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Community Health Promotion: The Church as Partner

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The purpose of this paper is to review the literature relative to church-based health promotion programs to assist health professionals in establishing effective prevention alliances with African-American churches. While the literature describing the role of churches, particularly African-American, is limited, the available evidence supports the assertion that many churches are engaged in providing primary prevention, preventive health, and social services to at risk populations. Two mini-cases, illustrative of programs which have been reported in the literature, are presented. What each program had in common is an alliance between ministers, health professionals, and trained church volunteers. Pastors acted as gatekeepers and advocates for a health program. The health professionals served as consultants (particularly in technical design, training, and evaluation). Interested church members, once trained, conducted health programs serving themselves, fellow members, and their community.

KEY WORDS: churches; wellness; prevention

INTRODUCTION

African-American health status indices are not encouraging. The gap in life expectancy between whites (75.4 years) and blacks (69.4 years) began

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to widen in 1986, after narrowing since 1970 (Department of Health and Human Services, 1991, p. 11). About nine percent (i.e., 8.7%) of African Americans report fair or poor health status, resulting in 16.7 limited activity days per person per year. The data for whites are 5.8 percent and 14.7 days (Ries and Brown, 1991). African-Americans are more likely to be without health insurance than whites, 20.2 compared to 12.8 percent (Ries, 1991). As a result, African-Americans made fewer primary care physician office visits in 1990 than whites, 2.1 versus 2.9 visits per person per year (Schappert, 1992). The overall low birthweight (LBW) rate, with minor statistical variation, increased between 1981 (66.4/1000 live births) and 1991 70.8/1000) (Centers for Disease Control, 1994). The 1991 rate for African-Americans was 2.3 times that of whites (13.6 vs 5.8 percent) (National Center for Health Statistics, 1993b).

Almost eight million African-Americans have used marijuana, cocaine, and other illegal drugs at least once in their lives. African-American women are more likely to use crack cocaine than white women (National Institute on Drug Abuse, 1989). Nobles (1987) reported that for African-Americans 77 percent have smoked cigarettes; 86 percent have consumed alcohol; and 58% have used illegal drugs. For African-Americans 15-24 years homicide and legal intervention were the leading causes of death and for those aged 25-44, HIV infection was the leading cause of death in 1991 (National Center for Health Statistics, 1993a).

The above health status indices are outcome indicators which reflect health related conditions, many of which are preventable. For example, access to primary healthcare services such as counseling, physical exams, immunizations, etc. can be improved through the provision of health education services which encourage persons to seek out services or apply for health insurance. Many LBW risk factors can be eliminated or reduced, through primary prevention services such as prenatal care, proper weight maintenance, healthful dietary behaviors, and attention to stress related conditions.

The Year 2000 national health objectives call on health professionals to "prevent, not just treat, the diseases and conditions that result in premature death and chronic disability." (Healthy People 2000, 1991, p.8). To accomplish this charge, health professionals will need to develop alliances with community organizations and members. The purpose of this paper is to review the literature relative to church-based health promotion programs to assist health professionals in establishing effective working relationships with African-American churches.

WHY THE CHURCH?

The following discussion attempts to answer the question, "Why the Church?" The discussion describes (a) why a health ministry (a term used by many ministers) is a "natural" activity for a church; (b) reported church sponsored health related activities; and (c) reported effectiveness data. While rather limited, the available literature appears to be supportive of health promoting alliances between churches and health professionals.

A Health Ministry is "Natural" for the Church

Barnard (1983) asserted that there has existed a centuries old relationship between religion and health and in many cultures priests and/or priestesses acted as healers. Sevensky (1983) agues, "[i]f we take seriously the relationship between religion and health...then representatives of both realms (i.e., health professionals and religious persons) must see each other as allies in the service of the whole person." Segall, Wince, and Constant (1985) echo Sevensky's sentiment. Many local churches, individually and collectively, and entire denominations have recognized this relationship and have implemented health ministries for their members and the larger surrounding communities (Presbyterian Church, US, 1976; Hatch, 1981; Levin, 1984; Levin (1984); and Elder, Sallis, Mayer, Hammond, & Peplinski, 1989). Miller (1987) wrote, "since the church has historically been associated with health and healing, it is an ideal setting for health programs to take place...it is well known that religious institutions (churches) have a unique influence on the communities they serve."

