

Lancaster Theological Seminary

**The Role of Clergy in Promoting Health and Wellness in the West-Mainline and
Philadelphia Districts of the Philadelphia Annual Conference
of the African Methodist Episcopal Church**

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in Candidacy for the Degree of
Doctor of Ministry

by

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The Role of Clergy in Promoting Health and Wellness in the West-Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church
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Abstract

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The mission of this project is to study the extent to which clergy promotes health and wellness clergy in the West-Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church (AMEC). In addition, the project highlights the impact of their health initiatives on the well-being of the congregants and members of the community served by the local church. Results of this project will help to define the most effective strategies for clergy in the promotion health and wellness. This study is significant because it encourages clergy participation in addressing health and wellness interventions and to engage in the conversation of healthcare access and healthcare equity in their communities. The findings of this study will be presented to the Philadelphia Annual Conference of the AME Church through the Health Commission. Research findings will be shared with other conferences within the AME Church, other interfaith organizations and religious institutions.

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Table of Contents

Abstract.....	iii
Table of Contents.....	vi
Chapter 1: Introduction and Significance of Study.....	1
Theological Perspective	4
Ethical Perspective	7
Significance of Research.....	10
Chapter 2: Mission of Research and Thesis Claim.....	15
Mission of Research	15
Thesis Claim.....	15
Chapter 3: Purpose of Health and Wellness Definitions and Terminology	26
Central Terms.....	33
Definition Review of Partnerships, Collaborations, and Coalitions	38
Chapter 4: Literature Review Best Practices.....	40
Faith-Based Health Initiatives.....	41
The Message from the Pulpit	44
Body and Soul Program	46
You Are What You Eat-Book of Daniel.....	48
Building Trust in the African American Community	50
Unjust Structures.....	53
Chapter 5: Methodology, Process of Survey and Interviews and Results.....	56
Project Survey	59
Project Survey Results	60
Summary of Findings and Project Survey Results.....	64
One on One Interviews.....	76
One on One Interview Instrument.....	78
During the Interview	80
Interview Results.....	84
Chapter 6: Eight Effective Strategies for the Promotion of Health and Wellness	92
Chapter 7: Findings and Future Initiatives.....	103
Sustainability and Diffusion.....	105

Research Awareness of Evaluating Health and Wellness Programs According to Other Experts	108
Conclusion and Future Initiatives	109
Untimely Death and HIV/AIDS	111
Wider Implications of This Research	112
The African Methodist Episcopal Church in Conversation with Health and Wellness	113
Bibliography	115
Appendix A-Informed Consent Form.....	119

Chapter 1: Introduction and Significance of Study

Health Commission of the African Methodist Episcopal Church

It was in the year of 1787, Richard Allen, Absalom Jones and a small group of faithful black congregants walked out of the predominately white St. George's Methodist Episcopal Church.¹ The walkout was a protest of social injustice which occurred in the church. Black congregants were full tithing members but were segregated from the white members of the church. In addition, they were restricted in "how" and "where" they could worship in the church. Many scholars detail this event to be the first recorded non-violent protest of people of color in the Americas. Directly after this event, Richard Allen and Absalom Jones with the help of Quakers from Philadelphia immediately established America's first black mutual aid society.² The society was called the Free African Society. The purpose of the society was to serve the "spiritual, economic and social"³ needs of the runaway slaves and free African Americans in Philadelphia and vicinity.

The walkout of 1787 was the response to social injustice happening within the four walls of St. George's Methodist Episcopal Church. It was social injustice which attacked the hearts and minds of the black congregants. Their emotional, spiritual and physical needs were not being fulfilled in the unhealthy and unfair worship environment of the Methodist Episcopal Church. Interestingly, the church is a place where a member can experience healing through the preaching of the pastor. In addition, the congregant experiences healing in the genuine fellowship with the body of Christ. Congregants experience healing in the black church when

¹ African Methodist Episcopal Church, *The Doctrine and Discipline of the African Methodist Episcopal Church 2016*, 50th edition (Nashville, Tennessee: AME Sunday School Union, 2017), 16.

² African Methodist Episcopal Church, 16.

³ African Methodist Episcopal Church, 16.

they can praise God in song and dance. The expression of song and dance is embedded in the African Culture as a way to connect with the environmental surroundings, ancestors from the past and the present community. It is through this cultural expression; African Americans experience well-being by a mutual common purpose equal to all humanity.

St. George's Methodist Episcopal Church no longer served as a hospital for people of color. African Americans needed a house of worship which recognized their well-being in the same manner as their white counterparts. Therefore, Richard Allen left the church and formed the African Methodist Episcopal Church (AMEC). Simultaneously, Absalom Jones left the church and formed the first African Episcopal Church. It is not by accident that the Book of Discipline in the African Methodist Episcopal Church gives purpose to the formation of the Health Commission.

The "*Doctrine and Discipline of the African Methodist Episcopal Church 2016*," (Book of Discipline) defines the purpose of the Health Commission. It states, "The Health Commission is to promote the health concerns of members of the AME Church."⁴ Dr. Leonadis Berry is the founder of the Connectional Health Commission. "Its original purpose was to provide health care to attendees to the General Conference."⁵ In Orlando, Florida, during the 1992 General Conference, "legislation was passed making the Health Commission a Connectional Organization of the Church."⁶

The Book of Discipline gives purpose of the Health Commission to challenge the systems of injustice. The Health Commission must advocate healthcare as a right. Specifically, the

⁴ African Methodist Episcopal Church, 234.

⁵ "History of The International Health Commission," n.d.

⁶ "History of The International Health Commission." n.d.

Health Commission serves as the fighting arm against unjust institutions which impede health delivery systems to people of color and the less fortunate.

Therefore, the AMEC realizes the right to healthcare for the African Americans and the poor come with a fight against the unjust structures. The challenge against unjust structures happens in the neighborhoods and the communities where the clergy persons serve. Specifically, the 2016 Book of Discipline, “encourages each organization in our church to include a health component in its life and work.”⁷

Furthermore, the 2016 Book of Discipline outlines in detail the curriculum for HIV/AIDS training and education. The HIV/AIDS pandemic is a prevalent disease in many of our local neighborhoods. The 2016 Book of Discipline lays the foundation for the strategies in the promotion of health and wellness against this disease. Additionally, this section is titled, “Leader Training on HIV/AIDS.” Therefore, this section adds increase to the role clergy plays in promoting health and wellness in their churches and communities. Specifically, the mandate says the training gives, “practical ways religious leaders can help to eliminate HIV infection, AIDS and death from AIDS-related causes.”⁸

When the health ramifications of a disease such as HIV/AIDS are not addressed in our community, persons in our communities experience untimely death. Using Jesus as our example, he addressed and healed persons in his community who were afflicted with devastating diseases. The Gospel of Matthew 8:1-4, details a story of man who was healed from leprosy. Therefore, clergy members and the church should use their theological framework or perspective to justify their efforts in promoting health and wellness in their communities.

⁷ Church, 234.

⁸ Church, 235.

Theological Perspective

During the end stage of a person's life, it is usually too late to have dialogue around the topic of their physical health and wellness. Healing miracles do happen, but end-of-life situations call for a hospice care ministry from the clergy. On the other hand, Jesus is recorded in the Bible as doing numerous miracles of healing and pastoral-care. Jesus was not only concerned with the spiritual health of a person prior to death, but the restoration of his or her physical health was included in their healing. There is a story of a woman, in the Gospels of Matthew 9:18-26, Mark 5:22-43 and Luke 8:14-56, who was in desperate need of a healing. She had an issue of bleeding for 12 long years. After trying everything at her disposal to be healed, she said in Matthew 9:21, "If I may but touch his garment, I shall be whole." The King James Version of this text uses the word 'whole' versus healed. With this thought in mind, for our congregants to be whole, clergy persons must consider the impact their message plays in paying attention to the physical needs of the congregants.

The man is stationed at the Pool of Bethesda waiting for the water to move. The story recounts when an angel came down to stir the water, the first person in would be healed from his/her infirmity. The story says that he was an invalid for 38 years. In addition, the man insinuates that others were being helped into the pool, but no one helped him. Upon reflecting on the physical condition of the man, the initial question is "why did no one help him to the moving and healing pool?" Obviously, the man may have been declared unclean by some of the pool community. On the other hand, when taking a second look at the man's condition, one could consider that there were many opportunities for others to have conversation with the man about his health and wellness. The author of the gospel didn't indicate whether he was crippled from birth. Therefore, did his condition develop or worsen during his span of illness? Could a health and wellness intervention measure improve his condition? Clearly in the story, his

condition had remained the same for 38 years. Therefore, no blame is put on a man seeking the healing intervention in the moving water of the pool. Nevertheless, could the man have experienced an improved quality of life through a health and wellness intervention? He wanted a healing intervention in the water. One could surmise that he wanted to be well, but only Jesus confronts him with the question of wellness. Jesus, looking to the wholeness of the invalid asks the question “Do you want to get well?” It was Jesus, ‘The Good Shepherd’ who addressed the man’s illness and healed his sick condition.

As the previous story of the woman with the issue of blood, Jesus was not only concerned about the man’s illness, but also was equally concerned about the man’s wellness, wholeness or total being. He not only healed the man but also used this opportunity to talk to the man about the need of wholeness. One could draw parallels with the story of the man at the pool with the teaching and healing modus operandi of Jesus. He used his authoritative pulpit to teach and heal many in his without-walls congregation. We too, as clergy, have an authoritative pulpit to teach about healing, wellness and disease prevention within our flock. It is a great opportunity for a clergy person to use the authoritative pulpit because our audience is captive and the long history the church has with the congregation. In fact, clergy observe the congregation at the least once a week. The opportunity for one on one and/or group conversations regarding health and wellness is greater than scheduled visits with their doctors and medical specialists. As another example, in the Gospel of Luke, Chapter 6:17-19, Jesus placed himself in the proximity of the multitude, so they could be taught and healed. He was not silent to their physical needs. He called himself into action for their healing but had many ponder on their need to be made well.

The common theological theme of the mentioned stories is the call to action by Jesus in his conversation of wellness and the deeds of healing. With this thought in mind, Jesus was

prophetic and was compassionately active in addressing the needs of the community. He used his mobile pulpit to preach a message of wholeness and healing. Therefore, his compassion for helping people caused an action to provide healings for those who were in his proximity. The article, “Pastors are Preaching Health from the Pulpit in Black Churches,” highlights black clergy being intentional about preaching the importance of wellness to their congregations. Sarah McColl said, “Their theology pointed to wholeness of well-being: We believe God wants us to be well-to be whole-in our physical [being], in our emotional [being], in our spirit.”⁹

The Sunday morning message in the black church has always been imbedded in a theology of what is happening to the physical, emotional and spiritual life of the congregation. The preacher in the black church realizes that the wholeness or well-being of a congregant falls short if the physical body and emotional well-being of the person is ignored in the message. Therefore, the preacher uses the pulpit as an opportunity to speak healing and wholeness to the hurt and abuse that one experiences by the ills of society.

Likewise, clergy have the same opportunity to make a difference in the health and well-being of persons in their local communities. In the publication, *Church-Based Health Promotion Interventions: Evidence and Lessons Learned*, it states, “Church-based health promotion interventions can reach broad populations and have great potential for reducing health disparities.”¹⁰ The great potential of the church to make a positive impact on the health and well-being of the congregants and community is complimented with a history of providing successful health interventions. The same publication states, “For African Americans, health interventions

⁹ Sarah McColl, “Pastors Are Preaching Health from the Pulpit in Black Churches,” June 3, 2016, <http://www.takepart.com/article/2016/06/03/black-churches-food-diet>.

¹⁰ Marci Kramish Campbell et al., “Church-Based Health Promotion Interventions: Evidence and Lessons Learned,” *Annual Review of Public Health* 28 (2007): 213–34, <https://doi.org/10.1146/annurev.publhealth.28.021406.144016>.

that incorporate spiritual and cultural contextualization have been effective.”¹¹ It is important to note that other marginalized groups, such as women, individuals with different sexual orientation, and other minorities, would benefit from the same kind of interventions. In summary, some have theological reasons for promoting health and wellness in the churches and communities in which we serve. When we consider the issues of health equity of services and health issues in disadvantaged communities, gives clergy ethical reasons for promoting health and wellness.

Ethical Perspective

Clergy has an ethical responsibility to address the physical, spiritual and emotional needs of persons in the community. When healthcare access, health equity and health and wellness of persons in our communities have been compromised, clergy persons must stand for justice by addressing the health challenges of the community. The commandment to love of our neighbors as yourself (Mark 12:3) gives clergy persons the operative to address the institutional systems which causes injustice in the community. A clergy persons work is to do for others as you want to be treated. In the book *An Introduction to Christian Ethics*, Roger Crook says,

“The details of how one is to act in specific circumstances vary because the conditions of life vary, but the perspective is constant. The perspective was stated in a dramatic way by Micah: “What does the Lord require of you but to do justice, and to love kindness, and to walk humbly with your God? (Micah 6:8). It was summed up by Jesus: You shall love the Lord your God.....You shall love your neighbor as yourself” (Mark 12:30-31).”¹²

The reflective biblical ethic of the commandment of loving your neighbor as yourself can be applied to the story of the man at the pool. This biblical ethic is a perpetual perspective in

¹¹ Campbell et al.

¹² Roger H. Crook, *An Introduction to Christian Ethics*, 4th Edition (Upper Saddle River, N.J: Prentice Hall, 2001), 100.

which clergy can operationalize their theology when promoting health and wellness in their churches and communities. Life experiences play a role in our determination to address social issues of justice. Nevertheless, the church needs to reflect on their moral and ethical obligation of addressing the health and wellness needs of the community. Historically, clergy persons in the black church have a positive track record of addressing the injustice which happens to the neighbors in the community. Black clergy have always been there to fight the battle for the victims of injustice. Matthew Lon Weaver in the essay, “Theology of Resistance in Bonhoeffer and Tillich”, suggest that “being-there-for others” is a unifying theme in Dietrich Bonhoeffer’s thought pattern.”¹³ They also state, “Bonhoeffer’s ethics is relational ethics, developed in the context of one’s relationship to Christ and Christ’s mediation of all human relationships.”¹⁴

When the Catholic Church was silent in not protesting the egregious torture inflicted on the Jewish race, they were not reasoning in an operative of relational ethics. In this case, silence was not an acceptable action. In fact, it was immoral for the Church to operate in silence.

Clergy persons should not concern themselves with the size or gravity of injustices afflicting their community. On the other hand, clergy persons should address any resemblance of injustice in their communities and neighborhoods. The man at the Pool of Bethesda did not experience the torture inflicted on the Jewish race in Germany. On the other hand, the injustice experienced by the man at the Pool of Bethesda resulted from the community being silent in addressing his physical and emotional needs. In this story, his health equity issue was only addressed by Jesus at the pool. The long-standing system of overlooking and remaining silent to the man was turned upside down when Jesus had a dialogue with him about his wellness. His

¹³ Matthew Lon Weaver, “Theology of Resistance in Bonhoeffer and Tillich,” in *Resistance and Theological Ethics*, ed. Ronald H. Stone and Robert L. Stivers (Lanham, Md: Rowman & Littlefield Publishers, 2004), 307.

¹⁴ Weaver, 307.

love was an act or demonstration of relational ethics. Likewise, Dietrich Bonhoeffer demonstrated his love for the Jewish race by protesting the evil acts of Adolf Hitler during the Holocaust.

In, *New Studies In Bonhoeffer's Ethic*, author William Jay Peck gives a condensed summary of Bonhoeffer's doctrine of love. Peck says, as the eighth reference, "Love is an act, not an attitude or warm feeling or sentiment."¹⁵ Specifically, clergy persons employ the same relational ethics when addressing the health and wellness of a person. Therefore, a clergy persons reason of involvement is not rooted in how they feel or their attitude towards the accountability of helping persons with health issues. Their reason is built upon the love they have for their neighbors because of their relational ethic. The relational ethic of the clergy person drives an action of addressing the needs of their neighbor. It is in that same dialogue of action in which clergy can demonstrate their love for others. In that same spirit, clergy can discover the needs of health and wellness issues in their communities.

Using Jesus as our example, we are called to address the health and wellness needs within our community. When clergy persons converse with the overlooked, hurting and broken people, they can discover the essential needs for promoting health and wellness in their churches and communities. Surely, clergy persons have been called to speak to the whole well-being and health of their neighbors in the communities. The biblical ethic of loving your neighbor as yourself (Mark 12:30-31) is one ethical reason for clergy persons promoting health and wellness in their church and the communities they serve.

¹⁵ William J. Peck, ed., *New Studies in Bonhoeffer's Ethics* (Lewiston, N.Y., USA: Edwin Mellen Pr, 1987), 232.

Serving others in the community is an ethic of the Black Church. In the article, “Role of Black Churches in Health Promotion Programs: Lessons from the Los Angeles Mammography Promotion in Churches Program,” suggest that the Black church has always been about the business of making the community better. Moreover, the article says, “One study found that both the Black Church’s collective ethos and its emphasis on God as active in earthly affairs support secular activities within the Black community.”¹⁶ In addition, the track record of the Black church demonstrates a passion for addressing the social injustice in the community. The Black church can be found in many of our economically challenged communities serving by addressing the local, state and national systems of injustice. According to the previously mentioned article, when one considers the health inequity issues in our communities; the Black “church is an ideal setting in which to offer health promotion activities for African Americans.”

Therefore, the title of this research is: The role of clergy in promoting health and wellness in the West-Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church (AMEC).

Significance of Research

This research carries the significance of discovering, “what are the effective strategies and practices employed by clergy to promote health and wellness in their churches?” In *the Doctrine and Discipline of the African Methodist Episcopal Church 2018*, (Book of Discipline) it defines the purpose of the Health Commission. It states, “The Health Commission is to promote the health concerns of members of the AME Church.”¹⁷ In addition, the Book of Discipline

¹⁶ Susan Markens et al., “Role of Black Churches in Health Promotion Programs: Lessons from the Los Angeles Mammography Promotion in Churches Program,” *American Journal of Public Health* 92, no. 5 (May 2002): 805–10.

¹⁷ Compilation Committee, *The Doctrine and Discipline of the African Methodist Episcopal Church*. Nashville, TN: AMEC Publishing Company, 2013.

gives purpose of the Health Commission to challenge the systems of injustice. The Health Commission must advocate healthcare as a right. However, the Book of Discipline does not elaborate on which strategies the clergy can use to promote health and wellness. Therefore, this research is significant in defining the effective strategies and practices employed by clergy to promote health and wellness in their churches.

Moreover, the Book of Discipline does not suggest where clergy can find accurate health information to share with congregants. This research project revealed 12 articles expressing how clergy received information on health and wellness in partnering with coalitions and research initiatives. As an example, in the book *Religious Interests in Community Conflict*, chapter 5 details an article of how two Lutheran ministers orchestrated the formation of a health coalition called Interfaith Health Services (IHS). The coalition consisted of religiously affiliated health systems and a college. This coalition provided healthcare and wellness to the congregants and community members in an urban neighborhood located in Omaha, Nebraska.¹⁸ First, this research will address, “What are the strategies for motivating clergy participation in health and wellness initiatives.” In addition, “What are the strategies employed by clergy in the promotion of health and wellness in their churches and communities?” Secondly, “What are the strategies for engaging with collaborations, partnerships and coalitions in promoting health and wellness initiatives?” This research study summarized in the literature review provides qualitative research that documents the role of clergy in promoting health and wellness in their churches and communities. Several articles included the phrase “Role of Clergy” or Role of Faith-Based in the title. These articles laid a common foundation for my research. In reviewing the similarities

¹⁸ Djupe, Paul A. and Laura R. Olson, *Religious Interests in Community Conflict* (Waco: Baylor University Press, 2007), 103.

and differences in the findings, the effective practices and strategies utilized by clergy to promote health and wellness in their churches and communities are summarized.

In conjunction, the research question was explored through the distribution of a survey. The survey was given to clergy in the West and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church. Their strategies for promoting health and wellness in their churches were documented through the survey. In addition, questions in the survey captured, “what motivates clergy to get involved in the promotion of health and wellness in the community?” Within the survey, clergy had the opportunity to document how they employ coalitions, partnerships and initiatives.

