
**THE ANATOMY OF GRACE: CLINICAL DEADLOCKS AND THE
RESTORATIVE POWER OF FORGIVENESS AT THE
AMBATONDRAZAKA HOSPITAL**

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ABSTRACT

This article explores the transformative role of spiritual forgiveness in addressing the dual challenges of mental and physical pathologies within the clinical setting of Madagascar. Focusing on the Regional Reference Hospital Center (CHRR) of Ambatondrazaka in the Alaotra Mangoro region, the study investigates how theological intervention serves as a vital complement to conventional medicine. Drawing on Lucan theology—specifically the restorative mandate of Luke 5:20—the research analyzes the psychological and sociological impact of terminal suffering on patients and their families. The findings indicate that many patients seek hospital care only after the exhaustion of traditional remedies, often arriving in a state of advanced despair exacerbated by the weight of healthcare costs. Through a mixed-methods approach, the study demonstrates that the FJKM hospital chaplaincy provides a "ministry of presence" that transcends traditional clinical treatment. By fostering a culture of forgiveness and reconciliation, the chaplaincy acts as a liberating force, mitigating extreme stress and preventing psychological collapse. This research advocates for a professionalized ecclesiastical strategy that bridges the gap between clinical science and spiritual healing, affirming that while the physician treats the body, the mediation of divine pardon restores the soul and ensures holistic recovery.

KEYWORDS: Hospital chaplaincy, spiritual healing, holistic care, forgiveness, FJKM mission, clinical theology.

1. INTRODUCTION

The pursuit of serenity and holistic well-being remains a universal aspiration for humanity; yet, the contemporary global landscape is increasingly characterized by a relentless assault on human health. Physical pathologies and mental distress continue to strike the living without mercy, creating an existential crisis that demands more than a purely clinical response. As noted by **Dubied (1991)**, the confrontation with illness and the proximity of death often triggers a profound ontological anxiety that medical science alone cannot soothe. While conventional medicine and hospital centers serve as the primary ramparts against these afflictions, this research posits that a profound theological contribution is necessary to address the deeper dimensions of human suffering. Consequently, this study explores the transformative power of spiritual intervention, operating under the title: "The Miraculous Virtues of Forgiveness in Terminating Mental and Physical Pathologies."

The empirical focus of this investigation is the Regional Reference Hospital Center (CHRR) of Ambatondrazaka, located in the Alaotra Mangoro region of Madagascar. Within this clinical setting, a profound sociological paradox is observed: many patients seek hospital care only after the failure of traditional remedies, arriving in a state of advanced physical decay and psychological despair. This delay often results in what **Kübler-Ross (1975)** identifies as a complicated grieving process or a premature surrender to terminality. In this context, the hospital must be reimagined not merely as a site of medical last resort, but as a catalyst for a renewed quality of life. Grounded in the Lucan Gospel—specifically Luke 5:20, where Christ declares, "Friend, your sins are forgiven"—this research argues that true restoration is mediated through Jesus Christ, who provides a divine "dispatching" of forgiveness that heals the soul while fortifying the body.

The core objective of this study is to demonstrate that forgiveness functions as a liberating power for patients, their families, and healthcare personnel alike. By conscientizing stakeholders that physicians and caregivers are essentially tools "on loan" from the Creator, the research seeks to foster a receptive environment for hospital evangelization. This approach aims to replace extreme stress and existential collapse with a motivated conscience and a flourishing peace, acknowledging that spiritual health is intrinsically linked to physical resilience (**van't Spijker-Niemi, 2011**). Referring to Jeremiah 33:3—"Call to me and I will

answer you and tell you great and unsearchable things you do not know"—the project emphasizes that while the physician treats, only God heals.

