A Health Evangelism Strategy for Reaching Rural Indians with Giffard Memorial Hospital as a Model

Measapogu Wilson

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ABSTRACT

A HEALTH EVANGELISM STRATEGY FOR REACHING RURAL INDIANS WITH THE GIFFARD MEMORIAL HOSPITAL AS A MODEL

by

Measapogu Wilson

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Title: A HEALTH EVANGELISM STRATEGY FOR REACHING RURAL INDIANS WITH GIFFARD MEMORIAL HOSPITAL AS A MODEL

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Date completed: August 1999

Problem

Like many nations, India offers notable opportunities for church growth in spite of its diverse cultural and language barriers. The challenge is to understand the growing populations.

Masses of Indians are suffering from disease, poverty, and ignorance. They desperately need to achieve health and learn how to maintain it. About 80 percent of the Indian population lives below the poverty line and many are ignorant of healthful living. Health evangelism work can break down prejudice as nothing else can.
At the same time, India is resistant to the gospel. A recent census shows that there are only 2.43 percent adhering to Christianity.

There seems to be a close relationship between health evangelism and church growth. In the prevailing condition, health evangelism is an effective way to reach the Indian masses.

Between 1950 and 1980, in an economically and socially backward rural area, Giffard Memorial Hospital (GMH) contributed to the establishment of thirty-five churches with a membership of 100 to 150 in each congregation.

Results

A contextualized strategy for health evangelism in India has been developed. The approach suggests the use of medical centers through Medical Evangelism Team (MET), local churches through Church Health Evangelism Team (CHET), and educational centers for a definite health evangelism—done in three steps: (1) Orientation and training, (2) Implementation of the program, and (3) Evaluation of the work done.

Conclusion

Health evangelism is a more effective and contextualized approach to reach Indians than the traditional evangelistic approach. A health approach provides access that many
cannot reject. Such work will find access to hearts and minds and will be a bridge to convert many to the truth. This is the right agenda for the remnant church in India.
A HEALTH EVANGELISM STRATEGY FOR
REACHING RURAL INDIANS WITH THE
GIFFARD MEMORIAL HOSPITAL AS A MODEL

A dissertation
presented in partial fulfillment
of the requirements for the degree
Doctor of Ministry

by

Measapogu Wilson

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To all who are genuinely interested
in reaching the Indian masses
for Jesus

Also to
Measapogu Sunder Rao, my father
Measapogu Varamma Rao, my mother
Measapogu Sofia Wilson, my wife--
for helping me shine
for Jesus the Savior
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ACKNOWLEDGMENTS

I would like to thank God and give Him the glory and honor for giving me an opportunity to study, and for giving me health and strength to write on this topic, which I hope will help create bridges of understanding and open doors to effectively influencing the Indian masses for Christ. I am very much indebted to the D.Min. dissertation committee, Dr. Bruce L. Bauer (chairperson), Dr. Jon L. Dybdahl, chair of the Mission Department at Andrews University, Dr. Nancy Vyhmeister and Dr. Selvaraj Muthaiah for approving my project and for their untiring guidance and corrections in shaping this paper.

My sincere appreciation to Dr. M. E. Cherian (late) for being my mentor in college, for encouraging me in ministry, and for supporting the D.Min. program of which I have been a part. Dr. John Sunderajan, Dr. Philip Virdhan, and Dr. Ronnie Gyi have also given many valuable suggestions in bringing this paper to an acceptable conclusion.

I am thankful to the Southern Asia Division for having given me an opportunity to study, and to Andrews University.
and its professors for equipping me with better knowledge for the strategic work in my ministry. I am grateful to Dr. Bruce L. Bauer and his wife, Linda, and to Dr. Gordon Christo for their vision and encouragement. Dr. Nancy Vyhmeister was tireless in her work on my manuscripts and gave valuable suggestions for the editing of this paper.

I offer my humble services in reaching the Indian masses in a contextualized and strategic manner with health evangelism to help in breaking down barriers and influencing people for Christ.

Finally, my sincere thanks to my parents who supported and encouraged me throughout my academic life; who, though not educated, emphasized the value of education; to my wife, Sofia, who inspired and supported me in joys and sorrows to complete this study; and to Vandaman and Queenston, my two children, who accepted my absence each summer when they needed me most. A special thanks to the Nuzvid church members who upheld me in their prayers, and to Latha, Anand, and Joseph for their moral support.
"Go ye into all the world and teach all nations" (Mark 16:14). This command from the Lord gives a sense of responsibility and constitutes a call for urgency. The church is at the very center of God's cosmic purpose and is His appointed agency for the salvation of all people. It was organized for service, and its mission is to carry the gospel to the world.¹

India is resistant to the gospel. At the same time, the Indian masses are in great need of medical assistance and health education. Ellen White has said that "the medical missionary work is to be a great entering wedge."² Experience has shown that health programs attract a variety of people, many of whom would never attend an Adventist church meeting for any other reason. "This work will break


down prejudice as nothing else can."¹ Many very prejudiced people have had their hearts softened by kind and sympathetic ministry to their physical needs. Thus the way has been "prepared for more decided proclamation of the truth."²

The example of Giffard Memorial Hospital suggests that medical assistance and health education can be used as an effective evangelistic method. One must ask what methods bring better results, which method works to train more church planters and mentors, and what produces greater results in the growth of the church.

Like many nations, India offers notable opportunities for church growth in spite of its diverse cultural and linguistic barriers. The challenge is to understand the growing gap between rural masses and modernizing urban populations. Theodore Williams enquires: "How many preachers and missionaries have labored in our country? And yet, how few have turned to the Lord; . . . there is certainly a place for multiplication and growth."³

While there is rather slow growth in evangelism, many

¹Ibid., 515.
²Ibid., 514.
in India are attracted by the Christian educational system. They also embrace the concept of Christian service and sacrifice as demonstrated by Mother Theresa of Calcutta who saw the face of Jesus in every dying destitute.¹ They are also being attracted to the simple lifestyle and non-violence principles developed by Gandhiji who was also influenced by the teachings of Christ.

Jonathan Lewis says that people reject the gospel for two reasons, even when they want to believe: (1) It appears to be alien, and (2) it seems to be a threat to their culture. On the other hand, they are more open when the gospel meets their needs. Health is a vehicle to carry the gospel into the homes where there is caste, and community or ethnic prejudice. It provides an access that cannot be rejected.²

Concerning the importance of health, U. N. Bhatt wrote: "Health is a partner in over-all socio-economic development." He then added: "Health directs toward the promotion of a general state of well being."³ On the same


³U. N. Bhatt, Public Health in India (Hyderabad: Bapuji Press, 1975), 27.
topic, Hiroshi Nakajima, director general of the World Health Organization, said: "Health is our most precious possession both individually and collectively. Let us communicate health rather than disease, let us talk about it. Nothing is possible without health."¹

Writing on the importance of health, Christian authors L. R. Dolson and J. R. Spangler expressed:

However, as we near the end of time we would expect that interest in health would be dramatically increased in our world. As tragedy piles on tragedy and man-made disaster is added to natural disaster, the lack of ample medical care facilities and health personnel is becoming increasingly apparent.²

As the end time approaches, Christianity should venture into a most effective method: Health Evangelism. Ellen White affirmed, "Nothing will open doors for the truth like evangelistic medical missionary work. This will find access to hearts and minds and will be a means of converting many to the truth."³

In planning for the future, the Adventist church in India should possess the vision to focus on health evangelism to achieve better results. Thus the work in

¹Ibid., 95.


India will grow faster and cross-culturally strong with many church planters and mentors.

**Purpose of the Study**

This study examines health evangelism as a viable evangelistic method in the Indian context, especially in reaching Indian rural masses with special reference to church growth at Giffard Memorial Hospital, Nuzvid.

**Justification for the Research**

Masses of Indians are suffering from disease, poverty, and ignorance of healthful living. They desperately need to achieve health and learn to maintain it. About 80 percent of the Indian population live below the poverty line and many are ignorant of healthful practices.

There seems to be a close relationship between health evangelism and church growth. The former supports the latter in breaking ethnic, social, and religious barriers to pave the way for Christian influence. In the prevailing condition, health evangelism might be an effective way to reach the Indian masses.

The Seventh-day Adventist Hospital at Nuzvid, Giffard

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2Ibid.
Memorial Hospital, has exhibited an attractive Christian influence and has fostered church growth in an Indian rural context. Between 1950 and 1980, in an economically and socially backward rural area, Giffard Memorial Hospital (GMH) contributed to establishing thirty-five churches with a membership of 100 to 150 in each congregation.¹

In this study the strategies used by GMH will be evaluated, and workable programs for medical, church, and educational centers will be suggested. Perhaps this will result in greater growth and influence for the church in India.

Methodology Followed

This study began by examining the theoretical basis for health evangelism. The Bible and the writings of Ellen G. White were especially rich in information. As a next step the impact of health evangelism on church growth was studied. The present health situation in India is examined. The history of Giffard Memorial Hospital was reviewed, with special attention paid to the development of the churches surrounding the institution.

Strategies employed in achieving the planting of

twenty churches and ten companies were analyzed. On the basis of the theory and the practical example of Giffard Memorial Hospital, new strategies for health evangelism were developed.

The researcher has been in touch with this medical center for twenty years, and has observed its developments. Further, he depended on interviews and personal experiences of the people in touch with the hospital. Books related to Adventist medical missionary work, health and evangelism, magazines, and diaries of missionaries, as well as testimonies of people healed, were used as sources.

Interviews with available pioneers and workers connected with Giffard Memorial Hospital were a part of this research. The goals of these interviews were:

1. To find what made the hospital team venture into outreach programs while doing medical work
2. To discover what methods and activities they fostered and to know some of the successes and failures in the outreach they undertook
3. To explore possible ways in which they could enhance their ministries
4. Further, to recommend such methods to health centers interested in church growth.

Based on these sources, conclusions were drawn to
develop an appropriate strategy for church and medical workers.

Overview of the Dissertation

This study is divided into six chapters. The first chapter is the introduction of the study, stating the purpose and exploring the reasons why this study has been undertaken. It also explains the methodology followed and states the way the study is organized.

Chapter 2 is theoretical, dealing with literature on health evangelism and its impact on church growth. Chapter 3 explains the setting and health needs of India. Chapter 4 tells the history of Giffard Memorial Hospital.

Chapter 5 narrates the planting of "daughter churches" as a result of the outreach work by Giffard Memorial Hospital. It also evaluates strategies used. Chapter 6 develops a strategy for health evangelism in India. Chapter 7 summarizes the work done, presents conclusions drawn, and makes recommendations for the further implementation of the gospel task.

With these basic guidelines for the research, chapter 2 deals with the theoretical basis for health evangelism from the Bible and writings of Ellen White.
CHAPTER 2

HEALTH EVANGELISM

The center of Christianity is Christ, the Creator of the universe who loves mankind (John 1:1-3,14). He is the model demonstrator of health, happiness, and service. The incarnated God served humanity in a strategic way. Ellen White wrote:

The Savior mingled with men as one who desired their good. He showed His sympathy for them, ministered to their needs, and won their confidence. Then He bade them, "Follow Me." There is need of coming close to the people by personal effort. If less time were given to sermonizing, and more time were spent in personal ministry, greater results would be seen.¹

This chapter describes health from a biblical standpoint and from the writings of Ellen White. Finally, it considers the impact of health ministry on the evangelistic work of the church.

Biblical Understanding of Health

From the beginning God intended His people to live a

harmonious, healthful life. Health is a blessing from the Lord who created life and blessed it with abundant resources to grow and be a blessing in turn to others.

The Bible is the basis for all Christian standards of living. It is the gift from the Lord to guide human beings from darkness into light (Ps 119:105). God's purpose through the plan of salvation is to radiate this light to all nations, kindred, and tongues (John 3:16; Rev 14:6-12). This can be accomplished by a proper understanding of health joined with a right strategy for evangelism.

The first and basic need for human beings is health. It is a basic foundation on which life and its enjoyment are built. God is the source of life and health (John 14:6) and in Jesus Christ He gave life in its fullness (John 10:10). Physical, mental, and spiritual well-being are the basic dimensions of every individual's life. This means health, happiness, and holiness.

Leo R. Van Dolson and J. Robert Spangler state that the World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."¹

The crowning act of creation is humankind (Gen 1:26). The human race was created perfect—physically, mentally, 

¹Van Dolson and Spangler, 56.
socially, and spiritually in the image of God. Because of sin, humanity has to fully understand the relation between healthy living and obedience to God.

Humanity from the Creator's Hand

In the beginning God created man and woman in His own image and blessed them with abundant life, health, and prosperity (Gen 1:1, 26-28). The origin of the human race is found in a divine council. God said, "Let us make man" (Gen 1:26). "God formed man from the dust of the ground, and breathed into his nostrils the breath of life; and man became a living soul" (Gen 2:7).

Adam, the first created human being, was perfect and sinless (Gen 2:7; 1:31). For continual growth and prosperity, God and His laws were the basis for all human life, but disobedience brought sin (Gen 2:17), which resulted in sickness, disease, suffering, and even death (Rom 6:23).

God's promise to the Israelites was that if they would obey Him, they would enjoy the good of the land that He was giving them (Deut 28:1-14). He also promised: "I will put none of these diseases upon you which I put upon the Egyptians; for I am the Lord, your healer" (Exod 15:26). Luther's translation of this last phrase is interesting: "I
am the Lord, your physician."¹

As laws of God, the laws of nature are designed for our good; obedience to them promotes happiness in this life, and aids in the preparation for the life to come.² The responsibility of human beings as children of God is to obey God by following His statutes and demonstrating to the world obedience to God through life and service (Exod 20:1-17).

In the Bible there are many instances in which faithful servants of God determined to demonstrate God's holy principles in spite of dangers and trials. Writing about the Babylonian medical missionaries, Dolson and Spangler said:

These young men [Shadrach, Meshack, and Abednego] witnessed, first of all, through a decided stand on health reform. They became known as the healthiest, happiest, wisest, and, yes, the holiest inhabitants of the entire kingdom.³

Through healthful living, God's children are to demonstrate a healthful life, and thus influence many others to seek the Lord, who is the giver of life and health. By this God has purposed to expand His kingdom in this sin-sick world (Deut 28:13).

¹Martin Kobialka, The Challenge of India (Pune: Spicer Memorial College, 1989), 45
²White, Counsels on Health, 390.
³Van Dolson and Spangler, 10.
Human beings are subject to the laws instituted by the Creator; therefore, their physical as well as mental, social, and spiritual well-being is enhanced as they intelligently understand and live in conformity with these God-appointed precepts. Writing about health and the Bible, Dolson and Spangler say, "A truly healthy person, from the Biblical viewpoint, is one who is physically well, mentally alert, socially concerned, and spiritually committed."¹

Christian anthropology affirms the perfect and indissoluble unity of the human being. But it also indicates that the body is to the soul what the outside of the cup is to the inside. Both are the work of God. Jean Zurcher points out:

Man is never more than the perfect expression of the interior man. . . . There is only a trace of dualism [in this concept], but also it is said that the interior man is the very same as the moral and physical corruption of man.²

Mosaic Health Regulations

When God created man in His Image (Gen 2: 26), it was the intention of God that they enjoy optimum health. Disobedience brought sin and sickness. Before the flood there is no account in the Bible of men and women dying of

¹Ibid., 44.

diseases. Obituary notices read like this: "And all the days that Adam lived were nine hundred and thirty years; and he died. And all the days of Seth were nine hundred and twelve years; and he died" (Gen 5:4, 5).

Our first parents and people in the patriarchal period were naturally healthy; they followed the precepts of the Lord. As a result their longevity was strengthened. Still sin marred their existence.

The increased disobedience and violation of God's laws brought suffering and sickness.¹ The healing of the whole human race became essential to God's plan for the restoration of human beings (Heb 9:22, 28). The Lord selected the Israelite nation to represent His true character and selected an efficient leader to lead that nation. Van Dolson and Spangler see Moses as "the greatest hygienist" and "the greatest sanitary engineer" of the ancient world, and suggest that he might be considered the father of preventive medicine.²

While the Babylonians and Egyptians were advanced culturally and scientifically, the Hebrews seem to have had advanced knowledge on healthful living and higher moral


²Van Dolson and Spangler, 33.
It is characteristic of the Mosaic law, as also of all Biblical history and Prophecy, that it passes over all the intermediate steps, and refers at once to God's commandments as the foundation of all human duty. The key to it is found in the ever recurring formula, "Ye shall observe all these statutes; I am Jehovah." In fact, the central thought of the book of Exodus is obeying God as a chosen nation, and fulfilling His purposes. Commenting about the laws of Moses as a nation, J. Strong says:

The character of Hebrew religion was intense religious devotion and self-sacrifice; there was a high standard of personal holiness and connected with an ardent feeling of nationality, based on great ideas and therefore, finding its vent in their proverbial spirit of proselytism.

By following the precepts of the Lord other nations would know the Hebrew God of shalom, holiness and health. The word shalom occurs over 250 times in 213 separate verses in the Bible. The shalom has eight different meanings; each has variations or shades of meaning: the main ideas are health, prosperity, and peace.

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1Measapogu Wilson, "A Comparison of Mosaic Laws with Those of Hammurabi, Lipit-Ishtar and Ur-Nammu" (M.A. project, Spicer Memorial College, Pune, India, 1988), 58.


3Ibid., 290.

Shalom is the result of God's activity in covenant fulfillment.¹ Shalom is also the word for peace, which demonstrates that soundness of body and wholeness of mind are closely associated in Hebrew thought. Both were God-given gifts to His people. Therefore it was a religious duty for God's people to remain healthy.²

Throughout history God's intention has been that "Shalom" (wholeness, peace, prosperity and health) be a reality among God's people. Linked to the concept of "shalom" is the word "life" as used in the New Testament. Jesus said, "I came that they may have life, and have it abundantly." (John 10:10) Key to understanding health and illness, therefore, are the concepts of life and salvation. Restoration of health and the alleviation of suffering are fundamental to the announcement of God's reign, and health and healing are sometimes spoken of theologically as "signs" and "sacraments" of God's reign.³

Moses was instructed in all the wisdom of the Egyptians (Acts 7:22). It is amazing that none of the fanciful nostrums of the day appear in the Pentateuch.

Many modern health writers emphasize that the Mosaic health measures are significant beyond mere ceremonial rituals, especially in the area of dietary restrictions,


²Van Dolson and Spangler, 33.

disposal of the dead, sexual hygiene, cleanliness, and sanitation. This indicates that the all-wise God did intend that conformity to these laws would result in healthier, happier, and holier people.¹

The Hebrew perspective of health in biblical times is totally dependent on the health regulations of the Torah. Of its 613 commandments, 213 are of a medical nature. In the expansion of the Torah in the Talmud, medicine occupies an important place.²

Health in Jesus' Ministry

According to Matt 4:23, the three aspects of Jesus' Galilean ministry were (1) healing the sick, (2) teaching in the synagogues, and (3) preaching the gospel. Ellen White writes:

Christ's model of ministry is indeed a practical demonstration of the Gospel. This style of doing the work is the heart and hand of the whole church and is to be employed if the work is to be accomplished.³

When Jesus began His public ministry, He started with His own people. When He came to Nazareth where He had been brought up and as His custom was, he went into the Synagogue

¹Van Dolson and Spangler, 35.


on the Sabbath day, and stood up to read:

The Spirit of the Lord is upon me, because he hath anointed me to preach the gospel to the poor, he hath sent me to heal the broken hearted, to preach deliverance to the captives and recovering of sight to the blind, to set at liberty them that are bruised. (Luke 4:16, 18, KJV)

While doing ministry, Jesus did not throw away the local customs. He always came to the level of the people and followed the local customs in healing techniques. P. E. Adolph observed:

It is interesting to note that Christ in two cases (Mark 8:23, John 9:6) used saliva to anoint the patient's eye for healing, for it parallels the fact that the Egyptians believed saliva to be a valuable remedy for blindness, and Pliny and Tacitus both voiced similar beliefs. Short conjectures that Jesus used saliva partly to strengthen their faith, and partly to teach that the divine healing may be used hand in hand with the use of recognized medical remedies.¹

Jesus never performed a miracle unless He had a purpose. He cured people and helped them to see the sin in themselves. He asked them to sin no more (John 8:11). He further opened the way for the healed person to give testimony by going and showing himself to the priest.

Jesus aimed at healing people from physical bondage and guided them to be free from spiritual bondage as well. "Healing means the restoration to full health of one who has

been ill in body or mind (or both). This includes recovery resulting from medical treatment and spontaneous remission of a disease."¹

D. H. Trapnell goes on to affirm, "God is the one who heals all our disease" (Ps 103:3; Acts 3:12-16).² Even today when medical and surgical skill is so developed, God is the healer, using trained or untrained persons to work for Him in the same way that He uses the governing authorities to maintain order and execute justice in the world (Rom 13:1-5).

The purpose of healing is theological not physical (Jas 5:3).³ During His earthly ministry Christ healed many: twenty-six recorded healings were of individuals and ten of groups. He was trying to reach people's hearts for the restoration of all of humanity.

Some were healed at a distance; some with a word but without physical contact; some with physical contact; and some both with physical contact and some other means, as in Mark 8:23. Luke's Gospel is the only one to give the story of the good Samaritan who helped the wounded traveler (Luke


²Ibid.

³Ibid., 622.
10:29-34). It also includes five miracles of healing not recorded by the other evangelists.¹

Jesus repudiated the attitude that viewed disease simply as divine judgment upon sin (John 9:3-5). He supported medical means and emphasized healing miracles in His ministry. During His short ministry Jesus did not focus on finishing the work by Himself but recruited and trained disciples to continue His work. He then commanded them to follow the same process.²

Health in the Acts and Epistles

Following the pattern of the Gospels, the work of bringing health and healing to humanity was carried out faithfully by Jesus' followers. In the newly founded Christian church, the disciples and apostles practiced the responsibility given by Jesus.

Christ had commissioned the twelve (Matt 10:1) and seventy (Luke 10:9). In Acts there are several accounts of individual miracles, which have much the same character as those performed by Christ. The lame man in Jerusalem (Acts 3:1-11), the one at Lystra (14:8-10), the paralytic (9:33-34) are some healing instances.³


¹Ibid., 622.
²Kerina P. Misati, "Jesus' Example in Training for Evangelism" (M.A. project, Union Biblical Seminary, Pune, 1994), 49.
³Trapnell, 623.
healing power. For example, when Peter and John were going to the temple for prayer they noticed a lame man asking alms of them at the gate called beautiful.

And Peter, fastening his eyes upon him with John, said, Look on us. And he gave heed unto them, expecting to receive something of them. Then Peter said, Silver and gold have I none; but such as I have give I thee: In the name of Jesus Christ of Nazareth rise up and walk. And he took him by the right hand, and lifted him up: and immediately his feet and ankle bones received strength. And he, leaping up stood, and walked, and entered with them into the temple, walking and leaping, and praising God. (Acts 3:4-8 KJV)

While Peter and Paul (as well as Philip in Samaria) had an extensive healing ministry as recorded in the book of Acts, they were not known as divine healers, nor is there any such designation elsewhere in Scriptures. Beginning with the time of the apostles (Mark 16:17, 18; Acts 3:1-10; 5:12-16), Christians introduced "the most revolutionary and decisive change in the attitude of society towards the sick," for "Christianity came into the world as the religion of healing", as the joyful gospel of the Redeemer and of redemption.¹

The term "gift of healing" appears three times in 1 Cor 12:9, 28, 30. It is one of the gifts given to the

church. Closely associated with the gift of healing is the "working of miracles" (1 Cor 12:10, 28, 29). In the book of Acts, miracles were associated with bodily healing and the casting out of evil spirits (Acts 8:6, 7; 19:11, 12). These were described as "signs and great miracles" (Acts 8:13).¹

James counsels that the sick should call for the elders of the church who are to anoint them with oil in the name of the Lord and pray over them (Jas 5:14). Biblical anointing is symbolic of the work of the Holy Spirit, who administers the manifestation of gifts (1 Cor 12:8-11). The use of oil symbolized sanctified commitment of the sick body to the operation of the Holy Spirit's ministry. This would quicken the mortal bodies of believers, to fulfill the ministry (Rom 8:11-17).