Braithwaite and Lythcott (1989) cautioned, "[t]he health community needs to develop comprehensive and culturally sensitive approaches to address the complex and multifaced issues of minority health and wellness." They further write, "[b]ecause health behaviors are culture-bound primary prevention efforts must emerge from a knowledge of and a respect for the culture of the target community." In addressing the Braithwaite and Lythcott concern, Levin (1984) and Eng, Hatch, and Callan (1985) argue that the African-American church can provide an effective and culturally appropriate entry portal into the African-American community for primary prevention initiatives. Levin (1984) asserted, "[t]he black church is the most important social institution in the black community and is the conservator of the black ethos...the service ethic inherent in the black ethos is complementary to the communitarian ethic of community medicine...[t]hese fun-

damental assertions suggest a compatibility between the therapeutic role of the black church and the mission of community medicine." Eng, Hatch, and Callan (1985) add, "[t]he uniqueness of the black church as both a unit of identity and solution makes it a potentially effective unit of practice for health professionals."

In discussing the role of the African-American church in educating its members and the community about teenage pregnancy, Stevenson (1990) argued, "[p]revention and education programs need a community focus, because many adolescents may be gaining knowledge about teenage pregnancy but are without a supportive context within which this knowledge can take root." Hatch and Lovelace (1990) assert that "the church provides a setting for the exchange of news [information], social support, and resources." They further mention, referring to the African-American church, "[t]he church continues to play a significant role... in caring for the ill and giving support to families in times of crisis." Elder and colleagues found, "[t]hese organizations [i.e., churches] are an integral part of the fabric of community life for a huge proportion of the population, so their potential influence is vast" (Elder, Sallis, Mayer, Hammond, and Peplinski, 1989).

The Church is Actively Involved in Health Ministries

The General State Baptist Convention of North Carolina conducted a statewide campaign in 1,000 of its 1,700 churches to reduce the rates of morbidity (illness) and mortality (death) associated with high blood pressure, diabetes, and birth and early life survival (Hatch, 1981). Miller (1987) reported that the United Methodist Church has developed a denomination-wide health promotion campaign.

Sutherland, Barber, Harris, Warner, Cowart, and Menard (1989) described the health programs of a coalition of six African-American churches in north Florida. The churches in this coalition each operate separate health programs governed by a health committee composed of church members. These committees are responsible for planning, conducting, and evaluating their health programs. Health program activities included: screening, lectures, group events, quarterly health Sundays, and community health education.

In a 50 church survey, Elder and colleagues (1987) found that 100 percent of the churches had some form of a health ministry which was initiated by members (41%), church leaders (34%), or jointly (24%). Most activities (53%) were seasonal or periodic, 34% were ongoing, and 12% happened only once. One-quarter, of the churches planned to add new

activities. Activities included: (a) distribution of health related materials (4% of churches did), (b) one-session group meeting (58%), (c) two or more sessions (16%), (d) individual counseling (8%), and (e) attempts to change the environment through local policy development. Single sessions were typically lectures by guest speakers. Multi-session programs were typically taught by health related organizations.

Olson, Reis, Murphy, and Gehm (1988) surveyed 176 inner-city churches from 21 denominations to determine whether or not the church community would be willing to offer five types of maternal and child health programs. The results were: (a) advertise availability of health and social services (92.6% would); (b) work with schools on family life education programs (87.5%); (c) support programs for teen parents (80%); (d) day care for teenage parents (73.2%); and (e) lobby for increased preventive maternal and child health services (48.6%). Support programs refer to self-help and adult led groups to assist teenage parents. Preventive maternal and child health programs included prenatal care, well baby care, and other programs to help mothers and children. Olson and colleagues also found that the churches offered many other services that could be included in prevention programs. These were pastoral counseling (98.9% offered), food pantry (47.2%), clothing pantry (34.1%), soup kitchens (9.7%) and emergency shelters (4.0%).