The results of this research will be shared in the Civic Engagement Report during the Philadelphia Annual Conference of the AMEC. The Civic Engagement Report is a presentation given at each annual conference. Information in the report addresses issues such as public-school funding, mass incarceration and healthcare. This study will summarize practices, effective strategies and the motivations of clergy for promoting health and wellness in their churches and communities. The Health Commission of the AMEC will conduct the conversation at the conference floor.

This research is significant because it provides key health and wellness intervention which can interrupt the chain reaction of diseases caused by diabetes or high blood pressure. Research suggests, when people have reliable information about healthcare issues, they can be better advocates for themselves. In the publication, *The Role of Religious Leaders in Health Promotion for Older Mexicans with Diabetes*, it explains how self-care of diabetes improves when reliable information regarding the diseases is intentionally given. The publication states, “Although the importance of engaging in diabetes self-care activities is well-established, older

Mexicans do not always have the knowledge or motivation to engage in self-management or comply with their treatment.”¹⁹ A disease such as diabetes can be reversed when a person becomes a better self-advocate through the application of reliable information. In the book, *Dr. Neal Bernard’s Program for Reversing Diabetes*, Dr. Neal states, “my research has shown that it is possible to reverse diabetes.....to decrease blood sugar, medication doses, and the risk of complications.”²⁰ Therefore, if a congregant is equipped with information and interventions which control or eliminate his or her diabetes, then maybe their other organs would remain healthy and functional.

In reviewing the findings from the early data compiled from the clergy surveys of this project, it was noted that question # 2 of the survey provides an inquisitive talking point for clergy around the topic of health and wellness. Question #2 asks, “What are the most prevalent diseases and conditions with which your members are afflicted.” Of the first 12 surveys a checkoff list was compiled of all responses. The most prevalent diseases mention on the surveys were cancer, high blood pressure and diabetes. In fact, out of the first 12 surveys, 11 respondents included diabetes as one of the most prevalent diseases and conditions with which their members were afflicted. Their response of diabetes being the most prevalent disease within their congregations and communities was no surprise due to the literature reviews which substantiated diabetes as one of the top diseases. Therefore, the focus of this research contends that clergy should address prevalent diseases such as diabetes. In fact, clergy should use their

¹⁹ Maricruz Rivera-Hernandez, “The Role of Religious Leaders in Health Promotion for Older Mexicans with Diabetes,” *Journal of Religion and Health* 54, no. 1 (February 2015): 303–15, <https://doi.org/10.1007/s10943-014-9829-z>.

²⁰ Neal Barnard and Bryanna Clark Grogan, *Dr. Neal Barnard’s Program for Reversing Diabetes: The Scientifically Proven System for Reversing Diabetes without Drugs*, 1st edition (New York: Rodale Books, 2008), 13.

pulpits to promote health and wellness against prevalent diseases experienced by members in their church and community.

The following chapter provides the mission and thesis claim of this research. The next chapter, Chapter 3 provides clarity on the operational definitions of the central terms used for the promotion of health and wellness in this project. Chapter 4 highlights a summary the literature reviews and best practices of the literature reviews. The survey and interview process along with the results of the research are documented in Chapter 5. Chapter 6 summarizes the effective strategies for the promotion of health and wellness. The findings, conclusion, future initiatives and other applications of this research are summarized in Chapter 7.

Chapter 2: Mission of Research and Thesis Claim

Mission of Research

The mission of this project is to study the extent to which clergy promote health and wellness in the West-Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church (AMEC). In addition, the project highlights the impact of their health initiatives on the well-being of the congregants and members of the community served by the local church. The results of this project help to define the most effective strategies for clergy in the promotion health and wellness. This study is significant because it encourages clergy participation in addressing health and wellness interventions and to engage in the conversation of healthcare access and healthcare equity in their communities. The findings of this study will be presented to the Philadelphia Annual Conference of the AME Church through the Health Commission. The research will be available to be shared with other conferences within the AME Church, other interfaith organizations and religious institutions.

Thesis Claim

The central thesis claim of this research contends that clergy in the African Methodist Episcopal Church (AMEC) promote health and wellness in their communities by engaging with coalitions and partnerships promoting health and wellness initiatives. There are four reasons why clergy should promote health and wellness in their churches and communities. The four reasons are listed below:

Reason 1: The Health Commission of the AMEC mandates the “denomination to be

a healing faith community and to promote the health concerns of church members and surrounding communities.”²¹

Reason 2: Clergy promoting health and wellness in the African American community increases the effectiveness of health and wellness initiatives and programs within a congregation.

Reason 3: When people have reliable information about healthcare issues, they can be better advocates for themselves.

Reason 4: When the clergy are informed and support researched-based health and wellness partnerships, congregational trust of health intervention advice is increased.

Reason 1: The Health Commission of the AMEC mandates the “denomination to be a healing faith community and to promote the health concerns of church members and surrounding communities.”²²

The Health Commission of the AMEC is designed to help the membership grow the ministry of health and wellness as a fundamental segment of the local and connectional church ministry. Specifically, the Book of Discipline says, “The Health Commission seeks to make the AMEC denomination a healing faith community.”²³ As previously mentioned, the 2016 Book of Discipline, places the responsibility of promoting health and wellness on the shoulders on every organization within the local and connectional church.

The clergy members of the AMEC can be intentional and confident with their responsibility for promoting health and wellness in their congregations. The intentionality for

²¹African Methodist Episcopal Church, *The Doctrine and Discipline of the African Methodist Episcopal Church*, 50 Edition (Nashville, Tennessee: The Reverend Rodrick D. Belin, 2016), 234.

²² Church, 234.

²³ Church, 234.

clergy promoting health and wellness in the church and community is detailed in the mission of the International Health Commission. The following mission is detailed in the, “*International Health Commission Handbook, 2017*” of the AMEC:

“Mission-The International Health Commission (IHC) serves, among other tasks, to help the denomination understand health as an integral part of the faith of the Christian Church, to seek to make our denomination a healing faith community, and to promote the health concerns of its members.

Specifically, the mission is to:

*Empower our congregations to advocate for improved access to affordable and quality health care.

*Provide Health Education and identify health resources.

*Assist with first aid for services and meetings at all levels: International, Annual Conferences, District and Local

*Collaborate with Ecumenical and Interfaith Health Projects while promoting health as a part of our faith and to care for our congregations by advocating health as a right not a privilege, by forming collaborative relationships with International, National, Regional and Local ecumenical and interfaith health programs or projects as well as Health Associations and Community Agencies.”²⁴

Clearly, the mission of the IHC encourages local clergy to promote health and wellness with other health organizations and interfaith health ministries. In addition, the IHC recognizes that the AMEC denomination must be a “healing faith community.”²⁵ The three words of healing, faith and community in the mission statement gives the AMEC a purpose for promoting health and wellness in the local church and community. Healing can only take place when the whole person is healed. The preacher must speak to the physical needs of the body for the

²⁴ Harry L. Seawright, “International Health Commission Handbook 4th Edition” (International Health Commission, 2017), 5.

²⁵ Church, 234.

congregants to experience wholeness. Therefore, the mission statement of the IHC gives clergy a license, so to speak to promote health and wellness in the church and community.

Reason 2: Clergy promoting health and wellness in the African American community increases the effectiveness of health and wellness initiatives and programs within a congregation.

In supporting this reason, research studies show that clergy in the African American community have a prime opportunity to make a difference in the health and well-being of people in their local communities. In fact, they play a major role in addressing the health needs of the local community.

In the article, “Promoting Healthy Behavior from the Pulpit: Clergy Share Their Perspectives on Effective Health Communication in the African American Church” it states, “Research indicates that the church and the pastor in the African American community could be enlisted to increase effectiveness of health programs.”²⁶ In addition, the article highlights the church to be one of the most highly regarded institutions in the African American community. The purpose of the study highlighted how the African American clergy perceptions around health promotion could create a model to enhance the engagement of health communications in their communities.

As another example, in the article, “The Praise Project: A Church-Based Nutrition Intervention Designed for Cultural Appropriateness, Sustainability, and Diffusion,” it highlights the challenges of reaching the African American community with cancer prevention programs.

²⁶ Crystal Y. Lumpkins et al., “Promoting Healthy Behavior from the Pulpit: Clergy Share Their Perspectives on Effective Health Communication in the African American Church,” *Journal of Religion and Health* 52, no. 4 (December 2013): 1093–1107, <https://doi.org/10.1007/s10943-011-9533-1>.

The first sentence, in the abstract of this article says, “Cancer prevention research has inadequately reached the African American community despite a higher risk for cancer and many other chronic diseases.”²⁷ In fact, this project named (Praise) The Partnership to Reach African Americans to Increase Smart Eating designed an intervention to increase nutritional health in the African American community. It is important to note: the African American churches were joint architects of this health and wellness intervention. The study was funded by the National Cancer Institute. The initiative’s increase in effectiveness was the result of employing the cultural relevance of the African American church. The program design incorporated common dietary and cultural traditions in building the nutritional intervention.

This is further substantiated in eleven dominant articles suggesting clergy and church participation as key ingredients in the formula of successful prevention programs. These articles employ the phrase “role of clergy” and/or “role of religious institutions” in health promotion or promoting health in their communities. Four articles dealt directly with clergy in the African American community. One article focused on the promotion of health for older Mexicans with diabetes. The other articles approached this topic with the same theme of clergy playing a vital role in the success of health and wellness promotion in their communities. With all this said, the common thread of the articles resonates a formula for increasing the effectiveness of health programs through clergy and/or church involvement.

Church-based health prevention programs can be effective in getting community buy-in. As an example, during the month of February, a clergy person discussed from the pulpit, the value of participating in healthy heart programs and initiatives. Several weeks after the

²⁷ Alice Ammerman et al., “The Praise! Project: A Church-Based Nutrition Intervention Designed for Cultural Appropriateness, Sustainability, and Diffusion,” *Health Promotion Practice* 3, no. 2 (April 1, 2002): 286–301, <https://doi.org/10.1177/152483990200300223>.

discussion, the members of my church demonstrated a renewed commitment to eating healthfully. As a result, the kitchen committee hosted several cooking classes around the benefits of baking foods as opposed to frying foods. In addition, the new church food menu included baked meats during afternoon fellowships and second services. The green beans were cooked with smoked turkey wings instead of a traditional ham product.

In the publication, *Church-Based Health Promotion Interventions: Evidence and Lessons Learned*, states, “Church-based health promotion interventions can reach broad populations and have great potential for reducing health disparities.”²⁸ Not only does the church have a great potential to make a difference in the health and well-being of a broad population, its interventions are successful. The same publication states, “For African Americans, health interventions that incorporate spiritual and cultural contextualization have been effective.”²⁹ I believe other marginalized groups, such as women, individuals with different sexual orientation and other minorities, would benefit from church health interventions. In addition, I believe the conversations by clergy, from the pulpit, can make a difference in reducing health disparities amongst other minorities and compromised groups. Therefore, when we increase the effectiveness of health and wellness interventions, we can study its’ impact on reducing health disparities. Clergy must have reliable information to effectively communicate a health and wellness strategy to the membership within their church. Clergy and the church can obtain reliable information about health care issues through partnerships and coalitions.

²⁸ Campbell et al., “Church-Based Health Promotion Interventions.”

²⁹ Campbell et al.

Reason 3: When people have reliable information about healthcare issues, they can be better advocates for themselves.

Reliable information regarding healthcare issues is imperative in the self-management and self-advocacy of a person's daily treatment. When people have reliable information about healthcare issues, they can be better advocates for themselves. Research suggests the lack of knowledge and reliable information about healthcare is a detractor of self-management and self-advocacy in the treatment plan of a disease. In the publication, *The Role of Religious Leaders in Health Promotion for Older Mexicans with Diabetes*, it states, "Although the importance of engaging in diabetes self-care activities is well-established, older Mexicans do not always have the knowledge or motivation to engage in self-management or comply with their treatment."³⁰ This article suggests when clergy is involved in the promotion of diabetes interventions, older Mexicans are more successful in self-management of the disease.

In the article, "Health Literacy: A Challenge for American Patients and Their Health Care Providers," highlights are made on the importance of health literacy skills. In the abstract of this article, the author, Ruth Parker says, "unfortunately, many patients with the most extensive and complicated health care problems are at greatest risk for misunderstanding their diagnoses, medications, and instruction on how to take care of their medical problems."³¹ Since much of the reliable information about health care is placed in written form, persons with literacy challenges are unable to be self-advocates or self-managers of their diseases. Therefore, Parker suggests this information is not obtainable to millions of Americans lacking 10th grade literacy skills. The oral dialogue of communication in the church can fill this void of providing reliable

³⁰ Rivera-Hernandez, "The Role of Religious Leaders in Health Promotion for Older Mexicans with Diabetes."

³¹ Ruth Parker, "Health Literacy: A Challenge for American Patients and Their Health Care Providers," *Health Promotion International* 15, no. 4 (December 1, 2000): 277–83, <https://doi.org/10.1093/heapro/15.4.277>.

health care information. The oral tradition of clergy speaking the information serves as an alternative to the written information regarding self-management of chronic diseases.

Ten years ago, Bethel AMEC, located in Coatesville, Pennsylvania participated in a program which focused on increasing the consumption of fruits and vegetables as healthy food choices. From the pulpit, the pastor discussed the purpose and benefits of the healthy eating and preparation program with the congregation. The pastor gave weekly healthcare messages of weight management and overall wellness, as they related to healthy food choices. As an example, the clergy member communicated the advantages of grilling foods versus frying foods. Although the program was coordinated by a registered nurse, the message was spoken from the pulpit. During the program, members in the church began to make noticeable changes in the menu for church dinners and fellowships. The menu included options of two vegetables per meal versus a vegetable and a starch. The past menus included a large helping of potato salad or mash potatoes with green beans prepared with a ham product. The new menu included an option of carrots and green beans prepared with smoked turkey wings.

In summary, the membership within the church became self-advocates of healthy eating, after receiving reliable information regarding their health and healthy food choices. In the article, “Promoting Healthy Behavior from the Pulpit: Clergy Share Their Perspectives on Effective Health Communication in the African American Church,” this program named “Body and Soul: A Celebration of National Eating and Living,”³² supports the same results of self-advocacy. During a 6-month follow-up, the participants were self-advocates in their eating habits. They

³² Lumpkins et al., “Promoting Healthy Behavior from the Pulpit.”

were motivated to decrease fat consumption in their diet. Simultaneously, the participants showed a substantial increase in the consumption of fruits and vegetables.

It is good news to the church community when partnerships and coalitions have a vision of improving the health and wellness of church congregants. When the good news is promoted and communicated by informed clergy, the congregants have increased trust in the health intervention. Health and wellness interventions in the church must be supported by clergy to increase trust by the congregants.

Reason 4: When the clergy are informed and support researched-based health and wellness partnerships, congregational trust of health intervention advice is increased.

In the article, “Promoting Healthy Behavior from the Pulpit: Clergy Share Their Perspectives on Effective Health Communication in the African American Church,” it suggests, “African American pastors see themselves as valued and trusted voices in relaying health behavior information to congregants and thus a critical part of the communication process in relaying pertinent health information.”³³

The congregational trust of the health intervention is increased because of the trusted voice of the pastor. It is the clergy in the African American church who has developed a spiritual guidance path with the congregants through sermons and individual encounters. Through this process, the pastor’s voice serves as a trusted communicator on the path of spiritual guidance. In the same article, “Promoting Healthy Behavior from the Pulpit,” the author state, “Public health professionals working with a key individual in the African American community such as the African American pastor, have a resource that is trusted, credible and a part of the

³³ Lumpkins et al.

African American life.”³⁴ Therefore, an informed clergy who communicates the benefits of a health partnership gains trust of the health intervention by congregants.

To gain trust from the congregants, clergy are surrounded with the question, “who informs clergy about health and wellness interventions?” Could it be through coalitions, partnerships and other health initiatives? What role does the AMEC Health Commission play in providing this information? Ideally, clergy is informed about health and wellness initiatives through coalitions and partnerships. There are eleven key articles around this conversation, suggesting this very point. Conversely, what happens to the trust factor of the intervention when clergy receives information from other sources? The article “Can Churches Play a Role in Combating the HIV/AIDS Epidemic? A Study of the Attitudes of Christian Religious Leaders in Madagascar” suggests, “Malagasy church leaders could potentially become key players in HIV/AIDS prevention if they improved their knowledge of the illness.”³⁵ In this study the authors highlight, almost 60% of the religious leaders received their information of HIV/AIDS from the media. Only 16% of the religious leaders received their knowledge from training. It is important to note 213 religious leaders participated in this study. In addition, “religious leaders represented 28 different Christian denominations.”³⁶ Condom use for preventing the spread of the diseases was one of the recommendations by religious leaders. Interestingly, cultural norms and church doctrine blocked the major use of condoms by congregants to prevent the HIV/AIDS. The study suggests the media and awareness campaigns needed to be more effective in communicating general information about the disease in the community. This study proves the

³⁴ Lumpkins et al.

³⁵ Jerry S. Rakotoniana, Jean de Dieu M. Rakotomanga, and Hubert Barennes, “Can Churches Play a Role in Combating the HIV/AIDS Epidemic? A Study of the Attitudes of Christian Religious Leaders in Madagascar,” *PLOS ONE* 9, no. 5 (May 13, 2014): e97131, <https://doi.org/10.1371/journal.pone.0097131>.

³⁶ Rakotoniana, Rakotomanga, and Barennes.

necessity to have a united front by the religious leaders or clergy on where and how to receive accurate information regarding health and wellness interventions. In addition, the strategy of condom use was not effectively trusted by the congregants because of inadequate partnership training of the religious leaders.

Congregational trust around health intervention is achieved when clergy is equipped with accurate information. In addition, the article “The Praise Project: A Church-Based Nutrition Intervention Designed for Cultural Appropriateness, Sustainability, and Diffusion,” communicates cancer prevention research to be deficient in the African American community. It goes on to suggest one reason its absence to be “historical mistrust of research and medical institutions.”³⁷ Some of the mistrust occurs when the intervention participants feel like they are “guinea pigs.”³⁸ Health intervention participants must feel like they are a recipient of better health and wellness from the partnership study. Trust of the health intervention partnership is increased when the study participant experiences a direct deposit of improved health in their communities.

In summary, the participation of clergy in the promotion of health and wellness does not involve the delivery of medical services. Therefore, the thesis claim and the four reasons supporting the claim of this study are rooted in health and wellness terminology which focus on health and wellness initiatives. Furthermore, it is important to note that the health and wellness terminology and definitions are relevant to this research. The next chapter will detail the purpose and definitions of this study.

³⁷ Ammerman et al., “The Praise! Project.”

³⁸ Ammerman et al.

Chapter 3: Purpose of Health and Wellness Definitions and Terminology

In determining the role clergy plays in the promotion of health and wellness in the churches they serve, it is imperative to focus on health and wellness terminology as opposed to healthcare definitions or medical terminology. Although, the conversation of health, wellness and healthcare fall on the same continuum of services needed for physical restoration to our bodies, there is a difference between healthcare initiatives and health and wellness initiatives. Vanessa Briggs, the consultant of this project and the CEO of the Brandywine Health Foundation, helped to focus this research as a health and wellness study. She was concise in distinguishing the difference between promoting health and wellness as opposed to health care. In addition, project supervisor of the study, Reverend Dr. David Mellott, clarified the understanding that this research should not be confused as a medical research project or a healthcare project. Therefore, terms of conditions such as diabetes high blood pressure and other medical terms labeling diseases were not included in the list of terms and definitions. Conversely, a term such as “wellness” denotes a desired state of healthy behaviors which greatly reduce diseases in the body.

As mentioned in the list of terms and definitions, “Wellness is an active process of becoming aware of and making choices towards a healthy and fulfilling life.”³⁹ With this thought, conversational definitions of health and wellness centers on preventative measures and information to improve the quality of life for congregants and community members. The definitions and terminology of this research provides information for the engagement of health and wellness strategies and initiatives. On the other hand, the definition of healthcare is the

³⁹ “Global Wellness Day,” accessed January 23, 2019, <https://www.globalwellnessday.org/>.

