, "How is Male Image a health program?" To which I reply, "The leading cause of death in African American males ages 18-25 is violence. If we do not educate these young boys in what the Bible teaches about being a Christian man, encourage them to stay in school and give them socially acceptable means for dealing with their anger, we will lose them to violence or jail."

Some of the traditional health programs have recognized the need for incorporated spiritual care but have admitted that they did not know how to go about it. Since I have done a fair amount of curriculum development and teaching throughout my career, Dr. Boelens asked me to write some lessons on training lay health personnel about evangelism.

Arguing that there are several excellent programs that provide training in evangelism I suggested that the lay health programs needed more education in the area of identifying spiritual needs and providing spiritual care. I contacted Judith Shelley, one of the authors of *Spiritual Care, the Nurses Role*, and asked her if I could adapt this material for lay people. She graciously encouraged me and gave me some additional resources. The result was seven lesson plans designed to teach lay health personnel about spiritual needs and how to provide spiritual care. A number of the programs have adapted them for use in their programs. I hope to revise them this year based on these experiences.

People

The people heading the Luke Society Domestic Mission program are all very special. But there is an exciting trend toward pairing people from different ethnic backgrounds that I have observed.

The Care Pregnancy Center (CPC) in Augusta, GA is being developed by Ophelia Simpson, an African American who lives in the Cherry Tree community, and Trisha Moseley, a white educator at CPC.

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Model # 11:

The Luke Society: Developing Domestic Ministries in the USA (part 5)

Shaun Harrison, an African American pastor in Boston, is working with Beth Kidd a white nurse at Place of Promise.

Kim Snapp, a white doctor, is working with June Hicks, an African American woman who is a leader in the community served by the Good Samaritan Clinic in Wichita, Kansas.

Kathy Rice is a white community health nurse working with Christine Evans, an African American woman from the community served by New City Fellowship in St. Louis, MO.

Ted Yuen, a Chinese American health educator, has collaborated with JoAnn Boss, a white parish nurse at Chicago Uptown Ministry, to begin the lay health program there.

This is a trend that is happening not only in the Luke Society Domestic Mission programs but also in other ministries as well. I believe it is a part of the broader move of the Holy Spirit to bring racial reconciliation to the Church so that God's Kingdom will be established and exemplified here on earth. It also illustrates the Biblical teaching on gifts -- how the Holy Spirit gives us different gifts that need to be used in concert with one another in order to be effective.

My African American brothers and sisters are very good at relationships. They know their communities, the people who comprise them, how they think and what they need. My fellow white brothers and sisters are very good at planning, budgeting, programming and administration. But to have successful programs that meet the needs of the community, we need both types of people. Neither one can do this alone. When the Lord Jesus Christ, the author of reconciliation, is added to the equation, great things begin to happen. "A cord of three strands is not quickly broken." (Ecclesiastes 4:12)

Problems

A common problem for persons beginning lay health programs is that they are excited about the concept of training lay people and begin training people without laying a good foundation for the program. Creating awareness within a community about a lay health program, assessing where the community is, what its resources are, what others are already doing to meet the needs of the community is tedious, time consuming work. Praying and seeking God about how He would have this program fit into His plans for this community is vital throughout the process. This gives direction to what it is that the lay health personnel will be doing and who should be recruited as a lay health person. It also helps to develop the curriculum and identify potential resource persons within the community.

Laying the foundation for beginning a program can also be a time of discouragement for the program leader. I try to encourage them by telling them that I do not expect any measurable results in the first year of a program. That is why the programs that the Luke Society supports are funded optimally for the first two years. My experience has been that funding agencies expect results too quickly and this leads to programming that meets the needs of the people funding the program rather than the needs of the community. We live in a society that is impatient. We often get ahead of God and ahead of the community because we lack the virtue of patience.

