

Health Disparities, the Faith Agenda, and Health Promotion/Disease Prevention: The General Baptist State Convention of North Carolina Model

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Faith and Health and the African American Experience

As increased emphasis has been given to holistic health and lifestyle issues in American health and healthcare policy, faith-based entities are more frequently viewed, or acknowledged, as one of the “players.” The intersection of faith and health to address societal “ills” has a rich history. This health and healing agenda is strongly rooted in the African American experience. Historically, “the black church” has been on the forefront of this movement as advocate for education, health, and justice. C. Eric Lincoln, a noted theologian and historian of the black church in America stated: “To understand the power of the Black Church, it must first be understood that there is no disjunction between the Black Church and the Black community. The Church is the spiritual face of the Black subculture, and whether one is a ‘church member’ or not is beside the point.”¹

Prior to the more formally organized black church, religious ceremonies and worship services provided a mechanism for African Americans to come together in a setting that not only facilitated worship, but enabled “messengers” to carry out human rights and freedom agendas.² This agenda continued as the church emerged as a leading societal institution and is well documented during the Civil Rights Movement.

Self-help movements were encouraged since resources to address emerging health and social needs were always in short

supply. Various auxiliaries were established to facilitate the church’s health and social ministries. For instance, nurse aide groups consisted of women appointed to help the elderly and others coping with disabilities. At a time when many insurance companies considered African Americans a poor risk for life insurance, church affiliated mutual benefit and burial societies filled this void for service immediately after slavery and gave rise to the emergence of African American insurance companies. Services were not limited to church members, but were provided to every community member as acts of goodwill and good citizenship.

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Today, the need for grass-roots church and community activism continues. The gains the science community has made in health knowledge are not matched with successful modes of application. Faith-based initiatives, with several notable exceptions (e.g., the Seventh-Day Adventist and Mormon churches have focused on health promotion over many years), are at the pioneering level. To address today’s concerns and the greater emphasis on lifestyle

issues will require mobilizing diverse community partners and resources and shifting focus from sick care to “well care” or health promotion.

Morbidity and mortality data reveal the African American population is one of the leading disparate groups. While it is increasingly common for health service organizations to enlist the support of “the black church” in attempts to reach the African American community, most are limited in scope and frequently ineffective. These efforts generally do not meet the

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definition of partnership. For instance, churches may be requested to provide assistance by announcing the availability of important health and human services, displaying exhibits and/or distributing educational materials, participating in research, and/or conducting presentations on health-related topics. There may be beneficial outcomes from these activities; however, the impact usually falls far short of need and potential. Too often, services are provided in a manner that diminishes the possibility for participation in the planning and decision-making processes and do not enable sustainability, capacity building, and/or empowerment.

More appropriate use of faith-based resources will require changing the rules of engagement. To efficiently and effectively engage "the black church" as a partner in health promotion, requires an understanding of organizational leadership, structure, demographics, and faith orientation. There must also be a conscious awareness of past history and a willingness to accommodate. Partnerships should be based on cooperation, communication, commitment, clear understandings, trust, and caring.³ This model enables the development of working relationships that best use the strengths and resources of both churches and health advocacy organizations.

Early Scientifically-Designed Faith-Based Health Promotion Initiatives in North Carolina

One of the first scientifically-designed and evaluated health promotion initiatives utilizing black churches was a North Carolina project targeting diabetes, hypertension, and maternal and child health. Through the use of lay health educators, the project was designed to raise the level of technical understanding and to encourage beneficial lifestyle changes. This initiative, based in the Department of Health Behavior and Health Education of the University of North Carolina School of Public Health (UNC-SPH), led to discussions with the leadership of the General Baptist State Convention of North Carolina, Inc. (GBSC) and the founding of the Convention's Health and Human Services (HHS) Program.⁴

Health professionals provided technical knowledge during church-based training. Learning took place at two levels: (1) the lay leaders and (2) the health professionals. Lay leaders gained increased understanding of diabetes and hypertension, including current information regarding disease prevention and control and available disease-related resources. Healthcare providers met community leaders and learned about community perceptions of healthcare issues and concerns.^{4,6}

GBSC is a voluntary association of approximately 2,000 churches and 600,000 congregation members. Sixty-two geographically dispersed Associations facilitate the work of this statewide organization. It is estimated that, on any given Sunday, approximately half of the African American worshippers in North Carolina attend a GBSC church. In addressing health promotion issues within the African American community, GBSC and its churches build on an organizational structure that formally started in 1867. For instance, one of the lay health advocates presently involved with a Faith and Health Initiative,

is from the family of deacons that are direct descendents of her church's founder. The founder was a slave who gained permission to organize a church in 1838.