“Services offered to preserve emotional and physical well-being and prevent or treat illness.”⁴⁰

Healthcare services are provided with a cost. Therefore, the cost is measured around the treatment of an illness. The illness carries a definition or terminology that labels the disease. It is important to note when describing an illness or a disease, the label may have the definition. As an example, some can define diabetes an illness or a disease. The definition of diabetes is, “A diagnosis of diabetes or prediabetes means the insulin in your body is not doing its job adequately.” “If for some reason your body is not making insulin, the result is rising blood glucose levels. Similarly, your blood glucose rises if your cells resist insulin’s actions.”⁴¹ This is important because, “African Americans are disproportionately at risk for Diabetes Mellitus (DM) and have the highest prevalence compared to other racial/ethnic groups [12–18].”⁴² In analyzing the description and definition of this disease, the fact that African Americans are at a greater risk of having DM is important to my research. Therefore, clergy can talk about the greater risk of diabetes in the African American Church directly from their pulpit. In addition, clergy can discuss from the pulpit, health and wellness education around the prevention of this disease. In addition, a discussion of health and wellness comes typically with no cost to the congregation and community. Therefore, the definitions and terminology throughout this research support the concept of interventions and/or preventions of a disease or medical condition.

While going through the list of definitions and terminology for this project, the researcher included definitions and terminology which amplified the work of health and wellness initiatives. In the list, some of the definitions and terminology included words such as prevention,

⁴⁰ “Medical Dictionary and Definitions,” WebMD, accessed January 23, 2019, <https://dictionary.webmd.com/default.htm>.

⁴¹ Barnard and Grogan, *Dr. Neal Barnard’s Program for Reversing Diabetes*, 5.

⁴² Laurens Holmes et al., “Racial/Ethnic Variability in Diabetes Mellitus among United States Residents Is Unexplained by Lifestyle, Sociodemographics and Prognostic Factors,” Research article, *International Scholarly Research Notices*, 2012, <https://doi.org/10.5402/2012/408079>.

intervention, wellness, well-being or health. Fifteen of the 19-definition and terminology list included at least one of the words in the definition. For instance, “Disease prevention is understood as specific, population-based and individual-based interventions for primary and secondary (early detection) prevention, aiming to minimize the burden of diseases and associated risk factors.”⁴³ In this definition, the words intervention and prevention are included to help define the hindrance of a disease. In another example, “an intervention designed to a combination of program elements or strategies designed to produce behavior changes or improve health status among individuals or an entire population. Interventions may include educational programs, new or stronger policies, improvements in the environment, or a health promotion campaign. Interventions that include multiple strategies are typically the most effective in producing desired and lasting change.”⁴⁴ In this definition the words health promotion campaign are defined as an intervention. Lastly, “a health prevention can be defined as programs designed to help the individual eat smart, exercise regularly, and get routine screenings and vaccinations.”⁴⁵ In this case, examples of health prevention programs are described. A few of the programs described are regular exercise and routine screenings.

The listed definitions and terminology are important because they are the foundation for the health and wellness literacy of the project. As mentioned previously, the article “Health Literacy: A Challenge for American Patients and Their Health Care Providers” highlights the importance of health literacy skills. In the abstract of this article, the author, Ruth Parker says, “unfortunately, many patients with the most extensive and complicated health care problems are

⁴³ World Health Organization, “Health Promotion and Disease Prevention Through Population-Based Interventions, Including Action to Address Social Determinants and Health Inequity,” 2018, <http://www.emro.who.int/fr/about-who/public-health-functions/health-promotion-disease-prevention.html>.

⁴⁴ health.mo.gov, “What Is an Intervention?” accessed January 24, 2019, https://health.mo.gov/data/interventionmica/index_4.html.

⁴⁵ “Prevention & Wellness | HHS.Gov,” accessed January 23, 2019, <https://www.hhs.gov/programs/prevention-and-wellness/index.html>.

at greatest risk for misunderstanding their diagnoses, medications, and instruction on how to take care of their medical problems.”⁴⁶ Parker’s statement supports the second reason why clergy should promote health and wellness in their communities. People do a better job of being their own advocate and managing their healthcare issues when they have reliable information.

Therefore, clergy must have a clear understanding of definitions and terminology throughout the conversation of health and wellness. The pastor of the congregation must be able to communicate reliable health related definitions and information to the congregants. This can only be achieved if the pastors and clergy of the congregations understand the concepts of health literacy.

With this in mind, one of the effective strategies for promoting health and wellness is that the clergy must first understand the definitions and concepts of health and wellness. Obviously, the list and definitions of each local church would be different according to the health and wellness challenges faced by the surrounding community. As an example, during an interview, one clergy member discussed a desire to focus on the health and wellness of the sick and homebound congregants. The interviewee’s goal was to provide a continuous stream of information to the sick and homebound regarding the prevention of depression and other mental health related diseases. In this situation, it would be important to establish an operational definition for “sick and homebound.” Interestingly, each church could define the sick and homebound status of persons differently from other churches. For instance, one church might define the sick and homebound status as a nursing home resident, or the length of the rehabilitation stay at a facility or mobility status.

⁴⁶ Pleasant, Andrew, McKinney, Julie, and Rikard, R.V., “Health Literacy Measurement: A Proposed Research Agenda,” September 27, 2011, <https://www.tib.eu/en/search/id/tandf%3Adoi~10.1080%252F10810730.2011.604392/Health-Literacy-Measurement-A-Proposed-Research/>.

Other factors, such as cultural habits and zip codes, might determine the definition list of health challenges. As mentioned in the magazine *Western Chester County Life*, Vanessa B. Briggs, President and CEO of the Brandywine Health Foundation, stated, “High rates and incidents of health disparities, like diabetes, hypertension, and mental health can still be determined by one’s zip code.”⁴⁷ Brigg’s statement supports the thought that health issues and needs are specific to a group of people or community. Therefore, definitions and terminology of this study supports the promotion of health and wellness as it relates to the conversational communities within this paper. The definitions provide clergy with a conversational foundation of how we combat the diseases common to our neighborhoods through health and wellness initiatives. In addition, there must be an evaluation of the effectiveness of the strategies employed by clergy. Consequently, the terminology and definitions of evaluation are included in the central terms and definition list.

The terms diffusion and sustainability are used to measure the distribution and maintainability of health and wellness programs in a community. Diffusion is the “potential of the intervention design that makes it possible for dissemination to other interested churches by those churches where it has become institutionalized.”⁴⁸ The diffusion of a health initiative is important because it must extend far beyond the church walls. Members of the community will benefit when the congregants leave the church with reliable information regarding their own well-being. When the conversation of health and wellness spreads into the community, seeds of partnerships are planted. “Most partnerships are formed by professionals and organizations to improve delivery of health and social services to vulnerable populations or to generate policy,

⁴⁷ Whitcomb, Jill, “The Brandywine Strawberry Festival: A Sweet Community Event,” *Western Chester County Life*, Spring/Summer 2018.

⁴⁸ Ammerman et al., “The Praise! Project.”

system, and environment changes.”⁴⁹ The diffusion of a health and wellness initiative and the common goal of promoting a healthy community in which people come together is the evaluative lens of the partnerships. Many partnerships are formed between the church and community. Partnerships share resources from institutions to the community and persons who need health services. Partnerships bring greater sustainability to health and wellness initiatives.

Partnerships and collaborations are closely related by way of definition. This is because both terms are defined as organizations and institutions coming together to fill a health need or void for the residents in the community. While this may be true, the term collaboration carries the spirit of groups “working together” to provide health initiatives for the health and wellness of the community. In a partnership, the spirit of “working together” is combined with an agreement of being responsible for contractual partnership liabilities.

The text, *Religious Interest in Community Conflict*, details a case study in chapter five. The title of Chapter 5 is “Religious Interests in Community Collaboration.” The story in chapter 5 tells how the religious interests came together to fill a void in the healthcare system. The coming together of the religious institution was a collaboration. Similarly, the case study of the healthcare initiative in the Southwest Bronx started as a collaboration. It is interesting to note, both healthcare collaborations were given names. The definition of collaboration is the “working together”⁵⁰ of health systems and organizations to provide health and wellness care for the “best interest of the individual.”⁵¹ The collaboration is where trust is developed between clergy and health institution or initiative. The name of the faith-based collaboration in the Southwest Bronx

⁴⁹ Susan J. Zahner, Oliver, Thomas R., and Siemerling, Kirstin Q., “The Mobilizing Action Toward Community Health Partnership Study: Multisector Partnerships in US Counties with Improving Health Metrics,” *Preventing Chronic Disease* 11 (2014), <https://doi.org/10.5888/pcd11.130103>.

⁵⁰ Jean E. Johnson, “Working Together in the Best Interest of Patients,” *Journal of the American Board of Family Medicine: JABFM* 26, no. 3 (June 2013): 241–43, <https://doi.org/10.3122/jabfm.2013.03.130075>.

⁵¹ Johnson.

is called REACH (Racial and Ethnic Approaches to Community Health). The name of the faith-based coalition in Omaha, Nebraska is called IHS (Interfaith Health Services).

Many coalitions consist of professionals and community leaders with varied backgrounds. These leaders are typically already established in the community. Therefore, they come to the table with valuable expertise and insight needed to provide one's trust of the coalition. As an example, "the REACH coalition recruited a trusted and well-connected community leaders to spearhead their effort. The inclusion of community leaders in the coalition leadership was vitally important."⁵² Partnerships and coalitions gain trust and support from the congregation and community when reliable voices from the community supports and participates in the health and wellness engagement. In addition, the sustainability of the coalition's health initiative increases with community leadership support.

The term sustainability is another measurement for determining outcome success of a health and wellness program. "Sustainability is defined including five constructs: (1) *after a defined period of time, (2) the program, clinical intervention, and/or implementation strategies continue to be delivered and/or (3) individual behavior change (i.e., clinician, patient) is maintained; (4) the program and individual behavior change may evolve or adapt while (5) continuing to produce benefits for individuals/systems.*"⁵³ The article, *The Praise Project: A Church-Based Nutrition Intervention Designed for Cultural Appropriateness, Sustainability, and Diffusion*, contains pivotal information why clergy participation and support increases the trust of health interventions. This article details that cancer prevention research is deficient in the

⁵² Sue A. Kaplan et al., "The Role of Faith-Based Institutions in Addressing Health Disparities: A Case Study of an Initiative in the Southwest Bronx," *Journal of Health Care for the Poor and Underserved* 17, no. 2 Suppl (May 2006): 9–19, <https://doi.org/10.1353/hpu.2006.0088>.

⁵³ Julia E. Moore et al., "Developing a Comprehensive Definition of Sustainability," *Implementation Science* 12, no. 1 (September 2, 2017): 110, <https://doi.org/10.1186/s13012-017-0637-1>.

African American community. As mentioned earlier, it suggests that the reason for the absence is the “historical mistrust of research and medical institutions.”⁵⁴ Some of the mistrust occurs when the intervention participants feel like they are “guinea pigs.”⁵⁵ Health intervention participants must feel like they are a recipient of better health and wellness from the partnership study. Trust of the health intervention partnership is increased when the study participant experiences a direct deposit of improved health in their communities. This article reflects on the terminology of sustainability and diffusion as a way of measuring the success of a health initiative. The authors lay the framework for the evaluation of health initiatives.

Central Terms

1. Collaborations

Collaboration is the “working together”⁵⁶ of health systems and organizations to provide health and wellness care for the “best interest of the individual.”⁵⁷ “The health and well-being of our entire community requires meaningful collaboration between civic, government, education, business, healthcare, community-based organizations and the public.” Collaboration is needed, “to address a broad range of personal, social, economic and environmental factors that influence health status and health inequalities.”⁵⁸

⁵⁴ Ammerman et al., “The Praise! Project.”

⁵⁵ Ammerman et al.

⁵⁶ Johnson, “Working Together in the Best Interest of Patients.”

⁵⁷ Johnson.

⁵⁸ Whitcomb, Jill, “The Brandywine Strawberry Festival: A Sweet Community Event.”

2. Diffusion

“Diffusion is the potential of the intervention design that make it possible for dissemination to other interested churches by those churches where it has become institutionalized.”⁵⁹

3. Disease Prevention

“Disease prevention is understood as specific, population-based and individual-based interventions for primary and secondary (early detection) prevention, aiming to minimize the burden of diseases and associated risk factors.”⁶⁰

4. Health

“Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity,”⁶¹

5. Health Commission

“The Health Commission is to promote the health concerns of members of the African Methodist Episcopal Church. It shall advocate health care as a right and not a privilege. It shall also challenge and work to reform the unjust structures that are prevalent in health delivery systems. It shall encourage each organization in our church to include a health component in its life and work.”⁶²

⁵⁹ Ammerman et al., “The Praise! Project.”

⁶⁰ World Health Organization, “Health Promotion and Disease Prevention Through Population-Based Interventions, Including Action to Address Social Determinants and Health Inequity.”

⁶¹ LaQuandra S. Nesbitt, “A Government Led Model for Health Equity and Social Determinants of Health,” (January 16, 2014),

http://fpha.org/resources/Documents/A%20Government%20Led%20Approach%20to%20Health%20Equity%20and%20Social%20Determinants%20of%20Health%201_14_14.pdf.

⁶² Church, *The Doctrine and Discipline of the African Methodist Episcopal Church*, 234.

6. Health Disparities

“Observed differences in health status among distinct groups of the population. These may be based on gender, race/ethnicity, and socioeconomic status, place of residence or differing abilities.”⁶³

7. Health Equity

“Observed differences in health status that result from systematic, avoidable and unjust social and economic policies and practices that create barriers to opportunity.”⁶⁴

8. Health Initiatives

In this study the health initiatives are faith-based or clergy promoted. “Faith-based initiatives utilize the capacity and resources of local faith-based institutions to change the knowledge and attitudes of community members concerning health promotion and management of the healthcare system. In addition, Faith-based initiatives mobilize clergy and church to seek changes in law, regulation, and policy to eliminate discrimination and promote equal access to care.”⁶⁵

9. Health Intervention

As in a health intervention, “an intervention is a combination of program elements or strategies designed to produce behavior changes or improve health status among individuals or an entire population. Interventions may include educational programs, new or stronger policies, improvements in the environment, or a health promotion campaign.

⁶³ Thompson Adams, Linda, “Health Equity: It Is Time to Meet the Challenges Head-On,” (April 14, 2016).

⁶⁴ Thompson Adams, Linda.

⁶⁵ Kaplan et al., “The Role of Faith-Based Institutions in Addressing Health Disparities.”

Interventions that include multiple strategies are typically the most effective in producing desired and lasting change.”⁶⁶

10. Health Literacy

“Health Literacy is an assessment of what individuals can read and understand in clinical contexts. In addition, it is a measurement of how individuals use information, and how health professionals and systems communicate with patients.”⁶⁷

11. Health Prevention

“Programs Health Prevention programs are designed to help the individual eat smart, exercise regularly, and get routine screenings and vaccinations.”⁶⁸

12. Healthcare

“Services offered to preserve emotional and physical well-being and prevent or treat illness.”⁶⁹

13. Healthcare Access

In summarizing the research on healthcare, healthcare access is the rate of effort it takes to access medical services.

14. Healthcare-Related Coalitions

Healthcare Coalitions are formed to address health disparities in each community. The work of the coalition is to advocate equal access for all people. A Coalition can be identified with a name or by the work it performs. It consists of a group of organizations or individuals with a common goal to address healthcare needs.

⁶⁶ World Health Organization, “Health Promotion and Disease Prevention Through Population-Based Interventions, Including Action to Address Social Determinants and Health Inequity.”

⁶⁷ Pleasant, Andrew, McKinney, Julie, and Rikard, R.V., “Health Literacy Measurement: A Proposed Research Agenda.”

⁶⁸ “Prevention & Wellness | HHS.Gov.”

⁶⁹ “Medical Dictionary and Definitions.”

15. Healthcare Equity

“Observed differences in healthcare that result from systematic, avoidable and unjust social and economic policies and practices that create barriers to opportunity.” In this definition, the word “health” was replaced with the word “healthcare.” A person’s health is measured as a status. Healthcare is a measure of the quality and effectiveness of medical services.⁷⁰

16. Partnerships

“Most partnerships are formed by professionals and organizations to improve delivery of health and social services to vulnerable populations or to generate policy, system, and environment changes. Multisector collaboration was valued in all cases. Outcomes attributed to partnerships included short- and long-term effects that contributed to improved population health.”⁷¹

17. Sustainability

“Sustainability is defined including five constructs: (1) *after a defined period of time, (2) the program, clinical intervention, and/or implementation strategies continue to be delivered and/or (3) individual behavior change (i.e., clinician, patient) is maintained; (4) the program and individual behavior change may evolve or adapt while (5) continuing to produce benefits for individuals/systems.*”⁷²

18. Wellness

“Wellness is an active process of becoming aware of and making choices towards a healthy and fulfilling life. It is more than being free from illness, it is a dynamic

⁷⁰ Thompson Adams, Linda, “Health Equity: It Is Time to Meet the Challenges Head-On.”

⁷¹ Zahner, Oliver, Thomas R., and Siemering, Kirstin Q., “The Mobilizing Action Toward Community Health Partnership Study.”

⁷² Moore et al., “Developing a Comprehensive Definition of Sustainability.”

process of change and growth. A good or satisfactory condition of existence; a state characterized by health, happiness, and prosperity; welfare.”⁷³

19. Well-being

“There is no consensus around a single definition of well-being, but there is general agreement that at minimum, well-being includes the presence of positive emotions and moods (e.g., contentment, happiness), the absence of negative emotions (e.g., depression, anxiety), satisfaction with life, fulfillment and positive functioning.⁷⁴ In simple terms, well-being can be described as judging life positively and feeling good.”⁷⁵

Definition Review of Partnerships, Collaborations, and Coalitions

In reviewing the definitions, first a *collaboration* is the “working together” of health systems and organizations to provide health and wellness care for the “best interest of the individual.”⁷⁶ “The health and well-being of our entire community requires meaningful collaboration between civic, government, education, business, healthcare, community-based organizations and the public.” Collaboration is needed, “to address a broad range of personal, social, economic and environmental factors that influence health status and health inequalities.”⁷⁷ Secondly, “Most *partnerships* are formed by professionals and organizations to improve delivery of health and social services to vulnerable populations or to generate policy, system, and environment changes. Multisector collaboration was valued in all cases. Outcomes attributed to partnerships included short- and long-term effects that contributed to improved population

⁷³ “Global Wellness Day.”

⁷⁴ “Well-Being Concepts | HRQOL | CDC,” November 5, 2018, <https://www.cdc.gov/hrqol/wellbeing.htm>.

⁷⁵ “Well-Being Concepts | HRQOL | CDC.”

⁷⁶ Johnson, “Working Together in the Best Interest of Patients.”

⁷⁷ Whitcomb, Jill, “The Brandywine Strawberry Festival: A Sweet Community Event.”, 44-45.

health.”⁷⁸ Thirdly, *Healthcare Coalitions* are formed to address health disparities in each community. The work of the coalition is to advocate equal access for all people. A Coalition can be identified with a name or by the work it performs. It consists of a group of organizations or individuals with a common goal to address healthcare needs.

Each health structure is similar in definition, but different in its focus as it relates to health and wellness. A health and wellness collaboration operate in the spirit of working together for the best interest of the recipient of healthcare. Partnerships are formed in the spirit of delivering health to the most vulnerable. Coalitions are formed to advocate against the health disparities in the community.

⁷⁸ Zahner, Oliver, Thomas R., and Siemering, Kirstin Q., “The Mobilizing Action Toward Community Health Partnership Study.”

Chapter 4: Literature Review Best Practices

As mentioned in the previous chapter, the focus of this research summarized the extent to which clergy promotes health and wellness within their local church and community. Additionally, the literature review research of clergy promoting health and wellness concentrates on literature reviews of the promotion of health and wellness as opposed to literature reviews of the promotion of healthcare. Moreover, the literature reviews presented in this study summarize the impact of the initiatives on the well-being of the community. Since the participants of the health and wellness initiatives of the literature reviews centered around clergy members, congregants and all aspects of the community, it is safe to say the health and wellness initiatives were faith-based.

Other aspects of the literature reviews helped to build the framework for defining the effective strategies for promoting health and wellness. Also, the reviews revealed what keeps clergy motivated to continue the ministry of promoting health and wellness in their church and community. More importantly, the literature reviews of this study in concert with the study results helped to define what the effective strategies for clergy promoting health and wellness in the West-Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church are. Therefore, the literature reviews in this chapter represent the best practices utilized by clergy persons promoting health and wellness in their churches and communities. The best practices of each literature review topic will be summarized at the end of each section. It is important to note that the best practices of some literature reviews have been presented throughout this research with the appropriate topic of each chapter.