At times, God's purpose may be served better by less than perfect health, as is demonstrated in the case of Paul's "thorn in the flesh" (2 Cor 12:7). The Bible supports the idea that illness, suffering, and pain are proper subjects of Christian concern but gives no guarantee that all suffering can or should be all eliminated in this present life (Gal 6:7-10).

The holistic concept of the Bible views body, mind,

and spirit as interrelated, inseparable components of the human being. The physical is not inferior and not to be despised. The New Testament portrays the body as the temple of God (1 Cor 3:16). Perhaps that is why Paul asked the Corinthians the rhetorical question: "What? Know ye not that your body is the Temple of Holy Ghost, which is in you, which ye have of God. . . . Therefore glorify God in your body and in your Spirit" (1 Cor 6:19, 20).

A dualistic concept of body as evil and spirit as good crept into the church. This brought in a divided view of man (especially during the Middle Ages) that led Christianity to place a low value on the importance of hygiene and physical fitness. Consequently, there was much death and suffering which the people blamed on "the will of God."¹

Many other concepts of people through the ages could be discussed, but a clear understanding of health is found only in the Bible. God made human beings in His image and in His likeness and said, "It is very good" (Gen 1:26,31). Though there is sin and deterioration, those who are willing to follow the principles of God find life is worth living.

The Lord in His providence foresaw an increase of sickness and disease in the last days. And He entrusted the

¹Van Dolson and Spangler, 42.
healing ministry as a gift to the Adventist church in these last days for practice and to propagate.

Ellen White's Concept of Health

One of the spiritual gifts for the last-day church is the Spirit of Prophecy. This is mainly the writings of Ellen G. White. Seventh-day Adventists believe the following:

One of the gifts of the Holy Spirit is prophecy. This gift is an identifying mark of the remnant church and was manifested in the ministry of Ellen G. White. As the Lord's messenger, her writings are a continuing and authoritative source of truth which provide for the church comfort, guidance, instruction, and correction. They also make clear that the Bible is the standard by which all teaching and experience must be tested.¹

Through inspiration she has written about many areas of Christian life relevant to the last days.² Her writings on health gave form to what Adventists have called the "health message."

In her book Welfare Ministry, Ellen White wrote about God the Mighty Healer who works with human beings, even those who have no opportunity to take a medical course.


Such persons could succeed "in the fear of God" as they "sought His guidance for wisdom at every step."¹

Her Testimony

Ellen White not only prophesied and preached what she received from the Lord, but also practiced it in her life, emphasizing the combination of gospel work with health ministry. She tells her own story:

Thus we combined prayer and labor. We used the simple water treatments, and tried to fasten the eyes of the patients on the Great Healer. We told them what He could do for them. If we can inspire the patients with hope, this is greatly to their advantage.²

A study on health and wholeness would not be complete without a survey of her comments on health and on the use of the "health message" as a missionary tool. She testified:

The Lord gave me great light on health reform; in connection with my husband, I was to be a medical missionary worker. I was to set an example for the church by taking sick to my home and caring for them.³

Medical Missionary Work

Early in her ministry the Lord revealed to her the combination of health ministry and evangelism.

²Ibid., 326.
Medical missionary work is in no case to be divorced from the gospel ministry. These two shall be as closely connected as the arm is with the body. Without this union neither part of the work is complete. It is the gospel in illustration. These two lines of work should be blended.¹

Disconnecting health from evangelism would result in a strange medley of disorganized atoms. She affirmed that the time had come when every member of the church should take hold of medical ministry work.² This would open closed doors,³ and gain access to hearts.⁴ This is exactly the pattern of Jesus' ministry. The union of Christ-like work for the body and for the soul is the true interpretation of the gospel.⁵

Medical missionary work, according to Ellen White, is the practical example of real Christianity. No charge was made for her services, and the gospel workers won the confidence of the people by the interest that they manifested in the sick and the suffering.⁶

¹White, Counsels on Health, 524.
³White, Evangelism, 513.
⁴Ibid., 514.
⁵Ibid.
By this kind of service the mind is prepared for the reception of the truth. The gospel work is to be bound up with the principles of true health reform.\(^1\) The heart and hand of the whole church is to be employed.\(^2\) Ellen White affirmed:

We shall see the medical missionary work broadening and deepening at every point of its progress, because of the inflowing of hundreds and thousands of streams, until the whole earth is covered as the waters cover the sea.\(^3\)

Every effort to heal the imbalance brought about by sin is part of genuine medical missionary work. Many have no faith in God and have lost confidence in humanity, but they appreciate acts of sympathy and helpfulness.

Establishing Medical Centers

Ellen White strongly supported the establishing of medical centers that would be symbols of love and service in the pattern of Jesus' ministry. Further she instructed that they should be different from that of the non-Adventist medical centers. While they offer curative treatment, Adventist centers must go beyond physical aspect. She said:

The Seventh-day Adventist Church must establish an

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\(^1\)White, *Testimonies for the Church*, 6:379.

\(^2\)White, "Camp Meeting at Williamsport," 13.

institution [referring to Battle Creek Sanitarium] for the treatment of the sick on rational principles, and for teaching patients how to preserve their health.¹

Further, she pointed out that such an institution, if rightly conducted, would be a means of helping the patients spiritually as well as physically. While their bodies were being treated, their minds might be opened to spiritual truths and their lives brought into closer relation with the will of the heavenly Father.²

Ellen White strongly supported the view of church work being combined with health ministry. It is indeed the pattern of God, demonstrated through Christ in His earthly ministry. In April 1906, while addressing the dignitaries gathered for the inauguration of the Loma Linda Sanitarium, Ellen White said:

Loma Linda is to be not only a sanitarium, but an educational center. A school is to be established here for the training of gospel medical missionary evangelists. Much is involved in this work, and it is very essential that a right beginning be made.³


Health Ministry and Mission

Health ministry strengthens the mission of the church. The work of the true medical missionary is largely a spiritual work. It includes prayer and the laying on of hands and impressing upon the person the need for a change of lifestyle. The implication is that if we are to reach people's hearts and change their character, we must begin by meeting physical needs and enabling them to rightly use the powers of mind and body. This will open the avenues of the soul for clear communication between man and the Holy spirit.¹

Different Opinions

There are different opinions on the relation between health or medical work and evangelism or church growth. For example, Jacob Chandy said:

The role of the medical personnel is distinctly different from that of evangelists or pastors; a sharp cleavage has developed today between the medical and the spiritual responsibilities, and different persons are entrusted with different responsibilities in keeping with their special qualifications. Medical work has largely become an end in itself in the treatment of patients, in administering medicines, or in performing an operation; there is no special feature that can be called Christian.²

¹White, Medical Ministry, 2.

In spite of assertions such as this, there is strong reason for bringing religion into health care. Medical research confirms that religion has a positive correlation to personal health. For instance, the Israel Ischemic Heart Disease Project reports that Orthodox Jews who pray daily have fewer heart attacks than those who rarely attend a synagogue.¹

Religion obviously cannot be separated from health. Because of this, medicine and psychiatry are now recognizing the need of incorporating the religious dimension into health ministry.² In an article in the American Medical News, Doctor Daniel, chairman of the American Medical Association Department of Medicine, noted that there needs to be a closer cooperation between physician and clergy for the care of the whole person.³

The American Medical Association holds that the spiritual component of every person is a large factor in problems relating to one's state of health. Further, they also believe that active cooperation between physicians and

²Van Dolson and Spangler, 19.
clergy can bring about improved patient care.¹

The gospel ministry is needed to give permanence and stability to medical missionary work and the ministry needs medical missionary work to demonstrate the practical working of the gospel. Neither part of the work is complete without the other.²

SDA Health Ministry

Health ministry has been part of Adventist church work since its beginning. World-wide, today Adventists operate approximately 159 hospitals, 306 clinics, 118 retirement homes and orphanages, three medical schools, and one dental school.³

They believe that the mission of the church can be better accomplished when proclamation, service, fellowship, and worship (1 Cor 13:1) are harmoniously intertwined. In the present "sick world" one of such strategies should be health. The reason for this emphasis is that health is a basic need for every person. Health is related to religion in that it helps one to understand the will of God and

¹Ibid.

²White, Testimonies for the Church, 6:289.

³General Conference of Seventh-day Adventists, 135th Annual Statistical Report (Silver Spring, Maryland: General Conference of SDA, 1997), 7.
provides a strong body with which to do the will of God.¹

Gospel and Health Together

Evidence of the conviction of the Seventh-day Adventist church regarding the need for balance between body and spirit, health and evangelism, is found in their fundamental statement of belief, number 21, which reads:

We are called to be a godly people who think, feel, and act in harmony with the principles of heaven. For the Spirit to recreate in us the character of our Lord we involve ourselves only in those things which will produce Christlike purity, health, and joy in our lives. This means that our amusement and entertainment should meet the highest standards of Christian taste and beauty. While recognizing cultural difference, our dress is to be simple, modest, and neat, befitting those whose true beauty does not consist of outward adornment but in the imperishable ornament of a gentle and quiet spirit. It also means because our bodies are the temples of the Holy Spirit, we are to care for them intelligently. Along with adequate exercise and rest, we are to adopt the most healthful diet possible and abstain from the unclean foods identified in the Scriptures. Since alcoholic beverages, tobacco, and the irresponsible use of drugs and narcotics are harmful to our bodies, we are to abstain from them as well. Instead, we are to engage in whatever beings our thoughts and bodies into the discipline of Christ, who desires our wholesomeness, joy, and goodness.²

Objectives of Medical Work

Ellen White identifies six objectives of the health ministry of the church. They are to stand as a witness for


²Seventh-day Adventists Believe...: A Biblical Exposition of 27 Fundamental Doctrines, 278.
God, to relieve pain, to stir inquiry, to shed light, to aid reform, to prepare a people for the coming of the Lord.¹

Any health-related work undertaken by the church in any of its branches of work should work with these objectives.

Further, Theodore R. Flaiz, pioneer medical missionary to India, affirmed principles which show the purpose of Adventist medical ministry.

1. Our medical ministry is today the ministry of our Lord, a means of relief from suffering and saving of life.  2. It is an effective agency for opening doors to hearts, to communities and to nations for the entry of truth.  3. It is the gospel in practice; medical staff ministering courteously, kindly, and patiently to those in need are silently preaching the gospel.  4. When medical missionary work is properly carried forward, it has a unifying influence in the church. It establishes institutions in a firm basis and for better growth and influence of the church work.  5. Our medical work calls for large educational programmes in various professions.  6. Health education both for the church and the community at large is significant area of service in medical ministry.²

The great object of health education and the purpose behind the doctrinal emphasis on health by the Seventh-day Adventist Church is for the perfection of Christian character. Since body and soul cannot be separated, health is essential for wholeness, and wholeness is the key to

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¹White, Testimonies for the Church, 7:104.
sanctification.¹

Commenting on the unique mission of the Adventist Church that combines health and healing, Van Dolson and Spangler wrote:

No other religious movement this side of the cross has understood so clearly that a person's spirituality is affected by his physical habits. Certain persons have sensed this truth but no movement has assumed the responsibility of living it and promulgating it. In the area of health, the outstanding contribution we have to offer the world is the principle that caring for the body temple is a part of religious duty.²

The commission of the Lord is yet to be fulfilled, especially in large populated countries like India with a population of 975.8 million, many of whom are living without basic needs and knowledge of healthful living.³

Health Ministry in India

Missionaries (both nationals and foreigners) saw that there was a need for educational and medical work, especially in undeveloped countries like India. Such were missionaries like William Carey, Ida Scudder, Vinobha Bhave, Pandit Ramabai, and Mother Theresa. Christian teaching became established through educational and medical

¹Van Dolson and Spangler, 54.
²Ibid., 142.
institutions. These missionaries established a noble work for the general public, not possible in any other way. Such centers played an important role in helping to restore health to the sick.

More recently the government has given top priority to medical work, which however has now become specialized, expensive, and beyond the reach of common people. Therefore, reaching rural areas with medical missionary strategy is still a meaningful task. (See table 3, in appendix 2, which lists the SDA medical centers in the Southern Asia Division, together with details about patients and services.)

About one hundred years ago the Adventist teachings reached the shores of India, first through the printed page and then through the establishment of medical centers and educational institutions. These medical centers broke through caste, cultural, and other barriers, thus creating a positive impact on church growth by bringing health to the population and contributing to the growth of the Adventist church.

Each of the SDA medical centers listed has contributed to the growth of the church. For example, GMH alone contributed in establishing thirty-five churches and companies in keeping with the denominational emphasis.
SDA health ministry in India has accepted the challenge, considering that medical centers are still relevant. The church today operates twelve hospitals within the territory of the Southern Asia Division. These health centers are committed to bringing health, healing, happiness, and hope to inpatients and outpatients, both through healing and teaching.

Evidence that the objectives of these hospitals have been met is to be found in the two testimonies cited below. The first is from a woman who had been cured at Nuzvid Hospital.

About forty years ago when I was a thirteen year old girl, my mother brought me to this hospital, where my father was admitted. During the chapel service I heard the story of Jesus feeding the five thousand. We were Hindus, but I was fascinated by the stories from the Bible. I began to read the Bible and was thrilled by the truths it contains. In spite of protests from my family, I openly confessed to become a Christian. Many Christians, hearing about me, wanted me to join their church, but today I have returned to the place where I first found the truth and want to join the Adventist church.

M. L. Narayana, presently chaplain of Giffard Memorial Hospital, who came from a strong Hindu background, narrates his conversion linked to GMH:

At nine, I was greatly impressed by the picture stories and songs. Later in 1962, I got interested in Bible correspondence course. On October 6, 1963 I suddenly

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took ill and was rushed to Giffard Memorial Hospital in an unconscious state in which I remained for three days. On the fourth day, late Pr. N. V. Jesudas, Chaplain, visited me and gave me a gospel tract to read. This drew me to church on the sabbath after I left the hospital. The door of my heart was opened to the Lord Jesus.¹

This chapter has traced the basis for health evangelism in the Bible and the writings of Ellen White. The health ministry in the Adventist church in the past and present was discussed with special reference to India. In chapter 3, the need of a strategy and the complexity of Indian society are briefly discussed. It also projects the need of health in India.

CHAPTER 3

THE SETTING AND HEALTH NEED OF INDIA

This chapter deals with a strategy for health evangelism within the Indian setting. One must understand the health conditions in India today before planning a new strategy. This chapter begins with a brief review of the changing trends in medical work in the local setting and then analyzes what Adventists have accomplished in one hundred years of health evangelism work in India.

The Indian Health Situation

To develop a health evangelistic strategy it is important to have an understanding of the Indian health situation. The complexity of the Indian society, the challenges the country faces in health care, and missionary endeavors thus far make up this general picture.

Complexity of Indian Society

India is a complex society with vast diversity of races, languages, cultures, economy, rural and urban population, religions, and castes.
Races and Cultures

The Indian subcontinent has basically three races, Dravidians in the south, Mongolians to the northeast, and Arians in the north. Each race has its own socio-cultural practices and ways of life. The Dravidians and Mongolians seem to be more receptive to the gospel than the Aryans.¹

Indian art and culture have developed over many centuries, with many different manifestations, varying from folk art to modern painting and sculpture. "Some mass communication facilities, such as the cinema, radio, and television have also been utilized to make the Indian people more conscious of their cultural heritage."²

Economy

India is economically poor, but categorized as a fast-developing country. Its poverty affects health and economic development.³ An Indian writer observed the following:

Today 40% of India's people live below the poverty line. The condition of the bottom 30% rural poor has remained more or less stagnant. The condition of the bottom 25% of the urban population has remained more


³Chandy, 29.
or less stagnant. This is a consequence of the continuous migration of the rural poor into urban areas in search of a livelihood. Their failure to find adequate means to support themselves resulted in the growth of pavement and slum lives in the cities of India today.¹

India has a sophisticated administrative and political structure, a well-equipped bureaucracy, a large supply of educated people, and a considerable transport and communications network. Since Independence in 1947, it has made great progress and undertaken large investments. Yet, economic progress for the lower classes remains slow.

India has acquired a sophisticated industrial base that has placed it among the top twenty industrial nations in the world. On the other hand, the country suffers enormous disparities in income, with the rich being very rich and the poor very poor. The Encyclopedia Britannica reports:

A small elite enjoy very high standards of living, while the bulk of the population has income below the subsistence level. India's fundamental economic problem remains one of ever-growing millions of people to feed, cloth, shelter and educate and of ever growing numbers of men and women who join the ranks of the unemployed.²

Languages and Dialects

There are 723 languages and dialects used in the Indian


subcontinent.¹ This provides a unique identity for people who live in segments called states. In many aspects, language barriers have become hindrances for the growth and development of the country.

Rural and Urban Population

After China, India is the most populous country in the world. In 1998 the population was 975.8 million.² In fact, one of every six persons in the world is an Indian. The population growth in the last decade has been approximately 23.85 percent. In spite of attempts to reduce the birth rate, it is generally admitted that "one of India's major problems is population control."³

A major section of the Indian population lives in about 600,000 rural villages; about 74.3 percent of these people are dependent to a large extent on agricultural work, and most of these are illiterate. About 25.7 percent live in urban areas.⁴ They are hired by landlords in exchange for their basic needs.

¹Ibid., s.v. "India: The People, the Languages."


⁴Matthew, 458.
At the same time, India is a country of large cities such as Calcutta, Bombay, and Delhi. Inhabitants of these large cities have access to better schools and services, yet a large percentage of the urban population is poor, having migrated from the rural areas in search of work.

Religions

India is the birthplace of many religions and has become the home to many others. The Encyclopedia Britannica states:

Through the ages Indians have shown strong proclivities toward a religious outlook, resulting in the development of indigenous religions, chief among which are Hinduism, Jainism, Buddhism, and Sikhism. This religious bent has also encouraged the growth of such extraneous religions as Islam, Christianity, Judaism, and Zoroastrianism.¹

Table 1 shows the percentage of religious affiliations of the Indian population.

According to Manorama Year Book-1999 records, Hindus number 672.6 million, which is 82.4 percent of the total population. Likewise, Muslims number 95.2 million, which is 11.7 percent, and Christians 18.9 million, which is 2.3 percent.² Since Independence, the Christian population has not grown in terms of percentage. In 1947 it was 2.4

¹New Encyclopedia Britannica, 1991 ed., s.v. "India: The People, the Religions."

²Matthew, 460.
percent. In 1961, 2.4 percent; in 1971, 2.6 percent; and in 1991, 2.3 percent. The growth is very stagnant.

TABLE 1

THE RELIGIOUS AFFILIATION OF INDIANS IN 1987

<table>
<thead>
<tr>
<th>Religion</th>
<th>Percentage</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hindus</td>
<td>82.64%</td>
<td>549,779,481</td>
</tr>
<tr>
<td>Muslim</td>
<td>11.35%</td>
<td>75,512,439</td>
</tr>
<tr>
<td>Christian</td>
<td>2.43%</td>
<td>16,165,447</td>
</tr>
<tr>
<td>Sikhism</td>
<td>1.96%</td>
<td>13,978,146</td>
</tr>
<tr>
<td>Buddhist</td>
<td>0.71%</td>
<td>4,719,796</td>
</tr>
<tr>
<td>Jains</td>
<td>0.48%</td>
<td>3,206,038</td>
</tr>
<tr>
<td>Other religions</td>
<td>0.42%</td>
<td>2,766,285</td>
</tr>
<tr>
<td>Religion not stated</td>
<td>0.01%</td>
<td>60,217</td>
</tr>
</tbody>
</table>


Of the twelve great religions of the world, four of them, Hinduism, Jainism, Sikhism, and Buddhism, had their origin in India. It has not been easy for Christianity to propagate its faith, although India has a secular government that allows its citizens freedom of faith.\(^1\) In spite of this, a Hindu leader once said:

Every Indian must learn to respect and hold in reverence the Hindu religion, must entertain no ideas but those of the glorification of the Hindu race and

culture or may stay in the country wholly sub-ordinate to the Hindu nation, claiming or deserving no privilege or any preferential treatment not even citizen's rights. Both the Muslims and the Christians are not the children of the soil because they are not true to their salt. Muslims and Christians in India are only our guests. They can live here as long as they wish to remain our guests.¹

Indian thinking is basically philosophical or religious. The Hindu mind is especially centered around the cosmic principle of the "cycle of Karma-Samsara," which affirms that whatever state one is in, "god assigned it" as the result of one's past life.

**Castes**

Caste is closely connected with Hindu beliefs, practices, and way of life. "Caste represents the ethical organization of Hindu social and religious life and has become an essential criteria for Hindu religious and social identity."² R. N. Dandekar relates that it is estimated that there are more than three thousand castes which include all caste, mixed castes, left-hand castes (weavers, leather workers, cow-herds, and some cultivating castes) and right-hand castes (traders, some weavers, musicians, potters, washer-men, barbers, and most of the cultivators and laborers castes). The term "outcasts" refers to the castes that are not included in the four main castes.

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(Brahmins, Kshathriyas, Visyas, and Sudras) held by the Hindu society.¹

While the caste system is considered to have originated with the Hindu religion, Edward Harper asks, "Why is it practiced by Christians and Muslims to some degree?" He then suggests that the "caste system was originated by some self-interested groups who sought the support of the religion to prevent any social change."² The Indian government has passed laws to do away with the caste system. Change is taking place, yet at a slow pace.

Health Care: A Challenge in India

Providing basic health care to the Indian population is the biggest challenge that India faces. Government and voluntary organizations must work together to reach the goal to make good medical attention a reality. Christians in India are known for selfless service, especially in health and healing. K. R. Narayanan, Vice-president of India, commented on the Adventists at the centennial of Adventism in India.

The activities of the Adventists spanning one hundred years are examples of courage, humanism, and service to the people. Institutionalization of your

¹Ibid.

philanthropic activities in many crucial areas of life across the globe have endeared the Adventists to the people of the world. Your emphasis on moral values, simple life, stress management, vegetarian diet, non-alcoholic and non-smoking practices have current and continuing relevance.¹

Illnesses

The Western-type of curative medicine has to a large extent not made an impact in India, where the Indian masses need prevention of diseases.² A missionary who analyzed the health situation in India in 1989 said,

Alarming is the terrible health situation in the country:
10 000 per year die of Polio
100 000 per year are crippled by Polio
150 000 per year die of Pertussis and related respiratory diseases.
130 280 per year die of neonatal tetanus
280 000 per die of measles and its complications
1 500 000 per year die of dysentery and malnutrition
16 000 000 have active tuberculosis, that is 2% of the population of India and almost half of the world's tuberculosis patients.
40 000 of these are dangerously infectious at any given moment.
4 000 000 people have leprosy, that is approximately one-third of the world's leprosy patients.
8 000 000 people are blind mostly due to vitamin deficiency.³

¹K. R. Narayanan, "Vice President of India at Centennial Celebration of Indian Adventism," in Images II (Bangalore: South India Union Office of SDA, 1993), 21.
²Kobialka, 79.
³Ibid.
Lack of Physicians in Rural Areas

Even today, health facilities for the growing millions in India are scanty. "It is rather unfortunate that 80 percent of all medical doctors stay in the cities where only 25 percent of the population live."¹ This is because the rural poor cannot pay the bills. Moreover, doctors are not willing to stay among the poor without proper infrastructure and services.

Government medical centers have helped to some extent, but they are far below the standards of modern medical work. Even in such centers, the work is not done in a responsible way. Moreover, such services aim only at curing disease, with prevention much neglected. There is a great need for community medical care and preventive education.