The first GBSC health promotion project was funded by Z. Smith Reynolds Foundation and focused on enabling selected church members/leaders to serve as lay health educators and health advocates within their respective congregations and the broader community. The GBSC Office of Health and Human Services (HHS) was established to facilitate the development of this demonstration project. Staff from HHS, with technical support from UNC-SPH, designed training programs and recruited health professionals to teach volunteers about the causes, prevention, and management of selected health problems (e.g., hypertension, diabetes, and infant mortality).

The Convention created the Health and Human Services Advisory Committee to provide oversight and guide the overall development of this evolving ministry. A Technical Advisory Committee was also formed. The Technical Advisory Committee included among its members clergy, lay leaders, health professionals from local universities (North Carolina Central University, Duke University Medical Center, Shaw University Divinity School, UNC-SPH and UNC School of Medicine), North Carolina State Division of Public Health, and civic leaders. The Committee, which included persons of other faith and ethnic backgrounds, was very helpful in identifying resources and allies from within the broader community. Through this process, learning took place at several levels. The professionals learned about church style, protocol, and church members' values. Church leadership learned the value of critical review, evaluation, and the overall assets health professionals could bring to the table.

The GBSC Model

The GBSC-HHS ministry is grounded in an awareness that many African Americans do not fully benefit from pioneering gains in health that new knowledge, medical technology, and research have made possible. The ministry is designed to build on the strengths present within the Convention and its member congregations through a strategy that draws on the combined resources, talent, and leadership of clergy, laity, and health professionals. The key methodology employed is training church-based volunteers to inform others about the causes of selected health problems, and then helping them to change behavior and gain access to necessary resources for prevention and control.

The role of the pastor is pivotal in this process.⁷ GBSC-HHS programs seek the counsel and advice of clergy in determining the overall course of implementation for local and regional activities. Pastors offer sanctioning and best ways to define, refine, and reshape faith-based health models. The life experience of the pastor and lay leaders is very influential in determining interest and support. Of the six pastors responding to a local diabetes initiative, five either had diabetes or had a spouse with the disease.

Most of the work of the Convention's health ministry is carried out by volunteers and is premised on theories, research,

and best practices developed in other settings.⁸ These volunteers are trusted and respected persons that others come to for advice. They are a part of the web of support systems in their communities. Most have resided in their community for over 20 years.

An essential factor to the long-term success of faith-based models is the education and empowerment of clergy and lay leaders.

*"The church can serve a role in bringing about a much better lifestyle, a much better health condition for all concerned. But, it has to be a situation where the ministry and the key laity in churches are educated and empowered with all the information about particular diseases and all the things that the health community would like to impart so that they might play the ambassadorial role that you [the public health community] seek."*⁹

Orientation and training congruent with project goals and objectives are provided for staff and volunteers. Sessions usually take place on Saturdays or evenings, when the majority of congregation members are available. In addition to technical health information, education sessions integrate faith and theological understandings to support the technical teachings. Hours of training vary by project with initial training generally averaging about 15 hours. Following the initial orientation and training, lay health advisors provide education and social support to the congregation and other community members. Continuing education and programmatic support are provided by GBSC-HHS staff and local and area healthcare professionals throughout the project.

Lay health advisors are asked to serve a minimum of two years. However, the majority continue for the duration of the project (generally three-to-five years). Most importantly, these volunteers remain health promotion advocates within their congregation once the formal funding period has ended.

An essential role for GBSC-HHS is to serve as a support to projects after outside funding has ceased. HHS maintains contact with prior externally-funded GBSC projects in an effort to continue services. Some groups have established support systems with local resources to enable continuation.

Faith-based models provide a unique opportunity for team building between congregation members and healthcare providers. Individuals have an opportunity to learn from and support each other as they share their experiences. Healthcare providers who assist with the training gain increased understanding of community concerns and priorities and an enhanced ability to involve community leaders. During training sessions, providers come on the "turf" of congregations in a setting controlled by members. This facilitates discussion that is more open and enables the building of trust.

Successes

Evaluation has been a continuous component of GBSC-HHS projects. Many noteworthy accomplishments have been made since the ministry's inception. These have included (1) increased knowledge and understanding of beneficial health information, (2) identification of knowledge transmission

patterns, (3) diffusion across faith, race, and neighborhood boundaries, (4) lifestyle and policy changes at the congregation level, and (5) increased awareness and use of healthcare resources. The basic elements identified with the importance and success of the first GBSC project funded by the Z. Smith Reynolds Foundation,¹⁰ continue to be reflected in Convention initiatives.