Faith-Based Health Initiatives

Two articles lay the foundation for the importance of faith-based health initiatives. The title of one article is “Church-Based Health Promotion Interventions: Evidence and Lessons Learned,” and the second article is, “The Role of Religious Leaders in Health Promotion for Older Mexicans with Diabetes.” These articles fit neatly into the framework of this research of clergy interacting with health initiatives. Interestingly, they employ terminology such as “Role of Clergy” or “Faith-Based” in their titles. The articles are pivotal research because they show the connection between clergy promoting health and wellness with effective health and wellness initiatives. In addition, the research of these articles illustrated the connection between having reliable health and wellness information. In the article, “The Role of Religious Leaders in Health Promotion for Older Mexicans with Diabetes,” it illustrates the healing of a disease which comes from the house of faith administering a health initiative designed specifically for religious leaders. The disease is diabetes and the study group are older Mexicans with diabetes. According to its research, clergy members gave constant messages of health and wellness from the pulpit. The healthcare messages from the pulpit increased the opportunities for parishioners to receive reliable information. At the end of the study, the older Mexicans became better managers of their diabetes because of the involvement of their clergy. When individuals receive reliable information, research suggests, “They comply with their treatment.”⁷⁹ The conclusion of this study found clergy to be key leaders in promoting reliable information on healthcare.

In the article, “Church-Based Health Promotion Interventions: Evidence and Lessons Learned,” the study addresses the question, “why conduct health promotion in churches and religious organizations?” With this question in mind, the weekly attendance of parishioners

⁷⁹ Rivera-Hernandez, “The Role of Religious Leaders in Health Promotion for Older Mexicans with Diabetes.”

visiting the church makes the clergy person and church leaders more familiar with their need than their doctors. In addition, in many cases the church already has some system of class leaders. The class leaders serve as an additional layer of oversight of the well-being and needs of the membership. In fact, the clergy are the first persons who are aware of the health challenges of the congregants. They are the first people that pray for the healing and restoration of their bodies.

Religious institutions and churches are usually blessed with space in the sanctuary or fellowship hall to do ministry such as health workshops. They usually have some space designated as a kitchen. In the kitchen, there is space to show how to prepare healthy meals. Religious institutions and churches already have a present or past presence in the community. Churches are experienced in doing outreach within the community. Therefore, the research shows the church and clergy as effective promoters of health programs in the community. In addition, it suggests that African American clergy have taken the role as health promoters in the church. In one case, information shows the correlation between the church and the success of disease prevention programs.

In *Religious Interest in Community Conflict*, Paul and Laura Olsen, detail how the Christian Community in South Omaha Nebraska designed a health care system to address the health needs of the most vulnerable in their community. Chapter 5 of the text outlines a firm framework for starting a coalition to fill the void in the community of addressing the healthcare needs of the community. In addition, they give examples of the role clergy plays in promoting healthcare.

In the article, “The Role of Faith-Based Institutions in Addressing Health Disparities: A Case Study of an Initiative in the Southwest Bronx,” the authors detail how a faith-based

coalition addressed the health disparities in the Southwest Bronx of New York City. The research gives strategies for implementing their health initiative. It also provides an understanding of why the church is viewed as a place for potential leadership.

In the article, “Can Churches Play a Role in Combating the HIV/AIDS Epidemic? A Study of the Attitudes of Christian Religious Leaders in Madagascar,” the authors conclude that Malagasy church leaders play an important leadership role in the fight against HIV/AIDS. Information in this article suggests they must be willing to improve their health literacy in this topic. Interestingly, the article deals with the biases of clergy towards the disease HIV/AIDS. In fact, this article deals with the negative impact caused by clergy not willing to participate in the faith-based initiative. The negative unhealthy behaviors of people continue in the community because of the lack of self-advocacy in promoting healthy behaviors towards the disease.

Summary of Best Practices

- Healthcare messages from the pulpit increased the opportunities for parishioners to receive reliable information.
- When congregants receive reliable information, research suggests, “they comply with their treatment.”⁸⁰
- Utilize space in the sanctuary or fellowship hall to do health workshops.
- Utilize faith-based coalition to address the health disparities in the community.
- Address the biases of clergy towards communicable diseases such as HIV/AIDS.

⁸⁰ Rivera-Hernandez.

The Message from the Pulpit

When clergy promotes healthcare in the African American community, the effectiveness of healthcare systems and initiatives increases. The article, “Promoting Healthy Behavior from the Pulpit: Clergy Share Their Perspectives on Effective Health Communication in the African American Church,” indicates African American clergy can be used as healthcare communicators. According to its research, a constant message of health and wellness coming from the pulpit, increases healthy behaviors. Healthcare messages from the pulpit increases the opportunities for parishioners to receive reliable information.

As mentioned earlier, when an individual receives reliable information, “they comply with their treatment.”⁸¹ In other words, the person with the disease becomes a better self-advocate and manager of his or her disease. This thought was examined in a study which involved clergy and older Mexicans with diabetes. The study determined clergy to be key leaders in promoting reliable information on healthcare.

Clearly, it is not difficult for clergy persons to communicate reliable information if it originates from a reliable source. If you do your homework in meeting with professional healthcare workers and follow the script, you can be successful in communicating reliable information. Furthermore, there is an agreement with the fact that when individuals receive reliable information, they do a better job at complying with their treatment plan. On the other hand, the power of a message from the pulpit exists in the repetition of the message. The reader of this research project might assume the message of health and wellness must only be preached or communicated to the congregation one time. This is not true with any message from the pastor in the pulpit. As an example, the message of God’s love is not a one-time message. His

⁸¹ Rivera-Hernandez.

love must be preached many times and many ways for the congregants to comprehend and feel in their hearts that God loves them. When they have experienced unexplained turmoil, hurt and pain in their lives, they must be reminded that God loves them. The pulpit is a place where common messages are given multiple times to effectively spark a need to change a destructive or negative behavior in the listener's life.

This article represents a best practice for clergy promoting health and wellness from the pulpit. The pulpit is the common place or one of the designated places where healing and wellness is preached and/or taught through a sermon. A sermon is preached from the pulpit to expound on a moral concept, a new perspective or law related to God. It is important to note the prior definitions are not an exhaustive list of defining what is a sermon. With this definition in mind, sermons of healing and wholeness are not much different than the promotion of health and wellness. Both sermons of wholeness and health promotion of wellness speak to the same person. A reflection of this section might suggest that when clergy members are only preaching to the soul and not the needs of the body, then they are not using the full extent of the pulpit. Therefore, the pulpit is a dedicated place to hear a sacred message of health and wellness of the body while speaking to the needs of the soul.

Summary of Best Practices

- Healthcare messages from the pulpit increased the opportunities for parishioners to receive reliable information.
- Meet with professional healthcare workers and follow a script, when communicating reliable information.
- Sermons of health and wellness from the pulpit must be given multiple times to effectively spark a need to change.

- Sermons of health and wellness must be preached many times and many ways for the congregants to comprehend.

Body and Soul Program

The Body and Soul church-based nutrition program is an intervention designed to increase the consumption of fruits and vegetables as healthy food choices. The article “Promoting Healthy Behavior from the Pulpit: Clergy Share Their Perspectives on Effective Health Communication in the African American Church,” highlights the details of this health and wellness intervention. Specifically, this program is named the “Body and Soul: A Celebration of National Eating and Living.”⁸² The healthy food choice intervention started as a study with a total of 15 African American churches and 1,022 church members participates. The churches were in California, Georgia, North Carolina, South Carolina, Delaware and Virginia. The churches were assigned to the Body and Soul program or the comparison group.

In this program, the participating pastor of the church or a designee made weekly messages regarding health and wellness interventions from their pulpit. I personally participated in this program after the initial study while serving as the pastor at Bethel AMEC, located in Coatesville, PA. In the messages from the pulpit, I discussed the purpose and benefits of this program with the congregation. In addition, from the pulpit, I gave healthcare messages pertaining to weight management and overall wellness, as they related to healthy food choices. Interestingly, during the initial study, a lay counselor conducted several wellness events, such as the topic of food preparation. Only one event was designed involving the pastor as the leader. As an example, during the introduction of healthy food preparation, I communicated with the congregants, the advantages of grilling foods versus frying foods. The program was coordinated

⁸² Lumpkins et al., “Promoting Healthy Behavior from the Pulpit.”

by a registered nurse, but the registered nurse encouraged me to increase my presence in the leadership of the initiative.

The 6-month follow-up found the Body and Soul Program participants consuming more fruits and vegetables per day than the controlled group.⁸³ In addition, they decreased their percentage of calories from fat.⁸⁴ During the program, members in the church began to make noticeable changes in the menu for church dinners and fellowships. The menu included options of two vegetables per meal versus a vegetable and a starch. It is important to note the past menus of church dinners included a large helping of potato salad or mashed potatoes with green beans smothered with a ham product. In the findings, congregants were self-advocates of healthy eating, after receiving reliable information regarding their health and healthy food choice consumption in their diet. Simultaneously, the participants showed a substantial increase in the consumption of fruits and vegetables.

This study represents a best practice because it demonstrates the role clergy plays in promoting health and wellness in their churches and local communities through health eating. The Body and Soul program is a partnership with local churches which embraces the pastor in their leadership model. It is good news to the church community when partnerships and coalitions have a vision of improving the health and wellness of church congregants.

Summary of Best Practices

- Promote health and wellness by partnering with health-related initiatives such as “Body and Soul: A Celebration of National Eating and Living.”⁸⁵

⁸³ National Cancer Institute, “Research-Tested Intervention Programs: Program Details of Body and Soul Program,” 2004, <https://rtips.cancer.gov/rtips/programDetails.do?programId=257161>.

⁸⁴ National Cancer Institute.

⁸⁵ Lumpkins et al., “Promoting Healthy Behavior from the Pulpit.”

- Utilize healthcare professionals such as a registered nurse or nutritionist to lead your health and wellness initiative.
- Healthcare messages from the pulpit increased the opportunities for parishioners to receive reliable information.
- Evaluate the effectiveness of the health and wellness initiative with a 6-month follow-up.

You Are What You Eat-Book of Daniel

In the book, *Living Holy and Healthy*, Reverend Dr. Esther L. Seales illustrates the benefits of fasting for improved health. Dr. Seales, highlights the improved health of Daniel and the three Hebrew boys from fasting or abstaining from food for a period of time. Chapter 1 of the Book of Daniel is an excellent scriptural text that demonstrates the benefits of making healthy food choices in your meals.

In the book of Daniel, Chapter 1, there is a story of Daniel and his three friends who refused to eat the king's food. They refused to eat the king's food because it was unclean. The food was unclean because it was food which had been sacrificed to idol gods. They refused to eat the king's food because it would have been a violation as stated in the Mosaic Law. So therefore, the king's food was forbidden for Jews to eat and in violation of the law.

In addition, the four young men refused to eat the king's food because it made one look less healthy. The food was "delicious rich food"⁸⁶ but it made the consumer appear less healthy compared to persons consuming just vegetables and water. It must have been difficult for Daniel, Hananiah, Mishael and Azariah to turn down the "tasty king's food compared to eating pulse (beans, lentils), drinking water, and come out looking better and healthier than the other

⁸⁶ Esther L. Seales, *Living Holy & Healthy: Living Holy & Healthy by Fasting and Praying* - (Bloomington, IN: AuthorHouse, 2012), 32.

young men that ate the king's food."⁸⁷ Therefore serving like a clergy person, Daniel goes to the king and promotes the benefits of eating vegetables and drinking water by using a makeshift pulpit. He receives permission from the king to eat vegetables and drink water. At the end of 10 days of the "Daniel Plan", the four Hebrew boys "looked much better than all other young men that ate the king's food."⁸⁸ Most biblical scholars suggest the determination in his heart was the factor which kept Daniel from eating the king's food. Reverend Dr. Seales refers to the determination phrase as being purposed in their hearts.

The "same purposed in the heart"⁸⁹ phrase can be garnered by clergy when promoting health and wellness in their congregants and community. Clergy persons can use this story from the perspective of healthy eating and food preparation, the negative institution of food choices and the heart of determination to promote health and wellness in our communities. In fact, the promotion of clean eating and the healthy preparation of foods helps a person to achieve a better quality of life. God desires not only that a person has life, but life more abundantly. In the scripture, Jesus said, "I come that they would have life and have it more abundantly (John 10:10). Improved health increases an abundance of life by following a healthy eating program. This review supports the previous literature review regarding the benefits of healthy eating.

Summary of Best Practices

- Use scripture to determine desired health outcomes for a greater quality of life.
- Promote health and wellness through fasting for improved health.

⁸⁷ Seales, 32.

⁸⁸ Seales,32

⁸⁹ Seales, 32.

- Health and wellness messages from the pulpit increased the opportunities for parishioners to receive reliable information. Have a discussion circle around books relating to healthy living.

Building Trust in the African American Community

How do you build trust in a healthcare system which is unjust in the delivery of services?

How do you build trust when persons of the African American community can be placed in harm's way as "guinea pigs" in experiments endorsed and funded by the U.S. Public Health

Service? How do you determine credible partnerships for the African American Community?

These are a few questions which must be investigated, answered and kept under strict scrutiny by the local community as a starting point of building trust in the healthcare system. Not only must the partnership be investigated by the local community, it must be inclusive of persons and diverse in its formation. Healthcare systems and health and wellness partnerships must exhibit a collaborative attitude with the players. Its mission must do what is the "best interest for the individual"⁹⁰ recipients of the health delivery system. Effective and credible collaborations are comprised of trusted and well-known members of the community. A case study of a trusted collaboration can be found in the REACH coalition of the Southwest Bronx.

The case study of the healthcare initiative in the Southwest Bronx started as a collaboration. Mentioned previously, the definition for the term collaboration is the "working together" of health systems and organizations to provide health and wellness care for the "best interest of the individual."⁹¹ A collaboration is where trust is developed between clergy and health institutions or initiatives. The name of the faith-based collaboration in the Southwest Bronx is called REACH (Racial and Ethnic Approaches to Community Health).

⁹⁰ Johnson, "Working Together in the Best Interest of Patients."

⁹¹Johnson.

A lesson learned in the REACH coalition is, “the recruitment of a trusted and well-connected community leader to spearhead the effort and to serve as part of the coalition leadership was vitally important.”⁹² When a trusted voice in the community support and participates in the partnership or coalition, trust from the congregation is formed. At one point, 22 clergy members were involved in the REACH coalition.

The REACH coalition was able to gain trust by (1) the engagement and recruitment of the church leadership and (2) by the utilization of existing church buildings for educational workshops and health and wellness interventions. Another interesting feature of the partnership is the role clergy played in the leadership of the health initiative. Clergy leaders were responsible for directing the health strategies. They were not mere participants. Church leaders were involved in the design of the program and the focus of the health and wellness initiative. As an example, one of the coalition’s dual agenda items included the advocacy of healthcare and the promotion of healthy behaviors. Clergy persons involved in the design of the health and wellness initiative demonstrated a greater ownership in the work of the coalition.

Another article previously mentioned illustrates the role clergy plays in the trust of health interventions. The article, “The Praise Project: A Church-Based Nutrition Intervention Designed for Cultural Appropriateness, Sustainability, and Diffusion,” contains pivotal information why clergy participation and support increases the trust of health interventions. This article details that cancer prevention research is deficient in the African American community. As mentioned earlier, it suggests the reason for the absence is the “historical mistrust of research and medical institutions.”⁹³ Some of the mistrust occurs when the intervention participants feel like they are

⁹² Kaplan et al., “The Role of Faith-Based Institutions in Addressing Health Disparities.”

⁹³ Ammerman et al., “The Praise! Project.”

“guinea pigs.”⁹⁴ Health intervention participants must feel like they are a recipient of better health and wellness from the partnership study. Trust of the health intervention partnership is increased when the study participant experiences a direct deposit of improved health in their communities.

In summary, there are two characteristics which increase the trust of a health and wellness initiative or study. First, the partners must be trusted members of the community. A local clergy person would be considered as partner in a health and wellness initiative. Therefore, it is imperative that local clergy be involved in the planning and administering of a health and wellness initiative. Secondly, the recipients of the health and wellness study must not be treated as guinea pigs of the initiative. The participants must feel like they are included in the plan or design of the health initiative. When the participants feel included in the coalition, the health and wellness initiative is trusted by the community.

Summary of Best Practices

- The mission of the health and wellness initiative must do what is the “best interest for the individual”⁹⁵ recipients of the health delivery system.
- “The recruitment of a trusted and well-connected community leader to spearhead the effort and to serve as part of the coalition leadership is vitally important.”⁹⁶ This brings community trust of the health initiative.
- Coalitions gain trust by (1) the engagement and recruitment of the church leadership and (2) by the utilization of existing church buildings for educational workshops and health and wellness interventions.
- Involve clergy and laity leaders in the creation of health initiatives and strategies.

⁹⁴ Ammerman et al.

⁹⁵ Kaplan et al., “The Role of Faith-Based Institutions in Addressing Health Disparities.”

⁹⁶ Kaplan et al.

Unjust Structures

Sunday morning sermons provides an opportunity for each clergy person in the local church to speak truth to the powers of unjust structures. Preachers that speak sermons against systems of injustice in the local community are ineffective if their action does not extend beyond the walls of the church. The voice of clergy promoting health and wellness justice within their community must partner with the voices of persons from other churches, other faiths and organizations with the same concerns. It is when the voice of one accord comes together against the unjust structures that a coalition is formed to address the health concerns of the community.

The document called *Supporting a Movement for Health and Health Equity: Lessons from Social Movements: Workshop Summary Guidance for the National Healthcare Disparities Report* is a 94-page online free book containing a wealth of information pertaining to the social movement of supporting health and health equity in our country. The statistical data and the summarized lessons of the document can be applied to conversation of eliminating or reducing the chronic diseases that plague our community. As mentioned, the conversations by clergy promoting health and wellness must extend beyond the pulpit in their local church.

There are several studies which point to diabetes as a leading chronic disease in the African American community. Diabetes is the disease in our communities, but another glance of the disease would cause an investigation of why our community is plagued by the disease. In the document, “A Government Led Model for Health Equity and Social Determinants of Health”, the author LaQuandra Nesbitt focuses on social determinants of health in our communities. Social determinants of health range from the community’s ability to purchase fresh produce and healthy foods to the community’s access of healthcare systems. Nesbitt’s work is an example of one place clergy can access reliable information about the social determinants of health and

wellness. The social determinants of health and wellness must be communicated by clergy to the congregation to give reasons for a health and wellness intervention. When considering the question, “Where does clergy receive reliable information on health and wellness facts and issues,” it is important to note some of the articles are not inclusive of clergy. This is one of the challenges of the question, “Who should supply the reliable information pertaining to the health and wellness of persons in the community?” A clergy member of the church is an overseer of the spiritual well-being of the congregants. Unfortunately, their insight and observations of the health and wellness of a person are overlooked. The clergy member or pastor of a church is the first person the congregant goes to for prayer or advice when they are facing health and spiritual challenges. It is important to note that health, spiritual and emotional challenges are all factors which must be considered when evaluating the well-being of a person. On the other hand, these articles provide the facts and truths of healthcare issues in the community for clergy. Moreover, these articles deal with issues of “delivery systems” and who is delivering the healthcare and wellness interventions.

Likewise, the document *Guidance for National Healthcare Disparities Report*, a 199-page online free book, says, “Access is a central aspect of health care quality. As such, the National Healthcare Disparities Report should give it prominent attention.”⁹⁷ In the same section of this statement, the document deals with an example of services of prior care and diabetes. It says, “African Americans with diabetes are more likely to have limbs amputated than Whites.”⁹⁸ The grisly fact of African American limbs being amputated at higher rates than Whites uncovers a major flaw in the health delivery system of the United States. This fact uncovers the reality in

⁹⁷ Elaine K. Swift, *Guidance for the National Healthcare Disparities Report*, 2002, <https://doi.org/10.17226/10512>, 76.