Furthermore, this research serves as a strategic call to action for denominational churches to move beyond their traditional boundaries. It advocates for a "missiology of distress" that reaches into hospitals, prisons, and asylums, recognizing that the Church's mission is fundamentally one of presence and compassion (**Royon & Philibert, 1995**). Such interventions represent a vital brick in the construction of a transformed society, aligning with the FJKM vision: "Saturate Madagascar with the Gospel; a Gospel that changes history." By addressing the soaring costs of healthcare and the tragic labeling of hospitals as "places of despair," this study interrogates current medical strategies through the lens of Lucan science and social ethics. Ultimately, it proposes a new ecclesiastical strategy to bridge the gap between biblical truth, scientific necessity, and social justice, ensuring that the "Good News" reaches every corner of the human experience (**Escobar, 2006**).

2. MATERIALS AND METHODS

2.1. Methodological design : A triangulated approach

The operationalization of this research is rooted in a "combatant spirit," characterized by a continuous commitment to delivering the Gospel within clinical environments. This missionary posture facilitates a peaceful environment where a receptive faith can encounter the restorative power of forgiveness. To ensure a comprehensive understanding of how pastoral presence influences patient recovery, the study adopts a rigorous mixed-methods research design, ensuring a high degree of analytical triangulation (**Creswell & Creswell, 2018**).

The following figure illustrates the religious landscape of the healthcare providers at the research site. This demographic context is essential for understanding the institutional atmosphere and the potential for interdisciplinary collaboration between medical staff and the chaplaincy team in facilitating spiritual care.

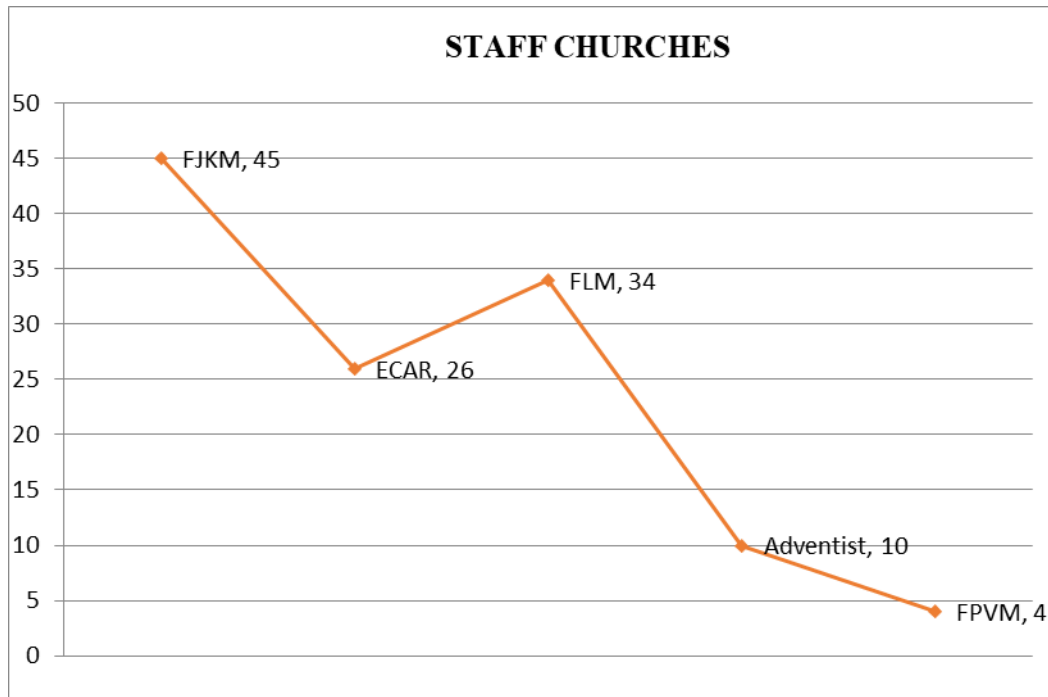


Figure 1 : Distribution of hospital personnel by ecclesiastical affiliation at CHRR Ambatondrazaka (February 2024)

Source : CHRR Ambatondrazaka (February 2024)

Figure 1 reveals a predominant presence of mainline Protestant and Catholic staff, with the FJKM representing the largest single group. This religious density suggests that the hospital is not merely a secular medical space, but a significant site for pastoral mediation. Such a configuration offers a strategic opportunity for professionalized chaplaincy to bridge the gap between clinical ethics and spiritual healing.