Specialization in Large Centers

India is growing in medical specialization. More and more super-specialty hospitals open in every city. But this will mainly help the urban rich. Jacob Chandy said that "it is a fallacy to think that more and more specialization will bring health and material benefits."² Specialization has advantages, but its service with sophisticated physical

¹Ibid.
²Chandy, 43.
facilities and treatment is very costly.

Today India is giving top priority to medical work for its masses. Much of the public funds are for the task of bringing total health to the common people. This can be possible through health education and preventive medicine rather than through large and specialized centers.

Cost of Medical Care

Because of rapid technological advancement, medical science and medical treatment have become expensive. When a laborer earns 20 to 30 rupees a day, and a hospital bill comes to approximately 500 rupees a day, there is no way for the poor family to pay. If major surgery is needed or a heart problem exists, there is no solution but to give up. Unlike Western countries, India provides no medical coverage for its citizens.

Missionary Health-Care Facilities

When the missionaries came to India, they found masses in dire medical need. Along with the preaching of the gospel, they started establishing medical centers. This helped in breaking down prejudices caused by caste, culture, 

\[1\] For example, Ida Scudder, when she came to visit her missionary parents in Madras, was impressed to devote her life to the service of women of India, to help in their medical needs. Today, Vellore Christian Medical Hospital is the testimony to her work. Silveria, 159.
and economic barriers and paved the way for the growth of the gospel.

As Entering Wedge

When the missionaries first came to India, medical ministry was used as the entering wedge for the gospel of love.¹ At that time common people lived without basic medical facilities, and missionaries observed no difference in dealing with people, in spite of the caste system dominated by the Brahmins.

To the missionaries the caste system meant nothing. They accepted all classes of people and met their health needs. Thus the missionaries provided what people did not have. This captured the minds of the poor who longed for liberation from a repressive social system. Health care was used as an entering wedge. Where the gospel message was forbidden, the health and temperance message was always welcome.

Changing Trends

In the early days the churches received dedicated, qualified medical and nursing personnel from overseas for service in mission hospitals. These missionaries were

accepted by all classes of people and communities. As long as they were at their posts, the work grew.

Unfortunately, the situation changed over the years. Today, the Indian government restricts the entry of missionaries, especially long-term medical missionaries. Financial help continues in many cases. Today, the era of the foreign missionary is gone, and the churches are increasingly becoming indigenous.¹

This has become a real challenge for the growth of medical ministry work in India. In today's specialized world, many in the church and outside of it feel that medical work has no connection with the gospel work. For example, Asante presents three schools of thought.²

In model one, everything besides the gospel work is peripheral to the church's task and is more properly the task of the state. God does not ask the church to do the work of the state. From this perspective the church should not be in the health and healing ministry at all, especially in institutional or programmatic health work.³ Jacob Chandy adds:

Since the Indian government has assumed responsibility

¹Chandy, 8.
²Asante, 5.
³Ibid.
for providing health services for the people, the relevance of programs of Christian hospitals that are only hospital centered and disease oriented is by no means clear.¹

In the second model, health services are considered as a preparatory agent to the real task of evangelism. Health programs are justified only when they open doors to the preaching of the Good News and help contribute to church growth.²

The third model is that of a church that ministers to both the spiritual and physical needs of people. Such a church is committed to continuing the healing ministry which was started by Jesus and entrusted to His followers.³

Many churches and para-church bodies have opted for the second or third models. Thus they have felt constrained, even in the face of difficulties, discouragement, and despair, to persevere and to continue seeking ways to keep alive the ministry of health and healing.⁴

The World Council of Churches (WCC) is active in health ministry through the Christian Medical Council (CMC). This council was to be an agency supporting the role of the

¹Chandy, 2.
²Asante, 6.
³Ibid.
⁴Ibid., 6-7.
church as a healing community. CMC, endorsed by the WCC, affirmed that a concern for healing and wholeness is central to Christian faith and life.¹

Medical Missionary Work Today

Today, even Christian hospitals and dispensaries are offering mostly curative services. Thus the purpose for their existence is minimized. Certain hospitals, meant initially for the poor, cannot serve the poor alone and still maintain themselves financially. A number of hospitals are being managed as business concerns, trying to make enough money to meet day-to-day expenses.²

There were 261 medical centers in 1947 that were operated by the Christian Medical Association of India; these were run mainly by missionaries, and the services were at their best. By 1997, 117 had been closed for lack of proper services, finances, management, and ability to stand the competition of secular medical work. Ninety-nine were added, but run mainly on a commercial basis offering curative health care.

Table 2 shows a listing of hospitals of the Christian Medical Association of India, and their situation in 1947

¹Ibid., 7.
²Chandy, 2.
and 1997. Many of the existing medical centers are barely managing to operate on a commercial basis with the help of a more specialized medical personnel.

TABLE 2
CMAI MEMBER HOSPITALS (1947-1997)

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TOTAL: 261 hospitals, 144 continuing, 117 closed, 99 new, 243 total.


Gwen Crawley said:

There is no one uniform way of doing health evangelism. Depending on the situation, the expression of a healing ministry will continue to vary from church to church within a country and from one part of the world to another. In all cases the
question will continue to be, what is the most appropriate way for Christians, in this place at this time, to engage in a healing ministry?1

Whatever the case may be, India needs Christian medical centers, in spite of many others throughout the land, to teach and motivate people to live in a healthful way and not merely to seek a cure when they are sick. For this reason, the church is in need of people with vision, with indigenous thinking, dedication, and commitment to do health work in the biblical way.

Adventist Medical Situation in India

When the Adventist Church started its work in India, the first missionaries followed a similar pattern. The first medical workers arrived on the shores of Calcutta in 1896. Dispensaries, treatment rooms, and a few sanitariums mushroomed throughout India.

These medical units served the elite of society as well as the poorest of the poor with the purpose of sharing the love of Jesus. This made a very definite impact. The medical work in India reached its peak in the early 1930s, followed by a period of decline as one institution after

another closed, partly due to World War II.\(^1\) Today the Adventist Church is strong in the areas surrounding the twelve medical centers in the Southern Asia Division.

As was noted in reference to Christian medical work in general, foreign missionary physicians and nurses no longer operate Adventist medical institutions. Not only are the foreign missionaries not in charge, the funds they brought with them have dwindled to a trickle. This has placed SDA medical institutions in a difficult situation.

Adventist Hospitals and Clinics

Health evangelism has been an integral part of Adventist church work since its inception. This is based on the biblical teachings and the counsels of Ellen White. Today the Adventist worldwide church operates 159 hospitals and sanitariums, 306 clinics and dispensaries, health launches and medical planes, 118 nursing homes and retirement centers, thirteen orphanages and children's homes, and seventeen medical or paramedical educational centers.\(^2\)

There are twelve medical centers in the Southern Asia Division, organized under the Council of Seventh-day


Adventist Hospitals (COSDAH), a legal body registered in 1972 under the Societies Act. In 1998 COSDAH also assumed an administrative role with the leadership of Subhod Pandit as secretary and the division president as chairman.¹

The twelve health-care institutions operated by the Seventh-day Adventists in Southern Asia not only heal the sick, but also strive to make man whole---physically, mentally, spiritually, and socially.² (Table 3, in appendix 2, describes the hospitals and their status operated by COSDAH in SUD.)

The uniqueness of Adventist medical care is to heal the whole person rather than only the body. The Adventist Church in Southern Asia has determined to do committed medical work in the pattern of Jesus and the counsels of the Spirit of Prophecy. Asante adds:

One aspect of uniqueness of the Christian hospitals is their quality care and reputation for very good general care and compassionate and respectful handling of patients. Such factors tend to attract patients to these hospitals from longer distances.³

Health Education

In India the causes of human illness are generally, as

¹Ruth Vanslyke, COSDAH Secretary, to M. Wilson, September 16, 1998.
³Asante, 43.
in other places, ignorance, superstition, and sin.\(^1\)

Therefore, educating the public and giving a basic understanding of health is very much the task of the health worker. That is exactly the Christian philosophy of healing ministry. Ellen White counsels that "a great work is to be accomplished through the promulgation of health principles in preparation for Christ's second coming."\(^2\)

Adventist health work is both curative and preventive. The church's Health and Temperance Department emphasizes the preventive aspect, holding to the motto, "Prevention is better than cure." "The medical ministry, on the other hand, tends to have a curative approach."\(^3\)

In the midst of the modern world, which is gradually engulfed by the powerful venoms of various addictions, prevention is the best remedy. Many of the activities of the Health and Temperance Department in the Southern Asia Division are centered around youth and educational centers. Thus the department serves as a forerunner, paving the way for the Good News to reach the unreached.\(^4\)

The Health and Temperance Department in the Southern

\(^1\)Van Dolson and Spangler, 20.

\(^2\)White, *Counsels on Health*, 206.

\(^3\)Tlau, 2-3.

\(^4\)Ibid.
Asia Division conducts health courses, health and temperance exhibitions and film shows, nutrition classes, and programs to stop smoking. It also sponsors the publication of health articles in newspapers and magazines, several radio and television programs on health, and the distribution of health literature. In 1995, this department reported that in the previous five years 1,783 persons have become Seventh-day Adventists through its work.¹

Adventist health-care institutions carry out the same kind of health education. They teach people to live in a more healthful manner and how to avoid the diseases that will take them to acute-care facilities. This work is not done in a purely scientific way, giving scientific facts only. "The information provided is grounded in religious motivation, which has been found to be the most effective way of achieving behavior change."²

This chapter explained the complexities of Indian society with its multi-ethnic, cultural, and socioeconomic barriers. The continuing need for health work in rural settings was pointed out. In chapter 4, the beginning, growth, and development of Giffard Memorial Hospital are discussed.

¹Ibid.
²Van Dolson and Spangler, 166.
CHAPTER 4

A HISTORY OF THE GIFFARD MEMORIAL HOSPITAL

Giffard Memorial Hospital (GMH)\(^1\) is a Christian medical center established in 1925. It is operated by the Seventh-day Adventist Church, located in a town called Nuzvid, fifty kilometers north of Vijayawada (Bezawada) on the east coast of central India.

It is the "mother" of Adventist medical institutions\(^2\) in the Southern Asia Division\(^3\) because of its training programs for Laboratory Technology and Nursing. The hospital is in a rural setting, has a moderate climate, and is surrounded by mango groves and many small villages of farming communities.

The history of this institution naturally falls into two parts: (1) Theodore Flaiz and the beginnings, and (2)

\(^1\)Also locally called the American Hospital.


\(^3\)The Southern Asia Division is one of twelve divisions of the General Conference of Seventh-day Adventists. It comprises India, the Maldives, Butan, and Nepal. Its name is normally abbreviated SUD.
the founding of the institution, and its growth and progress through later years.

Theodore R. Flaiz and the Beginnings

Missionaries came to India to preach the gospel but had to face many difficulties, such as language, culture, and other barriers. Explaining the situation in those days, Paul Hiebert says: "They came into a cross-cultural setting, often knowing that they faced death in a few short years, and those who survived gave their whole lives to the task."¹

Theodore R. Flaiz, an American, was one of these dedicated missionaries and a key person in the establishment of Giffard Memorial Hospital at Nuzvid. Flaiz was assigned to mission work in Andhra Pradesh as field superintendent in November 1920.²

His first task was to establish a school at Narsapur to train future church workers. This institution exists today as Flaiz Memorial Higher Secondary School and has been the training center for young people for all of Andhra Pradesh.


²Prasad Rao, Lest We Forget (Hyderabad: Andhra Section of Seventh-day Adventists, 1966), 12.
for the Adventist Church.¹

Seeing the misery of the people without medical facilities, Flaiz then established medical centers in Bobbili and Narsapur. These were also used as an entering wedge. He established work in districts where there were dozens of villages. He was a very active and disciplined missionary. He learned the local language (Telugu) and was willing to adjust to the local situation with very minimum facilities.²

Seeing the school at Narsapur as an opportunity for employment, many persons offered their services as teachers or evangelists. Flaiz announced that no one would be employed who had not spent at least one year selling Adventist health and religious literature. To train these workers, Flaiz, together with S. C. Shepherd, started a colporteur training institute on the mission compound in the year 1921.³

Two of the students in the new training institute, Ch. Samuel and Patibandla Abraham, had a sharp disagreement.


²Prasad Rao, Lest We Forget, 25.

Flaiz considered Patibandla to be at fault and dismissed him. Patibandla begged for another opportunity, but was denied. However, Flaiz was kind enough to allow him to ride in the missionary's car to Bezawada, where Flaiz was going for Ingathering, that is, to gather funds for mission work.

On the way, Patibandla suggested they should see the Rajah of Telaprole at a place called Nuzvid, sixteen miles from Hanuman Junction, on the way to Eluru. After arriving at the travelers' bungalow, Flaiz obtained an interview with Rajah Tahvor-O-Jaladat Dastagaha Sobhanadri Apparao Bahadur Zamindar of Telaprole Estate, Nuzvid.¹

Arriving at the beautifully kept palace, Flaiz met the Rajah, who was most cordial. After explaining his purpose, he then handed the Ingathering papers to the Rajah who looked at them. As he was about to hand them back, when his eyes fell on the back sheet that explained the medical work being done by Seventh-day Adventists in Simla, North India.

The Rajah was immediately interested. He stated that in 1908 his mother had been ill, but there were no medical facilities nearby, further his father vowed to build a hospital for the people of Nuzvid if his wife got well.

The lady recovered, but two years later the father died without fulfilling the vow, which left the responsibility to

¹Ibid., 1.
the son. Rajah (son) had started building in 1913. There was good progress but the war in Europe, starting in July of 1914, brought the construction work to an abrupt close.¹

After showing the site and the unfinished buildings, the Rajah said that if the Adventists would take the hospital over to develop it as a good general hospital, he would be happy to give Rs.10,000 as his first contribution and would follow this with further contributions. After discussing the matter in full detail, T. R. Flaiz accepted the proposal and agreed to take it to the hospital committee.

The following action was taken by the Southern Asia Division hospital board, which met on 18 November 1922:

Voted: That we inform the South India Union Mission Committee that we consider it advisable to take advantage of the opportunity offering at Nuzvid, and commence our work there, providing funds can be secured for the support of the foreign worker needed. That the doctor assume the responsibility of evangelizing the district, giving the major portion of his time to that work. That the treasurer be authorized in conjunction with the South Indian Union Mission superintendent, to draft an agreement with the Zamindar at Nuzvid, on the lines laid down in action number 834 dated 16th November 1922.²

The Rajah was impatient to see something done. Later

¹Ibid., 16.

²Southern Asia Division of Seventh-day Adventists, Giffard Memorial Hospital, "Minutes of the GMH Board," Pune, Maharastra, 16 November 1922, 834.
in 1923 the authorization was given and Flaiz moved in to finish the building work. Upon the approval of the project Flaiz put in a request for a doctor and in the fall of 1924 A. E. Coyne and his family arrived in Narsapur. The Coynes learned Telugu and moved to Nuzvid in the summer of 1925. This marked the beginning of the medical work at Nuzvid.¹

Shortly after the building was completed, the medical work started on 15 September 1925. A trust agreement was concluded between Sree Rajah Sobhanandri Apparao, Zamidar of Telaprole, and The India Financial Association of Seventh-day Adventists under terms negotiated by Flaiz and the Zamindar of Nuzvid. E. J. Hiscox, a later physician at the Nuzvid Hospital, wrote about the beginning:

The hospital site with several buildings was a gift to the Seventh-day Adventist church by the Zamindar Rajah with the understanding that there would always be a European (or American) in-charge. He had an English friend named Colonel Giffard whom he wished to memorialize, hence the hospital's name.²

Growth and Development

Giffard Memorial Hospital (GMH) opened in 1925, with Theodore R. Flaiz as its founder and A. E. Coyne as the medical superintendent. There was a staff of twelve, plus

¹Flaiz, "Beginnings," 17.

²E. J. Hiscox, To and from Nuzvid, India (Boise: Griffith Marketing and Publishing, 1986), 14.
other workers such as two dressers, three attenders, two gardeners, a caretaker, a laundry man, and a sweeper. The bed capacity was twelve. The Lord blessed the humble efforts of His servants so that by 1942 the hospital had forty-five beds.¹

The growth of GMH can be divided into three periods: (1) the beginning to the end of the war, the foundation years; (2) from 1946 to 1975, the expansion and maturing years, when the hospital reached its peak; (3) from 1975 to the present, a period of reorganization and challenge.

From 1925 to the End of World War II

This period is unique in the sense that it introduced to the community the concept of Christian medical work and service. The hospital started with very few basic facilities, but the little done was very meaningful because people were poor, without any kind of medical facilities nearby.

GMH was situated in a rural setting with a typical Hindu cultural life. Almost every aspect of life was dominated by the caste system; people were completely under the Brahmin rule. The lower caste, called sudras (later designated Harijans, "children of God," by Mahathma Gandhi),

was an oppressed group who embraced Christianity because of the liberation promised by the Christian religion.¹

The majority of the patients came from the peasants and the daily-wage-earning communities. M. R. Appa Rao, a prominent citizen of Nuzvid, remembers about those days:

When medical facilities of any sort were not available at or around Nuzvid, the first doctor in charge of the hospital was, I remember, Dr. Coyne who put the hospital on a firm basis and did excellent service to patients. Since then the hospital has been maintaining very high standards and it is considered to be a great asset not only to people of Nuzvid but to those in the surrounding districts as well.²

This was the period when the concept of Christian service was introduced to the general public, particularly to the Hindus. Medical work drew people closer to each other in spite of strong caste and economic barriers. The hospital was built for all people with a desire to demonstrate Christ through its services and attract people to His love and healing power.³

In those days there was no electricity, no proper public transportation, no communication facilities, nor other basic facilities. Describing the arrival of patients Elizabeth Hiscox says:

¹Lewis, 10.
³Prasad Rao, Lest We Forget, 67, 68.
Patients came to the hospital in a variety of conveniences like bundy (horse or ox drawn cart), a rickshaw and upside down bed, . . . . Automobiles were rare in those early days.¹

Other modes of transportation were palanquins and hammocks.² Further, Hiscox explains: "Nuzvid railway station is a small place not usually found on a map, situated about twenty six miles from Vijayawada railway station. This is far because the Zamindar who dominated the town at that time thought the train would adversely affect the atmosphere of the locality."³

Soon the hospital was in need of a lady doctor, since a lady patient could not be examined by a male doctor unless it was a case of life or death. In order to fulfill this need, Emma Hughes arrived in Nuzvid on 9 May 1927.⁴

When Coyne and family left for furlough, A. E. Clark took over the hospital from 1930 to 1932. When Clark left, D. W. Semmens was appointed as medical superintendent.⁵

Physical facilities were minimal. In spite of poor medical equipment and insufficient buildings, patients were

¹Hiscox, To and from Nuzvid, 18.
²Thomas P. Matthew, GMH Retiree, interview by author, 10 November 1998, Nuzvid.
³Hiscox, To and from Nuzvid, 13.
⁴Prasada Rao, Lest We Forget, 62.
⁵Ibid.
attracted to GMH. The selfless and efficient service rendered there was known all over Andhra Pradesh.¹

As the institution was prospering, World War II broke out and all overseas personnel were asked to leave the country. From May 1942 to August 1944, GMH offered only partial services and was maintained by the nationals. During this time GMH suffered for lack of trained professional missionaries.

However during this period, B. S. Solomon, Y. Daniel, and D. A. Grace, together with a few others, kept the hospital going, especially offering emergency services, until overseas workers returned.² About this time M. S. Prasad Rao, one of the church leaders in this area, wrote of the death of the donor of the hospital:

It was during this time that the Zamindar of Telaprole who had all his life supported the institution so loyally and generously began to fail in health. He was conscious of this and one day he called his family together and told them that when he died his body should be given a Christian funeral (burial).³

Early one morning, word reached the hospital that the Zamindar had passed away. The Hindu priest went to the palace expecting to perform the Hindu rites but in deference

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³Prasada Rao, Lest We Forget, 63.
to his wishes, his heirs politely sent the Hindu priests away. Brothers Solomon and Daniel gave the Zamindar or Rajah a Christian funeral.¹

This silent testimony of Sri Rajah of Telaprole influenced others to strengthen the establishment of Giffard Memorial Hospital at Nuzvid and also to strengthen Christianity.

From 1946 to 1975

The second period of growth and development can rightly be called the "Golden Age." By this time the hospital had gained influence in the community, its physical facilities were better, the work was better organized, and training centers had been established.

During the war years a group of Seventh-day Adventist medical personnel in the United States Army, stationed at Ramgarh, visited Ranchi, a city in Bihar state in North East India for Sabbath services. Among them was a tall young doctor, John B. Oliver. M. S. Prasad Rao spoke to him about the need for doctors at Nuzvid. He was convinced and was willing to do medical ministry work in India.²

After finishing his service with the army, Oliver and

¹Ibid.

²Ibid., 64.
his wife returned to become medical superintendent of the Nuzvid hospital in 1946. He worked there until 1952, and again served from 1953 to 1958 and from 1962 to 1967. During his time a large multipurpose auditorium was built. At first there were many negative remarks about the huge structure, but today this serves as a church and for many other purposes for the large Adventist community at Nuzvid.

The missionaries continued their dedicated service to attract all castes of people to this healing center; this helped in breaking down barriers so that the church could grow rapidly in this area. Medical workers in India were very few. Hiscox pointed to that in the Hindustan Year Book for 1948 where it was recorded that there were only 7,000 trained nurses in India, a ratio of 1 for 56,000 people. At the same time in the United Kingdom and the United States the ratio was 1 to 300.¹

Rapid Growth and Development

After the war the missionaries returned to continue their medical ministry. Soon there arose a pressing need to expand the physical structure of the hospital. A program was launched that resulted in acquisition of more land and expansion of the bed capacity from 45 in 1942 to 108 in

¹E. J. Hiscox, ”Giffard Memorial Hospital,” Southern Asia Tidings, February 1973, 16.
1945. Flaiz finished his medical studies and returned to India in 1945 as medical superintendent.¹

In 1955 a twenty-bed maternity ward was built, largely financed by the Zamindar of Elamarru. To meet the need for more beds for pediatric patients, missionary physician Elizabeth Janet Hiscox donated funds for a forty-bed block which was opened in November 1975 at the Golden Jubilee celebrations.

G. E. McWilliams, who arrived in 1953, gave much-needed relief to Hiscox’s busy schedule. As a team McWilliams and Hiscox provided the best possible medical care for the women and children who came to the hospital. McWilliams, in her own quiet ways, was a "mother to millions,"² as she attended the labor room calls day in and day out. Both women renounced their own family life for the service of God. McWilliams served as Medical Director from 1982 to 1984, then she retired.

Even the high-caste people felt it was an honor for a missionary or hospital worker to step into their homes. Local people cooperated in the growth and development of the hospital. For example, Paladugu Venkata Rao, member of the


²Ibid., 2.
Legislative Assembly and a local political leader, said on the occasion of the Golden Jubilee, "Lastly it is my duty to promise your management, as the citizens of Nuzvid Taluk, that I will always extend co-operation to your institution."\(^1\)

**A Model Medical Missionary**

Elizabeth Janet Hiscox, with her gift of healing, came to Nuzvid in 1938; her forty-two years of service covered the whole period under consideration. She was an outstanding missionary and a gynecologist gifted with the healing touch. Until 1953 she single-handedly managed the obstetric and gynecological services.