⁹⁸ Alison Mack, Alina Baci, and Nirupa Goel, *Supporting a Movement for Health and Health Equity: Lessons from Social Movements: Workshop Summary*, 2014, <https://doi.org/10.17226/18751>.

which there are two healthcare systems. If this statement is true, then one could agree that we have two healthcare systems for limbs or when it comes to protecting the health and wellness of the limbs of African Americans and Whites. Unfortunately, the preacher in the pulpit will eventually have an opportunity to address this problem during the funeral message of an amputee. On the other hand, a more proactive message from the pulpit would be the uncovering of unjust health systems which cause early deaths in the African American community.

Summary of Best Practices

- Investigate what are the social determinants of health in the community.
- Investigation why your community is plagued by a certain disease(s).
- Study issues of “health delivery systems” and determine who is delivering the healthcare and wellness interventions.
- The voice of clergy promoting health and wellness justice within their community must partner with the voices of persons from other churches, other faiths and organizations with the same concerns.

Chapter 5: Methodology, Process of Survey and Interviews and Results

Process of Survey and Interviews-West Mainline and Philadelphia Districts

This survey, using both qualitative and quantitative research models, was distributed to 34 churches in the Philadelphia and West Mainline Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church. There are 16 churches in the Philadelphia District and 18 churches located in the West Mainline District. A total of 70 clergy persons are assigned to the two districts. 40 clergy persons are assigned in the West Mainline District and 30 are assigned in the Philadelphia District.

Distribution and explanation of the survey commenced at the Christian Education Congress of the First Episcopal District on July 16-19, 2018 in Dover, Delaware. The distribution of surveys to clergy and their follow-up was also conducted at the Preacher's Retreat of the First Episcopal District of the AMEC on September 11-13, 2018 in northeastern Pennsylvania. Surveys were distributed during the months of July, August, September and October 2018. Follow-up calls and emails were sent to the churches to ensure opportunities to all the churches in the two districts.

All participants were required to complete an Informal Consent Form. The Informal Consent Form included the name of the researcher and the sponsoring seminary of the research. The purpose of the project was explained in the beginning of the form. The form explained the following: "My project investigates the role of clergy in promoting health and wellness in the West and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church. Your support of this research is needed by helping me bring together information on "what are the most effective strategies for promoting health and wellness?" In

addition, this research will capture what motivates clergy to participate in the health and wellness conversation.”⁹⁹

All participants in this study were required to sign an Informal Consent Form. Participation in this study was voluntary. In addition, the clergy person could stop his or her participation in the survey and interview at any point after starting the process. The participant could request to have any part or record of their responses destroyed at any time during the study. Moreover, the participant could stop the process completely if he or she experienced any distress from the survey and interview process.

Participants were able to complete the survey in approximately 45 to 60 minutes. The information is completely confidential, including the confidentiality of the clergy person. In addition, the results of the study will be permanently stored in a locked file cabinet.

17 of the 34 churches or 50 % of the churches responded to surveys. Participants sent their surveys by mail or electronically through email. In addition, some participants completed their surveys at the Christian Education Congress and Preacher’s Retreat. Ten respondents were selected from the 17 surveys for further investigation.

10 churches were selected to participate in one on one interviews. They were selected according to their prior participation in a community health and wellness. In addition, clergy who had not participated in a health and wellness ministry were included to participate in this study. In addition, their participation in community health and wellness programs and health partnerships was a factor in the selection process. The willingness of the participant to start a health and wellness ministry in their church and community was another factor in the selection

⁹⁹ Informal Consent Form.

process. Ultimately, the clergy's willingness to invest their time in the one on one interview was a deciding factor in the selection.

Clergy members of the two districts expressed a willingness to give their thoughts about health and wellness in their churches. In addition, even if clergy members were not able to complete the survey or participate in the one on one interview, they expressed a desire to be more informed of the strategies for promoting health and wellness in their churches. The data reported in this study is a sample of the promotion of health and wellness by the clergy participants. In addition, it does not capture the initiatives and activities of health and wellness promotion caused by their interaction with any aspect of the research project.

The summary findings of the promotion of health and wellness in the Philadelphia and West Mainline Districts of the Philadelphia Conference of the AMEC will be revealed in the next two sections. Survey results will be detailed first, followed by the results of the one on one interview. Figure 5.1 is a one-page summary of the responses from the project survey participants. A Survey ID has been assigned for confidentiality. The next document is the Project Survey.

Project Survey

1. Do you have an active Health Commission, Nurse Unit, and/or health or some other wellness ministry?
2. What are the most prevalent diseases and conditions with which your members are afflicted?
3. What transportation challenges, if any, do your members experience in getting to a healthcare facility?
4. Where do your members receive information regarding health and wellness? Where do your members receive information regarding disease prevention?
5. Do members of your community have access to healthcare and wellness services? If so, where are they?
6. Do you promote health and wellness in your church/and or community? If yes, what are your strategies and practices? How do you evaluate the effectiveness of your strategies and practices?
7. What are your strategies for engaging coalitions, partnerships, and health initiatives to promote health and wellness in your congregations? How do you evaluate the effectiveness of your health and wellness initiative?
8. Does your church participate in information initiatives such as Heart Health Month in February? Are there other initiatives they have participated in? If yes, what impact do you think the information has on the health behavior of members in your congregation? If no, why don't you participate?
9. What are the lessons learned from your participation in promoting health and wellness in your church? How do you sustain your health and wellness initiatives? If you don't participate in promoting health and wellness in your church, what would motivate you to do so.

Project Survey Results

Figure 5.1 Project Survey Results

Project Survey 22-Nov-18									
Survey ID	#1 Active Health Com/Ministry?	#2 Most Prevalent Disea in Church C	#3 Transportation Challenges?	#4 Receive Informatiom?	#5 Have Access to Services?	#6 Promote Hea/Welln ?	# 7 Strategies ?	#8 Participate Info Initiatives	# 9 Lessons Learned?
S1014	Developing	Type2 D, High B P	None	Hosp, ARRP	Does Have Services	Yes	Collaboration	Yes	Informed Church
S0927	Yes	Cans,HBP,Dia,Depre	None, adaptations	Senio. Center, WS	Dept of A., Hea Sys	Yes	Collaboration	Yes	Take Care of Self
S1002	Yes	Heart, HBP, Dia	None	Community Centers	Yes, Local Commu	Yes	Partnership	Yes	Pay Atte..To Body
S1009	Yes	Cans, Lupus, Aging	Rover, and Some Dri	Profess., Sun. Bullet.	Yes, Hea Care Fac	Yes, Weekly Bul	Spons Hea Sem	Yes	Stories from Survi
S0903	No	Aging	None	Unknown	Unsure	No	None	No	Finding the Needs
S1017	Yes	Heart, Dia, Asthma	CCT at low cost	Hospitals, Media	Yes, within counties	Yes, Many Opp	Partnership	Yes	Message of Health
S0921	Yes	Cans,Dia, Ht, Addi, Alz	None	Hosp, ARRP,Non-P	Yes, Multiple	Yes	Collab, Partn, Initia	Yes	Reduce Myths, Ster
S0926	Developing	Addic, Dia, High B P	Rely on others, memb	Hosp, Comm Ev	Yes, Uni of Penn	Yes	Collaboration	Yes	Health Awarness
S0816	Developing	Cans, Dia, High B P	None, Most Drive	Their Physicians	Yes, Local Hospital	Yes	Health Fair	Yes	Develop Contacts
S0724	Yes	Diabetes, High B P	None, CCT, Paratransit	Senior Cts, Media	Not Sure	Developing	Dev Workshops	Yes	MSG of Nutri Foods
S0911	No	High B P, Diabetes	During Inclement Wea	Dr, Local Clin, AMEC	Yes, Medicare, MC	AMEC,Clergy Mtg	Developing	Yes	No One is Exempt
S0912	Yes	Dia,Alz,Hyper,Cancer	Accessibility	Dr,Sem,WS, Church	Yes, Main Line Hea	Yes, Many Opp	Relationships	Yes	New Persp in Minis
S0913	Yes	High B P, Prost Cancer	Some Struggles	Fellowship Hall	Yes, thru Employ	Yes, H. Fair, Part	Collaboration	Yes	Pastor Empowers
S0810	Developing	High B P,Arth,COPD	None	Pers Care Facilities	Yes, Local Comm	Yes	Networking	Not really	Reminders
S1020	Yes	Dia,HBP,Can,MI,Aging	None, CCT	AMEC,H Agen,Media	Not Sure	Yes,WS,Bulletin	Collaboration	Yes	Results of Ignorance
S1008	No	Prost Cancer,High B P	None	Physicians	Yes, Health Center	Yes	Dev Partnership	Yes	Better Quality Life
S0914	Yes	Dia, High BP, Arth	Distance, Time on Tra	Media,Gym,Provider	Yes, Local Hospital	Yes, Every 3rd Su	Partnership	Yes	Persistence Pays Off

Figure 5.2 Active Health Commission/Ministry

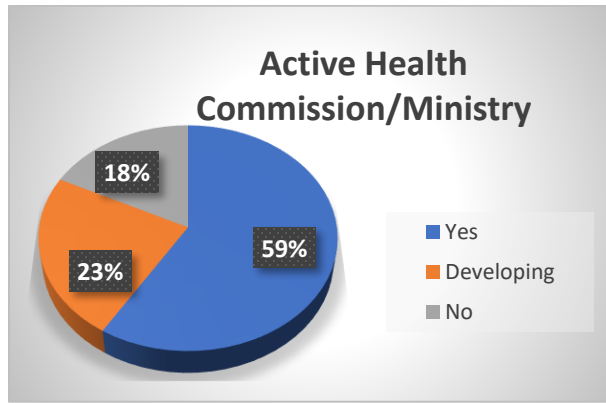


Figure 5.3 Most Prevalent Diseases in Church Community

#2 Most Prevalent Diseases in Church Community														# of Diseases
Survey ID	Diabetes	High Blood Pressure	Cancer	Depression	Heart Disease	Aging	Lupus	Asthma	Addiction	Alzheimers	Arthritis	COPD	Mental Illness	
S1014	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	2
S0927	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	4
S1002	Yes	Yes	No	No	Yes	No	No	No	No	No	No	No	No	3
S1009	No	No	Yes	No	No	Yes	Yes	No	No	No	No	No	No	3
S0903	No	No	No	No	No	Yes	No	No	No	No	No	No	No	1
S1017	Yes	No	No	No	Yes	No	No	Yes	No	No	No	No	No	3
S0921	Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	No	No	No	5
S0926	Yes	Yes	No	No	No	No	No	No	Yes	No	No	No	No	3
S0816	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	3
S0724	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	2
S0911	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	2
S0912	Yes	Yes	Yes	No	No	No	No	No	No	Yes	No	No	No	4
S0913	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	2
S0810	No	Yes	No	No	No	No	No	No	No	No	Yes	Yes	No	3
S1020	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No	No	Yes	5
S1008	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	2
S0914	Yes	Yes	No	No	No	No	No	No	No	No	Yes	No	No	3

Figure 5.3.1 Number of Most Prevalent Diseases

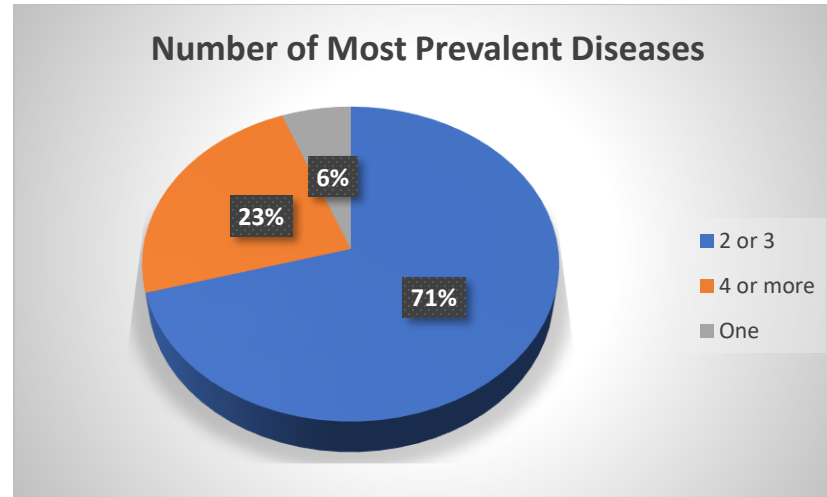


Figure 5.3.2 High Hitter Diseases

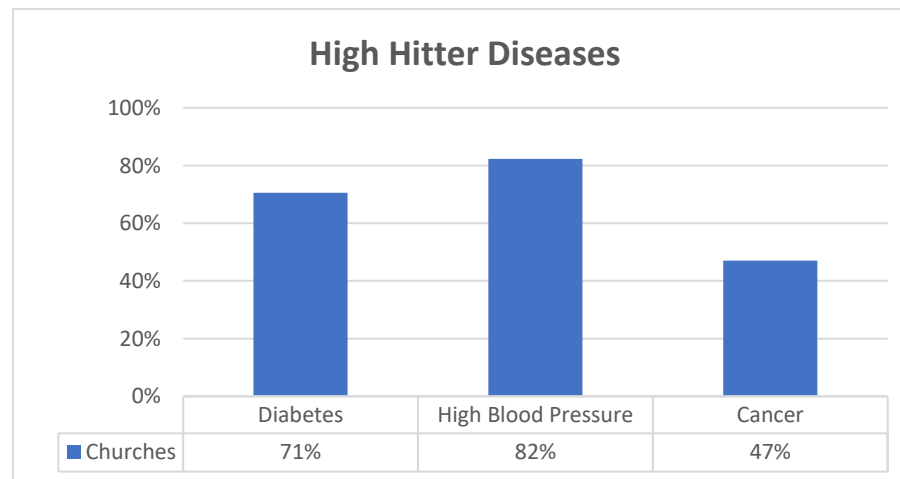


Figure 5.4 Churches Promoting Health/Wellness

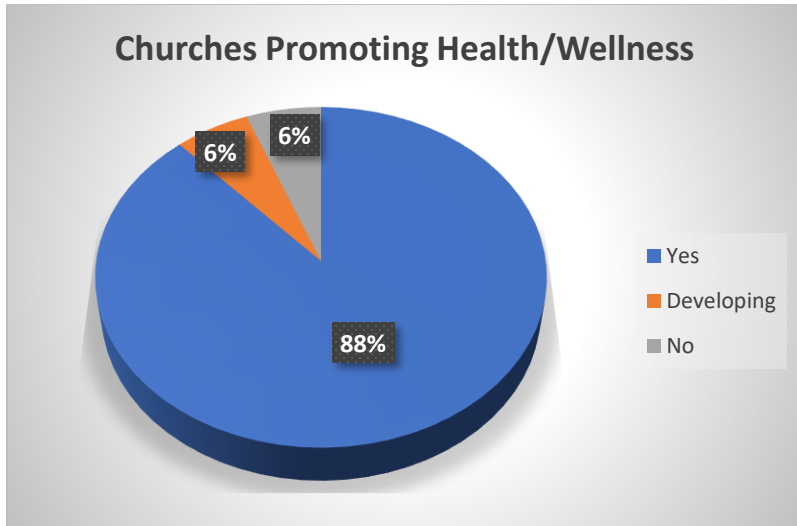


Figure 5.5 Strategies in Promotion of Health/Wellness

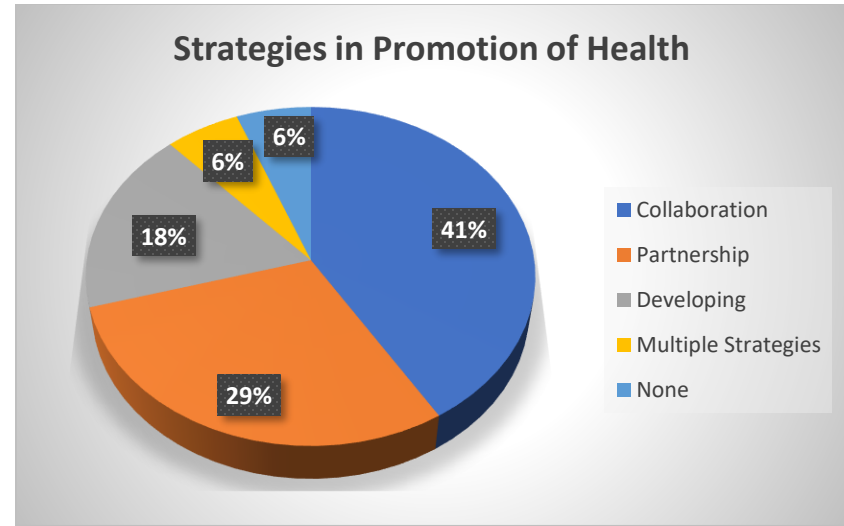


Figure 5.6 Churches Participating in Info Initiatives



Summary of Findings and Project Survey Results

Figure 5.1

Summary results of the Project Survey are represented in Figure 5.1. Survey IDs were assigned for confidentiality purposes. The first column is a listing of survey IDs. The next nine vertical columns coordinate with the questions from the project survey. Questions are summarized at the heading of the spread sheet with main theme words of the question. It is important to note that the questions coordinate with the questions on the survey. The most prevalent diseases shown in question #2 column have been abbreviated. As an example, Survey S104 list Type 2 D and High B P as the most prevalent diseases in the second column. Type 2 D is the abbreviation for Type 2 Diabetes and High B P is the abbreviation for High Blood Pressure. A more detailed summary of the abbreviated diseases is given in Figure 5.3. In addition, the complete spelling is given for each disease.

Patterns and practices of promoting health and wellness by the respondents are detailed in the project survey by means of chart and pie graphs. An example of a pattern, respondents overwhelmingly participate in health information initiatives. Health information initiatives or health campaigns are designed to increase health awareness of a disease, such as breast cancer. The pattern of this example is shown in figure 5.6. Specifically, 88% of the respondents participate in information initiatives.

The strategies practiced by the respondents promoting health and wellness is summarized in figure 5.5. Participants of the survey utilized collaborations, partnerships, and multiple strategies to promote health and wellness. As one example, 41% of the respondents employ strategies of collaboration for promoting health and wellness in their churches (See Fig. 5.5). On the other hand, the column #9 Lessons Learned gives a varied unique insight of each respondent.

As an example, respondent S1014 summarized the importance of having an “informed church” and respondent S0914 summarized persistency as a needed tool when promoting health and wellness in the church and community. Specifically, they said, “persistency pays off.”

The simplest initial questions of columns #1, #5, #6 and #8 which all begin with a “do,” “do you” or “does your” in most cases rendered a “yes” or “no” answer from the respondent. It is important to note that questions #5, #6, and #8 were designed with follow-up questions from the initial response of “yes” or “no.” As shown on the project survey table, figure 5.1, some respondents answered the question with an answer of “not sure” or “developing”. Developing means that the respondent is in the process of planning the activity or they are in the process of initiating the plan of the activity. During the survey and interview process of this study, participants expressed a desire to start or expand health and wellness initiatives in their churches and communities.

A summary of the results from the questions of the survey will be detailed on the next eleven pages.

Project Survey Questions

Question # 1-Do you have an active Health Commission, Nurse Unit, and/or health or some other wellness ministry? *See Figure 5.2 Active Health Commission/Ministry.*

Almost 60% of the respondents communicated an active Health Commission or Health Ministry operating in their church. The exact number is 59%. 23 percent said they were developing a ministry and 18% answered “no” to the question. This combines for a total of 41% indicating they did not have an active health commission.

Some of the respondents answered “no” with no additional conversation. Conversely, one respondent answered “yes” with a descriptive summary of their Health Commission. The respondent said, “Our wellness ministry consists of the Nurses’ Unit and Monthly Nutrition Class, and information/resource updates on wellness issues (holistic ministry-body, mind. Spirit) provided by Christian Education Ministry.” Another respondent described the persons administrating the Health Commission in their church. Their commission has a chair-person with a committee. The committee consists of physicians, nurses, an HIV/AIDS researcher and other persons who work in the wellness and medical fields. One respondent gave the name of the chair-person of their Health Commission. In addition, they described the work of their chair-person and their positive value to the health of the congregants.

It is important to note during the administration of the project survey, some of respondents initiated a conversational interview. During the interview, they gave thoughts about how a Health Commission would work in their church.