2.2. Qualitative and quantitative frameworks

The qualitative dimension focuses on non-measurable sociometric variables, including behavioral patterns, individual attitudes, and pastoral habits within the hospital. Textual data was derived from the sample population to map the psychological and social landscape of recovery. The research utilized structured and semi-structured interviews with hospital personnel to gather nuanced insights into the integration of homilies and pastoral visits within the clinical routine.

To provide a quantifiable foundation for the theological argument, a systematic quantitative framework was implemented. This involved the distribution of inquiry sheets and surveys to a representative segment of the population in the Ambatondrazaka district between 2007 and 2024. These measurable datasets allow for a statistical assessment of the frequency of

pastoral interventions and their perceived efficacy in reducing patient stress and promoting holistic well-being.

The ultimate objective of this methodological rigor is to provide an empirical basis for the nationwide expansion of the hospital chaplaincy. By establishing a professionalized and standardized presence of the Church within healthcare environments, the study envisions a comprehensive network of spiritual support capable of covering all medical institutions across the island, thereby fostering a culture of life and grace-centered restoration.

3. RESULTS AND DISCUSSION

3.1. Clinical observations : Pathologies and associated healthcare metrics

The following empirical data, gathered from the Centre Hospitalier de Référence Régionale (CHRR) of Ambatondrazaka, provides a foundational quantitative map of the health landscape in the Antsihanaka region. Understanding the distribution of patients across medical departments and the subsequent mortality rates is essential for contextualizing the social pressure surrounding terminal illness and end-of-life decisions.

Table 1. Annual distribution of hospital beneficiaries by department.

Patient category	Total count
General Medicine	8,421
Maternity	1,635
Deceased	215
Healthy/Discharged	4,173
Total Discharges	4,504

Source : CHRR Ambatondrazaka (2024)

The data presented in **Table 1** highlights a significant volume of cases in general medicine, representing the primary front of clinical engagement. While the number of patients discharged healthy is encouraging, the presence of 215 recorded deaths underscores the gravity of terminal conditions. This reality necessitates a robust support system that transcends somatic treatment to address the existential crisis inherent in the proximity of death (**Dubied, 1991**).

Further analysis of mortality rates across various departments reveals the specific areas where the "shadow of death" is most prevalent. Understanding these concentrations allows for a more targeted deployment of chaplaincy resources, ensuring that spiritual support is available where the confrontation with human fragility is most intense and frequent.

Table 2. Annual mortality rates by hospital service.

Service	Mortality count
General medicine	30
Maternity	44
Surgery	12

Source : CHRR Ambatondrazaka (2024)

Table 2 indicates a particularly high mortality rate in the maternity ward, a paradox where the expectation of life often meets the reality of loss. This specific context requires a delicate pastoral approach, as the pain of a "failed" birth often leads to deep spiritual questioning. Such statistics justify the presence of trained chaplains capable of navigating the complex emotions of grief and theological doubt (**Martin, 1987**).

3.2. The religious landscape of staff and patients

The efficacy of hospital evangelization is heavily influenced by the religious identity of the medical personnel. The following table maps the ecclesiastical affiliations of the staff, providing insight into the potential for synergy between clinical care and the spiritual values held by those who administer it on a daily basis.

Table 3. Religious affiliation of hospital personnel.

Denomination	Number of members
FJKM (Reformed)	45
ECAR (Roman Catholic)	26
FLM (Lutheran)	34
Adventist	10
FPVM	4

Source : CHRR Ambatondrazaka (February 2024)

As shown in **Table 3**, the staff is predominantly composed of members from mainline Christian denominations, with the FJKM holding a plurality. This religious homogeneity among caregivers can be a significant asset for the chaplaincy, as it facilitates a shared language of compassion. However, it also demands a professionalized approach to ensure that spiritual care remains respectful of all beliefs within the institutional framework.