There are many anecdotal stories that relay changes in behavior, lifestyle, access to healthcare resources, and effective healthcare utilization. In 1997, on a Saturday morning in Creedmoor, North Carolina, approximately 200 persons representing 20 or more churches attended a diabetes awareness session. Attendees told personal stories about what led to their diabetes diagnosis and encouraged others to be checked. A substantial number of the persons telling their story indicated that it was another individual in their network that recognized they had the symptoms of diabetes (not a physician) and encouraged them to be tested. The following Monday, in response to a significantly increased diabetes screening load, a health department staff member questioned one of the diabetes awareness session participants/screenees about the unusually large number of people coming in for testing.¹¹

It is well documented that education and income make a difference in health status. During two fatherhood projects in economically deprived areas, pastors, male congregants, and other supporters mentored unemployed fathers and fathers without a high-school degree. Six months following project initiation, 100% of 25 previously unemployed fathers were employed and 100% of 18 fathers previously without a high school diploma were enrolled in a GED program.

The Convention's Health Ministry continues to sponsor health promotion programs to: (1) reduce health risks, (2) promote health, (3) improve disease states through increased knowledge, improved practices, and improved access and utilization of healthcare services, (4) increase community involvement/participation in the healthcare delivery system, (5) build and expand the helping and social support role of the church, and (6) increase community capacity to initiate and sustain health promotion programs. These goals are carried out through programs reaching congregation members and the communities they serve.

In addition to focusing on specific diseases, lifestyle modifications, and service delivery concerns, special seminars/summits have been held with GBSC leadership to address current and cutting edge issues, such as stress in ministry and end-of-life decision-making. The Office has also served as an information and referral source for congregation and community members.

Since the inception of the program, GBSC has provided about 20% direct and lots of in-kind support. The Convention has continued to seek the support of a broader range of donors from both the public and private sectors. Following the Z. Smith Reynolds funding, the W. K. Kellogg Foundation funded two major projects. In more recent years, the Convention has received funding from the Kate B. Reynolds Charitable Trust, the North Carolina Hospital Foundation, the State of North Carolina (including the North Carolina Division of Public

Health, North Carolina Health and Wellness Trust Fund, and federal funds received through state-funded projects), direct church contributions, and private donations.

Sustainability

The HHS program has gone through several stages of development, from demonstration project to permanent program. In 2002, the Center for Health and Healing, a 501(c)(3) IRS-recognized nonprofit entity, took on the health and human services agenda of the Convention. This legally independent and structurally autonomous organization is similar in character to the relationship between the Catholic Church and the Catholic Relief Society and the relationship between the Unitarian Church and the Unitarian Universalist Service Committee. Advantages include access to a broader funding base and reduced liability for the Convention.

Capacity to sustain health promotion initiatives is essential to health status change. We believe the church in the African American community can play a major supportive role in the nation's effort to encourage and sustain healthy lifestyles. This must include all the prerequisites necessary to assure the institutionalization (e.g., ownership, commitment, and resources) of faith-based health promotion initiatives. Dr. John Hatch, a UNC-Chapel Hill professor of health behavior and health education at the time, has stated that he believes the project would not have survived had resources not been placed with the Convention.¹² Evidence of sustainability at the Association and local church level is evident in several GBSC models (e.g., Faith and Wellness Auxiliaries as part of formal Associations;

inclusion of the health ministry in some Association and church budgets; inclusion of ministry functions on church, Association, and Convention agendas).

In addition to building the internal capacity of communities, faith-based health programs enable the provision of community healthcare promotion programs at a time when resources are limited. A partnership with a local agency was compromised when the agency experienced the loss of a staff person that would have been able to assist with GBSC lay training. The agency director suggested a local community member to serve as a resource person. The individual she recommended was a GBSC grassroots Facilitator trained by GBSC-HHS.

Conclusion

The continued survival and growth of faith-based health initiatives will likely be dependent on a number of factors, including interest, financial, and programmatic support available from the faith-based organization, government, and private philanthropy. These ministries may vary in scope (e.g., lifestyle modification, advocacy and policy development, education, social support, self-help, information and referral, environmental change [inclusive of the church environment], demonstration/research, and career development) as a reflection of interest and resources.

However, as faith-based and other organizations continue an agenda of pursuing reductions in health disparities, partnerships between faith-based groups and health-interest organizations (public and private) are likely to continue. **NCMJ**

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