The Church Appears to be an Effective Foci for Prevention Services

Churches have been effective in helping to reduce the ill affects of high blood pressure (hypertension), cholesterol, and excess body weight among their members and others who have participated in church-based or sponsored health ministries (Perry and Williams, 1981; Kong, Miller, and Smoot, 1982; Saunders and Kong, 1983; Wist and Flack, 1990). Appleby, Kocal, Filinson, Hammond, Prebis, Ellor, and Enright (1987) reported that a church-based mental health program was successful in helping care-givers of Alzheimer victims, thereby helping to preserve families and care for the aged ill. The reader is invited to review the above reports for more specific information as interest permits. For the reader's convenience two selected effectiveness reports (drug use/abuse prevention and nutrition education) are profiled. Effectiveness data on church-based prevention initiatives regarding cardiovascular health risk reduction are presented in two case histories to follow.

Drug Use/Abuse Prevention

Sutherland, Harris, Barber, Kissinger, Lapping, Cowart, Lewis, and Turner (1994) reported drug prevention program effectiveness data, drawn from the same six church coalition described earlier. Each church health committee conducted a thorough self-assessment of drug knowledge, attitudes, and behaviors for both their adult and youth members. Activity reports from the churches indicated that during the first service year: 300 persons participated in coalition training programs; 800 persons were involved in community education programs; 2,000 attended Health/Drug Sundays; and 700 persons attended formal seminars. A summer drug prevention program was conducted for 500 youth.

Using a time series (longitudinal), design drug use attitudes and behaviors were assessed. In 1991, Sutherland, et al surveyed 160 youth church members to establish a baseline for comparison. In 1992, the authors surveyed church youth (250) across the above behaviors. With respect to attitude shifts, the following was noted: (a) marijuana is harmful, +16.3%; (b) marijuana is not harmful, -15.5%; (c) drugs help reduce boredom, +2.5%; (d) drug use leads to trouble with the law, -2.9%; (e) drug use can lead to loss of friends, -3.3%; and (g) sleeping pills are drugs, +9.5%. The following drug use changes were documented: (a) smoked cigarettes, +3.9%; (b) smoked marijuana, -2.2%; (c) consumed beer, -6.2%; (d) consumed wine coolers, -5.5%; (d) consumed hard liquor, -4.2%; (e) chewed tobacco, -3.0%; and (f) used other drugs, -1.6%. While these data were not tested for significance (too early), they do suggest that the intervention was helpful in changing attitudes and most probably some behaviors.

Nutrition Education

Lasater, Depue, Wells, Gans, Bellis, and Carleton (1989) have reported on the effects of a nutrition education program whose purpose was the primary prevention of coronary disease. The emphasis was on the development and application of practical skills in reading nutrition labels, salt limitation, fat and cholesterol intake limitation, and enhancing the frequency of selecting or adapting recipes. These four behaviors, if adopted, will reduce one's risk for having a coronary or cerebrovascular event (e.g., heart attack or stroke).

Sixty-four church members completed the course taught by trained, certified lay persons (other church members). A matched comparison of 80 non-attending fellow church members was drawn. Subjects were matched on age and gender. Baseline measures were taken on the experimental group prior to the nutrition education series. Follow-up data were

collected one year later. Comparison group members were asked to recall behaviors at one year post instrument administration and to report current behaviors. All data were self-report. Data were collected via mail survey with telephone supplementation.

Under *F*-test analysis, neither, the experimental or comparison group differed statistically ($p > .05$) on age or gender. There were no differences between groups across each of the four variables (behaviors) at baseline. There were statistically significant differences between groups across each of the four behaviors at the one year follow-up ($p < .05$). Those participating in the nutrition education program were more likely to read labels, limit salt intake, limit fat and cholesterol intake, and select or adapt heart healthy recipes.

ROLE ANALYSIS

Presented below are two brief case studies whose purpose is to show representative roles and relationships (i.e., church members, ministers, and health professionals) which are typically found within church health programs. The first profile was part of a much larger effort called the Health and Religion Project which was operated by several churches and an university in Rhode Island. The second profile was operated in Durham, North Carolina by six local churches and a university. Additionally, the individual roles of church members, ministers, and health professionals are examined.

Profile 1: Church Site Weight Control

Health problem. Excess weight is a risk factor associated with cardiovascular disease. By reducing this controllable risk factor (i.e., losing weight), a person's chances of cardiovascular disease is reduced (Wells, DePue, Lasater, and Carleton, 1988).

Program methodology. In this program, weight control classes were offered in selected local churches. The course consisted of eight weekly one-hour sessions. Course sessions were usually held in the evenings on church property. After completing the class, "support sessions" were offered to those course participants who wanted to get together for mutual self-help and support. Trained, certified lay people conducted the classes and the support sessions.