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Model # 11:

The Luke Society: Developing Domestic Ministries in the USA (part 6)

A second problem common to lay health programs is the use of didactic teaching methods as opposed to using adult education methods that foster problem solving and ownership of knowledge on the part of the learner. Frequently, I am shown curriculums that list the topic and the resident expert in a series of presentations. The American Red Cross comes in one week to teach CPR; the American Heart Association teaches about hypertension; the American Diabetes Association teaches about diabetes; the DARE officer talks about drugs; the American Lung Association teaches about smoking etc. They represent didactic teaching that is necessary to address common health problems.

Didactic teaching is passive. The learner sits and listens to a lecture. It is an efficient means of transmitting information. But the goal of a lay health program is to assist the lay health persons to identify and address the problems that contribute to poor health -- problems such as poor nutrition, inadequate exercise, improper discipline of children in the home, not having a personal relationship with God through Jesus Christ -- so that they can help themselves and others to live healthier lives. This requires interaction with the learners. Adult education methodology facilitates discussion, is based on the knowledge and experience of the learner, and is directed toward action.

Because it is not the way we have traditionally been taught in school, adult education methods need to be taught to the program leaders so that they can use them in their teaching of lay health personnel. The Luke Society has cosponsored two three-day workshops on adult education methods for persons interested in lay health programs.

Lessons learned

1. The Lord is building His Kingdom. We are privileged to be a part of the process. Each person is uniquely gifted for his/her part in the process. *It is important to take the time to appreciate the strengths of each of the people whom God has called; begin with where they are and the vision and calling that God has given them; and seek God's guidance for direction in developing a program.*

2. *We are fighting a spiritual battle.*

Satan will use all sorts of wiles to discourage us. Sexual sin has been a stronghold for Satan in many areas. Therefore, programs like Teen Treasures are extremely vulnerable and require much prayer support.

3. *Don't rush. Don't give up too quickly.*

It's easy to get ahead of God. We need to remember that He exists in a timeless world and acts in time with His plan. Also, it takes time to build trusting relationships. The success of lay health programs is built on trusting relationships - the relationship between the program leader and the lay health person, the relationship between the lay health person and the community they are serving, and most important of all, their relationships as brothers and sisters in Christ.

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Model # 11:

The Luke Society: Developing Domestic Ministries in the USA (part 7)

4. Remain flexible.

Sometimes God uses a lay health program as a means not as an end. Often we think we are responsible for building the Kingdom and use lay health programs to do it. In fact, He is using the lay health program to teach us about becoming the people of the Kingdom He is building. This gives us the freedom to change direction when God dictates a change, and to be content with what He is doing in the lives of others, even if it isn't what we have planned.

Domestic Mission Programs of the Luke Society, Inc.

Care Pregnancy Center, Augusta, GA

The crisis pregnancy center has a broader vision for health than preventing abortion. Ophelia Simpson lives in the Cherry Tree housing project and is committed to helping her neighbors who want to improve their lives. She and Tricia Moseley, the health educator, are assisting some of the young moms in practical ways, building trusting relationships, and inviting them to Bible study. The plan is to identify women who share their commitment and teach them to reach out to others. The center also has a well-child clinic run by a nurse practitioner.

Cary Christian Center, Cary, MS

Care Newhof heads up the parent child program at Cary and oversees the lay home visitors. This program is the basis of the video, *Christians Revolutionizing Health Care* and the prenatal and parenting lesson plans.

Jodi Pyper is the nurse in the medical clinic. She has had a burden to reach out to the young girls in the community and provide them with the motivation and skills necessary to postpone sexual activity until marriage. Last year she met with, was a role model for, and the cheerleader for nine middle school girls. They call themselves Teen Treasures. The girls in turn have shared their knowledge about STDs, birth control and abstinence with their peers. They are now assisting Jodi as the teachers of the next group of Teen Treasures.