In contrast to the staff, the religious profile of the patients reflects a broader and more diverse spectrum of faith traditions. The following distribution highlights the pluralistic environment in which the "Work of Chaplaincy" must operate, emphasizing the need for a missiology that is both inclusive and profoundly rooted in the Gospel.

Table 4. Religious distribution of patients. (beneficiaries)

Denomination/Group	Effective count
Gentiles (Traditionalists)	14
FJKM	24
FLM	20
ECAR	22
Refi	14
Rhema	15
Vahao ny oloko	15
Pentecostal	16

Source: CHRR Ambatondrazaka (2024)

Beyond the diverse denominational landscape of the beneficiaries, it is imperative to analyze the religious structure of the healthcare providers themselves. This sociological symmetry is crucial, as the interaction between the staff's personal convictions and the patients' spiritual expectations shapes the care environment and influences the institution's stance toward ancestral end-of-life rituals.

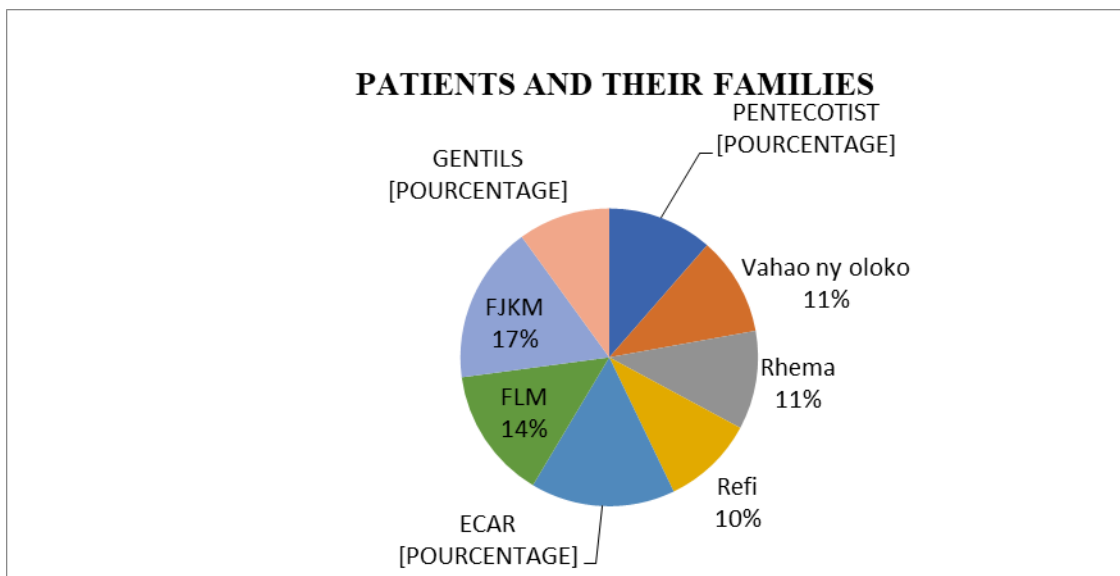


Figure 2 : Distribution of hospital personnel by ecclesiastical affiliation at CHRR Ambatondrazaka (February 2024)

Source: CHRR Ambatondrazaka (2024)

The data illustrated in **Figure 2** reveals a predominant presence of mainline Protestant and Catholic staff, with the FJKM representing the largest group. This religious density suggests that the hospital is not merely a secular medical space, but a significant site for potential

pastoral mediation. Such a demographic configuration offers a strategic opportunity for professionalized chaplaincy to bridge the gap between clinical ethics and spiritual anxieties. The patient demographics confirm that a significant majority of those seeking medical care are affiliated with Christian churches. This finding underscores the Church's strategic responsibility to provide ethical guidance and emotional support, as these individuals often find themselves torn between their Christian faith and the lingering pressures of existential despair when medical interventions reach their natural limits.