Question #2-What are the most prevalent diseases and conditions with which your members are afflicted? *See Figures 5.3 Most Prevalent Diseases in Church Community, 5.3.1 Number of Most Prevalent Diseases and 5.3.2 High Hitter Diseases.*

In this question 71% of the respondents listed 2 or 3 prevalent diseases with which their members are afflicted. Twenty-three percent listed 4 or more prevalent diseases. Six percent of the respondents listed one prevalent disease. See Figure 5.3.1 to review the findings.

Figure 5.3 provides a list of the diseases with a response coordinated from the survey ID’s. Figure 5.3 gives the full spelling from the abbreviated listing of the diseases in Figure 5.2. The diseases are diabetes, high blood pressure, cancer, depression, heart diseases, aging, lupus,

asthma, addiction, Alzheimer's, arthritis, COPD and mental illness. It is important to note, some of the respondents were more specific in listing the type or category of a disease. As an example, one respondent listed the type of cancer as prostate. In another example, one respondent listed diabetes as the disease and another listed Type 2 diabetes as the diseases with which their members are afflicted.

Figure 5.3.2 list diabetes, high blood pressure and cancer as the leading diseases plaguing the 17 churches participating in the survey. This pattern is visible in Figure 5.3, *Most Prevalent Diseases in Church Community*. Figure 5.3.2 is also labeled the High Hitter Diseases (HHD). This chart shows 81% of the respondents reporting high blood pressure as the most prevalent disease with which their members are afflicted. Diabetes is listed by 71% of the churches. Cancer follows in third place as the most prevalent disease with which their members are afflicted.

Question #3- What transportation challenges, if any, do your members experience in getting to a healthcare facility?

13 of the 17 respondents reported “none” as a response to transportation challenges. This is 76%. Some of the respondents detailed how adequate transportation is provided. Two respondents said most of the congregants in their church drive to their healthcare appointments. Another respondent communicated how adaptations are made to provide the needed transportation for the members and the community. Three mentioned the CCT transportation system as adequate transportation providers for their members getting to a healthcare facility.

Four out of 17 churches or 24% listed the transportation challenges their members experience in getting to a healthcare facility. One respondent is concerned with the amount of

time spent on transportation, the amount of waiting for public transportation and the distance the congregants must travel to get to their healthcare appointments. Another respondent listed accessibility to a vehicle as a transportation challenge. In addition, they listed the “distance of home from health facility” as a transportation challenge.

**Question #4-Where do your members receive information regarding health and wellness?
Where do your members receive information regarding disease prevention?**

Almost all the respondents listed a hospital or other organizations as places to receive information regarding health and wellness and disease prevention. 94% of the churches or 16 churches listed organizations such as the AARP and the AMEC Health Commission as organizations to receive health-related information. Two of the respondents listed the Senior Centers as places to receive health-related information. Four listed hospitals as a place to receive information.

In summary, the respondents use people, places and things/organizations to receive information regarding health and wellness and disease prevention. Human resources mentioned are non-professionals, Physicians and Health Professionals/Providers. The respondents receive their health-related information from the following places: Hospitals, Senior Centers, Workshops, Community Centers, Community Events, Local Clinics, Seminars, and Fellowship halls, Personal Care Facilitates, Gyms and Health Agencies. The listed things/organizations are the AARP, Sunday Bulletins, church and the Media.

Question #5-Do members of your community have access to healthcare and wellness services? If so, where are they?

28% of the respondents answered “yes” to this question. Three respondents were “unsure” or “not sure” where their congregants accessed healthcare and wellness services. Twelve respondents listed the names of places their congregants receive health and wellness services. Similarly, to question #4, the respondents listed a hospital or other organizations as places where congregants have access to healthcare and wellness services.

In general, the respondents listed places where their congregants receive health and wellness services. They listed the following places: Local Community, Healthcare Facility, University of Pennsylvania, local hospital, Main Line Health, Through Employment and Health Center. In addition, the respondents listed Health Systems and Medicare as where their congregants access their health services. It is important to note that the presentations of health and wellness were conducted in the church sanctuary and/or fellowship hall.

Question #6-Do you promote health and wellness in your church/and or community? If yes, what are your strategies and practices? How do you evaluate the effectiveness of your strategies and practices? See Figure 5.4 Churches Promoting Health/Wellness

88% of the respondents answered “yes” to this question. One respondent indicated they were developing a plan to promote health and wellness in the church and community. Conversely, another respondent answered “no” to the question. On question #7, the respondents listed the strategies and practices they used to promote health and wellness. Their strategies

employed collaborations and partnerships. On the other hand, they listed and discussed their strategies and practices for this question in practices over strategies. In other words, the respondents explained how they orchestrated their practices.

One of the respondents, explained his or her strategies and gave reflection on the valuation process of the program. They said, “Our outreach is through the church bulletin, occasional workshops, seminars and bringing guests from the medical field. We have not done a good job of evaluation effectiveness.” Another respondent said, “Yes, our practice is to conduct a presentation each quarter. In addition, promote health and wellness in sermons and announcements.” The publishing of information in the weekly Sunday bulletin was another response to this question.

Some of the responses to this question included their practice, the date of the practice and the location of other leaders to be trained. They said, “Yes. We coordinate with the mayor, Oxford Ministerium and other community organizations. For example, this Thursday, September 27, 2017, there is a “Let’s Talk About Drugs!” training for clergy, community and other leaders in Oxford, PA.”

One respondent organized a non-profit as a strategy to promote wellness workshops and seminars. The respondent gave the following statement, “We announce programs and services in our area, particularly for seniors. We have organized a new non-profit to promote wellness workshops and seminars to address the needs of seniors. We will evaluate by feedback from the participants.”

The evaluation of the practice of the strategy was included at the end of response to this question. As mentioned, one respondent will have the participants evaluate the effectiveness of

the program. Another one said, “We do not have an evaluation process or assessment to see how this service is impacting our members or stakeholders present, but one needs to be established.” One responded said, “We are working on a strategy to evaluate the effectiveness.” It is important to note that some of the respondents did not make a comment on the evaluation of the practices.

Question #7-What are your strategies for engaging coalitions, partnerships, and health initiatives to promote health and wellness in your congregations? How do you evaluate the effectiveness of your health and wellness initiative? See Figure 5.5 Strategies in Promotion of Health/Wellness.

The strategies used to promote health and wellness by the churches involved in the research engaged either a strategy of a collaboration or a strategy of partnership. Interestingly, 94% of the churches answered “yes” and listed the strategy engaged by the church. Forty-one of the respondents used a collaboration to promote health and wellness. A partnership to promote health and wellness was engaged by 29% of the churches. 88% of the churches were developing a coalition, collaboration or partnership to promote health and wellness. Six percent of the churches, which is equivalent to one church, engages multiple strategies to promote healthcare-related services. One church answered “none” to the question.

One respondent engaged a strategy of collaboration in the description of their practice. They said, “I will start with a health fair, with free screenings. I would also use Golden Years Group to bring in societies that address specific health care issues. The Golden Years Group is a support group for the senior members of the congregation and community. This group focuses on senior health issues, such as the process of aging. The Golden Years Group are responsible for providing health and wellness related information to the congregation through partnerships.

I will measure the effectiveness by counting the participants and those who have made contacts after the events.” It is important to note the evaluation process of this practice is measurable.

Another respondent described their strategy as a collaboration, they said, “we are currently collaborating with nonprofit organizations Pottstown Health and Wellness Program and Pottstown Trauma Informed Community Connection. They are in the beginning stages in creating a faith-based component to bring awareness and to help children who are suffering from trauma. Research tells us that trauma can come from various forms of abuse, incarceration of a parent, substance abuse, and neglect affects children’s physical and social development.” They had considered the evaluation of the program but did not give assessment details. “In 2019, we will know in the near future how the impact of the faith community can help us to uplift children and their families away from traumatic situations.”

The engagement of partnership was described by one of the respondents. In addition, they mentioned the evaluation process of the program would come from the participants. Specifically, the respondent said, “We are in partnership with the Frankford Hospital. This is where the health presenters come from. We have the members/participants evaluate the effectiveness of their presentations.”

It is important to note that some of the respondents discussed their strategy of engaging a collaboration or partnership but did not make a comment on the evaluation of the strategy.

Question #8-Does your church participate in information initiatives such as Heart Health Month in February? Are there other initiatives they have participated in? If yes, what impact do you think the information has on the health behavior of members in your congregation? If no, why don’t you participate? See Figure 5.6 Churches Participating in Info Initiatives.

88% percent of the churches participate in informative initiatives. One respondent communicated they did not participate in information initiatives, but they receive notifications regarding information initiatives in the mail. It is important to note they did not give a reason for their non-participation. Another respondent mentioned they did not have the time to participate in an initiative.

One of the information initiatives highlighted by one respondent is Breast Cancer Awareness Month. The respondent said they have a special testimonial by a current breast cancer patient. They have also done the testimonial with persons who have Sickle Cell Carcinoma. In addition, outside speakers are invited to cover presentations around the topics. The respondent communicated that the testimonials have a positive impact on the members experiencing the same diseases. Another respondent said, “the Breast Cancer and Alzheimer Awareness initiatives have a great impact on the congregants. In addition, they provide better choices with the reliable information.”

One respondent said, “information initiatives make persons aware of their health habits.” In addition, they said, “Walk-a-thons, HIV/AIDS and other initiatives are of great significance to the young and old. The congregants are excited to participate in the activities.”

The following is a list of other information initiatives mentioned as answers to question #8:

- The Annual Philadelphia Heart Walk.
- The Purple Bucket Challenge was adopted by the Alzheimer’s Association Delaware Valley.
- Prostate Cancer Awareness Month.

- Heart Health Awareness Month in February.
- Susan G. Komen for Breast Cancer.
- Mother’s Day Walk in Philadelphia.

Question #9-What are the lessons learned from your participation in promoting health and wellness in your church? How do you sustain your health and wellness initiatives? If you don’t participate in promoting health and wellness in your church, what would motivate you to do so?

All 17 respondents were able to provide a reflective answer of the lessons learned from their participation or consideration of promoting health and wellness in their churches and communities. Some of the participants gave multiple answers in response to this question. As an example, one responded with the following, “A vital part of doing effective ministry is an awareness of, as well as a plan to address various health and wellness issues that impact the community, including members. Sustaining health and wellness initiatives involves a multifaceted approach. In addition to the items mentioned above, we sustain health and wellness through Christian Education, Sermons, bulletins, website and Facebook. As the former father of the Allen African Methodist Episcopal Church frequently reminded me, “Your health is your wealth.” Effectively doing ministry means practicing self-care, which includes health and wellness, for both clergies, as well as laity.”

Another respondent answered, “We really don’t need much motivation as we witness the devastation that ignorance causes; however, it has to be a priority of the church and part of the church budget. Additionally, we are trying to start a wellness ministry which can be headed by someone with a medical background and has a passion for the people.”

One lesson learned in promoting health and wellness focused on the impact of reducing myths and stereotypes related to health. A respondent said, “Support has been promoted for individuals and families dealing with health/wellness issues. The stigma felt by some has been erased. Myths and stereotypes related to health issues are being erased. Members are feeling empowered to advocate on their own behalf and trusting others to advocate for them. Community has been provided with resources to assist in treatment, maintenance, and prevention. On-going bulletin blasts, e-blasts, and visits to the homebound by wellness ministry and outreach ministry have resulted in increasing quality of health and healthcare for the community.”

A common theme of lessons learned had a focus of being good stewards of our bodies and taking care of ourselves. One respondent said, “In 2018, God continues to call us to be stewards of our own bodies and take care of them for the benefit of his kingdom. Over the years, I have heard church leaders say, a great church is an informed church and I would like to add a great community is an informed community as well. It is vital annually for my church or any other local church to integrate health best practices in church goals and objectives.”

Developing a list of contacts and partners who share the importance of promoting health and wellness is a vital part in the planning of a health ministry. A respondent said, “I need time and to develop contacts for the church. As a result of this survey I realized that I did start a Grief ministry which is a part of mental health wellness. That is a result of 7 deaths in my church the first year of my assignment.”

Another lesson learned is the fact that no one is exempt from illness. This is a message which connects with everyone in the community, since illness early in life or during the aging process will happen for sure. One respondent said, “The lessons learned are, #1) no one is

exempt from illnesses. #2) everyone should get examined at least once each year. #3) People should at least know certain symptoms of various illnesses. #4) The sooner the diagnosis the greater the prognosis.”

The pastor plays a major role in the promotion of health and wellness in their church and community. It is the pastor who empowers the congregants and community to participate in the engagement of strategies and collaborations. On respondents said, “the pastor empowers health professionals to love God and serve his people.”

The following statements or summarized thoughts are other lessons learned from the respondents:

- “Understanding the actual health need is there to my taking greater participation as a pastor to my congregation.”
- Reminders about health information are important.
- People respond to messages from the pulpit.
- “It is difficult work to get people to change their habits.”
- “Pay attention to your body, on-going.”
- “As pastors, take care of yourself first.”
- “Members have a better quality of life from the information.”

One on One Interviews

The interviews were conducted with 10 clergy persons. The clergy persons were randomly selected from the 17 Project Survey participants. One of the central criteria of participation was determined according to the clergy person’s availability. The interviews were

conducted at the Christian Education Congress of the First Episcopal District on July 16-19, 2018 in Dover, Delaware and the Preacher's Retreat of the First Episcopal District of the AMEC on September 11-13, 2018 at The Poconos in Pennsylvania. It is important to note some of the clergy participants did their interviews immediately after completing the Project Survey.

The following criteria was used to determine the ten one on one interview participants:

- Have served as a pastor for 3 years in the AMEC.
- Have church membership of more than 20 congregants.
- Have expressed a willingness to promote health and wellness in their congregations.
- Have a willingness to participate in the interview.

One on One Interview Instrument

The following interview instrument was used for the One on One Interviews:

One on One Interview Questions

Community Served (congregates and broader community)

1. How many members are in your church? What is the mission of your church?
2. When new members join your church do you capture profiles for each member(s) including individual/community needs/challenges?
3. Do you track the number of members that you serve through benevolence or the sick and shut in that have health problems? If yes, do you track the type of health problems?
4. **Community**-Do you offer health and wellness programs to the broader community? If no, would you like to? And what are the barriers to offering health programs to the broader community.
5. **Church Congregation**- Do you offer health and wellness programs to your church members? If no, would you like to? And what are the barriers to offering health programs to the church members?
6. Describe the health and wellness programs offered in the surrounding community where your congregation resides.
7. Do you partner with groups outside of your church to offer health and wellness programs? If no, why not? If yes, please describe the groups and programs.

Health Promotion

1. How do you promote health and wellness among your congregation and or community?
Answer yes and no for each.

- a. Through sermons
- b. Offer health related Programs (health screens, group's education programs, walks/runs, health fairs, etc.)
- c. Disseminate Information on certain health topics
- d. Invite Guest speakers/announcement
- e. Partner health groups
- f. Other(s)_____

2. Do you have a desire to expand your health and wellness promotion efforts? If yes, How?
If no, Why?

3. If you answer yes to Question # 2 what tools and resources would you need to expand and or start a Health Ministry?

Interestingly, when comparing the responses to questions #4, #5, #6, #7, and #1 under Health Promotion, it was clear the answers would be redundant to answers given on the Project Survey. Therefore, the findings of the new information are not provided from the Project Survey, however they were summarized.

New information gained from the interviews highlighted the following topics: church, membership, church mission, tracking and profiles of congregants' health needs, desire to expand health ministry and tools and resources.

See the following questions:

Community Served (congregates and broader community)

1. How many members are in your church? What is the mission of your church?
2. When new members join your church do you capture profiles for each member(s) including individual/community needs/challenges?
3. Do you track the number of members that you serve through benevolence or the sick and shut in that have health problems? If yes, do you track the type of health problems?

Health Promotion

2. Do you have a desire to expand your health and wellness promotion efforts? If yes, How? If no, Why?
3. If you answer yes to Question # 2 what tools and resources would you need to expand and or start a Health Ministry?

The findings of questions #1, #2 and #3 under the heading, *Community Served (congregates and broader community)* and Questions #2 and #3 under the heading, *Health Promotion*, will be summarized from interviews. Figure 5.7 is one-page summary of the responses from the interview participants. An interview ID has been assigned for confidentiality. The next document is the one-page summary of the interviews.

During the Interview

During the interviews, their stories of promoting health and wellness employed an ethnographic skill from the interviewer, as the interviewees reconsidered their answers to the interview questions. Interestingly, during the initial answer to a question, a lightbulb came on in

his or her mind and produced a new answer within the same question. In other words, many of the questions caused a moment of reflection of their past or present experiences in promoting health and wellness in their churches and communities. In this process, the reflective answers changed their initial thoughts. In fact, some of the clergy were intentional in promoting health and wellness in their churches, but not in the name of a formal health and wellness program. In another case one clergy member communicated that they were interested in starting a health and wellness ministry in their church. They were in the process of communicating a negative response of not promoting health and wellness in the church during their career as an ordained minister. It was at that time the lightbulb came on. The interviewee begins to discuss with excitement of how they taught an aerobics class in the church years ago.

Question 5 of the interviewer asked the following regarding the church congregation.

Do you offer health and wellness programs to your church members? If no, would you like to? And what are the barriers to offering health programs to the church members?¹⁰⁰

Interestingly, the initial answer to the question was no. Specifically, the interviewee said, “I have not helped to offer health and wellness programs to the church members.” In addition, they begin to talk about how they would start a health and wellness ministry. There was a discussion about initially promoting healthy eating habits and the preparation of healthy foods as a beginning stage in a health ministry. Delightfully, it was before the last sentence came out of their mouth, a continuing sentence described their work as an aerobics instructor. The following statements details their discussion:

“A second choice health-wise would be to exercise. I used to teach. I used to teach in a senior citizens home with people in wheelchairs. I would teach them different things such as stretching and raising their arms and that might be a way I could implement it in the church. A stretching program to begin with. I was an aerobics teacher for years. I taught exercise in a salon. I’ve gone in the senior citizens homes to do stretching in the

¹⁰⁰ Question 5, One on One Interview

wheelchair and it was a pet peeve of mine as we were going through this survey, it is making me remember that there is something I can invite them to the church to experience by way of health and wellness. I can invite seniors to participate in this activity and then promote healthy eating. We are so busy feeding people at church, but why not for health reasons. This could be a way but stretching and exercising was my love and I believe I could do that even in this church in which I am presently serving. This could be geared towards senior members. When you mention exercise, people think mostly of jumping, running, and all of that, but there is a stretch program to keep ourselves healthy.”¹⁰¹

The conversation regarding exercise continued in question 7 of the interview. The interviewer asked a question regarding a desire to partner with outside groups to promote health and wellness efforts.

Do you partner with groups outside of your church to offer health and wellness programs? If no, why not? If yes, please describe the groups and programs.

During this question, the interviewee reflected and recounted her involvement in promoting health and wellness in the church. The following statements details their discussion.

*“I had a stretch class and aerobics class. I thought I implemented the class at my last church, since I operated this class in a church years ago. I was very popular. Some of the participants came from other churches and from the community. I did stretch aerobics classes even as a member of a church. I had a pretty good group and they use to look for me out of church when they saw me coming because I was such a general in keeping everyone on target during the class. It was a great time and great fun. It really worked, we had much success and I had a big group.”*¹⁰²

During this interview, while busy listening and recording, it was not necessary to ask additional questions in order to continue their conversation or to gain additional information as it pertains to the question. These questions seem to incite reflection which allowed the interviewee to take a second look at their experiences of promoting health and wellness. As

¹⁰¹ Question 5, One on One Interview, September 24, 2018.

¹⁰² Question 7, One on One Interview, September 24, 2018.

mentioned, much of the responses to the interview were given in story form as opposed to single sentences.

During the interview process of this research, the interviewer came to realize that many of the answers to the questions laid the foundation for health and wellness case studies. The reflections from the interviewed clergy in the West Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the AMEC provided strategies for the promotion of health and wellness in their churches and communities. In addition, it is important to note that their strategies were unique to their communities. As an example, one church was able to promote healthy eating by distributing free fruits and vegetables to the members of their church and community.