Chicago Uptown Ministry, Chicago, IL

Jo Ann Gragnani-Boss was the parish nurse for Chicago Uptown Ministry, an inner-city Lutheran ministry that addresses some of the basic needs of the homeless, immigrant, and multiply challenged persons that make up the melting pot of Chicago. Ted Yuen is the health educator that has coordinated the training and follow up of lay persons in general health and hypertension. Classes have included persons from the Philippines, Ethiopia, Native Americans, Hispanics, and African Americans and has been taught in English, Spanish and Amharic. The newest program is a Kids Helping Kids program, a program that seeks to help children identify and deal with strong emotions, such as anger, from a Biblical perspective.

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Model # 11:

The Luke Society: Developing Domestic Ministries in the USA (part 8)

Good Samaritan Clinic, Wichita, KS

The Good Samaritan Clinic is part of the World Impact ministry in Wichita. Kim Snapp, M.D. is an internist who is the medical director of the clinic that serves the mostly African American population of Wichita. The nurse in the clinic has been working with June Hicks to pilot the Stephen's Ministry program to the World Impact Staff. June was trained as a trainer in the Stephen's Ministry. The setting of a clinic rather than a church as well as the target population of African Americans has required modification of the Stephen's ministry materials. June plans to train the mentors of the World Impact By Their Love program, a comprehensive program for single parent teenagers. The next step will be to identify and train community persons to visit and provide health and spiritual counseling to clients of the clinic

healthCARE, Muskegon Heights, NE

Wilmer Cullen was first trained as a healthCARE worker and now coordinates the training and supervision of the lay health program. The program trains people from African American churches in the Muskegon area to visit the elderly, take blood pressures, provide health education in after school programs, etc. Brian Hinken has recently been appointed the Administrative Director and works closely with Wilmer to give direction to the organization, and work with the board of directors to insure the financial support and administration of the program. Hackley Hospital is partnering with healthCARE as a community outreach program of the hospital.

New City Fellowship, New Hope Health Ministry, St. Louis, MO

Kathy Rice is a master's prepared nurse in community health whose husband Tim is a primary care physician (internal medicine and pediatrics). Together they are the team that is planning and coordinating the health outreach of the New City Fellowship Church (PCA). Since January 1996, Kathy has trained two women, Christine and Kim, who live in the target area of St. Louis. They are working with the local public health clinic to identify and follow up on high risk pregnant women. Their presence in the community has already led to some of the young girls coming to them to talk about parenting, contraception, and other concerns.

Place of Promise, Boston, MA

Beth Kidd RN is the founder of Place of Promise, a home that takes in multiply injured persons. Many are substance abusers and/or HIV positive. Because the resources are available in Boston, but many of the persons whom she assists do not know how to access them, Beth and Pastor Shaun Harrison are training committed persons to serve as systems advocates and mentors to the people under the care of Place of Promise. Pastor Shaun is also beginning a youth program that will address the problems of gangs.

Victory Body of Christ, Luke IV Health Ministry, Gary, IN 46408

This Full Gospel Church has been ministering to the needy of Gary, IN through a food and clothing distribution program that is coupled with an offer to do a home Bible study. Volunteers from the church have been trained to do home Bible studies one on one. The church has also had a vision to provide health care through the

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Model # 11:

The Luke Society: Developing Domestic Ministries in the USA (part 9)

ministry they named Luke IV. It includes a free clinic and health teaching ministry. The plan is to include health promotion with the home Bible Study program. Sharon Randolph heads that ministry with input from Beatrice Eddie who is a nurse and home Bible study leader.

Vicksburg Family Development, Vicksburg, MS

Vicksburg Family Development has had a big sister program that paired mentors with the younger sisters of the teen mothers involved in the parenting program. The big sister program was successful in decreasing the teen pregnancy of these girls. The big sisters expressed a concern that there were also little brothers in the homes that often had no male role models. Linda Sweezer, co-director of VFDS approached Joseph Johnson with the idea of developing a big brother program called Male Image. The program has trained men to serve as big brothers and mentors. It differs from the little sister program by including a weekly Bible Study that provides the foundation for a discussion of issues that these young men face. School is emphasized and tutoring in homework is also an important element of the program. Of course, there are field trips and activities that engage the boys.