Hiscox cared for women of four generations in many families. In the field of gynecology her steady hands in surgery were the envy of a younger generation of workers.\(^2\)

Her service knew neither day nor night, neither rich nor poor. She never married but she had plenty of children. Hundreds of them whom she picked up in villages across Andhra Pradesh and sent them to get a whole-some education at the Adventist school in Narsapur. She literally gave her all: her time, talents, money in the service of God and man.\(^3\)

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\(^3\)Juanita Singh, "Nuzvid Bids Goodbye to Dr. Elizabeth Hiscox," *Southern Asia Tidings*, May 1980, 12.
Her life was devoted to the welfare of her patients. They held her in high esteem and came from far and near for her attention. Because of her interest in the education of young people she helped students with their finances for high-school and college educations. They are now working in support of the church at home and in many other countries.\(^1\)

R. D. Riches, chairman of the hospital board, paid a tribute to her during her retirement celebration in 1980 by saying:

During the past forty years the hands of Dr. Hiscox have touched and healed thousands of the population of Nuzvid and the surrounding areas. These and many others have learned to respect her as a physician and to love her as a person. Her uncomplaining devotion to her work has been an inspiration to all who have known and worked with her and a living illustration of the life and labor of the one in whom she has drawn inspiration for her own ministry of healing. Dr. Hiscox has well worn the mantle of Jesus Christ as she has lived His life in this part of Andhra.\(^2\)

One of the prominent residents of Nuzvid said, "She is an embodiment of devotion, dedication, and dexterity.\(^3\) Even in her last days her thoughts were on GMH. She donated a major portion of her estate, amounting to 78,000 dollars,

\(^1\)S. Amritharaj, "Dr. E. J. Hiscox: Brief History," in Golden Jubilee Souvenir, 3.


\(^3\)V. Ananthacharyulu, "Pushpaanjali to Dr. E. J. Hiscox," in To Dr. Hiscox Pushpanjali, 8.
with which a new hospital complex was built."¹

The same spirit of dedication and generosity was evident in other missionaries such as T. R. Flaiz, Genevieve McWilliams, A. E. Coyne, Eden Smith, D. W. Semmens, A. E. Clerk, J. B. Oliver, D. Smith, Philip S. Nelson, Miss C. K. Kruger, Emma Binder, E. L. York, E. M. Stoneburner, Marion Miller, Emma Hughes, and many others.

Nursing and Laboratory Technology Schools

When there was a need for more medical workers, especially nurses, GMH ventured to start a nursing school which has been supported by the mission since 1927. Before formal nursing training, between 1942 and 1944 the mission trained some nurses, both male and female, for mission hospital service. Some of these were Y. Daniel, S. Joseph, B. Solomon, Sr. Grace, D. Henry, J. M Lucas, and S. G. David.²

In 1945 a government-recognized nurses' training school was inaugurated. The School of Nursing started under the Christian Medical Association of India (CMAI) examining

¹Gyi, "History of GMH," 2.
²Thomas and Ponnamma Matthew, GMH, interview by author, 8 November 1998, Nuzvid.
board, and the certificate was recognized and registered by all state governments. The School of Nursing was formally opened with the admission of three students, Ruby Arthur, Anbu Asirvathan, and Nant U, in 1947.¹

This school is one of the very important activities of the hospital. From its very inception (except 1942-1944, when the school closed due to war) it trained many young people from all over India in this noble profession.

This not only filled the need, but helped other institutions in need of nursing staff. It was recognized by the Madras (Chennai) Nurses and Midwives Council of India in 1947.

Following World War II, in 1946, applicants were difficult to find when the nursing school was reopened. Only five applied in one year. Later, however, the situation was reversed.² For example in 1964, seventy students applied, but only twenty were accepted. As the competition grew, the process of admission became more restricted.

At one stage, a nurse was required to be 4 feet 10 inches in height. However, character and Christian


²John B. Oliver, "Want to Be a Nurse? This Is How You Start," Southern Asia Tidings, December 1964, 10.
experience were even more important for this profession. Each candidate was examined for knowledge, aptitude, suitability, good health, and scholarship. A recommendation from the local church completed the requirements to enter GMH nursing school.¹

The nursing school offered special training in hydrotherapy and electrotherapy, characteristics of Seventh-day Adventist sanitariums and hospitals.² Subjects such as ministry of healing, medical ministry, and personal evangelism were also taught.³

Many members of the SDA Church sent their youth to the training school at GMH. Perhaps they followed the counsels of Ellen White, who wrote:

For an Adventist youth to become a physician or a nurse is considered a very noble and worthy pursuit. Health evangelism has always been an essential element of the


²The first SDA sanitarium opened in Battle Creek, Michigan, in 1866. It provided water treatments (hydrotherapy) along with diet as a "means of cooperating with the divine power." Since disease was seen as the "result of the transgression of natural law," it was the "duty and privilege of Christians to obey these laws, and teach others to obey them." This philosophy permeates Adventist medical institutions worldwide. M. Ellsworthy Olsen, A History of the Origin and Progress of Seventh-day Adventists (Washington, D.C.: Review and Herald Publishing Association, 1925), 269, 270.

Seventh-day Adventist message and movement.¹

In fact, in later years the demand was so great and the fame of the nursing and laboratory school was so good that selecting became competitive. Edna L. York wrote, "We have tried to select wisely a class that will bring credit to the nursing profession, the denomination, and the school."²

Some of the pioneers in starting and laying a strong foundation for the nursing school were A. E. Coyne, Emma Hughes, and later Emma Binder, E. L. York, E. M. Stoneburner, Marion Miller, Mary Matthew, Ponnama Thomas, and many others who served as nursing school directors and staff. Gopal Rao, a medical missionary who served this institution for many years, wrote:

This Nursing School has boldly taken the place and solemn responsibility of a "central supply" for the medical work in Southern Asia Division and as she attempts to train Nurses to help improve the deplorable condition of medical aid in India.³

In 1970 R. D. Riches wrote:

Giffard Memorial Hospital has never in its history


enjoyed the excellent patronage it now reports. The students in our school of nursing at Nuzvid are making remarkable records of academic achievements.¹

When the hospital opened in 1925, M. Lucas was the first laboratory technician. He worked on the men's ward veranda. In 1952 John B. Oliver started a one-year matriculation lab school with N. A. David and Ebenezer Joseph as its first graduates.² In 1969 T. R. Flaiz described the laboratory training:

The graduates of the Nuzvid School are properly licensed and are qualified to set up their own laboratories. It is hoped that many fields will take advantage of this opportunity of establishing a good clinical laboratory in an appropriate location in their communities.³

In 1974 the laboratory school was upgraded to pre-university level. Manick Kisku was appointed as its director. As of 1998, 147 had graduated from the school, within a time period of forty-six years.⁴ Today it has a very good name recognized by the CMAI board. It has a good staff and active students.


²Thomas P. Matthew, "A Brief History of the School of Medical Technology," in Golden Jubilee Souvenir, 34.


⁴Gyi, "History," 5.
Chaplaincy Work

One of the basic differences between Christian and other hospitals is the work of the chaplain who meets the spiritual or emotional needs of patients and staff. Ralph F. Waddell described the work of the GMH chaplain in 1973.

The institution must have a strong chaplain who is active in caring for the spiritual needs of the patients and workers. The hospital chaplain and many of the workers assist the pastor in caring for many churches in and around Nuzvid.¹

From the beginning chaplaincy work was an ongoing program. Every day patients and staff had morning and evening worships. Visiting the patient at the bedside, distributing literature, and singing, as well as other spiritual activities in the hospital and at patients' homes, were common features. Hindus, rich and poor, opened their heart to Jesus the Master Healer.² Medical director Ronnie Gyi said:

As the right arm of the church, GMH has followed the work of her pioneers by having an energetic chaplaincy program. Regular Bible studies with patients, relatives, students, and non-Adventist staff members have yielded good results.³


²Gyi, "History," 6.

³Gyi, "Defeating the Devil at Giffard Memorial Hospital," 7-8.
Bringing people to Christ has always been one of the goals of the hospital.\(^1\) Speaking of this goal, R. D. Riches, Central India Union president, said in 1970:

> We are here for only one purpose, that is to win people for Christ. That is why morning and evening gospel messages are preached in the wards each day. The patients are constantly reminded that man can only treat, but Jesus heals.\(^2\)

Today the hospital has a very active chaplain, M. L. Narayana, who was converted from Hinduism by the influence of a former GMH chaplain. The hospital team with the help of doctors during their personal time visited the patients' homes to conduct prayer meetings and introduce the gospel wherever an opportunity arose. The workers built friendship circles and looked for ways to establish gospel work in different villages.

**Community Services**

In 1956 a community-based primary health care center was opened. It was strongly supported by government and volunteer health organizations such as the CMAI and the Voluntary Health Association of India.\(^3\)

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\(^1\) More details on gospel work by GMH are given in chapter 5 of this research.


\(^3\) Gyi, "History," 5-6.
Selected villages were covered by planned programs such as home deliveries, nutrition, immunization, health education, and family welfare. World Vision of India also funded rural development projects.\(^1\) The success story of the community health department and the comprehensive eye program made the hospital a place of field study for various organizations.\(^2\)

Today GMH not only treats patients who come to the hospital, but also reaches out to the people in the surrounding villages with a well-planned community health and development program. Recently the hospital completed a five-year community based primary health care project in four neighboring villages. This involved training local women in maternal and child health and first aid.\(^3\)

At present GMH operates a strong community-based health program in at least three centers. Sponsored by the Adventist Development and Relief Agency (ADRA) of Canada, the program is strong in the areas of health education, literacy, mother-child care, and preventive education. Hospital chaplains participate in an ongoing evangelization program.

\(^1\)Ibid., 6.
\(^2\)Ibid.
\(^3\)Gyi, "Defeating the Devil at Giffard Memorial Hospital," 7.
Adventist School

In the 1930s a small Adventist school was started to meet the educational needs of the children of hospital workers. During the years it grew with the support of the hospital into a major Adventist school. Tracing back its history, the editor of *Southern Asia Tidings* records:

The Adventist school at Nuzvid was established in 1931, in the small Coyne Hall which had only two class rooms. A few years later, the building was used as a school mainly for the children of staff members working at the Giffard Memorial Hospital.¹

In 1967 the school was opened to the public with instruction in English. Today there are more than 1,000 students, many of them living in school hostels. Looking at the growth of the church in this area and the many Adventist young people in want of Christian education, the SUD Board of Education approved it in 1989 as a recognized boarding school and also as a junior college.

Many worked to bring this institution to this level. People such as R. S. P. Rao, Anand Rao, Raja Rao, J. M. Lucus, I. D. Devadas, Y. Samuel, and T. Paul Raj worked from its start. J. Ballantine and Mrs. P. Jessiamma have done much to lay good foundations for training the young people.

for future church work.¹

Under the leadership of M. S. Jeremiah the quality of education was upgraded to ICSE (Indian Certificate of Secondary Education). The SUD News bulletin noted its growth:

Nuzvid school under Mr. M. S. Jeremiah has grown into a large self-supporting school. At the end of Dr. Fowler's visit, the school was officially recognized as a high school. The first batch of 10th standard students appeared for ICSE in 1986.²

After Jeremiah came P. V. Prasad, who was himself a product of this school. Under his leadership the physical structure grew and other facilities were added. The school took an interest in evangelism and established churches through the influence of Christian education.³ Wherever GMH established a church, the children who desired a Christian education posed a major challenge.

For example, after establishing gospel work in Reddygudem, P. V. Prasad noted the need for a good Adventist school in the village where hundreds of children did not

¹J. Ballantine, "Church School Students with Their Teachers," in Golden Jubilee Souvenir, 41.


³Gyi, "History," 5.
have the privilege for basic education. Some of these children were directed to the Adventist school at Nuzvid. The Lord blessed the humble efforts of the people of this area and the school developed as a unique institution. In 1996 the school celebrated its golden jubilee.

**Eye and Dental Services**

In 1979 GMH opened its eye department in partnership with the Christoffel Blinden Mission of Germany, with Ronnie Gyi as the ophthalmologist. At this time GMH launched a community eye project.2

Through this service an average of thirty people regained their sight every week through cataract and other eye operations. The eye department has a comprehensive eye program to visit all village homes and to see all school children in order to screen people for eye diseases.3

Dental services were started by George Abraham in the 1960s. All kinds of dental problems are cared for.4 This service to the community has continued until now.

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1P. V. Prasad, "Giffard Memorial Hospital Workers Accept the Call," *Southern Asia Tidings*, September 1984, 13.


3Ibid., 6.

4Gyi, "History," 5.
The work of Giffard Memorial Hospital has continued, even during difficult times. The community health services, eye services, and other departments of the hospital have done a commendable job.

On the other hand, missionaries who came in the early days retired and new doctors could not come to replace them because of the restricted entry of non-nationals, especially in the medical field. The mantle of leadership fell on nationals. C. A. Ninan was the first Indian physician; he led the work from 1967 to 1972.

However, not all was grim. Theodore R. Flaiz, founder of the hospital, seeing the work at GMH when he visited after a long absence, commented:

Never in the forty-four years of history of Giffard Memorial Hospital as an institution enjoyed the good repute and high patient registration which it is now enjoying under the leadership of C. A. Ninan as medical director and staff.¹

His service was followed by others: Noel Fernando, 1972; K. P. George, 1974 to 1975; and M. Jaganada Rao, 1975 to 1976. M. Jaganadha Rao was the first Telugu to be medical director, in whose time the Golden Jubilee was celebrated.

Philip J. Virthan Jamman served from 1978 to 1982. He developed a health program in the village by conducting regular clinics attended by doctors. S. Mohan Chander Shekar served from 1985 to 1990 as an excellent surgeon.

Difficult Years: 1976-1990

A government health center was opened in Nuzvid in 1957, but the people seemed to like the Christian services at GMH. Elder E. R. Sorenson, president of the mission field, wrote:

There is a new government dispensary, but people have confidence in Seventh-day Adventists. They see the gleams of the golden morning through us and we see the gleams as the people throng into our institution, our schools, and hospitals, longing for what we have to offer.¹

However as the years moved on, the picture changed. More private clinics and hospitals opened. The government mandated free medical care. It has become difficult to maintain the hospital as in the early days.

To provide full services for free, in order to attract people, is an impossibility since operation costs are very high. For many years it was a real challenge to keep GMH going. The founder of the hospital in 1969 spoke of the changing trends in the medical field and new challenges:

¹E. L. Sorenson, "Gleams of the Morning in South India," Southern Asia Tidings, January 1957, 8.
Yes, very significant changes have taken place in our medical work and certainly at GMH, in India generally. Some of these changes bear significantly upon the future of our medical work.¹

Martin Kobialka, an Adventist missionary in India, after observing the changes in post-independence India, identified some of the reasons why Adventist medical centers should modify their structure and function:

The main reasons for the loss of nearly two thirds of all the hospitals may be seen in: loss of the objective to win souls for Christ, lack of evangelistic efforts in the hospitals, no sufficient follow up work with interested patients, budget and personnel problems, profit making as the main objective, syncretism and secularism.²

Although some of the reasons stated by Kobialka may not have been true at GMH, the influence of and transition in the society made a definite impact. The founder of the hospital said about the financial management of the hospital:

Southern Asia's medical institutions in the past have been based on the concept that they should be able to largely support themselves financially of recent years (1980's and 90's), but because of the changing conditions a tendency to require outside subsidy in balancing the hospital budget has become inevitable.³

Physicians in the hospital were frequently changed; some worked only for a short time. The managing board could

¹Flaiz, "Medical Council Announces Objectives," 8.
²Kobialka, 21.
not develop a strategic plan or maintain steady growth. Slowly the vision to make this a great center for medical missionary work grew dim.

An all-time low outpatient count and low inpatient bed occupancy, financial difficulties, frequent management changes, and difficulties in operating the nursing and laboratory schools are some of the evidences. At the same time, people were not encouraged to sacrifice and work for the institution or the church that supported it. There arose some differences of opinions. Many talented workers started going to other counties for a more comfortable life and higher pay. There was a great change in the attitude and thinking of the people.¹

¹Some of the reasons for this transition were identified by Jacob Chandy:

(1) Hospitals and dispensaries in India are now mostly offering only curatively oriented services, programs that will only take care of the sick. Since the government has assumed the responsibility for providing health services, the relevance of a Christian hospital program is by no means clear. (2) Nearly 80% of Christian hospitals in India are approaching obsolescence, they need renovation or rebuilding and better equipment. (3) Most of the staff are underpaid, many large numbers of hospitals are depending on the services of expatriate missionary personnel supported by overseas agencies. But it is not possible because of restrictions. (4) These hospitals though meant essentially for the poor cannot serve the poor alone and maintain themselves financially. They have to cater to the rich as well to maintain themselves; as a result only a few poor people can be attended. (5) A number of hospitals are being managed as business concerns, trying to make money to meet day-to-day expenses. (6) Almost all the hospitals and dispensaries are operating as individual entities. If there
Under such trying circumstances, understanding the challenges of the situation, the SUD combined all hospitals and centralized the management on 31 December 1972. This group, called Council of Seventh-day Adventist Hospitals (COSDAH), made great efforts to help solve some of the difficulties with renewed objectives. One of the objectives was:

To promote, aid and assist hospitals and/or other institutions for the reception and treatment of persons suffering from illness, mental defectiveness or for the reception and treatment of persons during convalescence or of persons requiring medical attentions or rehabilitation and existing solely for philanthropic purpose and not for purposes of profit. ¹

At different times boards met, studied the situation, and proposed better plans. In 1984-1985 COSDAH sent a study team under the chairmanship of I. E. Grice to study and make proposals for the future of GMH.

There was a suggestion to close it or to shift it to Ibrahimpatnam or Vijayawada. The main opposition to this motion came from hospital workers and local people, supported by the international community of former students is a board, they are not able to execute the work. They depend on foreign funds; as such there is still dependency. There is a definite need to sit and think as to where it has gone wrong. Chandy, 2, 3.

¹Southern Asia Division of Seventh-day Adventists, Hospital Association, Council of Seventh-day Adventist Hospitals: Memorandum of Association and By-Laws (Hosur, India: Hosur, 1972), 2-3.
and workers.

The ophthalmic services continued under the able leadership of Ronnie Gyi, financed by Christoffel Blinden Mission of Germany. The community health services went very well, serving the public in Nuzvid and surrounding villages, supported by ADRA, World Vision of India, and other Christian organizations.

From 1978 to 1982 Philip Virathan emphasized the collaboration of medical work and evangelism. He trained evangelists for a few months and sent them to nearby villages to do evangelism while attracting people with medical work. This helped the gospel work to grow well.¹

From 1982 to 1984 Genevieve McWilliams tried her best to run the hospital with a few outside doctors, but there were some practical difficulties. She retired in 1984 and left Nuzvid. In some cases the temporary solutions brought in growth and development. But these were temporary and did not contribute to a strong and steady growth of the plant. In spite of the difficulties, the hospital board could write:

After all the dark forbidden predictions against Giffard Memorial Hospital, today its new dawn gives hope of a new day. Financially the hospital records an operating gain in spite of the fact that the appropriation has

been much reduced. For the second half of the year there was 90 percent bed occupancy. The gain on patients with a wide variety of cases gives hope of a minimum of ten new students to be taken into the nursing school.¹

In 1985 Ronnie Gyi was asked to be acting medical director. Many national doctors joined hands to support and strengthen the institution. In 1986 Mohan Chandra Shaker, an excellent surgeon and scholar, worked out plans to develop it. He proposed plans and requested financial support from the management. Unfortunately, the leadership did not see what he envisioned.²

In 1984 the nursing school was closed, but opened again in 1987. The Laboratory Technician School could not continue its training program. Doctors became discouraged; some left for other countries and some for higher education.

There was not much income; salaries were not paid for months. The number of inpatients reached an all-time low. With all these difficulties, Narender Rao was appointed in 1990 as medical director; in the same year for a few months, Pramod Hansdak and Suresh Babu were acting medical directors.

²M. B. Jesudas, retired GMH worker, interview by author, November 10, 1998, GMH.
Rebuilding GMH: 1991 Onward

Ronnie Gyi took over the hospital in January 1991. Apart from his regular work in the eye department, he did his best to develop the general hospital work. With the support of new Division leadership (especially M. E. Cherian) there was a combined effort to rebuild the work. Strategies were laid to gather funds for a modern hospital. Ronnie Gyi, along with others, gave untiring and sustained service. Together with the financial support of E. J. Hiscox, world missions funds, and the SUD, plans were laid for an ultra-modern hospital. Ronnie Gyi said: "Dr. E. J. Hiscox, one of the pioneers who expired a few years ago, willed a major portion of her estate to GMH, amounting to US $78,000."

With the blessing of the Lord and the cooperation of the staff and local people the situation is rapidly changing at GMH. On 6 December 1998, a festive atmosphere prevailed on the campus of the GMH, Nuzvid, as a large crowd milled about taking a close look at the four-story building, the largest in this town. "Several dilapidated buildings have been brought down to make place for this large building.

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1Gyi, "Defeating the Devil at GMH," 8.
GMH born again is the theme."¹

On the occasion K. S. Rao, a member of Parliament, recalled the services of missionaries such as E. J. Hiscox, who spent forty years of her life serving the people of Nuzvid and the surrounding villages. "To these men and women who dedicated their lives in the cause of medical missionary work, service and sacrifice were all that mattered."²

D. R. Watts, president of the SUD, dedicated the building to the glory of God and service of man. He said, "GMH has made a new beginning. Unless everyone works together, this new born babe will not survive." On the occasion of the inauguration of the GMH new block, R. S. Folkenberg, General Conference president, said:

Throughout these past 72 years, there have been many dedicated people who have given outstanding leadership and service to the hospital. Thousands of lives have been touched by your ministry of healing. I know there will be souls saved in the kingdom through the influence of this Christian medical institution.³

The new block is only the first step in the rebuilding


²Ibid.

of GMH.¹ In the days to come GMH needs united support and prayers. It is no easy task to run a 150-bed hospital. If a medical college is set up here by the government, as one of the local leaders envisioned, GMH may in the near future be attached to the medical college, expand its services, and reach more people, especially the less fortunate.²

Amidst many hurdles and difficulties, GMH has withstood the test of time. Being one of the oldest institutions under COSDAH, it must be said that GMH has truly been the right arm of evangelism and to its credit stand the many churches in South Andhra. The dedicated Christian medical service to the community through the hospital expands to the many villages around, through their community health projects and their well-known eye services.³

At present COSDAH has changed the system of management in GMH. Thus far the medical director had been head of the institution, but now an administrator was appointed to develop the plant. Rayavarapu Joshi Victor has been appointed the first administrator. With added facilities in the new complex, and consultants (specialists) in the area of gynecology and general medicine, there is a "new look" at GMH. The dedication of GMH workers, support of the GMH


²Abraham, "Giffard Memorial Hospital Enters New Phase," 15.

alumna, and the vision of the church leaders for the plant will enhance new growth and development.

This chapter traced the history of GMH from its beginning (1925) to the present. Since 1980, because of changing trends in the medical work in India, GMH has faced some serious challenges. However, in spite of the ups and downs over the years, GMH has been successful in planting many churches in the surrounding villages. Chapter 5 narrates the history of twenty churches and ten companies established by GMH outreach work and analyzes the strategies used.
The expansion of the kingdom of God is the ultimate goal of every church-oriented program. Evangelism can be defined as bringing people from Satan's kingdom to God's kingdom, through the power of the gospel that alone can set people free.¹ This chapter narrates the growth and development of twenty churches and ten companies that were established with the influence of GMH and evaluates the strategies used.

GMH's main church grew to be one of the largest churches in the Southern Asia Division. On any single day an average attendance would be between 800 to 1,000. The believers consist of the local lay members, retirees, school staff, faculty, and students, along with GMH workers and students.

This church has an average annual growth rate of 5-7

¹Ponraj, 137.
percent in membership, and it is the main supporter for the local section in giving tithes and offerings. There is no dedicated church building, but a multipurpose auditorium built by John B. Oliver in 1949-1950 is used. The church has many lively activities with outreach interests. The researcher himself has been the pastor for this church since 1991 to the present.