Program evaluation. The effectiveness of the program was determined by comparing results with those from a comparison group. The comparison group did not receive the course or the support sessions. The program

helped participants lose 4.19 pounds as measured 12 months after course completion against a matched comparison group of nonclass attending fellow church members who reported a .6 pound weight gain. No statistically significant differences were found. The church-based program attracted people who had never participated in organized weight control programs. The attendance rate for class sessions was 80%.

Church members' role. Church members were recruited to become volunteer lay control leaders. The volunteers' training, under the direction of a health education specialist, lasted for 16 hours over four weeks. The volunteers were provided with a course manual with structured exercises and information handouts. There was no need to lecture. Volunteers were taught small learning group management techniques and necessary administrative procedures and forms. When the training was completed, a written examination was given. There were also demonstration segments concerning standardized methods for weighing course participants. Volunteers agreed to teach courses during the next year at their church.

Health professional's role. Health professionals approached the churches about participating in the program and conducted all of the training, including evaluation activities. The professionals provided consultation when needed.

Minister's role. The health professionals first approached the pastors by mail asking for an appointment. Once an appointment was secured, at least one of the professionals visited the pastor asking for cooperation in the health program, after a full explanation. Pastors who wanted to participate were asked to consult their church boards for approval. Most of the pastors approached agreed to participate. Pastors were then asked to identify or select at least one member who would serve as that church's lay weight control leader. According to Lasater et al, "[t]he primary roles of the pastors or priests in all of the...churches were to recruit the initial task force members, assist in arranging the training sessions, and act as advocates for the project and assure continuing evaluation."

Profile 2: Fitness Through Churches Health Problem

Health problem. Inadequate exercise is a risk factor for cardiovascular disease. Adequate exercise strengthens the heart muscle, reduces the ill effects of stress, and causes a loss of excess weight (Hatch, Cunningham, Woods, and Snipes (1986).

Program methodology. This project was funded by the American Heart Association and sponsored by the University of North Carolina, Chapel Hill. The project relied on a combination of cardiovascular education and

aerobic exercise. The education course, participants attended, provided information on heart healthy nutrition, smoking cessation, weight management, and blood pressure control.

Program evaluation. The church health instructors improved their flexibility (85%), body tone (90%), reduced blood pressure (50%), and lowered resting heart rate (40%).

Church members' role. Six churches contributed a total of 14 members to become course leaders. Instructor training consisted of 42 hours of instruction, demonstration, and testing. Instructional units consisted of CPR, aerobic fitness, and heart healthy nutrition content. Decision-making and problem solving skill development sessions were included. Instructors were cleared by their personal physicians. Instructors, completing the course (all did), were awarded certificates and participated in a graduation service held at a participating church. Instructors received continuing education. Aside from instructional duties, these volunteers were to act as advocates for the program and for healthier lifestyles in general. To help institutionalize the program within each participating church, a sponsoring church organization was sought. This was necessary if a local church planned to conduct any other health programs.

Health professional's role. Health professionals approached Durham's Ministerial Alliance. Prior to presenting the program to the Alliance, health professionals talked individually to most of the ministers about the health risks African-Americans face and the potential benefits of church-based health programs. The professionals designed and conducted all the training, consulted as needed, and provided continuing education. The professionals also provided a workshop for ministers.

Minister's role. Pastors of the participating churches attended a ministerial workshop where the program was thoroughly explained and ministers participated in an aerobic exercise session. The pastors suggested names for a community "Oversight Board." Pastors advocated for the program within their individual churches.

The Church Member's Role

Within the initiatives reported, church members (a) initiated programs, (b) served on management committees, (c) provided individual leadership, (d) acted as advocates, (e) provided services {after appropriate training}, (f) served as role models, and (g) assisted with the institutionalization of initiatives within church governance structures and processes. The key concept is that church members were trained, conducted their own programs, and were provided relevant technical assistance.

Sutherland, Barber, Harris, and Cowart (1992) described the usual role of church members in church-based initiatives. They wrote that representatives from six African-American churches, within a coalition, received content and process specific training, formed a church health committee (CHC), and planned and conducted prevention programs for their members and the surrounding community. This activity consisted a self-assessment; priority determination; and management functions (e.g., scheduling, funding, staffing, etc.). Services provided included: direct instruction, quarterly health Sundays, community education, blood pressure screening, and cooperative programs with other coalition churches and organizations (e.g., health department and American Heart Association). Training and technical assistance were provided by the authors.