Interview Results

Figure 5.7 One on One Interviews

1:1 Interviews						
Survey ID	# Members?	Mission of Church	Capture Profiles?	Track -Sick/Shut Health Problems?	Desire to Expand?	Needed Tools and Resources?
IN0913	160	Commitment to Faith, Love and Commission	Yes	Yes	Yes	Partnership Developer
IN0927	89	Meet the needs of the church and community	No	Yes	Yes	Funding and resources
IN1009	74	Restore, Rebuild, Inspire and Lift Families	No	No	Yes	Time and Energy
IN1008	24	Reach Souls for Christ	Yes	Yes	Yes	Staff, Medical Background
IN1002	183	Strengthen Restoring, Reviving and Rebuilding	Yes	Yes	Yes	Staff, Nurses
IN0920	64	Save Souls, Change Lives!	Yes	Yes	Yes	Space, Exercise Program
IN0924	40	Restore to the promises of Jesus Christ	Yes	Yes	Yes	Use what they already have
IN1017	26	Christ can find you no matter where you are	Yes	Yes	Yes	Time and People
IN0912	160	Encourage people to live the Bible	Yes	Yes	Yes, Shelter for Wom.	Building
IN1123	80-85	Minister to Physical and Spiritual Needs	Yes	Yes	Yes	Printer, Defibulator,budget

Community Served (congregates and broader community)

Question #1-How many members are in your church? What is the mission of your church?

As designed in the selection process of church size for the interviews, the churches varied in size of membership. The church with the largest membership has 183 congregants. The smallest church has 24 congregants.

The big church with a large congregation does not necessarily equate to having all the staff needed to promote health and wellness in the church and community. Conversely, a church with a small congregation may not have greater needs in staffing a health and wellness ministry. Interestingly in this study, both churches mentioned in the previous paragraph needed staff, medical professionals and nurses to administrate their programs.

It is possible to have a health and wellness ministry with a relatively small congregation. As an example, one interviewee with a membership size of 40 congregants discussed many ways they could implement a health and wellness ministry. The interviewee explained how they could implement an exercise program or a healthy eating ministry. They were able to vision a health and wellness ministry with participants from the community. The interviewee said, “use what you have.”

What is the mission of your church?

All 10 interviewees were clear in stating the mission of their church. They did not fumble through this question. Interviewees were visionaries when discussing their mission. The mission of the churches used similar words such as restore and rebuild. As an example, one interviewee said, “the mission of their church is to restore, rebuild, inspire and lift families.” Another interviewee said, “their church mission is to restore to the promise of Jesus Christ.”

Action words were main parts of the mission statements for participating churches. The action words were minister, meet, restore, rebuild, inspire, lift, reach, strengthen, revive, save, change, find and encourage. The action words were directed at the nouns in their mission statements. Participants mentioned nouns and description of nouns in the mission statements. Physical and spiritual needs, needs of church and community, families, souls for Christ, souls, lives, promises, you, people, commitment, faith, love and commission were the nouns given by the participants. With this thought in mind, the mission statements lay the foundation for clergy participation in the promotion of health and wellness in their churches.

The physical needs of a person are their health, wellness and well-being. Jesus ministered to the physical needs of the person before engaging about his or her future in the kingdom of heaven. Jesus restored a man's withered hand and restored a woman with an issue of blood. He restored a detached ear. He revived a dead man named Lazarus. Jesus lifted a man by his hand who was sinking in the sea. Jesus used his mobile pulpit to promote health and wellness to the persons in the community. He came with a mission to give life and to have it in the fullness of health and wellness.

Likewise, the mission statement of the church should be the driving force which causes clergy to engage in the ministry of promoting health and wellness in their churches and communities. One interviewee said the mission of their church is to, "Save Souls and Change Lives." Clergy persons in the church have a great opportunity to preach a sermon which saves souls and improves the physical life through the promotion of health and wellness.

Question #2- When new members join your church do you capture profiles for each member(s) including individual/community needs/challenges?

All interview participants answered “Yes” to this question. Interviewees were varied in their response to this question. Some of the interviewees gave responses which were proactive to the engagement of health and wellness. As an example, one participant answered, “Yes, we keep a list of attendance every Sunday, we talk about their health problems. In addition, we keep them informed of what is happening in the church.” Another interviewee said, “Yes, but certain data is recorded. The survey made me realize, we have not captured enough data. Medical issues are not recorded. We need to do a better job.” Clearly, their participation in this research caused them to reflect on their practices of capturing profiles of the members.

Question #3- Do you track the number of members that you serve through benevolence or the sick and shut in that have health problems? If yes, do you track the type of health problems?

In the AMEC there is a ministry called the Class Leaders System. The class leaders are mainly laity who are responsible for watching over members on their assigned list. In addition, they are responsible for watching over new members with special care. The responsibilities of class leaders can be found on page 91, in *The Doctrine and Discipline of the African Methodist Episcopal Church*.¹⁰³

Class leaders are used to oversee the health and well-being of the congregants on their list. Moreover, they are required to give a report of the health status and needs of the members

¹⁰³ African Methodist Episcopal Church, *Doctrine and Discipline*.

on their list. The report is given to the pastor and members of the health commission. This system is used to track the status of the sick and homebound.

During an interview, one participant gave a copy of their class leaders list. The list was coded with a color which coordinated with a condition or status of the members. The following categories were listed: Sick, Moved, Missing, Member, Active and Growing. To have a class leader report of the congregants which summarized their health status summary elated the pastor. Another interviewee used weekly tracking of the sick and shut-in through the engagement of the class leader system. Clearly, the class leader system can be used to track the health status of the sick, homebound, and missing congregants.

The sick and homebound list is developed from the class leaders list. A visitation from the pastor is the result of your name being placed on the sick and shut-in list. One said, “I myself will visit the members at least when I know they are in dire need. In fact, I will visit them at least twice a month.”

Health Promotion

Question #2- Do you have a desire to expand your health and wellness promotion efforts? If yes, How? If no, Why?

All interview participants answered “Yes” to this question. Moreover, the interviewees gave their reflections on the details of the expansion. One interviewee said, “I want to expand it with more organization. I am surveying the congregation to find members with nursing backgrounds. These persons will help me organize the health ministry.”

One interviewee is planning to expand their programs through a partnership. They said, “Yes, we are developing partnerships.” The interviewee continued and responded to question #3, regarding what are the tools and resources needed to expand the ministry. The interviewee said, “We are trying to create partnerships with local colleges and hospitals. We plan to develop our Golden Years Program, a Grief Ministry and Health Fair.” The Golden Years Program is a health ministry for Seniors. It was started by the interviewee’s mother 20 years ago. It is important to note the interviewee’s father was a senior pastor in AMEC when the Golden Years Program was implemented.

During the mentioned interview, it was the reflective thinking of answering question #2 which caused an interviewee to visualize another methodology for expanding their promotion of health and wellness efforts. The interviewee said, “The interview is making me realize that there’s another methodology to bring people together.” The new methodology focused on the body as temple which must be maintained.

A methodical and well-thought-out plan is imperative to implement the promotion of health and wellness in the church. Previously, an interviewee expressed the need to be organized in their efforts of expanding a health and wellness ministry. In their mind, the interviewee outlined the necessary steps to plan a health and wellness program.

As previously mentioned, another interviewee used a similar process of mentally outlining their plan. The interviewee talked about the importance of people needing knowledge. They said, “Knowledge without Vision is when people perish.” First, they said, “I mentioned having a flea market and then inviting Healthcare professionals to come and offer health promotion information to people who attend the flea market.” Secondly, “I’d like to see seminars where people who have dealt with serious health issues, come in and explain what they

went through and how they overcame difficulties.” “Thirdly, I like to see small groups engage in dialogue about what people are facing. and then explore solutions together as a group.”

Question #3 of the interview asked, “what tools and resources would you need to expand and or start a Health Ministry?”

Question #3-If you answer yes to Question # 2 what tools and resources would you need to expand and or start a Health Ministry? *See Figure 5.7 1:1 Interviews*

In this question, one interviewee didn’t request any additional tools or resources to expand and or start a Health Ministry. They suggested using what you already have. In other words, build the health and wellness ministry with partners from the community. Utilize the skills and expertise of the congregants in your church and members around your community.

In summary, the requested tools and resources needed to expand a health ministry were characterized as time, energy, people, material and program. People were requested as staff with medical backgrounds, nurses and a partnership developer. Material was requested in the form of equipment, budget and funding. Time was requested as time. Program was requested as an exercise program.

The next chapter of this study will utilize time, energy, people, material and programs/ministry as key ingredients in the promotion of health and wellness by clergy persons. In addition, Chapter 5 will summarize the practices and effective strategies used by clergy promoting health and wellness in the West-Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church (AMEC). It is important to note the listed practices and effective strategies are supported by the practices and effective strategies highlighted in the literature reviews. Participants of this study are in the

process of evaluating the next step for determining the success and effectiveness of their health and wellness initiatives. Therefore the, sustainability, diffusion and institutionalization of the strategies were difficult to measure. Moreover, the one on one interviews did not include questions specific enough to capture the sustainability, diffusion and evaluation of the health and wellness strategies. This is an apparent flaw in the survey and interview instrument. In the final chapter, concluding thoughts and future initiatives will close this study of promoting health and wellness.

Chapter 6: Eight Effective Strategies for the Promotion of Health and Wellness

After reviewing research from the project surveys, one on one interviews, and the best practices from the literature reviews, the following eight effective strategies are recommended for clergy promoting health and wellness in the churches and communities of the West-Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church (AMEC).

Communicate Reliable Information about Healthcare Issues in the Weekly Bulletin

Reason 2: When people have reliable information about healthcare issues, they can be better advocates for themselves.

94% of the churches or 16 churches listed organizations such as the AARP and the AMEC Health Commission as organizations from which to receive health-related information. It is important to note, that the respondents organized the presentations and workshops to occur in the church and/or church grounds. Churches are places where congregants who may have transportation challenges to hospitals and health and wellness clinics can receive health related information in their weekly bulletins. This strategy provides the church community with another way to receive reliable health-related information.

Two participants of the project survey listed church and the Sunday Bulletin as places they receive information regarding health and wellness. One clergy member communicated they receive information partially from the church bulletin. In fact, they use the church bulletin as a supplement to other sources. During an interview on October 10, 2018, the clergy member displayed three Sunday Bulletins which contained Health and Wellness information. Another

clergy member of the same church explained that the Sunday Bulletin Health Corner has been their institutional practice.

During a health and wellness workshop, a CEO of a local health system stated, the church bulletin is a great tool to give reliable information regarding healthcare and wellness. In fact, the CEO is working on a plan to provide health-related information for church bulletins. The church's Sunday Bulletin is a place where a congregant can receive reliable information regarding health and wellness.

Create Collaborations, Partnerships and Coalitions to Promote Health and Wellness

Reason 1: Clergy promoting health and wellness in the African American community increases the effectiveness of health and wellness initiatives and programs within a congregation.

The strategies used to promote health and wellness by the churches involved in this research engaged either a strategy of a collaboration or a strategy of partnership. As mentioned in the previous chapter, 41% of the respondents used a collaboration to promote health and wellness. A partnership to promote health and wellness was engaged by 29% of the churches. A total of 70% of the respondents used either a collaboration or a partnership to promote health and wellness in the community. Collaboration is a strategy used by clergy in the promotion of health and wellness.

Literature reviews have shown great success by clergy using a partnership or a collaboration to promote health and wellness. A collaboration or partnership are category labels of the initiative or program. The programs or initiatives are the strategies used to promote health. Reason 1 claims that the initiatives and programs are successful when clergy promotes

health and wellness activities. 70% of clergy who participated in this study promote health and wellness as collaboration or a partnership.

A collaboration to promote health and wellness can be implemented with help from the community. Collaborations in the community requires a spirit of working together for the well-being of the community. As an example, one interviewee explained how they could implement an exercise program or a healthy eating ministry. They were able to vision a health and wellness ministry with participants from the community. The description of this health and wellness strategy is a collaboration. Finally, when a collaboration is promoted by a clergy person, the effectiveness of the strategy increases.

It is important to note that this strategy also supports, *Reason 3: When clergy is informed and supports researched based health and wellness partnerships, congregational trust of health intervention advice is increased.*

Share Personal Experiences

Reason 4: When clergy are informed and support researched-based health and wellness partnerships, congregational trust of health intervention advice is increased.

When a clergy member has a firsthand experience with a diseases or condition, they develop an increased awareness of the diseases. The clergy person becomes more knowledgeable of the challenges and patterns of the disease. Moreover, the clergy person is more passionate in helping others with the disease.

Clergy members who experience a disease or condition have more ownership of meeting the goals and objectives of the strategy or initiative. One interviewee connected their personal experience with the need to promote health and wellness as a survivor from an illness.

During the interview process, one participant described their firsthand experience of surviving a disease. The interviewee was passionate about the survivor seminar programs at the church. It is important to note that this ministry is effective and expanding because of their personal story with a disease. The interviewee said, “I would like to have more seminars where survivors of different conditions and diseases present their stories. In the past, we had cancer survivors and transplant recipients speak at the seminars.” Telling a personal story of being a survivor of a disease is an effective strategy. The stories are “seeds of hope” to others fighting the same diseases.

Determine What are the Most Prevalent Diseases and Conditions Which Afflicts the Health and Wellness of the Community

Reason 2: When people have reliable information about healthcare issues, they can be better advocates for themselves.

Diabetes, cancer and high blood pressure are the most prevalent diseases and conditions afflicting the members of the 17 churches. This information is highlighted in figure 5.3.2 of chapter 5. Seventy-one percent of the participants in the project survey reported diabetes as a prevalent disease afflicting their congregants. High blood pressure was reported by 82% of the participants. The disease of cancer was reported by 47% of the participants.

The process of designing a health and wellness strategy or initiative to initiate a strategy to reduce prevalent diseases in the community is effective. It is effective because it gives purpose to a strategy that intentionally targets a healthcare issue in the community. The purpose of a health and wellness strategy or initiative is to improve the health of persons afflicted with a

disease or condition. In addition, a prevalent disease such as diabetes can be a root cause of other diseases. Diabetes causes destruction to other vital organs in the body such as the skin and blood vessels. Therefore, one must determine what the most prevalent diseases in the church and community are before implementing a strategy to improve the health and wellness of persons in the community.

Data of prevalent diseases in a community can be found by employing a community survey. A less complicated method of receiving the same data can be achieved by visiting the local hospital. When the clergy of a church visits the hospital to meet with healthcare professionals, he or she are presented with an opportunity to form partnerships with that hospital. This strategy is effective because the clergy must do their own investigation to find reliable and accurate health-related information. One interview reflected on their partnership with a local hospital. After visiting the hospital to learn about disease prevention and health information, they formed a partnership. Presently, a professional from the local hospital visits the church regularly to give health and wellness presentations. Topics of diabetes and tissue damage are covered during the presentation.

The reduction of prevalent diseases and conditions which afflict the health and wellness of the community is an effective health and wellness strategy. This strategy gives clergy the opportunity to investigate the disease and condition.

At times, a clergy member must go through training in order to administrate a health and wellness strategy. An example of this thought can be found in the Body and Soul Program. This initiative focused on fighting obesity and health related diseases caused by making unhealthy food choices. The initiative trained pastors and lay members how to make better choices of food

consumption and preparation. Pastors were required to attend the training. In fact, clergy played a major role in presenting health information to the congregants and community.

Operate Through the Mission of The Church.

Reason 1: Clergy promoting health and wellness in the African American community increases the effectiveness of health and wellness initiatives and programs within a congregation.

Implementation of the mission statement of the church is a strategy for the promotion of health and wellness of the church and community. In the AMEC, “the mission of the church is to minister to the social, spiritual and physical development of all people.”¹⁰⁴ The mission statements of all 10 churches of the interviews used nouns and verbs which implied similar meaning to the words of the AMEC mission statement. The verbs or action words were minister, meet, restore, rebuild, inspire, lift, reach, strengthen, revive, save, change, find and encourage. The following nouns and description of nouns were mentioned in the mission statements: Physical and spiritual needs, needs of church and community, families, souls for Christ, souls, lives, promises, you, people, commitment, faith, love and commission.

The mission statements the churches of this study employ words that promote healing and wellness for the congregants and the community. As an example, the word “restore” carries the same meaning of returning to an original state. A person is made well again when their health is returned to its original state.

The physical needs of a person are their health, wellness, and well-being. Therefore, the promotion of the health and wellness ministry in the church must not be an afterthought.

¹⁰⁴ Church, 23.

Conversely, it is the fabric of the mission of the church. The mission statement of the churches of this study parallel the same mission followed by Jesus. It was Jesus who “ministered to the social, spiritual and physical development of all people”¹⁰⁵ within his presence. The mission statement of the church is an effective strategy for promoting health and wellness to the whole person.

Utilize Existing Tools and Resources

Clergy can promote of health and wellness in their congregations and communities by utilizing existing resources. This strategy emerged from the observation of how clergy employed existing tools and resources at their disposal. As an example, all clergy of the AMEC have access to the, “*International Health Commission Handbook, 2017*” of the AMEC. The handbook can be used to assist in developing health and wellness strategies. In addition, the IHC handbook provides a framework for organizing the health commission in the local church.

During the one on one interview, one interviewee didn’t request any additional tools or resources to expand and or start a Health Ministry. They suggested using what you already have. They said, “use what you already have.” In other words, clergy can utilize the skills and expertise of the congregants in his or her church.

One might assume the building of a new health and wellness ministry requires more staff, medical background, people and nurses to launch the new ministry. According to this research, others believe that new equipment, an expanded budget and additional funding are needed to start or expand new health and wellness ministries. During the study, the respondents were thoughtful and creative in requesting what resources are needed to start a health ministry. As the

¹⁰⁵ Church, 23.

researcher of this study, all clergy should obtain a copy of the, “*International Health Commission Handbook, 2017.*” The IHC handbook is available to anyone as a free planning resource of a health and wellness ministry.

All 17 participants of this study were engaging some level of clergy promotion of health and wellness in their churches and communities. The membership size of the church did not matter. The membership size ranged from a church with 24 members to a church with 183 members. The larger churches of this study participated in more health and wellness strategies and programs. Conversely, the smaller churches participated in fewer health and well-being programs and activities. Ultimately, the silver lining and encouraging news of the study found that clergy persons of any size church can participate in a health and wellness ministry. Use what you have!

Utilize the Class Leaders System

Clergy persons can promote health and wellness by utilizing the class leaders’ system. This strategy emerged from the observation of how clergy tracks the sick and homebound members of their church. The design of the class leaders’ system can be found in “*Doctrine and Discipline of the African Methodist Episcopal Church 2016.*”¹⁰⁶

The AMEC has a ministry called the Class Leader’s System. The class leaders are mainly laity who are responsible for watching over members on their assigned list. In addition, they are responsible for watching over new members with special care. The responsibilities of

¹⁰⁶Church, 90-91.

class leaders can be found on page 91, in the “*Doctrine and Discipline of the African Methodist Episcopal Church 2016.*”¹⁰⁷

The class leaders’ system is an effective strategy because it is used to oversee the health and well-being of the congregants. Moreover, they are required to give a report of the health status and needs of the members on their list. A report is given to the pastor and members of the health commission. This system is used to track the status of the sick and shut-in. The class leaders’ system is an effective strategy because it gives the pastor reliable information regarding the health status of the sick and shut-in members. One could argue that this thought is in line with reason #2 of why clergy should promote health and wellness in their churches and communities.: Reason #2 states, “When people have reliable information about healthcare issues, they can be better advocates for themselves.” On the other hand, the reversal of this claim is the fact that clergy persons become better advocates for their members when they have reliable information about their healthcare issues.

As mentioned in Chapter 5, during an interview, one participant gave a copy of their class leaders list. The list was coded with colors which coordinated with a condition or status of the members. The following categories were listed: Sick, Moved, Missing, Member, Active and Growing. The pastor of the church was elated to have a health status summary of the congregants in a class leaders report. Another interviewee used weekly tracking of the sick and homebound through the engagement of the class leader system. Clearly, the class leader system can be used to track the health status of the sick and shut-in and missing congregants.

¹⁰⁷Church, 90-91.

The sick and homebound list is developed from the class leaders list. A visitation from the pastor is the result of your name being placed on the sick and homebound list. The clergy member said, "I myself will visit the members at least when I know they are in dire need. In fact, I will visit them at least twice a month." It is important to note the participants of this study discussed how they utilize the class leaders list to track the sick and shut.