World Outreach Inc., Jacksonville, FL

Cindy Cooke-Dew, RN has used Resource Mothers materials to train women from supporting churches to become resource moms to pregnant teens in a program she calls Baby LUV. The response from the teens and the resource moms has been great! Currently Cindy is working on a new after school program, Discovery Club, designed for children from abusive homes that will in addition to tutoring include teaching caring behaviors through looking after a horse at a local stable.

1/21/97

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Model # 12:

Lighthouse for Christ Mission & Eye Centre in Kenya

Timothy S. Ghrist

This project utilizes resident and volunteer ophthalmologists working in a clinic and surgery centre in Mombasa, Kenya. They collaborate closely with chaplains, specially trained in evangelism of Moslems, Hindus and other traditional African religions as animism and spiritism.

The Vision and Organizing Principles

The clinic was begun by Dr. William Ghrist in 1969. After having served in a small bush hospital for 2 years, he moved to the second largest city of Kenya (Mombasa). He determined from his past experience that he needed to be in a large population center, so that a specialty (ophthalmology) practice could thrive. In that same year he attended a "lay institute for evangelism" with Campus Crusade for Christ and saw the need to combine aggressive evangelism with ophthalmic care.

For the first 12 years, the clinic was a "one-ophthalmologist" outpatient practice. From the start, before outpatient surgery was popular in the rest of the world, the clinic did all its regular surgery on an outpatient basis. In the 1970's when post-cataract patients were being kept on strict bed rest for a week, with sand bags to each side of the head, he was sending them home the same day with no particular post-op complications. One patient even fell and injured his lip getting off the operating room table, but the eye was unaffected.

Also from the beginning there was a strong attempt to have as modern and progressive a medical practice as possible. First-rate equipment was brought to Africa and surgical microscopes were acquired. The first intraocular lens implant in the country was done at the clinic, and it introduced the first use of the laser.

Another key to his practice was the decision that continuing education was vital to keeping current. Every other year, Dr. Ghrist would return to the USA for a short 4 month furlough and would attend the Academy of Ophthalmology and other eye courses.

In combining evangelism with ophthalmology, each day Dr. Ghrist or his wife would open the clinic with a Gospel talk and would speak to many of the patients about their need to know Jesus. He prayed with every surgical patient. All employees and technicians of the clinic were trained in personal evangelism and expected to witness on a regular basis. From the beginning a Sunday School was held in the clinic waiting room that soon became a church on the roof of the clinic. By early 1980, seven churches had been planted from the witness of the clinic.

In late 1982, Dr. William Ghrist was found to have a very fast growing cancer. He returned to the USA and died in May 1983. but his vision continued. After his death, Tim Ghrist, his son, became the mission director and within 2 years, Dr. Dean Larson, MD assumed the position of medical director. Under their leadership, in the 80's the clinic began to grow from about 500 surgeries a year to 800 and a short term volunteer doctor program began which provided a second ophthalmologist helping about 50% of the time. A number of Rotary Club grants were given to upgrade equipment, and with the addition of nationals, the staff grew from seven to about 20.

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Model # 12:

Lighthouse for Christ Mission & Eye Centre in Kenya (part 2)

Still the spiritual side was emphasized and during this time chaplains were trained with the idea in mind that every patient should have a brief 5-10 minute presentation of the Gospel. A large screen TV and video was acquired and "The Jesus Film" was shown twice a day. A Bible school was also begun to help young men grow in the Lord.

At present the clinic has two full-time ophthalmologists and depends upon the volunteer doctor program to provide another ophthalmologist about three-fourths of the time. A Kenyan clinical officer (nurse practitioner) is being trained. Monthly, about 1500 patients are being seen and approximately 100 surgeries are being performed. The most common surgery is cataract extraction, and most are done with intraocular lens implants. Two mobile eye camps are also held each month.