The Minister's Role

As the spiritual and temporal leader of the local church, the minister is probably the most important person in determining whether or not, and to what extent, a church participates in a primary prevention initiative. Eng, Hatch, and Callan (1985) suggested that a minister's "fundamental task" is to determine strategy and what people to involve in the program. Miller (1987) believed that the "primary role of the ministers would be to initiate planning sessions for the program task force and act as advocates for the [health] project...[and] would be responsible for supervising continuing program evaluation." Stevenson (1990) wrote that the pastor, in addition to the above, should seek out needed professional assistance and network with local organizations which can assist the local church in its efforts.

Levin (1984) summarized Bruder's thoughts about the role of a pastor in church-based mental health services. According to Levin, Bruder saw the pastor as:

Role	*Description*
Church Liaison	"acting as a bridge between churchgoers and community health promotion efforts"
Provider	"being able to offer church facilities as loci for...health education interventions"
Social Change Agent	"getting individuals involved in their own health"
Policy Maker/Program Developer	"making sure interventions are culturally relevant and that they meet the needs of the clientele"

As revealed in the present paper, Bruder's taxonomy is appropriate for primary and other prevention initiatives. The minister plays the key leadership role in any church-based or sponsored initiative.

The Health Professional's Role

Braithwaite, Murphy, Lythcott, and Blumenthal (1989) have found the success of health promotion efforts (including prevention), within minority populations, is enhanced when "the community at risk is empowered to identify its own problems, develop its own intervention strategies, and form a decision-making coalition board to make policy decisions and mange resources around the intervention." The role of the health professional is to help facilitate such empowerment.

Health professionals most often approach local ministers or ministerial associations with a specific programming request for which they have sufficient funding (or at least seed money). Once a local church or church coalition agrees to form a partnership (or alliance), the health professional then assumes the role of consultant. Such consultant services have included assistance with or provision of: (a) community needs assessment, (b) training, (c) technical program design, (d) marketing, and (e) evaluation. In some partnerships, the health professional has had to raise funds. Health professionals seem to work through whatever internal governance processes exist but most often encourage the creation of a church health committee (or body of equivalent function), composed of church influentials, to plan, manage, and conduct prevention programs. The chief contact is usually either the chair of this committee or the church minister.

DISCUSSION

Following is an examination of (a) specific attributes that a health professional may employ when assessing prevention partnership potential of a local church or church coalition and (b) recommended strategies for building effective prevention partnerships.

Useful Church Attributes

Churches possess many attributes which will facilitate preventative and other health related initiatives. Lasater, Wells, Carelton, and Elder (1986) listed the following characteristics: (a) churches exist in all areas of the

country; (b) churches have a history of volunteerism; (c) churches can influence entire families; (d) churches "have a history of helping in a wide range of programs"; (e) members are likely to live near the church they attend; and (f) church members belong to many organizations throughout the community and can be role models. Eng, Hatch, and Callan (1985) reported that churches: (g) are composed of social networks (friends, families, choirs, women's or men's auxiliaries, committees, etc.) which are necessary for people to change values, behaviors, or develop new skills; (h) set norms and enforce a community's most positive values; (i) provide leadership development; (j) "provide a structured response to help its members through major transitions in life"; and (k) "serve as a unit of identity and solution." Additionally, Sutherland, Barber, Harris, and Cowart (1992) have pointed out that churches have: (l) organized governance structures, (e.g., committees, boards, etc.); and (m) established communications networks, e.g., newsletter, bulletins, etc.

Health professionals should find these attributes useful in assessing church candidates for alliance formation. The closer a local church or coalition personifies these characteristics, the greater should be the likelihood of a successful alliance. The characteristics, present in almost all African-American churches, form the supportive environment, as advanced by theory (Becker, 1974 Bandura, 1977; and Fishbein & Ajzen, 1985) needed to initiate, maintain, and successfully conclude changes in health values and behaviors in both church and community members.