The class leaders list can be utilized by clergy to determine what the most prevalent diseases are which afflict the sick and homebound community. This practice or strategy gives accurate data for the determination of health and wellness initiatives. Therefore, the promoting of health and wellness by using the class leaders list is an effective strategy.

Operate Through Information Initiatives

Reason 1: Clergy promoting health and wellness in the African American community increases the effectiveness of health and wellness initiatives and programs within a congregation.

In the project survey, 88% of the clergy participants reported that their churches participate in information initiatives. One respondent communicated they did not participate in information initiatives, but they receive notifications regarding information initiatives in the mail. Another respondent mentioned they did not have the time to participate in an initiative.

Clergy's promotion of health and wellness by participating in information initiatives is an effective strategy. It is an effective strategy because there are a plethora of organizations, hospitals and medical centers who provide free health and wellness literature on information initiatives. In addition, civic organizations such as the LIONS Club are supporters of providing health-related literature. Recently, the District Governor of a local LIONS Club presented information regarding the diseases of diabetes. During the information initiative, the District

Governor discussed the connection between the disease of diabetes and diabetic retinopathy. Moreover, the presenter supplied health-related information about the disease.

Many of the interviewees are involved with multiple information initiatives. One of the respondents highlighted the importance of Breast Cancer Awareness Month. The respondent said they have a special testimonial by a current breast cancer patient. They have also done the testimonial with persons who have sickle cell. Outside speakers presented information on the topic of Breast Cancer. The respondent communicated the testimonials have a positive impact on the members experiencing the same diseases. Another respondent said, “the Breast Cancer and Alzheimer Awareness initiatives have a great impact on the congregants. In addition, they provided better choices with the reliable information.” One respondent said, “information initiatives make persons aware of their health habits.” In addition, they said, “Walk-a-thons, HIV/AIDS and other initiatives are a great significance to the young and old.

In summary, health and wellness information initiatives are one of the simplest methods of starting a health ministry. As mentioned in the previous paragraph, the presenters are members of the local church. Health related information is provided at no cost from local hospitals, medical facilities and civic organizations.

Chapter 7: Findings and Future Initiatives

The beginning of this research project was both a faith and learning journey. As mentioned in Chapter 1, the research methodology included qualitative data, quantitative data and bibliographic sources obtained by conducting clergy surveys and interviews. The findings gained from this study were informative, uplifting and puzzling.

The clergy participation rate of this study was uplifting. This is true because 50% of 34 churches participated in the study. That is an amazing effort of participation by clergy in the West Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church. The findings of this study were informative. As an example, the project survey found that cancer, diabetes and high blood pressure are the three most prevalent diseases afflicting members in 17 churches of the West Mainline and Philadelphia Districts. Furthermore, the three most prevalent diseases afflicting members in the 17 churches gives clergy a stalwart “arrow” of what the promotion of effective health and wellness strategies should target. A finding of this study was puzzling for the fact that HIV/AIDS was not communicated by clergy as a most prevalent disease afflicting their congregants and communities. In addition, the epidemic proportions of mental health and suicide in our communities did not show up as diseases most afflicting our churches and communities.

Another finding of this study found that all the participants were willing to promote health and wellness in their churches and communities. This fact demonstrates the willing “hearts” of the 17 participants, to improve the quality of life of their congregants and communities they serve.

During the one to one interview, ten clergy members were able to communicate their willingness to promote health and wellness in their churches and communities. These participants were randomly selected, but ultimately it was their desire to participate in the interview which determined their selection. The scheduling of their interviews came with some challenges but it was part of the journey.

The journey of this work has been a glorious faith walk because it has provided effective strategies and practices the 17 clergy participants use in promoting health and wellness in their community. This journey has been a glorious faith walk because the participants' effective strategies of promoting health and wellness in the community mirror the effective strategies of the literature reviews. In addition, the effective strategies support the four reasons why clergy should promote health and wellness in their churches and communities. The four reasons are listed below:

Reason 1: The Health Commission of the AMEC mandates the “denomination to be a healing faith community and to promote the health concerns of church members and surrounding communities.”¹⁰⁸

Reason 2: Clergy promoting health and wellness in the African American community increases the effectiveness of health and wellness initiatives and programs within a congregation.

Reason 3: When people have reliable information about healthcare issues, they can be better advocates for themselves.

¹⁰⁸African Methodist Episcopal Church, *The Doctrine and Discipline of the African Methodist Episcopal Church*, 50 Edition (Nashville, Tennessee: The Reverend Rodrick D. Belin, 2016), 234.

Reason 4: When clergy are informed and support researched-based health and wellness partnerships, congregational trust of health intervention advice is increased.

This study provided other effective strategies for clergy promoting health and wellness. Some of the strategies focused on the transportation challenges of congregants arriving to their scheduled medical appointments. Another strategy of addressing health care issues came with a name. The name of the initiative is the Golden Years Group. This health and wellness initiative has been strategically focused on the quality of life for seniors for over 20 years. The sustainability of this initiative is admired throughout the community. One might ask the question, “What has kept the Golden Years health and wellness strategy working for so long?” The next section will provide some light on this question. In addition, the study will review the evaluation and sustainability of health and wellness strategies mentioned in this project.

Sustainability and Diffusion

One must measure the effectiveness of a health and wellness interventions strategy through a lens of sustainability and diffusion. In the conclusions and recommendations of the article, *The Praise Project: A Church-Based Nutrition Intervention Designed for Cultural Appropriateness, Sustainability, and Diffusion*, the authors state, “It is imperative that community-based lifestyle change interventions designed to promote health and prevent disease are designed for long-term sustainability, so that they will not fade after the researchers complete their task.”¹⁰⁹ The authors go on to say that effective health and wellness initiatives diffuse into

¹⁰⁹ Ammerman et al., “The Praise! Project.”

the community. In other words, the health and wellness ministry goes beyond church walls. It spreads the health and life changing ministry into the homes of the community.

These words around the topics of sustainability and diffusion were discussed in Chapter Three. After discussing the details and definitions of both words, these concepts are the evaluative tools for assessing the effectiveness of the health and wellness initiatives from the project surveys and one on one interviews.

In review, “sustainability is defined including five constructs: (1) *after a defined period of time, (2) the program, clinical intervention, and/or implementation strategies continue to be delivered and/or (3) individual behavior change (i.e., clinician, patient) is maintained; (4) the program and individual behavior change may evolve or adapt while (5) continuing to produce benefits for individuals/systems.*”¹¹⁰ Diffusion is defined as “the potential of the intervention design that make it possible for dissemination to other interested churches by those churches where it has become institutionalized.”¹¹¹

Since the one on one interviews did not include specific questions regarding the sustainability, diffusion and evaluation of the health and wellness strategies, the project survey did include a question pertaining to the evaluation of a health strategy or initiative. The second part of question #6 asks the question, “How do you evaluate the effectiveness of your strategies and practices. In retrospect, question #6 should have drilled down more and asks the question, “How long has the strategy been effective?” or “When did this strategy reach the community.” or “Does the strategy extend into the community?” This is an apparent flaw in the one to one interview questionnaire and the project survey. Nevertheless, some of the interviewees gave thought to how they evaluate health and wellness practices.

¹¹⁰ Moore et al., “Developing a Comprehensive Definition of Sustainability.”

¹¹¹ Ammerman et al., “The Praise! Project.”

One interview said, “I would also use Golden Years Groups to bring in societies that address specific health care issues. I will measure the effectiveness by counting the participants and those who have made contacts after the events.” It is important to note the evaluation process of this practice is measurable.” Another interviewee communicated that their health and wellness partners count the number of people screened during their health fairs. One participant indicated congregant and community attendance at the event is the evaluative measure for a successful strategy.

Many of the participants indicated that they were working on a process for the evaluation of their health and wellness strategies. Another participant said, “we have not done a good job.” One interviewee indicated that they have no reported statistics of effectiveness of strategies. On the other hand, they have received reports from the recipients of the strategies.

The Golden Years Group strategy is the only strategy in which the clergy person communicated the sustainability of their program. This health and wellness initiative has been strategically focused on the quality of life for seniors for over 20 years. It is important to note other clergy participants promote health and wellness strategies beyond the church walls.

As previously mentioned, during an interview on October 10, 2018, a clergy member displayed three Sunday Bulletins which contained Health and Wellness information. The placing of Health and Wellness information in the Sunday bulletin has become an institutional practice.

Research Awareness of Evaluating Health and Wellness Programs According to Other Experts

Ideally, the effectiveness of health and wellness initiatives should be the determinant whether it becomes part of the permanent church ministry. Health and wellness initiatives should change according to the health needs of the congregants and community. In addition, the effectiveness of health and wellness initiatives should be measured by its impact on the health and wellness of the congregants and community members. Robert John Adams, In the article, *Improving Health Outcomes with Better Patient Understanding and Education*, suggest the, “Evaluation of the effectiveness of programs and their impact on public health is difficult to establish.”¹¹² This statement is true because other factors influence a person’s health such as social determinants.

Therefore, the evaluation of the promotion of health and wellness can be evaluated in terms of its sustainability and diffusion in the community. At the same time, Adams suggests that “health literacy which is the capacity to seek, understand and act on health information,”¹¹³ is another method for evaluating the effectiveness of health education programs. As previously mentioned, in the publication, *The Role of Religious Leaders in Health Promotion for Older Mexicans with Diabetes*, suggests when clergy is involved in the promotion of diabetes interventions, older Mexicans are more successful in self-management of the disease. Likewise, Adams says, “Interventions to improve self-care have shown improvements in self-efficacy, patient satisfaction, coping skills, and perceptions of social support.”¹¹⁴

¹¹² Robert John Adams, “Improving Health Outcomes with Better Patient Understanding and Education,” *Risk Management and Healthcare Policy* 3 (October 14, 2010): 61–72, <https://doi.org/10.2147/RMHP.S7500>.

¹¹³ Adams.

¹¹⁴ Adams.

Conclusion and Future Initiatives

In summary, when reading comments from the project surveys and interviews, one could tell something positive and effective is happening in the promotion of health and wellness in the local churches and communities. Clergy members in this study are committed to promoting health and wellness in their churches and communities. The fact that 50% of the pastors in the West Mainline and Philadelphia Districts eagerly participated in this study shows their desire to engage in a discussion of promoting health and wellness in their communities.

As this research comes to an end, it is both a faith and journey learning experience. The beauty of the journey was discovered in the statistical from Chapter 4 in which three high hitter diseases were made known. The diseases of high blood pressure, diabetes, and cancer are preventable if health and wellness strategies are engaged to confront the disease. Another beauty of the journey is the eight effective strategies for clergy promoting health and wellness in their communities. The finding of the eight strategies for clergy promoting health and wellness came from the results of the project survey and the one on one interviews. The promotion of health-related information printed in the Sunday Bulletin was a discovery from this study. Another discovery was found in the question, “how can we crystalize an evaluative instrument to determine the effectiveness of health and wellness initiatives?” When summarizing responses from the surveys and interviews, it became clear that more work is needed in the evaluation process of health and wellness initiatives. In summary, the participants expressed a desire to spend more time in the future on an evaluation process to determine the effectiveness of their health and wellness strategies.

This research caused the participants to reflect on their practices of health and wellness. It was during the time of reflection that the clergy participants discussed with creativity new

possibilities of promoting health and wellness in their churches. It was a refreshing moment to hear a clergy member discuss how the class leader's system of the AMEC is used to track the health and wellness of the congregants in their church. Nevertheless, the journey of this study was not always beautiful, but it has been a learning experience.

The learning experience has been challenging. As an example, the project survey and one on one interviews did not produce an effective instrument for measuring the effectiveness of health and wellness strategies. Another challenge of the research findings was the fact that certain diseases were not mentioned by the participants. There is an assumption that this study would identify obesity as one of the most prevalent diseases. Obesity which is a major health condition in the African American community was not listed as a most prevalent disease. One of the major challenges of the research was the fact that no clergy member in both districts communicated to be a member of a coalition. This is a challenge because coalitions typically fight for healthcare equity in the community. Nevertheless, there is faith that clergy people are equipped with the reasons for promoting health and wellness in their congregations and communities. Clergy people visit the sick, homebound and hospitals several times each month. It is a tradition of the AMEC visit to give communion to the homebound members. During the visitation period, the health and wellness needs the congregant becomes evident with their visible condition and the verbal discussion of their health needs.

The process of this research provided a space for clergy members to discuss their health and wellness needs of members in their church and communities. This is important because clergy members have few opportunities to discuss the needs of their churches with one another. It is a blessing in knowing that this study and conversations with the participants of this study

may provide clergy with an effective strategy to prevent a congregant or community member from experiencing an untimely death.

Untimely Death and HIV/AIDS

As mentioned in Chapter 1, when the health ramifications of a disease such as HIV/AIDS are not addressed in our community, persons in our communities experience untimely death. With this thought in mind, during the survey and interview process, HIV/AIDS was not communicated by clergy as a most prevalent disease afflicting their congregants and communities. The finding of HIV/AIDS not being a most prevalent disease afflicting their members was puzzling because current national data trends communicate the African-American Community infected with HIV/AIDS at disproportionate levels compared to the general population in the United States. The 2016 Book of Discipline outlines in detail the curriculum for HIV/AIDS training and education. It is true that this research does not document the new reported cases of HIV/AIDS in the communities served by churches in the West-Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church (AMEC). However, The Book of Discipline mandates training because this disease is so prevalent in the African-American Community. This training gives, “practical ways religious leaders can help to eliminate HIV infection, AIDS and death from AIDS-related causes.”¹¹⁵ Moreover, the information pertaining to HIV/AIDS in the 2016 Book of Discipline more than doubles the information pertaining to the purpose of the Commission on Health. As mentioned in Chapter 1, the HIV/AIDS pandemic is a prevalent disease in many of our local neighborhoods. Therefore, HIV/AIDS education and training must be a health and wellness promotion of every AMEC in our communities.

¹¹⁵ Church, 235.

Wider Implications of This Research

Just because this research was conducted in the West-Mainline and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church (AMEC) does not mean that the results only apply to African Americans or other groups of color. As mentioned earlier, several studies point to Diabetes as a leading chronic disease in the African American community. Diabetes is the disease in our communities, but another glance of the disease would cause an investigation into why our community is plagued by the disease. Social determinants such as the unavailability of healthy food choices can be a shared social determinant. The unavailability of healthy food choices can be a shared social determinant with other ethnic groups and economic classes of income.

The fatty selections, lower quality meat selections from the pig and wings from the chicken were prepared by African Americans for daily consumption. African Americans received the last or the spoiled part from every food choice because of their poor economic status. Other persons such as poor whites received the same choices of food because of their low economic status. Likewise, poor whites used the leftover meat selections to prepare delicious meals for their families. In addition, they used an unhealthy choice of lard to prepare the meals. Many of these families passed down their recipes of the foods to their children. Therefore, both families and ethnic groups experience some of the same diseases such diabetes. Yes, this research can be applied to other ethnic groups which share the same history of preparing food with lard. In fact, all persons regardless of faith tradition, no tradition or ethnic background can benefit from this research. This is true because diseases, poor health and challenging economic

times can afflict all persons in the community. Therefore, clergy people in the community are blessed with a great opportunity to preach wholeness and healing to all within their reach

The African Methodist Episcopal Church in Conversation with Health and Wellness

Church has always been a place where a person can experience healing from the challenges and injuries of life. The daily spiritual challenges experienced by a person, presents the daily chore of moving forward with the new mercies given by God each morning. In the church, it becomes a difficult task for a congregant to move forward when the preacher's sermon is solely focused on the spiritual healing within the body, while invalidating the physical illness of his or her body. In fact, when the mission of the church does not speak to the physical well-being of the congregant's body, a healing of wholeness cannot be achieved. In other words, the mission of the church must be in conversation with the health and wellness of the church body for the church body to experience wholeness and well-being. With this thought in mind, the African Methodist Episcopal Church was formed to provide this very conversational connection with the physical needs of the congregants and the community.

In 1814, Richard Allen founded the African Methodist Episcopal Church to minister to the well-being of the whole person. He realized the physical body of a person needed to be ministered to and cared for. In Philadelphia, Pennsylvania, former slaves and runaway slaves attended church services which provided sermons which only addressed the spiritual conditions of their bodies. The preacher and the members of St George's UMC overlooked the pain, damage and physical neglect of their bodies caused by the torture of slavery in the United States of America. As a former slave, Minister Richard Allen addressed the pain and agony caused by the physical abuse of their bodies. Bishop Richard Allen did not seek revenge for all of the pain

and torture received from the system of injustice. Conversely, he demonstrated love to humanity by ministering to the healthcare needs and well-being of all people in the community.

In 1793, Minister Richard Allen and Minister Absalom Jones, founders of the Free African Society helped the white community of Philadelphia afflicted with the disease yellow fever. Richard Allen's wisdom of caring for the physical needs of all persons is a common belief of what it means to be an AME. With this thought in mind, I emphatically believe the grace of the AMEC is embedded in the mission of the church. The mission of the AMEC is in conversation with the spiritual, emotional and physical needs of the congregants and the community. When reflecting on the wisdom that Bishop Richard Allen deposited in the AMEC and the churches in the United States, I am encouraged. I am encouraged because when following his footsteps, I see the historical calling of the AMEC. Bishop Richard Allen's calling addressed the physical injustice of slavery experienced by the black community to the dreadful disease of yellow fever experienced by the community of Philadelphia, Pennsylvania.

When reflecting on the wisdom of Bishop Richard Allen regarding the present physical needs of the AMEC and community, I am encouraged. I am encouraged because the AMEC is alive, well and able to combat the physical health and wellness challenges of persons in the community afflicted with the dreadful diseases of diabetes, high blood pressure, heart disease, cancer, mental illness and HIV/AIDS. Truly, caring for the well-being of all persons in community is what it means to be a member of the African Methodist Episcopal Church.

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Appendix A-Informed Consent Form

Informed Consent Form

Doctor of Ministry- Major Project

Lancaster Theological Seminary

Hello, my name is Linwood M. Smith, Jr. I am a student in the Doctor of Ministry Program at Lancaster Theological Seminary, located in Lancaster, Pennsylvania. I am conducting interviews for my dissertation project. My project investigates the role of clergy in promoting health and wellness in the West and Philadelphia Districts of the Philadelphia Annual Conference of the African Methodist Episcopal Church. Your support of this research is needed by helping me bring together information on “what are the most effective strategies for promoting health and wellness?” In addition, this research will capture what motivates clergy to participate in the health and wellness conversation.

Your participation is voluntary. You can refuse to participate or stop taking part at any time of the survey without giving any reason and without penalty. You can ask to have all the information related to your participation and input removed from the research records or destroyed.

There is no expected harm or discomfort, either psychological or physical, to the participant. You do not have to answer a question or complete a task if it causes you to become uncomfortable.

Should you choose to take part in this project, you are encouraged to respond freely and openly. The survey will take approximately between 45 to 60 minutes to complete. There are no “right” answers except those you offer I will compile this information for use only in my doctoral project and will not share this data.

I will be taking notes on our conversation and recording it with an audio recording device. In addition, in any case, what you say will be kept confidential. Your real name will not be shared in my reporting on this project and actual voice recordings will not be used in class. I will use synonyms to protect the confidentiality of the participants. The data will be stored on my personal computer. In addition, the information will be stored on zip drives and printed as paper copies. This information will be placed in a locked file cabinet in my home office.

There are no direct benefits for those who participate in this project. And there are not foreseeable risks or discomforts that will result from your participation in this survey.

Should you have questions, comments, or concerns of any kind, you can contact me personally at 484-889-8886 or lmsmith@lancasterseminary.edu you may contact my project advisor Reverend Dr. David Mellott at dmellott@lancasterseminary.edu or the Chair of the Doctor of Ministry Committee, Dr. Anne Thayer (athayer@lancasterseminary.edu) or (717) 290-8721.

This project has been reviewed and approved by the Franklin & Marshall Institutional Review Board. Questions concerning your rights as a participant in this research may also be addressed to Marcus Thomsen, Ph.D., Office of the Provost, 102C, Old Main, marcus.thomsen@fandm.edu, (717) 358-4283.

Thank you for being part of my project.

Signatures:

Interviewer: _____ Date: ____/____/____

Interviewee: _____ Date: ____/____/____