Motivation for Integration

"What does it profit if you gain the whole world, yet lose your soul?" From this passage comes the brunt of our motivation. Many are the Christian medical ministries around the world that get sucked into the trap of doing good and healing the bodies of men. But what is the profit eternally, unless the patient is moved toward the cross?

From a Muslim evangelism course that I took, I was made aware that I should not simply look at people as Christian or non-Christian. People and cultures are at varying points in their readiness to accept the Lord. The Engles scale (I believe that was the name) ranks people from -10 to +3. A "0" was ready to accept Jesus and just needed to be challenged to pray to receive Christ. A +3 was a mature, multiplying, disciplined person. The values of -1 to -10 spoke of readiness to receive Christ and how much negative information individuals would have to overcome.

Part of our purpose with every contact is to move the person closer up the scale toward salvation without causing damage along the way. About 60% of our patients are Muslim and much of what we do is show "The Jesus Film". For most, this is the first time they have seen the full life of the Historical Jesus. We also give testimonies using the following pattern: my lost condition, how I found and accepted Jesus, and how much my life has changed because I know Him.

All our staff are trained to be evangelists and are looking for opportunities to share in word, in loving actions, or in prayer. We are continually reminded that though each patient comes to us sick in their physical eyes, they are also sick spiritually and that to withhold treatment of the spirit would be just as negligent as withholding the physical treatment. It is the "Good News"!

Approach to Integration

Leadership stresses integration. The Board of Directors strongly feels that a physical ministry which does not include aggressive evangelism (where legally permitted) is only doing the least important half of the task of ministry. As mission director, I push the need to keep the spiritual as a priority as important as the physical. Furthermore, all resident doctors are born again and active in spiritual ministry themselves.

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Model # 12:

Lighthouse for Christ Mission & Eye Centre in Kenya (part 3)

All missionary and national staff have the role of evangelist as part of their job descriptions. All receive training and are expected to be evangelists. To emphasize the importance of this role, effectiveness in evangelism is part of the evaluation done every 6 months for promotion and salary increases.

While everyone receives some training, chaplains are trained in special evangelism to reach Muslims, Hindus, and other traditional African religions (animism and spiritism). We want them to be able to relate to the diverse patient population. We try to create a Christian working environment. Every morning begins with a short Bible devotion and prayer. Evangelism and Christian character are praised and rewarded.

We have as high a standard of eye care as we can, keeping it as close to 'US' standards as possible with the staffing, equipment, supplies and finances we have. One purpose is that people of all faiths, and tribal and cultural backgrounds will want to come to us. (Our patient population is diverse: 60% Muslim, 35% non-coastal tribal people, 4% Asian, 1% European).

The high standard allows us to be an uplifting influence on the medical community as a whole for the country. We believe that it brings glory to God and people will give glory to God for the care and love that is shown in our center. Our final goal is that in the end, individuals will receive Jesus as Savior through our ministry.

We plan the patient routine so that every patient is presented with the Gospel at least three times. This includes a 7 AM and 2 PM group presentation of the Gospel by way of a testimony. These group talks are shared by all national and missionary staff. We then have the patients registered and triaged, and they are asked to wait in a waiting room where a large screen TV plays "The Jesus Film". Before seeing the doctor, a trained chaplain meets one-on-one with each patient in a private room to assess readiness to accept the Lord. If the patient seems ready, the chaplain gives a challenge to receive Christ. Otherwise, a gentle informational talk on how a person could accept Jesus as Savior is presented. Purposely, we teach our staff not to argue or pressure, but to let the Holy Spirit do the opening of hearts. We are there to show love, care, plant seed, water and sometimes harvest, when God gives the increase.

When we go to eye camps or screening situations, we can often see well over 200-300 patients in a single day with an average team consisting of 1 doctor and 5 attendants. For this, we give a tract to every patient and a chaplain begins the clinic with a ten-minute talk while the rest of the team members are setting up. The chaplain then progresses up and down the long line of waiting patients, talking with those who are interested in hearing more.