Strategies for Building Successful Partnerships

The community development model outlined by Braithwaite, Murphy, Lythcott, and Blumenthal (1989) provides a useful discussion framework. They sequenced these steps: (a) learning the community, (b) understanding community ecology, (c) effecting the community entry process, (d) building credibility, (e) developing a community board, (f) conducting needs assessment, and (g) intervention planning.

Learning the community. Health professionals should be familiar with the local church's or denomination's theology, governance processes, and social teachings and behavior. This can be assessed by studying the church's community behavior, attending church services, and informally talking with members or the minister. Reading church or denomination materials may be helpful.

Understanding community ecology. Learning the physical layout of a local community, determining local issues and their importance, as well as

walking about the community will help understand local culture and values. Eating in local restaurants, attending sporting events or concerts, and having informal conversations with community members will also be helpful. Visiting the community around the church during different days and times will be very revealing. Learning which church and local organizations are active in the community will provide valuable insight. In some instances, it might be wise to have a local colleague along for company.

Effecting community entry. Hatch and Derthick (1992) have suggested the use of "cultural mediators" to "alleviate cultural suspicions" between health professionals and church members. Sutherland, Barber, Harris, and Cowart (1992) advise that a local community health representative or church minister are effective gatekeepers. It is important to learn who are informal leaders in the church and immediate surrounding community. These persons can be key allies or powerful adversaries. Consult extensively with formal gatekeepers concerning the informal power structure, especially its mores and values.

Building credibility. Hatch and Derthick (1992) have advised health professionals seeking to work with churches to ensure that (a) programs not conflict with core church values and strengthen the viability of the local church and (b) the principles of local decision-making, ownership, and empowerment be included in any programming request. Sutherland, Barber, Harris, and Cowart (1992) have suggested that specific steps be taken to develop trust between the church and health professionals. Such steps might include: (a) demonstrated respect for the minister and church members; (b) a reliance on the church's existing governance processes; (c) donating time to present a talk on a topic of interest; or (d) helping in a local fund drive or other local initiative. The health professional must demonstrate good will, respect, and positive regard for church members, the minister(s), and the surrounding community. The formal recognition of individual and/or group contributions will assist in building credibility.

Developing a community (church) board. In each of the reports presented within the present paper, local church governing boards have been present and strongly suggested. The minister is usually the person to name or suggest board members. This board should be the real authority over prevention partnerships, unless church governance requirements specify otherwise. To enhance the effectiveness of the church board, the health professional should (a) recognize that the church must be encouraged to pursue its own health agenda; (b) work with the board to develop clear role specifications; (c) have a willingness to start where the church is with respect to prevention services; and (d) begin with those topics that are of interest to the local church or coalition. The health professional may need

to help raise needed funds or be expected to provide adequate funding and/or arrange for board governance training. It is essential that the health committee be the policy making body for the prevention alliance.

Conducting needs assessment. Within this function, the health professional can assist board members to develop the competence to conduct a needs assessment study. Data collection methodologies can include key informant interviews, vital statistics review, surveys, or any other relevant methods. The health professional may need to tabulate and report findings. However, any policy decisions should come from the board. This is an excellent opportunity to build increased credibility and good will.

Intervention planning. During this phase, the recognition that the key role of the health professional is technical consultation (e.g., program design, staff training, technical support, and program evaluation) is most critical. It may be (and often is) necessary for the health professional to provide training sessions, manuals, technical consultation, and limited supervision. Whatever technical assistance is necessary, the goal should include at least these two objectives: (a) to provide competent prevention services and (b) to enable participants to replicate programming with maximum self-reliance.

CONCLUDING THOUGHTS

The church-based prevention literature is characterized by (a) few reports distinguishing between levels of prevention {e.g., primary, secondary, or tertiary}; (b) inconsistent nomenclature across reports to describe prevention activities; (c) mostly descriptive reports; and (d) few empirical studies examining the prevalence and/or effectiveness of church-based prevention initiatives. These conditions argue for substantial investigation into the prevalence, organization, and effectiveness of church-based prevention initiatives. However limited, the literature does provide at least preliminary evidence of successful and effective partnerships between African-American churches and health professionals.

Churches and other religious organizations represent a potentially productive avenue into American racial and ethnic minority communities. It is hoped that the perspective provided within the present paper will encourage and assist health professionals, particularly those involved in primary prevention, to seek out and build prevention partnerships with churches.

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