Churches and Companies Established by GMH

Information for this section was gathered mostly by interviews with and enquiries to different church members, hospital workers, and pastors. Very little information is available in written form; however, many activities and procedures in starting the churches are fresh in the minds of the church members and GMH staff who initiated and worked for the establishment of the Adventist Church.¹

Twenty Churches

The story of each of the twenty churches founded by

GMH is fascinating. Each had its own unique beginning. O. B. Jonathan, an evangelist connected with GMH during the 1950s, told about the evangelistic interest of the GMH workers:

It is a part of Giffard Mission hospital program to conduct every summer two or three evangelistic efforts in the neighborhood of Nuzvid. Last year village efforts were conducted in three different places, and many came in contact with the truth. This year we have thought of conducting village efforts in some unentered places.¹

The stories of the twenty churches established through the outreach work of GMH are presented in alphabetical order. The information gathered for these churches was in the form of interviews.

Adventistpuram

Adventistpuram, which means "Village of the Adventists," is located approximately seven kilometers northwest of GMH.² The place is locally known as Kukkalagudem. At the end of 1998 the church membership was ninety-seven. During 1998 there were twelve baptisms, which gave a yearly growth rate of 14.11 percent.


²Interview with Pamu Suryanarayana and M. B. Jesudas, GMH Workers, Nuzvid, 10 March 1998.
The church has been pastored by a volunteer hospital worker, Pamu Suryanarana, since 1989. Among other hospital workers supporting the church are Dasara Subba Rao and Daniel, who are natives of this village. Activities of the Adventistpuram Church include communion services, marriages, and revival meetings.

In 1960 Borugu Venkateshwar Rao came to GMH because he was not able to father any children. He was introduced to doctors Hiscox and McWilliams by Lazarus, a GMH worker. After undergoing treatment his home was blessed with a child and his faith was strengthened.

Venkateshwer Rao testified of his faith and invited the hospital staff to hold a prayer meeting at his home. Taking advantage of the invitation, M. Sukrutham, M. B. Jesudas, Y. Daniel, M. Jacob, Y. Samuel (a village evangelist), and G. Lazarus and others held a branch Sabbath School at his home for many Sabbaths. On conversion, this caste Hindu took the name Prabhudas (meaning, servant of God).

In 1970 a series of evangelistic meetings was organized. Of these meetings the Southern Asia Tidings recorded:

Nuzvid laymen are conducting four efforts in the
villages around the town. Their main work will be in the village of Kukkalagudem. It is their aim to convert the whole village and make a change in the name from Kukkalagudem to Adventistpuram.¹

As a result of this work, a company of believers was established. Many caste Hindus, instead of opposing the conversion, came forward to take a stand for the Lord.

Through the years, the lay members of Nuzvid Church have taken an interest in the support and growth of this church. Not having a church building, the members met for some time under a tree and later on the veranda of a rich man's house. In 1974 a church building with clay walls and tile roof was built.

In 1996 the roof of the church was damaged by a cyclone. Genevieve McWilliams, who had served as a physician at GMH for thirty years, contributed Rs. 50,000 towards the repair of the building. T. D. Newton, a hospital worker, undertook the renovation work. M. E. Cherian, then president of SUD, dedicated the church to the glory of God in 1996.

Annavaram

Annavaram is five kilometers west of the town of

Nuzvid. At the end of 1998 the church membership was fifty.\textsuperscript{1} During 1998 there were seven baptisms, which gave a yearly growth rate of 16.27 percent.

The church has been pastored by a retired GMH volunteer, M. B. Jesudas, since its beginning. Now many children are getting an Adventist education, and we hope will soon join the working team. Members of this church sing with enthusiasm and are strict in Sabbath keeping. They are self-supporting, able to run the church and generate finances without outside help, and pay tithe faithfully. Indeed this is a model Adventist church that grew with the support of GMH.

In 1967 hospital workers started a Branch Sabbath School at Yelogolagudem in their free time. This was held on a veranda of the home of a caste Hindu who wanted a child. Many people of this village were happy for the presence of the "American hospital" (GMH) people coming to visit and pray for their welfare. They were willing to cooperate. At an opportune time gospel messages were preached. The villagers also visited the hospital and experienced the love and Christian service rendered there.

\textsuperscript{1}Interview with M. B. Jesudas, GMH Worker, Nuzvid, 10 February 1998.
With the passing of time, caste people such as Kaapus and Kammas, together with lower castes such as Dobies, Barbers, and Shephards, joined the new Christian church along with the Harijans or untouchables.

Dunbar Smith, M. L. Narayana, Louis Daniel, and B. Mohan Rao, all graduates of the GMH School of Nursing, bought a piece of land to construct a church building. Moses, a graduate of the GMH School of Medical Laboratory Technology, working in the United States, contributed a major share towards construction of the building. P. T. Isaac, who lives in the United States, took part in dedicating the church, when he visited Nuzvid in 1976.

Borvancha

Borvancha is a Muslim-dominated village with very few Hindus. It is six kilometers east of Nuzvid. At the end of 1998 the church membership was twenty-five. During 1998 there were two baptisms, which gave a yearly growth rate of 8.69 percent. The church has been pastored by a volunteer, S. J. Sathynandam, a retired evangelist since 1994. Many others supported and strengthened the gospel work in this place.

1Interview with J. Mark Lazarus and Church Elders, Borvancha Church Pastor and Members, 14 January 1998.
Today there is no church building as yet. There is no pastor, but God's work is sustained. The members meet for worship on a veranda.

In 1967 a patient from this village invited M. B. Jesudas to have prayer in his house. The few Christians who lived in the village were members of the Church of South India (CSI). Kollipara Santhosamma and her brother Nagabushnam initially responded to the Sabbath truth, but the members of the CSI caused some disturbance. With the passage of time, people clearly understood the true Bible teaching. In 1968 six Hindu people were baptized into the Adventist church.

Missionaries such as E. J. Hiscox volunteered to help provide an Adventist education for children of church members. Some members made a courageous decision to send their children to the SDA boarding school at Narsapur, 150 kilometers away. This was especially daring when a girl child stepping out of the house was considered bad. Today some of these (B. Suvartha and others) are serving their alma mater and are supporting the church work.

**Chintalavalli**

Chintalavalli is fifteen kilometers north of Nuzvid.
At the end of 1998 the church membership was 150. During 1998 there were seven baptisms, which gave a yearly growth rate of 4.89 percent. The church has been pastored by P. P. Kumar since 1994.

The work was started in 1964 or a little later by Pagidipalli Devadanam, who made contacts with the people who had experienced healing at GMH. N. V. Jesudas and Y. Daniel conducted evangelistic meetings in 1967. S. J. Sathyanandam was asked to do follow-up work. The Southern Asia Tidings reported:

GMH Chaplain N. V. Jesudas, with the assistance of Hospital Treasurer Y. Daniel and some nurses, is conducting an effort in Chintallavalli village 6 miles from Nuzvid. Health talks and Bible lectures are given each evening, with 300 attending regularly. A Sabbath School has been started. A vacation Bible school is being held and Bible studies given by brother S. J. Satyananadam from Gopavaram.

After the campaign, when 107 people accepted the Adventist message, CSI members were unhappy and caused a lot of tension and confusion. In response, evening meetings were held, lasting until two in the morning. Young people took part in singing and study, and other programs were

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1P. P. Kumar and Church Elders, Chintalavalli Church Pastor and Members, interview by author, 2 February 1998.

arranged to train youth to be firm in their faith.

In 1969 the local conference supported the construction of a church building. GMH helped by sending people to support the work, and missionaries as well financed Christian education for some children. Because of the shortage of ministerial workers and the rapid growth of churches, providing a full-time pastor to care for a group like this was very difficult. Thus there was no strong follow-up work.

In September 1986, while doing an ADRA survey for GMH, the team found in Chintalavalli a dilapidated church building. Such a state could be attributed to neglect of up-keep for over a decade. Upon inquiry, Shayam Sunder, one of the eighteen baptized at the inception of the work, said that they had not been holding any meetings in the building for want of a pastor. The GMH church took it as a challenge, as part of the Harvest '90 program, to reclaim inactive members and reach the unreached.¹

The researcher had opportunity to associate closely with this church between 1994 and 1996. Harvest festivals, communion services, and other programs were conducted

regularly. Because of these programs, growth has been substantial.

Danammathota

Danammathota is in the western end of Nuzvid. At the end of 1998 the church membership was thirty. During 1998 there were eight baptisms, which gave a yearly growth rate of 16.66 percent.

The church has been pastored from its inception by M. B. Jesudas, a retired hospital worker, on a volunteer basis. He trained members well in the Adventist truth. Today this is a self-supporting church, attended by many high-caste people, such as Kammas and Kaapus, Muslims, and others. Many young people of this church are getting an Adventist education. This church is a strong influence for God in this part of town.

The work started here in 1974 through Kalapala Vasantha Rao, who was already acquainted with Adventism. He came to settle here because of his employment in a government school. Gumpula Sunder Rao, pastor of the church in his native village, continued visiting him. Since he had complaints of diabetes and high blood pressure, he went to

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1 Interview with K. Vasantha Rao and M. B. Jesudas, Danammathota Church Pastor and Elder, 7 March 1998.
GMH for treatment.

Seeing his interest in God's Word, hospital workers started visiting him at home. Later he made his commitment to the Lord and instructed his children to keep the Sabbath strictly. Vasantha Rao was so impressed with the missionary services that he named one of his daughters Hiscox after missionary E. J. Hiscox.

He donated his own land for the mission to construct a church. In 1973 he financed a portion of the building of the church, which was inaugurated by Philip Virthan of GMH in the same year.

Devaragunta

Devaragunta is twelve kilometers northwest of Nuzvid.¹ At the end of 1998 the church membership was 140. During 1998 there were seven baptisms, which gave a yearly growth rate of 5.10 percent. The church has been pastored since 1994 by P. P. Kumar. About ten children of this church are studying in the Adventist school at Nuzvid.

The work started here in 1971 when some Hindus who experienced healing at the hospital invited M. B. Jesudas and T. A. Joseph to their homes. The people of the village

¹Interview with Mrs. Mannasseh Prasad and Philip Virthan, Devaragunta Church Volunteer Helpers, 20 July 1998.
appreciated their visit and were impressed by their good work. Philip Virthan, medical director of GMH, opened a village clinic manned by an evangelist who was trained to treat minor ailments.

GMH doctors visited the village weekly. Many caste Hindus appreciated this noble work done in a remote village like Devaragunta. When Philip Virthan left Nuzvid in 1981, the work came to a close.

Manasseh Prasad, a retired worker of GMH, heard that many ladies of this village were requesting prayer meetings and medical help. She took the initiative to revive the work and to construct a church building. The family of Manasseh Prasad Rao raised funds and built and dedicated a church in 1996. Regular worship services among Hindus tell of God's miraculous power to bring about conversion.

Gopavaram

Gopavaram is sixteen kilometers north of Nuzvid.¹ At the end of 1998 the church membership was 175. During 1998 there were twenty-five baptisms, which gave a yearly growth rate of 16.66 percent. The church has been pastored since 1996 by Ch. John.

¹Interview with Kodali Jesurathnam and Church elders, Gopavaram Church Elder and Members, 4 March 1998.
In 1941 mission evangelist Pagidipalli Devadanam visited this village while working as pastor of the Hanumanthulagudem Church. He presented the Sabbath truth and explained the principles of healthful living. The Sabbath truth sounded strange to the people and they were eager to know more about it. The residents of this village requested Devadanam's relatives, who were living with them at Gopavaram, to invite the pastor to teach them the Sabbath truth.

At first they met on a veranda of a large Hindu home. They also met at a public place or under a tree for worship. The first convert was P. D. Pursotham. The missionaries sent him to the Adventist school at Narsapur. Koorpati Satyanandam followed him to care for the church. He worked hard and the church was organized in 1950 with the help of D. W. Semmens, a missionary doctor at GMH.

Gospel workers then faced difficulties such as threats from other relatives, trouble from caste Hindus, and difficulties from other denominations. In spite of difficulties such as poor transportation, poor communication, low wages, no housing facilities, and no church building, a strong work took root from very early times.
Kota Israel, Kodali Jesurathnam, P. D. Solomon, and Sajjan Rao, all natives of this village, were sent to the Adventist school at Narsapur. They were encouraged and financed by missionaries. Many pastors worked in this place with great sacrifice.

**Gudem Madhavaram**

Gudem Madhavaram is fifty kilometers southwest of Nuzvid.\(^1\) At the end of 1998 the church membership was 325. During 1998 there were eighteen baptisms, which gave a yearly growth rate of 5.86 percent. The church has been pastored by V. A. James since 1995. Today G. Madhavaram is a strong Adventist church, faithfully waiting for the Lord's coming.

T. R. Flaiz began work here in 1930. At that time, the area was covered by a dense, tropical forest where Flaiz use to hunt for recreation, at the same time providing protection from wild animals for the villagers. He gave the local people the flesh of the animals he hunted and sold the skins to raise funds to educate poor children.

When Flaiz came to Madhavaram he would pitch a tent

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\(^1\)Interview with Rayavarapu Isaiah, I. N. Rao, M. Sunder Rao, Pedapudi Jacob, V. A. James, Gudem Madhavaram Church Members and Well-Wishers, 1 January 1998.
near a canal. While there, he drank only milk, to protect himself from water-borne diseases. He spent Sabbaths explaining God's love and the creation of the world. Thus he became a friend to all people there.

After many visits, Flaiz conducted evangelistic meetings. He was assisted by Jacob Pedapudi and Ch. Sundaram. A few people accepted the truth and a company of believers was established. The fact that God loves all people alike and that there is no caste distinction among Christians were unbelievable for them since the high-caste Hindus oppressed the poor.

K. Elijah of Pegadlapadu was asked to do the follow-up work. A simple church was constructed in 1950. Jacob Pedapudi pronounced a blessing on the inaugural day saying, "May there be some pearls from this church, for ministry."¹ For many years Rayavarapu Ananda Rao, a layman, worked here and contributed much to the growth of this church.²

This is a remote village without proper infrastructure and often tormented by robbers. The high-caste Hindus did not cooperate with the evangelists in carrying on the work.

¹Interview with Jacob Pedapudi, Retired Gospel Worker, Nuzvid, 10 February 1998.

²Prasada Rao, Lest We Forget, 25.
In spite of these unfavorable conditions, a number of pastors worked here patiently and steadfastly.

Today twenty people from this village, including myself, are workers for the church and many are being trained for future work. The gospel message spread from here to three more nearby villages. The Lord blessed the efforts of these men and today it is a self-supporting and active church.

The pastor assigned to this church not only fostered spiritual growth of its members, but also encouraged youth to the Adventist school at Narsapur. In 1980 Helen Eager, director of the Asian Aid Organization of Australia, helped to start an elementary school in this village. In spite of many challenges, members' children are receiving a good Christian foundation.

In 1963 a church for one hundred people was built with the help of T. R. Flaiz. The building had granite walls and a tile roof. Due to heavy cyclones, the church roof and floor were damaged. Considering its potential, Adventist church leaders helped generate funds to build a new church. In April 1998 a beautiful new sanctuary was dedicated.
Hanumanthulagudem

Hanumanthulagudem is seven kilometers west of Nuzvid. It is one of the very first Adventist churches established by the pioneers in the Nuzvid area. At the end of 1998 the church membership was 150. During 1998 there were sixteen baptisms, which gave a yearly growth rate of 11.94 percent. The church has been pastored by Y. Jayaraj since 1996.

When medical work started in 1925 in this area, Flaiz also started the gospel work. Two evangelists, Pagidipalli Devadanam and Meesarapu Jacob, were connected with the work. It was a mandate for the medical institutions to do evangelism along with the medical work.

Missionaries such as Coyne, Semmens, Nelson, and Oliver strongly supported the work in this village. The first convert was Marapaka Brahmananadam, followed by others such as Pulpaka Aharon, Yentrpati Johan, and Premavathy. Vacation Bible Schools, Branch Sabbath Schools, and free medical clinics were the first missionary methods used.

When the church gained strength, the caste Hindus objected to Christians using the common well. Missionaries played a mediatory role in solving this social problem.

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1Interview with Y. Jayaraj and Church Elders, Hanumanthulagudem Church Pastor and Members, 18 March 1998.
Miss Binder contributed Rs. 8,000 to construct a church building in 1935, but because of cyclones in 1959, it was damaged. It was repaired with some modifications in 1960. Because of the hospital's support, the church grew and members were added.

The missionaries found employment for some of the villagers and helped their children in their educational pursuit. Today nearly thirty children are in Adventist education, in high school and college. People like Y. Abraham John and Israel John, Jacob, and Jayaraj were sponsored by missionaries and today are faithfully serving the church.

**Jaganadhapuram**

Jaganadhapuram is fifteen kilometers south of Nuzvid.¹ At the end of 1998 the church membership was 250. During 1998 there were twenty baptisms, which gave a yearly growth rate of 8.69 percent. The church has been pastored by Pagidimalli Manohar since 1993. Today there is a strong church in this place. About fifteen children are now studying in the Adventist school to be future workers for

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¹Interview with K. Reddy, P. V. Prasad, P. Thomas Mathew, Jaganadhapuram Church First Member and Initial worker, 20 November 1998.
In 1983 the chaplaincy team from GMH visited this village to conduct prayer meetings at a patient's request. Along with others, Hindus took the initiative in supporting the gospel work by attending the meetings, serving meals to the participants, etc. This work was part of the 1000 Days of Reaping program:

Giffard Memorial Hospital's response to the challenge of the 1000 days of reaping brought in 125 precious souls to the Lord Jesus. February 5 was a day to remember for the people of Jaganathapuram, a village 15 kilometers from Nuzvid, for they witnessed the baptism of the 125 who accepted the sovereignty of Christ in their lives.¹

At Jaganadapuram, three-day health screenings and exposure to Adventist health education programs were part of the evangelistic thrust. These included seminars on "Fit free, Stay clean," "Smoking Causes Cancer," and "Sound Mind-Sound Body." Pitta Prabhudas and his wife, P. Thomas, T. D. Newton, M. B. Jesudas, G. Sunder Rao, K. Victorsam, G. S. George Nelson, M. Babu Rao, and T. A. Joseph are some who assisted in the meetings.²

The meetings were conducted for nearly two months,

²Ibid.
both in Jaganadhapuram and in Reddygudem, another village close by. Those who accepted Adventism were members of CSI, who found it hard to give up their Sunday observance and accept the Sabbath truth. At the same time, this was a confusion for Hindus who thought that all Christians are the same and the difference in the worship day took some individuals time to join the Adventist church. A. Reddy from the high caste was the first to take his stand for baptism.

Jangamgudem

Jangamgudem is eight kilometers north of Nuzvid. At the end of 1998 the church membership was 150. During 1998 there were ten baptisms, which gave a yearly growth rate of 7.14 percent. The church has been pastored by P. P. Kumar since 1994.

The work was started around 1947 by B. S. Solomon, a laboratory technician, in response to an invitation from a resident of this village, who was a patient in the hospital. He was assisted by Sadanala Joseph along with other GMH staff in conducting regular night meetings.

The missionary doctors trained Solomon in medical work

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1Interview with M. B. Jesudas, Jangamgudem Church Initial Evangelist, 20 June 1998.
and he started his work as an evangelist at this village. His services were supported by other GMH workers.

Commenting on this work, K. Gopala Rao said:

A village effort at Jangamgudem, a village five miles away from Nuzvid is being planned. Mr. Solomon and I have been visiting and conducting a branch sabbath school for this group for more than a year now. We have a number of people attending whom we hope will take their stand for Christ after the efforts.¹

The first converts from this village were Mark, Laban, Solomon, and a lady who was especially impressed by Adventist education but had no money to pay for her only daughter's tuition. With determination she worked hard and educated her daughter in the Adventist school at Nuzvid. This girl is Kamala Prasad, working as an English teacher in Gujarath Adventist school.

In 1965 the hospital helped to construct a church with the strong support of Sathynandam and other pastors who followed. Though this village received the message early, it did not grow as it should have because it was an interior village far from the main road with no pastoring on a regular basis.

Kandrika

Kandrika is ten kilometers west of Nuzvid. At the end of 1998 the church membership was seventy-five. During 1998 there were seven baptisms, which gave a yearly growth rate of 10.29 percent. The church has been pastored by K. Elisha Rao since 1995. Today, two young people from this village are working for the church while others are still studying. A good group of believers meets each Sabbath to worship the God who gave them the Sabbath.

Work started here around 1965. At that time Balentine, the headmistress of the Adventist school at Nuzvid, and evangelist M. L. Aptha Rao were looking for a place for outreach work. A suggestion came from Moturi Devasahayam, a former CSI pastor, to enter Kandrika village. At first when the Sabbath message was preached, interest was aroused in the minds of the people.

But when the time came to make a decision to keep the Sabbath, there were some difficulties. Later the GMH chaplain, along with a team of hospital workers, steadfastly kept on working with the villagers until they were fully convinced to keep the Sabbath. When a call was made,

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1Interview with G. Israel, M. Jamayamma (late), M. L. Aptharao, Kandrika Church Members and Initial Evangelist, 23 March 1998.
Israel, Ananda Rao, and Tirupatiah were the first to take their stand.

A few days after the baptism, two of their close relatives suddenly passed away, causing great discouragement. The deaths were interpreted by many as being caused by the observing of the seventh day as the Sabbath. Many held the view that the Jews who kept the seventh day as Sabbath were a cursed people and a similar curse had come upon the new Adventists. However, the work went on without interruption with GMH continuing to show real love and concern for the people.

In 1975 Balentine took six children from this village to give them an Adventist education. She kept them under the care of Moturi Devasagayam. Thus began the Adventist hostel at Nuzvid; today it is a major boarding school, housing 450 children.

In 1993 the Nuzvid church pastor and GMH chaplain raised funds and constructed a small church building for the believers in Kandrika. This building could not be completed because of a shortage of finances.
Katrinepadu

Katrinepadu is eighteen kilometers north of Nuzvid.\(^1\) At the end of 1998 the church membership was 225. During 1998 there were eighteen baptisms, which gave a yearly growth rate of 8.69 percent. The church has been pastored since 1992 by Ch. John. Many young people studied with the help of the missionaries; today some of them are serving the church.

Work started around 1947. An invitation came from this village through a patient who wanted prayer at his home when he experienced healing at GMH. At that time the nearest Adventist church was in Gopavaram five kilometers away.

In 1947, while Koorpati Satyanandam was working in Gopavaram, the people of Katrinepadu invited him to teach them this new faith. With the help of Jacob Pedapudi, meetings were conducted in 1950. As a result Kamala Prasad Rao, Aadiah, Asirwadam, Chittiah, and Immanuel were baptized.

Songs and systematic Bible study attracted many CSI people. At first they were unable to understand the Sabbath

\(^1\)Interview with Lamu James and I. Subhushnam, Katrinepadu Church, September 1998.
because of their strong CSI background. But after a systematic study of the Bible they understood the truth, and a church was established in 1955.

Missionaries took full interest in them. In the beginning the villagers did not freely mingle with Sabbath keepers. There were no marriages between the Sabbath keepers and the others. Brides or grooms were chosen from the Adventist believers of other villages.

For example Lamu James of this village was married to Marthama of Yelamandala village. Pedapudi Jacob, S. J. Satyanandam, and others worked here as church pastors.

Kondaparva

Kondaparva is about twelve kilometers west of Nuzvid. At the end of 1998 the church membership was seventy six. During 1998 there were two baptisms, which gave a yearly growth rate of 2.70 percent. The church has been pastored since 1992 by Gumpula Sunder Rao.

Along with other pastors, Thomas P. Matthew, a GMH worker, took interest in the development of this church. From here God's word was carried to Chittapur, a village five kilometers away. At present eight children of this

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1Interview with Cherukuri Azariah and G. Sunder Rao, Kondaparva Church Elder and Pastor, 17 February 1998.
church are studying in the Adventist school. The work started in this village in 1976. Ch. Azariah, son of an Adventist pastor, was working here for the government as a school teacher. In those days government employees at a village had the dual responsibility of taking care of the post office by day and the school by night. Azariah paid his tithe faithfully. Along with his friends he conducted cottage meetings.