We emphasize to our staff that Christians can do at least three things to witness to Muslims and yet not be offensive:

*Show that Jesus is alive and real in your life, and He makes a difference.
Explain that difference to others.

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Model # 12:

Lighthouse for Christ Mission & Eye Centre in Kenya (part 4)

*Ask the person: "How did you become a Muslim?" This gives you a chance to listen carefully and be interested in the life of the other person. It also earns the right to share how you became a Christian.

*When you find a Muslim who is ill, ask if you may pray for him or her, stating that in Christianity we pray to Jesus for the sick. The Muslims here believe that Jesus is the Prophet of Healing, and do not refuse.

Prayer in the name of Jesus often gives God a means of getting their attention as He works in their lives, through healing and other events.

Animists come to us with charms to ward off evil spirits hanging from their necks, or dangling around their wrists. Before surgery, we emphasize prayer for protection from the Great Spirit who created the entire world. The result of their acceptance of the Gospel is like a page from the Bible in the book of Acts. They cut off the charms and burn them.

The Volunteer Ophthalmologist Program

Volunteer physicians are an integral part of this ministry and are recruited from at least two major sources. The Christian Ophthalmological Society has shared a mailing list of 700-800 members with the Lighthouse for Christ Mission. We send mailings to these people. Also, the Academy of Ophthalmology has an annual convention which I attend. I arrange for a booth in the exhibit area to advertise the work and talk with prospective volunteers.

The policy for volunteers is non-discriminatory. They do not have to be Christians. However, it is made clear that they will be working with a church-based mission and they are asked to adhere to a "statement of practice" while with us in Kenya. This includes things as refraining from drinking alcoholic beverages, smoking and extra-marital sex. It is explained that they must maintain a lifestyle which will not be offensive to the Muslims and other populations with whom they will be working. If the individual is not a Christian, someone from the mission is assigned to clearly explain the gospel message during the stay.

As soon as the mission receives a letter of interest, a volunteer in the USA gives the physician a personal telephone call. The purpose is to explain the work further and to get a commitment for a particular month. (The minimum stay is 3 weeks.)

This program maintains standards of excellence. Once the application has been received, a physician from the USA reviews the individual's credentials and qualifications. If there is any doubt of competency, the applicant will be asked for a video tape of performance of the surgical procedure(s) in question. If the reviewing doctor is not satisfied, the volunteer may still participate, but with the stipulation that he/she will be doing medical ophthalmology, not surgery. The mission does not allow their patients to be "used for practice".

While in Kenya, the mission provides a place to stay and a car. The visiting doctors are responsible for their own airfare, food, and money for tourist activities. They are considered a part of the ministry, and work closely with resident mission ophthalmologists.

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Model # 12:

Lighthouse for Christ Mission & Eye Centre in Kenya (part 5)

Challenges overcome

One issue has been missionary doctors who wanted a sharp division between spiritual and physical ministries. Usually this meant they did not want to do spiritual ministry themselves. They saw the spiritual ministry as something that "slowed down the works" and was not as important as taking care of peoples' physical vision. However, the mission director refused to allow the spiritual care to become subservient. At times it actually became necessary to refuse to allow the doctor to sign up for another term of service.

It has been a challenge to limit chaplains and other staff to giving their testimonies in a timely manner. We have a strict 15 minute maximum for our testimony talks. We emphasize that "short and sweet" is more effective than "long and boring".

Sometimes, we have had staff who talk so much about the Lord that they cannot get their regular work done. It can be a hard tight-rope to walk, keeping the balance. We want our staff to be talking about Christ, but we must also show physical caring. The supervisor has been able to take the employee aside privately and clarify job description and expectations in handling this issue.