3.2. The ontological and psychological weight of terminal suffering

From a medical perspective, death represents the definitive rupture of the psycho-physical organism's unity and the dissolution of its structure (Dubied, 1991). Traditionally, death was viewed as a natural, everyday occurrence alongside which one had to live (Martin, 1987). However, for those enduring terminal illness, pain often becomes a protracted and nearly unbearable burden (Reverant et al., n.d.). This is particularly evident in victims of severe trauma, such as road accidents, who report intense physical suffering as their bodies collapse, confirming that pain remains the most significant hardship for the living (Randegger, 2013). Theologically, this suffering is often illustrated through the biblical figure of Job, whose affliction—likened to a sarcophagus of pain—encloses the individual in a state of total isolation (Nocquet, 2012). The Greek term *mastix* (fléau) further emphasizes that illness is a "scourge" that overwhelms the body, a reality experienced with extreme intensity by those in agony (Noël, 2017). Consequently, the psychological state of the patient and their family becomes a critical area of study, as illustrated by the following data on stress and anxiety.

Table 5. Psychological impact : Stress, anxiety, and fear among stakeholders.

Stakeholder	Stress	Anxiety/Worry	Fear
Patient	16	25	—
Close Family	17	28	—

Source : Field survey data

This table highlights that family members often experience higher levels of anxiety than the patients themselves. This heightened state of worry frequently drives the family to seek alternative, even ritualistic, solutions to terminate the perceived "scourge" of suffering, especially when medical intervention appears to be failing or becoming financially unsustainable.

Furthermore, the emotional trajectory of the stakeholders often descends into despair and anger. When the hope for recovery fades, the frustration directed toward the medical system or the perceived spiritual cause of the illness can lead to radical social behaviors, as quantified in the following assessment of emotional reactions to health failure.

Table 6. Emotional responses to clinical failure.

Stakeholder	Despair	Failure/Anger
Patient	10	5
Assistant/Caregiver	13	7
Close Family	9	14

Source : Field survey data

As demonstrated in **Table 6**, the assistant and the family unit bear a disproportionate share of the emotional failure. The high incidence of anger among close relatives suggests a breakdown of the "helping relationship," where the absence of a "peaceful conscience" prevents a dignified approach to suffering. Without the mediation of the chaplaincy, these emotions can solidify into a permanent spiritual crisis.

3.3. Socio-economic constraints and the pastoral response

The loss of health, whether temporary or terminal, profoundly shakes the individual’s identity (**van’t Spijker-Niemi, 2011**). While faith-based confidence should theoretically oppose fear and worry (**Kraege, 2000**), the reality of prolonged hospitalization introduces severe financial strain. As noted by **Kübler-Ross (1975)**, the accumulation of medical costs and the extension of treatment often force families to sell their assets, including their homes, to cover expenses. Indeed, survey data shows that 6.84% of families were forced to sell their housing due to the heavy financial burden of medication.

This financial and emotional abandonment is often exacerbated by a perceived lack of communal support. The following data explores the "insurance" problems and social betrayals reported by patients and their families, illustrating the isolation that often precedes the recourse to traditional life-terminating rituals.

Table 7. Social and financial suffering: perceptions of betrayal and neglect.

Category	Lack of christian visitation	Feelings of betrayal by kin
Patients	11	6
Families	14	10

Source : Field survey data

These results reveal a significant gap in pastoral care and familial solidarity during times of crisis. The feeling of being "betrayed" or neglected by the church and close relatives creates a vacuum that traditional rituals often fill, offering a definitive, albeit violent, resolution to the social and financial "deadlock" of terminal illness.