In 1978 the evangelist Victorsam worked along with Azariah and Seelu Moses (first convert of the village), conducting evangelistic meetings. GMH was actively involved. Patients of this village were treated without cost.

The gospel message and health talks, supplemented by audiovisual aids, made a deep impression on the minds of the people. The local section and the hospital provided funds to construct a small church building.

Kothapalli

Kothapalli is sixteen kilometers north of Nuzvid.¹ At the end of 1998 the church membership was thirty. During

¹Interview with M. B. Jesudas and P. Estheramma, Kothapalli Church Initial Evangelist and First Lady, 10 May 1998.
1998 there were six baptisms, which gave a yearly growth rate of 25 percent. The percentage of growth is high because pastor Ch. John was appointed to this church in January 1998.

Today this is a self-supporting church; members themselves purchased the land and built their own church. They give tithes and offerings faithfully to support the pastor. The women of this church are also very active and eager to share their faith.

The work started here in 1975 with M. B. Jesudas, an active hospital worker who took an interest in establishing truth in many other places. In this village it all started when a high-caste (Kamma) convert, Ramulamma, a member of the Adventist church at Annavaram, decided to give her daughter in marriage to a young Hindu man in Kothapalli village. Through this marriage relation doors were opened for a growing gospel work.

In the beginning, almost every evening after hospital work, M. B. Jesudas and his friends visited this village and conducted evangelism. They went on foot, by bullock cart, on bicycles, or by bus. These humble efforts were not in vain. The truth of the true Savior touched the hearts of the people. Many were impressed and changed their
lifestyle. Some experienced healing from the GMH medical services.

Pothireddypalli

Pothireddypalli is three kilometers northwest of Nuzvid. At the end of 1998 the church membership was 175. During 1998 there were fifteen baptisms, which gave a yearly growth rate of 9.37 percent. The church has been pastored by P. Christiandas since 1995.

In 1954 Neelaiah was sent by the hospital missionaries to this village to do ground work. Along with Bible training he also had some medical training. Evangelist O. B. Jonathan comments about those days:

Though Pothureddypalli is a small village, yet most of the people living here belong to a high caste and they never cared to attend at Christian meetings in the time past.

Neelaiah pastored here between 1947 and 1950; after him came Pedapudi Jacob, followed by others such as S. J. Sathaynandom, L. S. Philip, Pedapudi Eliah, Benjamin, Jeevarathnam, and many others.

Thadigadapa Joseph was the first convert.

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1 Interview with A. Neelambram, G. Yohan, P. Jacob, Pothireddypalli Church Members, 25 November 1998.

2 Jonathan, 5.
Evangelistic meetings were conducted with the help of GMH. Abbadasara Neelambram, Tagaram Philip, Gundala Yohan, and J. Mark were some of the early believers who joined the church.

Today many of the children from Pothireddypalli are studying and some are already working for the church. For many years there was no pastor's house or worship place. Only a mud-walled house with a grass roof was put up. This was often damaged by violent winds. Many times it was repaired, but the problem was not solved. Now plans are being made to construct a new church building.

In 1957 and, again at other times, Hindus did not like the Christians and refused to allow them to use the common well. The problem became serious. The missionary doctors, who were respected even by the high-caste Hindus, settled the problem with the help of the police.

Bushy paths, rugged roads, poisonous snakes, poor transportation and communication, low pay, poor housing, and other difficulties did not stop the work. The zeal for the gospel grew.

**Ravicherla**

Ravicherla is five kilometers east of Nuzvid, the
majority of its people being Hindus. At the end of 1998 the church membership was seventy-five. During 1998 there were nine baptisms, which gave a yearly growth rate of 13.63 percent. The church has been pastored by J. Mark Lazarus since 1994, along with two other churches that are under his care.

The work was started in 1968 by the GMH chaplaincy team. Ch. Anandaraj initiated the work along with other hospital workers. At first, a resident of this village came to the hospital for treatment and became well. In gratitude, he invited the hospital staff for a prayer meeting. At his request, the meetings continued for many days and, as a result, a strong Christian friendship was established.

M. B. Jesudas visited this village to do follow-up work. High-caste people such as Kamma, Kaapu, Golla, Telaga, and others bravely took their stand to join the Sabbath-keeping church. Ch. Anandaraj continued the work along with N. S. Bhasker Rao. P. Yesurathnam was the first convert, but later drifted away since he was expecting some monetary benefits and did not receive any. However, many

1Interview with Mary Grace Anandaraj, GMH Retired Worker, 22 April 1998.
caste Hindus were converted and are a strong testimony to those people around them.

Today, twelve young people of this village are receiving an Adventist education at Nuzvid. Ch. Paulraj is one of the products of this church and is presently working at GMH. In 1976 a beautiful church was built here with the help of the hospital, local section, and the family of Ch. Anadaraj. Grace Anandraj, though retired from hospital services, is still continuing her support for the growth of the church.

Vattigudipadu

Vattigudipadu is seven kilometers east of Nuzvid. At the end of 1998 the church membership was listed at 127. During 1998 there were fifteen baptisms, which gave a yearly growth rate of 13.39 percent. The church has been pastored by J. Mark Lazarus since 1994. Today the members are building a house for the pastor to live in and the gospel work is growing.

The Adventist message reached this village around 1975. Ch. Anand Raj, N. S. Bhasker Rao, M. B. Jesudas, and

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1Interview with Mary Grace Anandraj and Church Elders, GMH Retired Worker and Vattigudipadu Church Members, 10 March 1998.
others wanted to start the work, but first they felt they should preach among the high-caste people. Everything seemed good at first and the response to the gospel message was positive.

A few years later, though, there was a difference of opinion between the high and low castes as to where to build the church. Plans were made to buy a site and build the church, but were delayed because of the differences of opinion among the people. GMH doctor Philip Virthan and other workers came forward to build a church among the poor who were more receptive to the messages.

In 1996 the researcher had the opportunity to help the church to conduct revival meetings and communion services. In 1995 the damaged roof of the church was repaired with funds raised by GMH staff.

Venkatadripuram

Venkatadripuram is about six kilometers west of Nuzvid, on the main road to Vissanapet.¹ At the end of 1998 the church membership was reported to be at 135. During 1998 there were four baptisms, which gave a yearly growth rate of 3.05 percent. The church has been pastored

¹Interview with Y. Martin Daniel and D. Dasu, GMH Workers, 18 April 1998.
voluntarily by B. Bhimaraj, a GMH worker since 1996. Fifteen young people are getting an Adventist education at Nuzvid.

Duvooru Dasu, who had no children, went with his wife to GMH. They expected a miracle from the hands of the missionaries who treated them and soon they were blessed with a child. Y. Daniel, GMH manager, became their good friend. His faith was strengthened from this acquaintance and he became an agent for the gospel work in his village.

A hospital team started the work in 1970. Y. Daniel and Meesarapu Jacob were invited to teach the Sabbath truth. At first this new message was strange and confusing to the people, but as the visits and Bible studies continued, people responded positively. Dasu, a new member, was poor; GMH employed him as a gatekeeper; and he has since become a faithful Christian. In 1976 Louise Daniel, daughter of Y. Daniel, financed the building of a church.

**Yelamandala**

Yelamandala is five kilometers south of Nuzvid.¹

At the end of 1998 the church membership was seventy-nine. During 1998 there were twelve baptisms, which gave a yearly

¹Interview with R. I. Matthew and P. Jacob (late), Former Pastors of Yelamandala Church, 10 April 1998.
growth rate of 17.91 percent.

The church has been pastored by N. Franklin since 1990. About twenty-five village children, including Hindus and Muslims, are studying at the Nuzvid Adventist school. Two of the believers of this church have finished their studies and are now working for the growth of the church. One of them is K. John Prasada Rao, the Adventist World Radio speaker in Telugu. Along with others, a few high caste people, such as Venkateshweramma, were also converted to Christianity.

Yelamandala was one of the earliest church centers to receive the full attention of GMH missionaries. Truth reached here around 1942. Paramanandam, Mullapudi Nehemaiah, R. I. Matthew, P. Jacob, and others were the pioneers in starting and strengthening the work here.

GMH missionary doctor, E. J. Hiscox, took great interest in this village. The missionaries were liked by the people when they came for medical clinics. Evangelistic meetings were held outside the village in a garden, but only low-caste people attended. The high caste treated converted Christians as untouchables.

Evangelists faced many difficulties with caste Hindus who liked hospital services but not Christianity. Landlords
such as Nallaboni Pichodu, Kolkaluri Chinraiah, and Varikoti Somaiah were not in favor of the gospel work in their village. On the other hand some Hindus liked this new religion that treated all men equally; furthermore, those who experienced healing at GMH appreciated Christianity.

Around 1955 Kolukuluri Gnana Sunderam and his wife, Ruthamma, accepted Adventism and were baptized; later others joined. The church was supported by the village head and as a result a company was established.

E. J. Hiscox and J. B. Oliver helped this church in many ways, such as buying land for a church building and assisting in building a pastor’s house. E. J. Hiscox contributed substantially to the work and also strengthened the work here by holding many free eye and medical clinics.

Ten Companies

In addition to the many churches mentioned above, GMH also established ten companies in the area. The difference between a church and a company is that a company does not have an assigned pastor to visit on a regular basis, neither does it have a church building. In many of these companies there was no strong follow-up work after the initial campaign.
In other cases the work started by the hospital workers could not be carried on because it was too much in addition to their regular medical work, and the local section authorities could not take up the work because of limited resources. Over the years about twenty companies were started that never became churches with a pastor and a building. Ten of them that are still doing well are identified and described.

Chinnampeta

Chinnampeta is a small village thirty kilometers west of Nuzvid. At the end of 1998 the membership was at 125. During 1998 there were five baptisms, which gave a yearly growth rate of 4.16 percent. The company has been pastored by D. Israel since 1996, but he moved to Keesara church in January 1999, so there is presently no one to care for this group.

The Adventist message reached this village around 1955 through Kommu Ramulu, whose Christian name was Daniel. Ramulu had relatives in Gopavaram where an Adventist church already existed. He attended the prayer meetings whenever he visited his relatives. With his CSI background, he had

1Interview with M. B. Jesudas, GMH Retired Worker, 15 March 1998.
many questions and was eager to know the message.

After careful study, he concluded that the Adventist church is the true church and began telling his people in his own village that the GMH church was the true church. He conveyed the message that Sabbath is not only for the Jews of the Old Testament but also for Bible-based Christians today.

Against all odds he was baptized and started teaching people around him. One day he invited S. J. Satyanandam, who first brought him the truth. Accepting the invitation, Satyanandam went to the village. On the way he enquired where Ramulu's house was. A high-caste businessman responded that Ramulu used to be notorious in the whole village, that he did not know what changed him, but that now he was a most noble man.

After the meetings in 1965, several people joined the church. A beautiful church was built, financed by E. J. Hiscox. A few young people from this village studied in the Adventist school. M. B. Jesudas and P. T. Isaac helped in the strengthening of the work here.

**Chittapur**

Chittapur is a small village fifteen kilometers west
of Nuzvid. At the end of 1998 the church membership was sixty-two. During 1998 there were two baptisms, which gave a yearly growth rate of 3.33 percent. The company was pastored by Gumpula Sunder Rao from 1985 to 1998. At present there is no place to worship and no pastor.

In 1991 work started with the help of the section evangelist, P. J. Jesurathanam. Before this the ground work was done by Ch. Azaraiah, a government school teacher in Chittapur. After twenty days of evangelistic meetings, forty people took their stand for Christ. There was no planned follow-up work done. Consequently, there is no church or a pastor to care for the members.

Digavalli

Digavalli is ten kilometers west of Nuzvid. At the end of 1998 the church membership was fifty-two. During 1998 there were twelve baptisms, which gave a yearly growth rate of 30 percent. The company has been pastored by K. Elisha Rao since 1994.

The work started in this area among the shepherds and

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1Interview with Ch. Azariah, and Thomas P. Matthew, Chittapur Church Initial Evangelist, 15 May 1998.

Kammass in 1960. Initially an invitation was received from a person who was treated at the hospital and who became well. N. V. Jesudas, along with M. B. Jesudas, T. D. Newton, P. Thomas, and others, visited this village. After some contacts, evangelistic meetings were conducted.

While the meetings were being conducted in 1963, a Hindu by the name of Bekkam Kollaiah, on his way home from his mango garden, was curious to see what the American hospital people were saying. At once he became interested in what they were saying about a unique person called Jesus, the Savior of mankind.

Soon he was baptized. Later he and his brother's children went to visit the missionaries requesting financial help to place their children in an Adventist school. Hiscox first educated Bekkam Ventkateshwer Rao, then his brothers. After several years these young people were educated and then settled in the United States.

Presently there is no place of worship in the village. The GMH chaplain and I have had opportunity to visit the company and conduct weekly prayer meetings for many years now. Pedda Samuel, a lay member of Nuzvid, is also working in this village among caste Hindus.
Kirthirayagudem

Kirthirayagudem is seven kilometers south of Nuzvid.\(^1\) At the end of 1998 the church membership was sixty-six. During 1998 there were no baptisms. Today the members do not have a place to worship or a pastor to care for them. Neither do they have a pastor to visit and guide them to grow spiritually. At the same time, other independent Christian groups are regular and stronger in missionary work. For many years L. S. Philip took an interest in this company and volunteered to visit them, but now he is too old to help.

In 1982 L. S. Philip began the work here. Afterwards, ground-work meetings were conducted for fifteen days in 1983. One of those who attended the meetings was Manda Pulliah, who took his stand for Jesus. Pulliah was interested in the hospital work and the Sabbath-keeping church.

Pedapudi Judson Moses, then president of South Andhra Section, took an interest in this work and supported it. The company started with twenty-five baptized members. During the years different caste people showed an interest

\(^1\)Interview with L. S. Philip, Kirthirayagudem Church First Evangelist, 10 May 1998.
in the Adventist church, especially those who came in contact with the medical ministry at Nuzvid.

Kodur

Kodur is thirty-five kilometers west of Nuzvid. At the end of 1998 the church membership was seventy-six. During 1998 there were three baptisms, which gave a yearly growth rate of 4.10 percent. Work started here around 1975. The Adventist school in Nuzvid, an offspring of GMH, took an interest in outreach work and this church is the result of their work. At present there is a small church building but there has been no pastoral care for the last five years.

At first there was an invitation for the principal, M. S. Jeremiah, to visit Kodur to tell of the Sabbath-keeping church. After visiting the village, Jeremiah conducted fifteen days of evangelistic meetings. People liked the American Hospital (GMH) church, and the messages impressed them.

At the end of the meetings fifty people took a stand for Jesus. The follow-up work was done by school teachers; later, it was handed over to the local section, who built a church and placed a worker there. However, after a few

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1Interview with M. B. Jesudas, Kodu Church First Evangelism Helper, 10 May 1998.
years the pastor was transferred and was not replaced by anyone. Since this is a remote area with no proper facilities, no one took an interest in the development of the work and the group has suffered as a result.

**Kothuru**

Kothuru is three kilometers east of Nuzvid.\(^1\) This is a very small village whose inhabitants are mainly of the shepherd caste and other Hindus. At the end of 1998 the membership was eighteen. During 1998 there were no baptisms.

The Seventh-day Adventist truth reached here around 1974. Patients who had visited the hospital felt that they were healed because the hospital possessed a special power. The kindness shown in the healing ministry touched their hearts. One day two Hindus asked them if it was possible for hospital workers to visit their home, perhaps to express their gratitude or to find out about the power behind their healing work.

M. B. Jesudas, Ch. Anandraj, and N. S. Bhaskar Rao visited them. The people showed an interest in the preaching and message so the workers faithfully continued their humble

\(^1\)Interview with Mary Grace Anandaraj, GMH Retired Worker, 15 June 1998.
efforts to establish a strong work. They conducted evangelistic meetings for fifteen days with fifteen Hindus, mainly ladies, taking their stand for Jesus. N. S. Bhaskar Rao, GMH church pastor, and Ch. Anand Raj, GMH chaplain, did the follow-up work.

When they were transferred in 1978, no one took an interest in guiding the group. The believers started losing interest in the church because there was no one visiting them. The researcher had an opportunity to visit them on more than one occasion to encourage them, but they are still without a full-time leader.

Mukkidlapadu

Mukkidlapadu is eight kilometers northwest of Nuzvid.¹ At the end of 1998 the church membership was eighty. During 1998 there were eight baptisms, which gave a yearly growth rate of 10.52 percent. Since 1995 the group has been visited from time to time by P. P. Kumar.

Since 1998 a strong work has been started with regular visitation programs, free health clinics, branch Sabbath Schools, and cottage meetings regularly taking place. This increase in activity is largely because ADRA (Adventist

¹Interview with M. B. Jesudas, GMH Retired Worker, 10 May 1998.
Development for Relief Agency) Canada has sponsored a community health project based in Mukkidlapadu.

M. Suryanarayana is the ADRA manager and he takes an interest in combining health and the gospel. The GMH chaplaincy department is also active in visiting this village regularly so there is a very bright future for this company.

The Adventist message reached this village in 1977 through patients who came to GMH. Because of the lack of workers the work came to a halt. Again in 1996, the chaplain of the hospital took an interest in this area. At first he visited people with his team of helpers. The members who knew the hospital and Sabbath truth welcomed them, but because of the lack of workers the work again came to a halt.

Reddygudem

Reddygudem is fifteen kilometers south of Nuzvid. At the end of 1998 the membership was 160. During 1998 there were twelve baptisms, which gave a yearly growth rate of 8.10 percent. Since 1994 the company has been pastored by P. Manohar, with two other churches under his care. Today

1Interview with P. V. Prasad and M. B. Jesudas, Reddygudem Church Initial Evangelists, 20 March 1998.
there is a group worshiping every Sabbath but there is no church building.

The work started around 1975. A few patients from this village visited GMH for treatment. They were impressed by the kindness shown to them by the doctors and nurses. These people invited the staff of GMH to conduct meetings and teach them more about Christ. In describing the village, P. V. Prasad reported that

Reddygudem is a backward area. There are about 1,500 families living mostly by selling Toddy and smoking "Chutta" a local made cigar. Among all these families there is only one boy who has studied up to the intermediate level.  

The hospital workers visited them and gave Bible studies, also treating some patients in their homes. This made a definite impact on the people's thinking. At one time Rami Reddy was sick and visited many hospitals before going to GMH. Here, by God's help, he recovered from his illness. In gratitude he invited the hospital staff to conduct a prayer meeting at his house.

Seizing the opportunity, the hospital team went to his house and conducted meetings every night for many days. The whole village was moved. The lifestyle of the people started changing and many were serious about this new church

1P. V. Prasad, "GMH Workers Accept the Call," 13.
with a Sabbath like that of the Jews.

P. Thomas, chairman of the 1000 Days of Reaping campaign, was helped by T. D. Newton, M. Babu Rao, and G. McWilliams. Every evening during the campaign, they would take the hospital jeep and visit this village to preach the Word of God.

Injety James, Union Health and Temperance Director, gave "Better Living" lectures using visual aids. Lively singing added much to the meetings. People were moved by the health lectures and also by the Sabbath truth. After thirty days of meetings, 134 people took their stand for Jesus.¹

Rami Reddy was the first one to be baptized followed by many others. E. S. Sudershanam, the credit manager of the hospital, took full interest in developing this church.

Regunta

Regunta is four kilometers east of Nuzvid in a jungle and mountain area.² It is small village with mango orchards and calcium deposits. At the end of 1998 the church membership was thirty-seven. During 1998 there were two

¹Ibid., 14.

²Interview with Y. Robinson Daniel, Regunta Church Volunteer Care-taker, 12 March 1998.
baptisms, which gave a yearly growth rate of 5.71 percent. There is no pastor or place for this group to worship. Robinson Daniel, like his father Y. Daniel, is visiting them once in a while.

The Boravancha Adventist church members brought the truth to this village in 1960. Pedapudi Jacob, N. S. Bhaskar Rao, and Sushelas's husband took an interest in visiting and conducting meetings in this village.

L. S. Philip worked for this church as an evangelist. After much work and visitation, nineteen people were baptized. No mission worker was assigned to do the follow-up work. Land for building a church was purchased, but no funds were available to build a church.

**Sunkollu**

Sunkollu is about six kilometers south of Nuzvid.\(^1\) At the end of 1998 the church membership was seventy-three. During 1998 there were four baptisms, which gave a yearly growth rate of 5.79 percent. Since 1990 the company has been pastored by N. Franklin who has an additional church to care for as well.

The Adventist message reached Sunkollu in 1950 when

Pagidipalli Devadanam conducted meetings, preceded by his visits and prayers. Kaalapala Paradesi was the first convert. In 1952 he donated his own land for building a church.

Since Sunkollu has been a Catholic stronghold, there was much tension between Sabbath-keeping Christians and Roman Catholics. In 1974 Gumpula Sunder Rao was appointed a church pastor and he worked closely with the people, guiding them in the truths of the Adventist church.

The members are working to build a church and are also very much interested in educating their children for church work. Under the sponsorship of Kalapala Vasantha Rao, the son of the first convert, many revival meetings have been conducted. The researcher had the opportunity of participating in church meetings and encouraging the believers.

Other Companies

At least another ten companies of this nature could be mentioned along with the ones described. Only an initial campaign was conducted; people were baptized and very little was done after that. At present these companies are not functioning. Almost all of them were started by GMH with
the encouragement of the missionaries, but the hospital could not pay full attention for a strong follow-up work, being occupied with medical work.

The responsibility was then passed on to the local section that had no funds or personnel to maintain and help the growing needs. The local section is still unable to appoint a pastor for each church established because of financial strain. Building a church is expensive unless someone from abroad takes a specific interest in funding the construction of a church building.

In places like Thathaguntla, Vissannapeta, Mundadugu, Leelanagar, Bothuluvarigudem, Ponsanapalli, and Goduguvarigudem, gospel work has been done. Each of the villages had a membership of around fifty, but for want of funds, no church pastors have been appointed or church buildings constructed so these companies no longer function.

**Analysis of the Outreach of GMH**

Analysis and evaluation of the work done can help improve the growth and influence of the gospel work. In this section health evangelistic work done by GMH is analyzed and evaluated. The work once done can now be done by the nationals, with some modifications, and also by
taking advantage of modern transportation, communication, and medical help.

Mission of GMH

Theodore R. Flaiz, founder of GMH, also set aims and goals for the institution. These were based on the Bible and on the Adventist philosophy of health ministry. These goals were reflected through his life and service, in the structure and functioning of the institution.

The primary purpose of the hospital was to serve the community's health needs and to help break social and cultural barriers to influence church growth. Flaiz concluded his message at the Golden Jubilee Celebration:

The importance of the Giffard Memorial Hospital does not lie in the material assets and facilities there, rather it is in the fifty years of witness to the truths which mean so much to the Christian. The importance of this hospital is in the hundreds of young people educated there who have gone out to serve the less fortunate of their own land and in many other parts of the world. I have met Nuzvid graduates in many places, doing a good work. The presence of the hospital there with its various training programs, its excellent Christian medical ministry has contributed greatly to the building of a large and growing Christian community of people who look for the soon coming of our Lord.¹

Emma Binder, a missionary at GMH, wrote about medical

¹Flaiz, "Beginnings of the Giffard Memorial Hospital," 18.
and gospel work saying:

There is much to be done, not only to cure the sick but to teach hygiene, sanitation, prevention of diseases, and last but not least to carry the gospel commission of Jesus to all. To this end means and lives are dedicated that all who choose may experience the fullness of life, hope and peace in Him.¹

Strategies Used by Missionaries

In the early days when the missionaries first started medical work along with gospel work, certain strategies helped them open doors for Christianity.

1. When they first came, missionaries carried guns for hunting; they killed wild animals that troubled local people and their cattle. This developed friendship and opened the way for preaching the gospel.