Follow-up is our hardest and biggest problem, as we often see over 100 patients in a day and over 100 pray to receive the Lord in a month. Furthermore, our postal system has only post office boxes and no residential addresses. It has been very difficult to follow up on decisions. Generally we refer to local churches in the area near where the individual lives. We send letters and we have invited them to weekly teas, but we are not as effective in this area as we would like.

Results

On the average, about 100 decisions are made and recorded each month. There are now 18 churches, and the Bible School trains about 10 students per year. Though situated in a predominately Muslim culture, there is a great feeling among the community that the Lighthouse is a place where excellent eye care is given by a loving and caring staff.

Lessons Learned

1. Keep the spiritual purpose as high as the physical or it can easily get pushed aside

As time is limited, space is limited, staff are limited, and funds are limited, the physical demands can crowd out the care of the spiritual side of patients and relatives. *Matthew 16:26* has to be repeated constantly, especially to Western medical staff.

2. Take time for evangelism seminars for all staff, missionary and nationals as well.

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Model # 12:

Lighthouse for Christ Mission & Eye Centre in Kenya (part 6)

3. Attempt to give multiple exposures to the Gospel with the strategy to move the patients closer to Christ.

As Paul mentions, one sows, another waters, and someone else harvests. This is why we show "The Jesus Film", have testimonies, encourage all staff to speak and pray, and finally, arrange for a chaplain's short interview in private.

4. Encourage an atmosphere of prayer for individual patients as well as the work as a whole.

"Not by might, or by power, but by MY Spirit says the Lord."

For more information:

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Models of Christian Witness in Health Care

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The Challenge

A theme pervading this research has been the need for prayer and dependence upon the Holy Spirit for guidance and wisdom. The result of that prayer has been a wide variety of projects, each uniquely adapted to its own specific context. Within the uniqueness of each project, however, there are elements which could easily be adapted to other areas. For example, one person mentioned utilizing principles of TEE (theological education by extension), and developed a health education by extension. Time and space do not allow the in-depth telling of many other stories, but several more creative approaches to health care ministry will be briefly outlined here.

The Vellore Hospital in India has a unique chaplaincy program. Each chaplain is not only assigned to the traditional load of patients but also is responsible for a group of caregivers in the hospital. Departments of the hospital meet weekly with the assigned chaplain to gain spiritual insights and to discuss spiritual care for specific individuals.

Dr. Harold Cross of Maine has developed a creative computer program which is being used in area high schools. It is a health assessment program which helps to identify high risk physical, emotional, and spiritual behaviors. Students receive feedback on commendable and risky life style behaviors.

In one area of Africa, the primary lay health workers are the pastors and elders of the churches. If out-of-area patients need to stay for treatment, the local Christians feed and house them, giving opportunity for showing Christian compassion and sharing the gospel.

Parish nurse programs are being developed in the USA to meet health care needs of church members. Nurses are hired as staff, sometimes designated as the Minister of Health. They work closely with pastors to do health assessment and teaching, counseling and referrals to community resources. They also coordinate volunteer efforts to provide help for the elderly and chronically ill. Here the nurse has the ideal opportunity for the integration of theology and health care.

In the area of training for a short-term health care missions experience, the First Baptist Church of Pensacola, Florida has a unique program. A group of 10 MD's each trained 11th and 12th graders for one year before the trip. This mentoring relationship involved teaching/learning the skills needed to set up and run clinics, as well as opportunities for spiritual growth and development. In the Dominican Republic, the teams did hospital/clinic work by day, and music programs with witnessing in the evenings.

Several Christian organizations in Mississippi have discussed joining together to begin a managed care health service for the poor. Through cooperative agreements, they will be able to pool resources for more effective health care.

Many ideas have been shared in this report, but the dream of those working on this research project is that the information and insights gained will not remain within the covers of this book. Instead, it is our hope that these will be utilized by readers to create new ministries around the world. The desired result is that every Christian health care worker will become an effective minister in using health care as a vehicle to fulfill the Great Commission.