In response, the role of the pastor and the community must be reimagined as a "ministry of presence." The arrival of a visitor is likened to a "sunflower" announcing a brighter day, breaking the monotony of the hospital bed (**Association Plaire au Seigneur, n.d.**). However, when the Church fails in this duty, believers may succumb to indignation—a form of anger directed at bad examples of faith (**Calvin, 1541**). Faced with inexplicable evil, even the faithful may blame God as "unjust" or "sadique" (**Hubscher et al., 2013**). This internal wounding can lead to deceptive actions and a profound fear of dying alone (**Buchhold, 2015; Reverant et al., n.d.**), necessitating a robust and empathetic ecclesiastical intervention.

4. DISCERNMENT AND INTERVENTION : THEOLOGICAL AND SOCIOLOGICAL PARADIGMS

4.1. Biblical archetypes of healing and mediated care

The historical trajectory of healing, as depicted in the Judeo-Christian tradition, reveals a sophisticated interplay between divine intervention and the use of material or symbolic media. In the Old Testament, healing was not strictly a supernatural bypass of physical reality but often involved the sanctification of natural elements. For instance, the prophet Isaiah utilized a cake of figs to treat King Hezekiah’s inflammation, while David’s music served as a therapeutic intervention for Saul’s psychological distress. These examples establish a precedent where the "Great Physician" operates through both the spiritual and the material.

The following table provides a structured overview of these mediated healing practices within the biblical corpus, highlighting the continuity between the two Testaments in addressing human infirmity.

Table 8. Scriptural modalities of healing : Agents, Media, and biblical attestations.

Agent	Therapeutic medium	Biblical reference
Isaiah	Fig poultice (Masse de figues)	2 Kings 20 :7
David	Dried figs and raisins / Music (Harp)	1 Samuel 30 :12 ; 16 :23
Jesus	Saliva / Spoken word and touch	John 9 :6 ; Matthew 9 :29
Paul	Handkerchiefs and aprons / Vocal command	Acts 19 :12 ; 14 :9-10

Source_: Author’s synthesis of scriptural data (2024)

Table 8 underscores that throughout salvation history, God has utilized diverse tangible means to manifest His restorative power. Sociologically, these media act as "symbols of efficacy," bridging the gap between the invisible divine will and the visible human need for physical relief, thereby legitimizing the role of the caregiver as a divinely appointed mediator.

Transitioning from the ancient text to contemporary pastoral theory, it is essential to analyze how these biblical models inform modern African and Malagasy healthcare practices. The integration of the "Spiritual" into the "Clinical" requires a nuanced understanding of how faith interacts with physical and social pathology to produce a holistic state of well-being.

4.2. Dimensions of the holistic ministry

4.2.1. The physical realm : somatic restoration

In the Gospels, Jesus demonstrated his authority as a healer by directly restoring organs and bodies, as seen in Luke 5:12-25. Christ's ministry establishes that the physical body is not a secondary concern but a vessel of divine image-bearing. Pastoral care within the hospital setting recognizes that while medicine treats the disease, faith addresses the person. When prayer is offered in faith, it serves as a psychological and spiritual adjuvant that can foster biological resilience (**Hentz, 2006**).

4.2.2. The spiritual realm : Reconciliation and grace

The core of Christian healing lies in spiritual restoration and the strengthening of faith (**Maillot, 2006**). This involves helping the patient find a "peaceful conscience" through repentance and the total acceptance of God's perfect pardon (**Buchhold, 2015**). As **Tillich (2023)** argues, God is the ultimate answer to human finitude. By addressing guilt and fear, the Church empowers the patient to face their illness with a dignity that transcends their clinical diagnosis, replacing the despair of terminality with the grace of Job's perseverance (**Calvin, 2011**).

4.2.3. The social realm : Community and continuity

Healing in the Sihanaka context is incomplete without social restoration. Jesus did not only heal the body ; he returned individuals to their families and reinstated their social utility. Sociologically, there is a "permeability" between faith and social health; religious practices offer a framework for understanding unexplained illnesses that medicine cannot prove (**Durish Gauthier et al., 2007**). This holistic approach is essential in Madagascar, where the

FJKM chaplaincy provides not only Sunday worship and the Holy Supper but also direct social action for those isolated by poverty or disaster.