For example the work done initially by Theodore R. Flaiz at Gudem Madhavaram village in the 1930s is typical. He first went to relax, made friends with the locals, helped them by killing the wild animals that troubled them and their cattle, then preached the good news of Jesus. For the nationals the situation is different, but they can live a healthy life among the people as Flaiz did, and offer something which the locals do not have.

2. Missionaries aided the poor by sending their children for Christian education, who are now educated so that future generations could be different from the present social stigma. Elizabeth Hiscox wrote:

A women near death from lung abscess and eye ulcers was in the hospital for several weeks, but finally she recovered. A little daughter named Dayavathamma was her constant helper, and I decided to send the eleven year-old girl to Narsapur school. The cost was 30 rupees per year (about $5).¹

Financial support and encouragement given to local children for Christian education has yielded good results. Today there are many workers in Nuzvid and all around the world who, because of the vision, financial help, and guidance of these missionaries, are contributing substantially to the growth of the church.

Today nationals can start elementary schools or adult literacy centers in towns and villages and educate the members. Paying for a member's child to attend school is not possible for nationals. This strategy was excellent for missionaries, but nationals must emphasize self-support strategies.

3. Wherever there was a quarrel, missionaries came to the rescue and helped solve the problem. Even the police

¹Hiscox, To and from Nuzvid, India, 41.
had high regard for the missionaries who were willing to help. As a result the missionaries acted as middlemen to help solve some of the problems between high- and low-caste people.

This was done while establishing church work at Hanumanthulagudem and Pothireddypalli. The white-skinned people are well respected even today. In the present society, only medical doctors have the necessary status in society to help solve local problems.

4. Social and caste barriers were broken down. Missionaries mingled with all people, treating all equally. This gave common people a sense of relief and freedom, as well as warmth of love. Elizabeth Hiscox recorded in her diary:

Friday July 21, 1939, Terepeti was bitten by a scorpion on his thumb and went through considerable agony. . . . He was a good servant, who loved the chickens and the garden plants. He originally came to the hospital as a patient with beriberi so severe he could hardly crawl. When he recovered Dr. Emma Hughes took him on as a servant, trained him to be a gardener and to clean the house. He eventually became a faithful Adventist. 

At the same time, they maintained friendships with rich landlords and petty kings. Nationals can attempt to do the same. However, meetings between people of low caste and

1Ibid., 38.
the rich or high caste can only take place in a public place such as a school or hospital. Nationals must try to break barriers and witness wherever it is possible.

5. Missionaries helped in sickness. They demonstrated the power of a great healing God. This changed the people's thinking. Missionaries dismissed from their patients' minds the magical powers or spirit healing that had dominated them for centuries.

The work of the devil was weakened. People received peace of mind and understood the real source of true happiness. People were very satisfied with the healing the Christians offered since it was beyond mere physical healing. This can be very well done by the nationals in whatever way possible: by hospital or community services, community, health education, or other means of bringing healing to the body and the soul.

6. Through their lives missionaries demonstrated what Christianity is. Their lifestyle of simplicity, humility, hard work, and sacrifice were in the pattern of the teaching of Jesus. Theirs was the attitude described by Ellen White: "charged with the life-giving power of faith, courage, and
hope and sweet with the fragrance of love."

In many cases people were eager to follow Christianity since they realized that partnership with Christ brought blessings and prosperity. Nationals have the same challenge; through their personal lifestyle they can influence many. Hard work, commitment to the church, an attitude of service will make all the difference in working for God. R. W. John explains major hindrances for evangelism in India:

Lack of moral discipline in the churches, and the toleration in church members of such acknowledged evils as caste discrimination, corruption, and litigation. These are public sins, which cause a public scandal.

Other Strategies

Doctors and other hospital workers took an interest in meeting people in their homes, inquiring about the patients' health and praying for them, thus creating a bridge to build Christian relationships. Medical workers along with the missionaries were active in doing the follow-up work for the people who came in contact with GMH. Some of the strategies

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they used follow.

**Christian Friendship**

Missionaries built bridges between rich and poor by their friendship; in turn they built a positive attitude toward Christianity. For example, E. J. Hiscox mentions in her diary her friendship with the rich or high-caste people:

Occasionally we received invitations to visit the palaces of different Ranis (wife of a petty king or land lord) of the town, especially Mrs. Rao (the Rani of Teleprole), the Rani of Indupalli, and Seethamma Rani. These women belonged to the Zamindari caste, which owned extensive property and even towns.¹

At the same time she mentions visits to patients' homes in nearby villages. On these visits they read Scripture and had prayers. According to her diary some of the places visited were: Boravancha, Yalamandala, Atkur, Vissannapet, Annavaram, and Gandiganamala.²

Not only Hiscox, but also other GMH workers followed this pattern. M. B. Jesusdas, S. Joseph, G. Lazrus, P. Thomas, Ch. Anadaraj, Daniel, and others were active along with the missionaries.

Through cordial interaction, friendship circles developed. These friendship circles resulted in Bible

¹Hiscox, 18.

²Ibid., 141, 77, 250, 132, 110, 315-316.
study. As a result Hindus started reading the Bible privately at home. Sometimes after the visit, workers left Christian literature at the homes and they looked for an opportunity to open a branch Sabbath School. This is how work started in many villages. This method can be very well used by the nationals today by involving themselves in more health, social, and educational services.

Adventist Education

Missionaries and GMH workers envisioned that one of the ways to help gospel work grow strong was by educating the next generation. Members were encouraged to send their children to Adventist schools. Financial support and encouragement were given to local children to attend Christian schools.

Today there are many workers in Nuzvid and all around the world who succeeded in life because of the vision of these missionaries and their financial help and guidance.

This is a good avenue to reach the public. Nationals caught the vision and have improved on it; as a result there is a higher secondary school in Nuzvid, educating many non-Christian young people. The only difference is that the missionaries financed the education of others, while the
nationals offer quality service by offering good Christian education.

**Church Programs**

Medical missionaries supported many church programs. There were regular morning worships that involved both patients and relatives. Weekends were a time for celebrating the goodness of the Lord. It seemed as though while Hindus had a monthly festival, the Adventists had a weekly festival.

Other church programs were also important: youth activities, branch Sabbath Schools, singing bands, Dorcas society, literature ministry, and temperance programs. In a similar way, nationals can be part of church programs and involve others in them. Nationals have an advantage over the missionaries by speaking the local language and knowing how to contextualize their message to the local customs and culture.

**Evangelism**

Medical workers encouraged public evangelism, built churches, and conducted outdoor clinics.¹ This was the chief activity apart from the medical work done by GMH.

¹Ibid., 175.
Missionaries, along with the national workers, visited families, conducted prayer meetings, and offered help whenever the opportunity came.

Evangelistic meetings were the ground work, after that came Bible studies. Meetings usually were held for fifteen to twenty nights. Activities such as group singing with musical instruments, stories for children, and health made the meetings interesting. There was strong follow-up work after the meetings.

Furthermore, they helped build churches and appointed a part-time or full-time worker as soon as the work was established. These are very practical methods and proved successful. Such methods need to be followed for greater success in evangelism today.

In order to make the work strong, the conversion process must be long, teaching people to depend financially on themselves, to build their own church, and to teach the new members to give to the Lord liberally to support their pastor. Such a training at the very beginning would make a church more dynamic and self-reliant.

Free Medical Clinics

In the evenings, whenever possible, missionaries, with
the help of other workers, conducted free medical clinics. This was especially done in remote villages, where there were no medical facilities. These clinics provided free physical check-ups and free medicine whenever possible.

If a person was acutely ill, they were directed to the hospital for free treatment. Often, at the end of the clinic, one of the team members would give a health talk about maintaining healthful habits.

These clinics are one of the best services any medical center can render to the poor and unfortunate who live far from basic medical facilities. This work fulfills the commission of Jesus and also boosts the image of the medical center.

Witnessing

Medical workers witnessed whenever possible. While traveling, they distributed Christian literature. Before surgery they offered prayer and this made an impact on the patient. They talked to patients and relatives whenever possible.

Whenever there was an invitation to a wedding, a

\[1\] Ibid., 196.

\[2\] Ibid., 126.
housewarming, or a festival celebration, they became part of the activity without compromising the truth. This is one area nationals must learn in order to promote effective gospel work. Of course they had the advantage of being the medical workers, but the nationals have different advantages.

Vision for Mission

The missionaries were committed to their task. They worked day and night to attend to the patients or help with church activities. Missionaries molded a deep level of devotion and dedication to the mission of healing. Their generosity and sacrifice for the welfare of their fellow men are commendable. Many of them gave up a normal family life for the service of humanity overseas.

The church in India today needs the same kind of committed, self-sacrificing, and devoted people in its work. When commitment and vision are lost the church suffers. Priorities are confused and dishonesty creeps in. A life of vision and commitment must be demonstrated by the leadership in order to be reflected at the local level. Without vision the people perish, and without mission, dedication, and commitment there will be no quality growth.
Community Health Program Attempted

In 1980 the Union president and chairman of the GMH board described the beginning of village health evangelism as a most gratifying experience. A group of ministerial graduates from Ibrahimpatnam Ministerial Training School were brought to Nuzvid for health education and later for community services. They were to prepare to be efficient in health evangelism while working on a stipend support basis.

Within a year the project was so successful that the Christian Medical Association of India secured funds from a Dutch agency to expand the project with Rs. 78,000 a year for the following five years. A community health team was set up. In a year three villages without medical facilities were given good facilities.

There was training for community health workers. Three young seminary graduates moved into three villages after six months of health education that included the diagnosis of common disorders and their treatment. Hydrotherapy, sanitation, village health, and nutrition were given special attention.

These health evangelists led out in a mass immunization program. They provided mother and child care training, nutrition classes, and an adult literacy program.
They also gave physical examinations under the supervision of GMH. All these programs received ready and enthusiastic cooperation from the village communities.

When Vara Prasad first went to Devaragunta, the village provided him with an old shed. At the onset of the monsoons, it began to leak badly. He reported this to the village elders who did nothing about it. GMH doctors worried that without the involvement of the community the program would be weakened. However, during Philip Virthan's visit to the village with his medical team from GMH, a group of young people, sons, and relatives of the village leaders offered to build Vara Prasad a new house. This they did within a week--well thatched, strong, and right on the village square.

When the center was officially opened, more than one thousand people came to hear the Bible message presented. The young people continued their support by planting a garden and building a fence around it. They intend even to find a girl for him from the village as his life partner. Vara Prasad helped thirty illiterates to learn to read. Three of these were baptized.¹

For the first time in the Southern Asia Division, the idea of training village-supported stipend field workers for village health evangelism was implemented by GMH. These young men had only a small stipend, but they were successful in achieving the cooperation of the village people. They were successful in helping the sick to recover and their credentials as medical workers were upheld.

Some of the goals and objectives of training community-based health evangelists are:

1. To determine the impact a person trained in health gospel ministry will have in a rural setting as an attempt is made to work for the whole person

2. To use the hospital center as a means of influencing the community through active participation in the community life

3. To provide minimum basic health care to the community, to treat common disorders, and to provide first aid.

4. To start health education to encourage regular immunization for children, to work towards providing safe drinking water for the entire village, to give instruction on nutrition, to teach general cleanliness, to conduct adult
literacy classes, and to provide for spiritual needs.\footnote{Charles, "GMH Village Health Evangelism," 15.}

Unfortunately as this project was gaining momentum, the GMH medical director was moved to Pune, the chaplain died, and others did not share the same interest in the project. Thus the project came to a close, and the young men were absorbed by the section as regular paid workers.\footnote{Health evangelism projects of similar medical centers are proposed in chapter 6 of this dissertation.}

Changing Trends and New Methods

GMH started in an undeveloped rural setting. Today, medical practices are specialized and the methods have changed. When the work started at Nuzvid there was only one government-operated clinic, but today there are at least fifteen hospitals and clinics with an average of fifty beds each.

Even in evangelism the approach and strategies have to be modified. The methods and strategies used in the early days may not be very practical or effective now. Missionaries paid fees and educated the members' children. Now we encourage the members' children to go to a nearby Adventist school.

There is definitely a need for new ways of doing
medical evangelism. While taking advantage of modern medical knowledge and facilities, the emphasis should not be so much on curative medicine as on prevention. The old saying, "An ounce of prevention is worth a pound of cure," is true and its value should never be forgotten.

The emphasis should be on the community rather than on the individual, on education, rather than prescription. Such programs will make a definite impact on the community in bringing a definite change and in encouraging church growth.

Today medical and gospel workers have more advantages such as transportation, communication, and other facilities that make the work a lot easier. Speaking the local language and understanding the cultures and customs of the area also give national workers advantages over the missionaries.

Whatever the means, there is a need to reach the rural Indians with love and care. Adventists need to teach healthful living by pointing to Jesus, who can heal both mind and soul.

God has blessed GMH in planting twenty churches and ten companies. What GMH has accomplished can be duplicated in other areas of the Adventist Church. In chapter 6 a
contextualized strategy is developed with the suggestion that local churches and educational institutions can also accomplish what GMH has achieved.
In this chapter, a contextualized strategy\(^1\) for health evangelism in India is developed. This program has been designed in harmony with the principles of the Bible and the writings of Ellen White.

This suggested strategy for health evangelism can be carried out by medical centers and health-care facilities through the medical evangelism team (TEM), local churches through the church health evangelism team (CHET), and schools and educational centers throughout India, with

\(^1\)A contextualized strategy consists of developing a program according to the local needs of the people by understanding their way of life and their world view. A strategy is a systematic plan for reaching targeted groups through health evangelism within their situation and culture, without compromising truth. "Contextualization is the process of putting a message into appropriate socio-religious, and cultural understanding of its receptor without changing the fundamental doctrines of the Bible. This is the process by which the recipients of the gospel and theology are brought into an understanding within their own context and setting." John E. Apech, "Socio-Anthropological Implications in Cross-Cultural Planting," Indian Journal of Theology 38, no. 1 (1996): 96.
special emphasis given to community-oriented health programs.

There are important guidelines that must be kept in mind by every volunteer working in health centers, church health centers, and educational institutions. Adventists who are involved in health evangelism should be taught the importance of also being a strong prayer warrior.

Those working in health-related areas must learn to depend on the Lord and His power. Many of the sicknesses can be attributed to the work of evil spirits. Often when demonized people are prayed for, the devil causes disturbances. Expect the Lord to set people free. This is the Lord's work, He will intervene and influence the humble efforts done in faith. In every training program for health-evangelism volunteers, there should also be training sessions to teach people how to pray for the sick and how to pray for demonized people.

Multitudes of people have been enslaved by Satan throughout history and he rules over millions today. When evangelists go to these enslaved people with the good news of the gospel of freedom, Satan is threatened because he will lose his grip over people. The gospel alone has the power to set people free from Satanic forces. Evangelism is always effective when the gospel is proclaimed in the power of the Holy Spirit.¹

There will be greater success for medical personnel if

¹Ponraj, 137.
they learn to also draw on God's power to heal and set free. Medical workers must model a life of discipline. They should be willing to adjust to the local situation and have a deep dedication for the welfare of the people. They must be a people with a vision and a people of prayer, who desire to touch lives with the loving concern of Christ.

Medical Centers

Each medical center can have a strong witness for God when medical workers and gospel workers work together. The hospitals must encourage and support the chaplaincy program. Administrators and doctors must recognize the value of spiritual healing.

The present world believes in specialization. Adventist hospitals have followed this modern trend by employing chaplains to deal with a patient's spiritual and social needs, while the medical professionals deal with the physical aspects. However, in the Bible and in Adventist literature the concept of the "priesthood of all believers" and "every believer a soul winner for God" suggests that medical workers also need to be involved in sharing the Good News.

While treating patients, look for opportunities to talk to them about spiritual values, lifestyle change, and the purpose of God in creating man in His image. Such an
approach will encourage the patient to think about spiritual things and create a desire to know more. Do not leave spiritual aspects of the patient to be dealt with only by chaplains or pastors.

In India the gospel worker is unknown, but a doctor is well accepted. For this reason a doctor and a minister should work as a team for greater success. This relationship may not be easy, but it is essential.¹

The very purpose of medical centers operated by the Adventist church is to reach people with the message of health in preparation for God's kingdom. Health evangelism is a tested way for the fulfillment of such a purpose. Medical centers should lead out in doing health evangelism suggested in the following paragraphs.

There is a need for every medical worker to realize that they are involved in a very noble work for the Lord. They have a solemn responsibility to follow Jesus' pattern of ministry and to give loving care not only to help heal physical sickness but also to touch the spiritual needs of people by pointing them to Jesus.

¹The doctor-minister relationship is hampered when the physician is not committed to spiritual goals, is absorbed in his or her profession, feels superior to the pastor, or has a different lifestyle than the minister.
Every medical center should have an outreach department, organized under the care of a doctor (one with an interest in health evangelism or who has studied public health) or a chaplain. The hospital will set aside a budget for the activities of this department. If possible the support of ADRA and the government should be used. Donations for such a noble work can be gathered, even from the public.

Medical centers with outreach departments should develop satellite points at every targeted village (the village selected for outreach must hold potential for future evangelism and have medical needs). The workers in the medical center who are interested in outreach work should form a team called the Medical Evangelism Team (MET).

The MET will consist of a male and a female doctor, a pastor, two nurses or ward-aids, a driver with a little electrical knowledge, a counselor/story teller, and others who are interested in learning to do such work in the future. A leader should be selected to organize and lead the program. The MET will meet at least once a week at the base point (hospital) to plan, pray, and strategize.

The MET will organize and work at the satellite point (a Hindu/Muslim area/village with no medical facilities) for six months with the goal to change the lifestyle of people,
teach health habits, and give basic knowledge about better healthful living.

Programs dealing with mother and child care, common treatments, first aid, stop smoking, the how and why of AIDS, and natural remedies can be taught. The treatment must be curative and preventive. There must be social motivation to change and a spiritual outlook for stability. Thus the people will open their minds to Jesus.

In other words, this is a hospital-based program, but the activities are carried out at a satellite point. Curative procedures (medical or surgical) are handled at the hospital. Preventive medicine (primary health, teaching lifestyle change) is cared for at the satellite point. This will be possible only when the doctor and pastor, along with their team of helpers, work together.¹

Twice a week villagers are called together to learn basic health principles usually in the evening after their daily work is done. Here the MET will organize a free medical camp, after which the people will be taught using demonstrations and available aids such as movies, flip charts, and illustrations with the hope that such activities

¹A similar, community-based health work was tried by GMH at Polsanapalli, Siddhardanagar, and Mukkidlapadu. The program was sponsored by ADRA Canada, but the emphasis was on medical care with the evangelism aspect neglected.
will motivate the listeners to change their lifestyle.

Villagers learn faster when programs are presented in historical, epic (story) cultural style. Such programs need to be developed so that the work done will be effective.¹

Orientation and Training

Both in urban and rural medical centers people must be motivated to participate in health evangelism. The kind of strategy used by a medical center for the urban population² must be specialized and professional. Pune Adventist Hospital has undertaken community health projects that have been well received by the elite of society.³ On the other hand, rural communities need basic health orientation.

¹"Community-based health care is a much better vehicle for evangelism than in hospitals and clinics. In many places where this method of health care has been implemented communities have also been transformed by the Gospel. Community oriented primary health care requires committed individuals who will recognize individuals, families, churches and communities as responsible partners. Hospitals must take up more community and preventive oriented programs." David Hilton, "The Future of Medical Mission," International Review of Mission 76 (January 1987): 79.

²Urban populations are more educated, busier, and commercially minded. They have money to go to the doctor when sick. Generally they live under stress.

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has done community health projects targeting community needs.¹

For the convenience of MET members all training and orientation sessions will be offered at two different times so MET volunteers would not be forced to attend training at times that are inconvenient for them. Training sessions can be held in the evening after working hours on the weekly days off or on the weekends. MET training lasts for two months.

The instructors selected to give training and orientation should be well experienced in both evangelism and health work (doctor-minister team). Material must be prepared by the doctor and chaplain according to the target group and the activities needed. The resources can include the Bible, the writings of Ellen White, and programs that have been worked out in other centers. Presentations in the training and orientation must be simple, relevant, and

¹For example, in rural areas, "GMH not only treats patients who come to the hospital, but also reaches out to the people in the surrounding villages with a well-planned community health and developmental program. Recently, the hospital has completed five-year community-based primary health care projects in four neighboring villages. This involved training local women in maternal and child health and first aid. A referral system was established. All this led to a significant improvement in the health of that community." Gyi, "Defeating the Devil at Giffard Memorial Hospital," 7.
practical, and fit the local needs.

Further, more of the teaching should include demonstrations, illustrations, and visual aids. Topics presented must be goal oriented for the target group. The programs should be professionally prepared, and can include topics such as rehabilitation for the chemically addicted, seminars on AIDS, the New Start program, natural lifestyle, vegetarianism, temperance, and community health. There should be an emphasis on prayer and a personal commitment to God and His healing ministry.

There should be special training sessions to teach people about power encounters and to explain the concept of prayer for the sick. Miraculous healings are a gift the Lord chooses to use from time to time when there is a need or a purpose. Both physicians and volunteer health workers should work as a team, putting self aside. Doctors should be encouraged to be involved in outreach activities because, in the people's minds, a doctor has high social status, is respected and accepted, and will be more easily listened to.

If the MET is aiming to reach a rural community, subjects such as community health, mother and child care, and the prevention of common illnesses should be included. Subjects such as first aid and common health problems are easy to prepare since the presenters are already working in
the hospital. An emphasis on natural remedies, particularly on the use of water (hydrotherapy, fomentations), use of charcoal, massage, and other programs are ideal in rural settings.

Along with medical training, the art of witnessing, Bible teaching, and the methods of Jesus' ministry will provide for effective evangelism since pointing to Jesus the Mighty Healer is the ultimate goal. All members of the MET must be well-trained, but of even greater importance is the need for each person to have a genuine desire to share God's love with people in need.

Further, on the part of the volunteer there should be dedication and commitment to serving the less fortunate humanity. Members of the MET should not only know facts and figures but they must have a personal religious motivation that will inspire people to want to change their lifestyle. Perhaps at the end of the program a small dedication program can be conducted to make an impact in the minds of the MET that this program has more than a human agenda in bringing people to Jesus.

Implementation of the Program

Implementation begins at the hospital, while the staff is working with the patients. The hospital staff should look for potential contacts among the patients or their
relatives who will help with the ground work for the MET to work in their village. Such an individual or family may initially be interested only in knowing why sickness comes and how to prevent it, but at a later time they may join the MET to be the contact person between the MET and the village head or other influential people needed to support the MET's programs and efforts.

After the training period it may be best to allow the workers to divide into two groups. This will improve the functioning of the MET. If one group is busy in the hospital or occupied somewhere else, the other group can take over and carry on the work. Implementation begins as soon as a village is selected.

After selecting a village, find a building or a small room that can be used as a clinic. The village square can be used for teaching and demonstrations. Missionaries who visited some of the hospitals in India in 1973 envisioned similar programs for greater influence of the health centers.¹

¹Ralph Waddell, an American medical missionary, after visiting many churches and medical centers in India, concluded: "Community outreach may well be the most fertile of endeavors in which southern Asia could become involved." He even suggested that "it might be feasible for the institution to develop a medical van program, into the isolated villages where a physician and attending nurses could provide emergency health care." Waddell and Yesudian, 5.
The MET will work for six months, perhaps alternate weeks for each group implementing the program prepared at the base, visiting people in the area, explaining the concepts of a healthy lifestyle, and encouraging people to leave their unhealthy habits. They will aim at the group, not the individual. They will target health education and prevention rather than the curative process. They will be friendly and create an atmosphere of care and concern. The teams will take turns visiting and spending time with the people; if possible, they will live among them.

While building confidence, efforts must be made to point the people's attention to Jesus the healer. Explain His purposes in each one's life, so that the Good News of God's salvation will capture the mind of the nonbeliever without much difficulty.