The following synthesis categorizes the diverse pathologies encountered in the field, illustrating the necessity of a multifaceted intervention strategy that addresses the visceral realities of patients in the Alaotra Mangoro region.

Table 9. Classification of pathologies and domains of intervention.

Corporeal (Physical)	Spiritual (Internal)	Social (Relational)
Traumatic injuries / Wounds	Sin / Spiritual malaise	Addiction / Drug abuse
Communicable diseases	Depression / Nervous exhaustion	Criminality / Incarceration
Accidental trauma	Crisis of faith / Loss of hope	Murder / Intra-familial violence

Source : Author’s field analysis (2024)

Table 9 highlights the broad scope of human suffering that the chaplaincy must address. By categorizing these issues, the Church can move beyond generic prayers to targeted interventions—such as spiritual counseling for oppression or social mediation for relational crises. This comprehensive strategy ensure that the ministry remains relevant to the complex lived experiences of the suffering, providing a life-affirming alternative to cultural despair.

5. STRATEGIC SUGGESTIONS : THE ECCLESIASTICAL MISSION OF CHAPLAINCY

5.1. Structural foundations and FJKM jurisprudence

In the specific context of the FJKM, the "Work of Chaplaincy" is defined as a fundamental missionary endeavor rooted in Scriptural mandates and formal ecclesiastical law. Its implementation is strictly codified within the **Principles of the FJKM (Foto-dalana sy Fitsipika)**, specifically under Articles 7(3), 8(8), 9(4), 10(5), and 15(4). This ministry represents a professionalized expression of the Church’s mission, requiring specifically trained clergy and laity to manifest the Gospel in institutional settings (**Rakotoarisoa, 2024**). The institutionalization of this ministry requires a clear hierarchical structure to ensure that spiritual care is delivered efficiently across the medical landscape. This framework coordinates theological standards with the practicalities of hospital life, bridging the gap between high-level administrative oversight and the visceral needs of the patients and their families in the local wards, ensuring a consistent and professionalized presence.

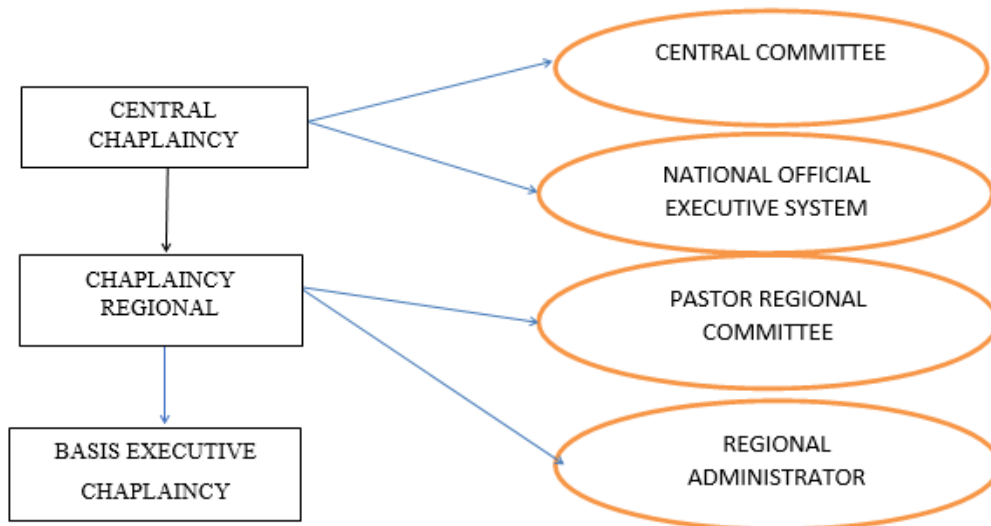


Figure 3 : Organizational structure of the FJKM hospital chaplaincy.