Contextualize the message, quote Hindu scripture, use vegetarianism as a common point. Join Hindus in celebration of festivals such as Devali, the festival of light. Perhaps have a meeting during Devali and speak of Jesus, the light of the world. If possible, supply small candles and light them from a big candle, symbolizing Jesus sharing light to all.

Some cautions while doing the work are:

1. Do begin the work with the high caste if the high
and low caste are living together (in urban areas this may not be a problem, since they always live together).

2. Do not talk about religion too early or openly unless the mind is matured and confidence is built.

3. Be sensitive to the people's needs and beliefs and practices. Go along with them as long as the truth is not compromised; when disagreement occurs, explain why and what is your basis. These attitudes will build confidence and break down barriers that will allow for later gospel work.

**Evaluation of the Program**

After six months of work with the selected group, the program should be evaluated. Even before six months, whenever the MET meets, discuss and share opinions on improving the services for effective witnessing.

Ask questions such as: (1) How will this program bring change in people's thinking? (2) What kind of programs or activities will help build better friendship circles? (3) Has there been any individual who is enquiring about religion or God? Asking these questions will help to evaluate the work done and do a better job for greater impact in the future.
Local Church as a Health Center

While the medical centers aim for community-oriented programs, local churches should aim to develop local health centers. These will be places where non-medical people teach basic health knowledge and practices in locations where there are no medical facilities. The aim of the centers is preventive and not curative. When Adventist churches do this they will be following the principles of the Bible and guidelines given by Ellen White. Ellen White wrote that as the end time approaches, "health evangelistic work should be carried with earnestness" and every member should be encouraged to be part of it.¹

In India, Christianity is looked upon as a foreign element. Health can be used as a bridge to evangelism, and the work of the church would be like a "hospital" serving the physical and spiritual needs of the community where the church is established. Indeed it should be a center for sin-sick souls to be healed by the mighty healer Jesus. With such an aim the local church pastor and all the members should rally to the task.

¹"Every member of the church should take hold of medical missionary work." White, Ministry of Healing, 148, 149. "The gospel of health is to be firmly linked with the ministry of the Word. It is the Lord's design that the restoring influence of health reform shall be a part of the last great effort to proclaim the gospel message." Idem, Evangelism, 515.
Indian villages need health centers and these can be church centered for addressing their real problems in suffering and poverty.¹ Like many medical missionaries, one should be willing to live among the people, to demonstrate the way of life by pointing people to Jesus. Anfenson Vance suggests that if the Adventists really believe their task is to spread the gospel, "we would want to permeate rather than concentrate, to go where the Christians aren't."² For example in south Mexico, a health evangelism program in the rural setting proved very beneficial.³ In India, a similar church-centered health


³J. Samuel Hofman identified some basic principles in doing indigenous health-gospel work. They can be summarized as: (1) Begin with simple and safe medicines and equipment. (2) Aim your work at the remote village level where the medical need is greater. It is better to bring health to 75% of the total population than to concentrate on the small percentage of critically ill people. (3) Tie the medical work to the church. (4) Use only mature church leaders in the health centers; the task demands a spiritual and emotional maturity. (5) A clinic manual in the indigenous language is absolutely essential, because no person can remember all the uses and dosage of the medicines on the shelves. (6) Avoid making medical workers dependent on a missionary. Permit them to be financially independent from the beginning, leaving off the profit of their own work
work could be implemented with some modifications according to situation and need.

Orientation and Training

A group of ten active church members who can read and write, who have an interest in health evangelism, but who may not necessarily have medical knowledge can form a Church Health Evangelistic Team (CHET).

CHET volunteers could be organized into a learning group. As head of the local church, the pastor should be active in organizing and leading the CHET. He should work with vision, aiming for greater results by using health evangelism as an entering wedge.¹ In doing such work, prayer life is very important; this is the Lord's work. Volunteers should become prayer warriors. There should be also training on power encounter and miracle healing.

¹In this regard Van Dolson and Spangler suggest: "How much better it would be, if we must encourage competitiveness, or judge a pastor by the number of lay soul winners he leaves behind when he moves." Spurgeon expressed it this way: "He who converts a soul, draws water from a fountain; but he who trains a soul winner digs a well, from which thousands may drink to life eternal." Van Dolson and Spangler, 86.
Perhaps two or three days a week in the evening for two or three hours each time, for a three-month period, would be adequate to learn basic health evangelism principles and how to carry them out. Church premises should be equipped with facilities for this training. Church members and the pastor and the local conference leaders can be a part of this training.

Finances for such programs could be gathered from church funds, mission funds, and individual donations. Asante suggests that the church should work with governmental health interests and accept their support in promoting community health centers.¹

People with experience, learning skills, vision, and commitment for such work should be invited to teach and train the CHET. Oosterwal suggests that any training program must be mission oriented and mission focused.² Subjects like common sicknesses, first aid, natural remedies, balanced diet, prevention, and cleanliness should be dealt with in detail. Practical lessons in hydrotherapy, use of herbs, and things like charcoal should be demonstrated.

¹Asante, 10.

In the training, a biblical and Spirit of Prophecy basis for healthful living should be explained, pointing to the pattern of Jesus' style of ministry. Perhaps at the end of the training a dedicatory service could be conducted to impress upon the minds of the CHET that health evangelism is not a human agenda but rather heaven's prescription for our sin-sick world.

Implementation of the Program

After the training, the CHET must practice in their own local churches and among their own members under the supervision of their tutors to gain confidence in handling different situations.

After a one-month internship, and after practicing doing health work at their local church, new plans need to be made for outreach, perhaps at a health center or in the village square. In teaching the general public about health and human dignity, we must always remember that the ultimate goal of the church is to introduce Christ to the people.¹

This work should be done in a pleasant, optimistic,

¹One of the best ways to draw attention to this unique health and healing approach is to offer people something better than that which they possess, even the peace of Christ which passes all understanding. "As a church we must tell them of God's holy law, the transcript of His character and an expression of that which he wished then to examine." White, The Ministry of Healing, 156.
affirmative, and positive way.

The Adventist Church Manual states: "The church must accept its responsibility to make Christ known to the world. We believe this includes a moral obligation to preserve human dignity by obtaining optimal levels of physical, mental, and spiritual health. In addition to ministering to those who are ill, the church must teach in a way to prevent disease through effective health education and leadership in promoting abundant health."1

At first the work should start with the rich or high caste people, since their cooperation for facilities and other purposes is important. The CHET will meet with the villagers two evenings (that is the time when people are free and willing to listen) a week to teach healthful living. Also they will speak about why certain common illnesses prevail in the area and what can be done to prevent them.

While doing this, it is necessary to get close to the headman, the rich landlords, and the high-caste people. If the high caste join, the low caste will also easily join. If possible, arrange for a ladies' program, in which the ladies can come to the village square to hear tips on

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healthful living.

Mother and child care is important. Teach how to prepare a healthy diet on a limited income. Show how to avoid common sicknesses and administer first aid to help build bridges and minimize caste and economic barriers. If the ladies give their support, a change is guaranteed and their men will become very supportive. This method gives, at no cost to the common people, very basic and important principles for a healthy, happy life.

While teaching or explaining in simple language, always demonstrate and use illustrations. In this way people can learn better and remember longer. For example while explaining the hazards of smoking, demonstrate with the help of a smoking machine.

The next step could be to ask people to support and participate in the village health work and to help clean up the whole village. While doing the health work, conduct a branch Sabbath School for children; the action songs and moral stories will not cause objections.

It is appropriate to talk to people who are more friendly about the mighty healing of God. Tell them of a God who can remove all the bad Karma without a struggle as a gift of love through Jesus. Contextualize the message and respect their viewpoints; share their good and bad, be part
of them. By this process the minds of the people are prepared for evangelism. The Southern Asia-Pacific Division has done successful health evangelism. Some of their programs could be attempted in India.¹

Evaluation of the Program

At the end of six months of the medical ministry, the work should be evaluated. What common challenges were faced? What are some advantages of this method? Was there any difference in the lifestyle of the people before and after the medical ministry work? Has the program built a positive image of the true God?

After critical evaluation and analysis, improvements can be recommended. Those who have worked steadily and reasonably in the various situations can be recommended to lead out in the health follow-up work and in future evangelism. When this is done in a new area with no church,

¹The Adventist Church in the Southern Asia-Pacific Division (formally the Far-Eastern Division) has adopted their own methods of making our health message reach the people. Some of their methods are: "Presentation of health topics in all evangelistic meetings, Bible and health seminars, clinics (where actual treatments are given), free health screening, health expositions, caring church, entering closed areas by caring for the need of that locality, temperance films, health displays in stores, van ministry, radio ministry, development of audio and visual aids, rural health evangelism, doctors giving Bible studies, new Five Day Plan, and Newstart program." "Health Evangelism," Southern Asia Tidings, June 1986, 5.
active medical evangelists can be used on a stipend basis instead of hiring a full-time evangelist to take care of the church.

**Educational Centers**

There are at least 150 Adventist educational centers (elementary, high and higher secondary schools, and colleges) in the Southern Asia Division, making it one of the largest educational systems in the country maintained by any one single Protestant organization. Schools are intended to educate youth and to be a witness of Christianity to the public.

People come to an educational center without any bias. This provides a great opportunity to attract and influence students to adopt a healthy lifestyle. Moreover, Adventists have the responsibility of teaching moral values and showing a balance between the physical, mental, and spiritual aspects of the individual.\(^1\) It is important to teach people

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\(^1\)A former Health and Temperance director at the General Conference said: "As Adventists, the significance of our role as health promoters is even greater today than in the past. This includes healing and health promotion as part of a holistic approach for physical, mental and spiritual restoration and well being. It is our spiritual dimension, that makes us whole by the grace of God, unique. Without this spiritual dimension we have no reason to be involved. Others have resources to do a better job in the secular context." Albert S. Whiting, "The Adventist Health Message," *Southern Asia Tidings*, December 1991, 9.
while they are young, for they are tomorrow's leaders in society.

Selecting and Orientation

This program is primarily for non-Adventist students who come to Adventist schools. Before the beginning of the school year the school administrator must be approached about teaching children healthful living. The general idea of what the program contains and what benefits this can bring to student life must be explained.

Perhaps a month after school opens, a two-month training and orientation session can be started with the help of the school administration. A few of the Adventist teachers who have some background and interest in health should be selected and trained.

Subjects such as cleanliness, good habits, diet, cautions on common sicknesses, first aid, and other youth-related topics could be taught. Teaching materials and visual aids must be provided for the teachers so that they can later present the material to the students. Leisure periods, holiday time, and after-school hours are suggested times for conducting this orientation program. The program orientation sessions can be led by the temperance or health department personnel of the school.
Implementation of the Program

After the two-month training period, a strategy must be worked out to teach the students. Classes below the fifth standard may not understand all the concepts, and classes above the ninth standard may be too busy with their intensive study to finish high school. Thus the instruction would be best for standards five to eight.

In addition to the health classes, the Bible class, physical training hour, or chapel periods could be utilized to teach students about healthful living. It may not be possible to see the concrete results in terms of souls won or churches built, but this will definitely contribute to building a responsible society. Teaching about health should be a part of the regular courses and should be combined with other temperance programs. This health emphasis will give added justification for the establishing of Adventist schools.

Teaching healthful living, encouraging good habits, and explaining the way the body functions are vital and should be taught in every educational institution. Some of the programs that have been in practice in the Indian Adventist schools are: temperance speech contests, temperance rallies, and walking for health. We must always remember that Adventist schools are established to train medical
missionaries.

Evaluation of the Program

After six months of teaching children about health, an evaluation should be done. All the teachers who were teaching health can be called together. They should be asked if there is any lifestyle change among the students, especially among the teenagers. Questions about their health habits, performance in school, and other questions will help evaluate the work. If a student is weak and not able to overcome smoking or is overeating; if someone is inactive or drawn to drugs, pay special attention and help that person. This will indirectly influence parents too.
CHAPTER 7

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter begins with a brief summary of the first six chapters then lists conclusions drawn from the research. The final section lists recommendations to leadership in health institutions, schools and educational facilities, and local churches. The goal is to utilize all three areas of work in sharing the principles for healthful living and in that process build bridges that will allow the Good News to be shared.

Summary

The meaning of the command of Jesus to go into all the world and preach the gospel involves a healing ministry. He commissioned twelve to preach the kingdom of God and heal (Luke 9:2). He then sent the seventy to heal the sick (Luke 10:9). The mandate to heal is for the whole church; its purpose is to proclaim that Christ is Lord. While the call to evangelize the world is urgent, it is not easy, particularly among the Indian masses.

Health evangelism is a tested avenue to break barriers
and influence people. The Bible and the writings of Ellen White support the concept that health evangelism done through medical, educational, and church centers not only changes lives but also contributes to church growth. The biblical concept of healing involves the whole person, that is, body, mind, and spirit.

Such a holistic ministry can be accomplished by following the pattern of Jesus' ministry. He mingled with people "as one who desired their good, showed sympathy, ministered to their needs, won their confidence and bade them 'Follow Me'."¹ A healthy body leads to a healthy mind, enabling holiness of life.

The Adventist health ministry has been in India for a century. An institution that has been a model is Giffard Memorial Hospital (GMH). There the pioneer medical missionaries with their emphasis on medical ministries, health education, service, and educating children in mission schools proved beneficial and have produced fruit.

The visible results are people who bettered their lives and who today continue the work of these early missionaries long after the missionaries have left India. Another result was the establishment of at least twenty churches and ten or more companies. Each church center has a unique story, but

¹White, Ministry of Healing, 143.
the methods and means used and the lifestyle lived are an example of Christ's model of medical ministry. Friendships made, the encouragement for Christian education, different church programs, evangelism, free medical clinics, witnessing, and other programs helped in building a strong Christian community around GMH.

It is challenging to evangelize the Indian society with its many races and cultures, poor yet unequal economy, and at least 723 languages and dialects. There is enormous population growth in both urban and rural areas, with many religions and a caste system that dominates the life of every individual, making India a very complex society.

Health care among the masses is a dire need. Ignorance and superstition, especially among the rural population, along with common illnesses and a lack of medical care, make life difficult. In urban centers there is specialization and high-cost medical care that make access for common people very difficult, thus creating an open agenda for health evangelism.

Medical missionaries used health evangelism as an entering wedge. This is relevant even today. There are differences of opinions about health evangelism as an avenue to reach or influence people. But the Bible and the writings of Ellen White claim this may be the only avenue
open while others are closed. Following Jesus' pattern is more important than accepting a human mandate.¹

Adventist medical ministry in India is facing many new challenges. In spite of its success in many instances, the power of the gospel through health ministries has not been fully implemented or explored. Health evangelism, to a certain extent, has been done only by medical centers but not by churches or educational institutions.

Even in medical centers curative methods have dominated, while the emphasis on prevention, community health, and health education has been largely neglected. This is contrary to what the Adventist viewpoint on health demands.

A three-phased strategy has been developed: orientation and training, implementation of the program, and evaluation. This process will encourage the involvement of health centers through Medical Evangelism Teams (MET), church health centers through Church Health Evangelism Teams (CHET), and educational centers that will teach healthful living. These programs are simple, practical,

¹"Those who will study the manner of Christ's teaching and educate themselves to follow His way, will attract and hold large numbers now, as Christ held the people in His day." Ellen White, Counsels to Teachers, Parents, and Students (Mountain View, California: Pacific Press Publishing Association, 1943), 57.
contextualized, and based on previous successful programs.

The church needs to be actively involved in health evangelism. Programs and plans with a community orientation are applicable; these will make an impact on the life of the community if they are combined with the power of heaven to reach others for Christ.

Conclusions

The call for evangelism is sure, true, and urgent. Health evangelism is a tested avenue to reach rural Indians. In the past, medical missionaries (both nationals and foreigners) have accomplished much in breaking down barriers and influencing people. This was clearly demonstrated at GMH by establishing twenty churches and ten or more companies. In spite of all the challenges, the work accomplished was substantial.

The time has come for Southern Asia to emphasize health evangelism. The involvement of medical, church, and educational centers in this unused avenue will provide for greater influence and growth of the church.

Contextualizing, giving to people what they do not have, and following the pattern of Jesus' ministry are the ideals for the mission mandate for India. M. E. Cherian, the former president of the Southern Asia Division, said:

I look forward to a church that is involved in social
service, development activities and relief work; committed to health care, literacy programs for children and adults, and doing all the good we can in all the way we can.¹

The missionary era is gone. India needs mentors who live according to the pattern of Christ and demonstrate His power above all other powers by teaching, healing, and saving for Jesus. Ellen White said:

In the future our work is to be carried forward in self-denial and self-sacrifice, even beyond that which we have seen in the past years. God desires us to commit our souls to Him, that he may work through us in manifold ways. I feel intensely over these matters. Brethren, let us walk in meekness and lowliness of mind, and put before our associates an example of self-sacrifice. If we do our part in faith, God will open ways before us now undreamed of.²

This can be accomplished by following the guidelines already known to Adventists. Churches must become health centers involving believers to be more responsible in reaching out to their neighbors by using health evangelism as an entering wedge. Educational institutions must emphasize healthful living by teaching it to their secular students. Medical centers must modify their services either


²White, Selected Messages, 2:206.
to become specialized or to serve the community to reach the masses.

The Adventist church is 150 years old world-wide and little more than 100 years in the Indian scene. It is a sufficient period for us to look back, and find out what one may call the lessons of history as we step into the second century of Adventism in India.¹

In brief, one can say that it is time for evaluating what is accomplished and to plan to face the future challenges. The time is short and the work is great to reach 975.3 million people in India. The church needs dedicated, cross-cultural, contextualized mentors who will work strategically for greater growth and development of His work in this part of the world.

Recommendations

This research has pointed out the tremendous potential that health evangelism programs in the Southern Asia Division can have as an entering wedge. To utilize health more fully in India, I recommend the following:

Recommendations for Health-Care Institutions

1. COSDAH should develop outreach programs for each hospital patterned after the program at GMH. All Adventist health institutions should keep in mind their dual purposes:

to provide medical care but also to share the gospel in their communities.

2. Every health-care institution should develop a strong chaplaincy program. Chaplaincy work should be allotted a budget to carry on outreach and follow-up work. Along with the chaplain, each medical worker should commit to being involved in helping to meet each patient's spiritual and social needs while also attending to his or her physical needs.

3. Health-care workers must be involved not only in the curative healing processes but must also promote primary health care and preventive health in the communities where they are living.

Curative and preventive medical care can be maximized by developing programs that encourage the doctors and other medical workers to go to the surrounding villages to work hand in hand with the church members and the pastor. This kind of team work will bring greater results for both the church and the medical center.

4. The Division Health Department, as well as the union and local field, must take advantage of the twelve medical centers by co-ordinating programs to strengthen the healing ministry. While medical centers should care for the physical needs of people, the Health Department can
emphasize gospel work in the areas surrounding Adventist hospitals.

5. Based on what has been done by GMH at Nuzvid, further research should be undertaken to design strategies to reach urban populations. A study should be made of Pune Adventist Hospital or other urban medical centers where presently programs dealing with natural remedies, hydrotherapy, massage, and New Start lifestyle programs are being run.

Effective medical work can be accomplished by the twelve medical centers in the Southern Asia Division. These centers can help the church fulfill its healing mandate. Some Adventist medical centers must specialize and operate on a commercial basis, but they can still serve the rural villages in their areas.¹

Recommendations for Educational Institutions

I recommend that the Division Education Department and Union school board management encourage all schools to become involved in health evangelism. The Southern Asia

¹"More and more mobile hospital units must extend their services to the unentered and inaccessible places where the doctors do not visit ordinarily. There are many patients who need to be cured and rehabilitated. The church must be determined to meet the demands of modern medicine and match her zeal with professional competence and efficiency." Samraj, Maturing of Adventism, 33.
Division has more than 100 Adventist educational centers with over 24,000 students.

1. Health programs at each of the Adventist schools can be carried out in an effective way. The thousands of non-Adventist students provide a ready audience for programs dealing with health and hygiene. School chaplains should be appointed to teach health along with morals. Health activities such as temperance contests, public health rallies, health screenings, and the showing of films and videos should be a part of the curriculum.

Such an approach will not only build a responsible society for tomorrow but also give an added justification for the existence of the schools. A healthy lifestyle and good habits among the young people of the school will create a positive image for the school.

2. Spicer College should train its future pastors in health evangelism. The training should acquaint religion majors with the principles of health evangelism, share the details of successful programs in India, and influence them to include health as one of the approaches that can be used to reach the Indian masses.

Recommendations for Local Churches

I recommend that the Division, Union, and local Fields develop strategic programs that will encourage every local
church to function as a village health center.

1. The Sabbath School and Personal Ministries departments at the various levels can promote this goal. The purpose is to teach primary health care, health education, and lifestyle changes.

2. Each union should establish a health evangelism program that will teach all interested church members about health evangelism. A syllabus and other training materials should be written and translated into the local languages.
APPENDIX
APPENDIX 1

MAP OF GMH WITH SURROUNDING DAUGHTER CHURCHES
GMH: SURROUNDING CHURCHES AND COMPANIES

MORE DETAILS NEXT PAGE
LIST OF CHURCHES AND COMPANIES ESTABLISHED BY GMH

List of Churches

1. Adventistpuram,
2. Annavaram,
3. Borvancha,
4. Chintalavalli,
5. Danammathota,
6. Devaragunta,
7. Gopavaram,
8. Gudem Madhavaram,
9. Hanumanthulagudem,
10. Janganadhapuram,
11. Jangamgudem,
12. Kandrika,
13. katrinepadu,
14. Kondaperva,
15. Kothapalli,
16. Pothureddipalli,
17. Ravicherla,
18. Vattigudipadu,
19. Venkatadriipuram,
20. Yelamandala.

Companies

21. Chinnampeta,
22. Chittapur,
23. Digavalli,
24. Kirthirayagudem,
25. Kodur,
26. Kothuru,
27. Mukkidlapadu,
28. Reddygudem,
29. Regunta,
30. Sunkollu.
APPENDIX 2

SOUTHERN ASIA DIVISION OF SDA:
DETAILS OF HOSPITALS AND
SANITARIUMS
## Table 3

**SOUTHERN ASIA DIVISION OF SDA**

**Details of Hospitals & Sanitariums**

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Place</th>
<th>Bed Capacity</th>
<th>Average daily census</th>
<th>In Patients</th>
<th>Out Patients</th>
<th>Total Employees</th>
<th>Charity in $</th>
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<td>S D A Hospital</td>
<td>Ottapalem, Kerala</td>
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<td>76</td>
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<td>Simla Santarium</td>
<td>Simla, U.P</td>
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**TOTAL = 12**

68,663

**Source:** Ruth Vanslyke, Secretary COSDAH, Southern Asia Division of SDA Hosur, February 12, 1997.
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VITA

Personal Family Background

Name: Measapogu Wilson
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Academic Experience

1971 - 1980: Elementary and High School, Flaiz Memorial School of SDA, Rustumbada, Narsapur, A. P. India
1981 - 1982: Plus Two Program at Spicer Memorial College, Aundh Road, Pune
1983 - 1986: Bachelor in Religion at Spicer Memorial College, Aundh Road, Pune
1986 - 1988: Master of Arts in Religion, Andrews University Extension, Spicer Memorial College, India
1996 - 1999: Student in Doctor of Ministry Program, Andrews University, Seventh-day Adventist Theology Seminary, Michigan, USA

Ministerial Experience

1989 - 1991: Church Pastor, SDA Church Ibrahimpatnam, Krishna Dt. A. P.
1991 - 1999: Church Pastor, SDA Church, Nuzvid, Krishna Dt. A. P.
1995: Ordained to the Gospel Ministry
1996 - 2000: Member of the Executive Committee, General Conference of SDA, Washington, D.C.: USA
1996 - 2000: Member of the Executive Committee, Southern Asia Division of SDA, Hosur, India