Source : Leaflet from the chaplaincy

Figure 3 delineates the structural flow of authority and service within the FJKM chaplaincy system. By centralizing the committee's oversight while decentralizing field operations, the Church maintains a consistent theological witness across various medical departments. This organization is vital for ensuring that every hospital unit operates as a sanctuary of hope, protecting patients from the social pressures of terminal despair and isolation.

5.2. Holistic intervention : From clinical support to spiritual accompaniment

Hospital chaplaincy is an internal service, not an external organization, designed to provide spiritual support while respecting the patient's autonomy. As noted by **Kübler-Ross (1975)**, the chaplain's mission is to listen, answer existential questions, and prepare the individual for the transition to the afterlife or recovery. This intervention is holistic, offering physical, mental, and spiritual comfort through the proclamation of Jesus Christ as the ultimate source of restoration.

The "helping relationship" aims to empower the person to find internal resources during a crisis (**Valloton, 2002**). In this paradigm, the pastor acts as a catalyst for self-help, utilizing specialized training in ethical counseling and empathetic, non-verbal listening (**Hentz, 2006 ; van't Spijker-Niemi, 2011**). This "listening-accompaniment" allows for a deep path into the soul where God meets the sufferer, transforming the hospital experience from one of abandonment to one of divine encounter (**Auque, 2001**).

To evaluate the operational impact of this ministry, it is necessary to examine the consistency of human resources deployed in the field. The following data tracks the monthly mobilization

of chaplaincy members and their assistants, reflecting the Church's commitment to maintaining a permanent presence in the Alaotra Mangoro region throughout the academic and liturgical year.

Table 10. Monthly deployment and engagement of chaplaincy personnel.

Month	Chaplaincy Members	Assistants	TPM (Theological Staff)	Total
January	20	34	32	86
March	28	52	20	100
June	0	38	16	54
August	0	7	4	11
November	28	44	48	120
December	28	48	32	108

Source : Author's field data (2024)

Table 10 reveals a high level of engagement during the year-end period, coinciding with times of heightened familial needs. The significant involvement of theological and professional ministry staff (TPM) in November and December demonstrates a strategic intensification of pastoral care. This robust presence is essential for providing a spiritual counter-narrative to practices that threaten human dignity and exacerbate the "culture of death" in terminal settings.

Ultimately, the Church's mission on earth is to serve the *Missio Dei*, and theological education must be oriented toward strengthening this witness (Rempp, 2017). By acting as a bridge between the clinical environment and the community of faith, the chaplain ensures that the Gospel remains a source of life and authority in every circumstance, replacing clinical despair with the eternal hope found in Christ (Hebding, 2008 ; Blandenier, 1977).

4. CONCLUSION

The socio-theological investigation conducted at the Regional Reference Hospital Center of Ambatondrazaka demonstrates that the integral healing of a patient cannot be dissociated from a profound spiritual dimension. This study has brought to light three fundamental pillars that structure the approach to hospital chaplaincy in the Alaotra Mangoro region. First, the recognition of pathology as a holistic phenomenon: while medicine treats the body, faith addresses the soul, transforming the hospital from a place of isolated suffering into a space of ontological restoration.

Secondly, the research highlights the crucial importance of forgiveness as a clinical adjuvant. By releasing the patient from the emotional burdens of bitterness, guilt, and anger, the

chaplaincy ministry promotes increased biological and psychological resilience. This spiritual mediation is essential for restoring the patient's dignity, as it provides a direct answer to the metaphysical anxieties and existential stress that clinical science alone cannot satisfy.

Finally, the article emphasizes the strategic necessity for a professional and permanent ecclesiastical structure within healthcare institutions. This presence should no longer be perceived as an auxiliary or optional service, but as a central pillar of integrated care ethics. Ultimately, the future of healthcare in this society depends on the ability to reconcile scientific rigor with evangelical compassion. By ensuring that every individual is accompanied in their totality—physically, mentally, and spiritually—the Church acts as a transformative force, fostering a future defined by the absolute preservation of human dignity and the eternal hope found in Christ.

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