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Commentary

Incorporating Health-Related Policies within Urban Churches: A Strategy for Reducing Health Disparities

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Beliefs are to religious denominations as policies are to corporate organizations. Thus, if beliefs do not target healthy lifestyles, programs to encourage healthy lifestyles cannot be easily maintained or institutionalized. For over a century, urban Seventh-day Adventist Churches have espoused health-related beliefs or policies. Garvin (2013) shared the benefits of these health-related policies. An African American cohort of 96,000 persons was enrolled in a longitudinal study from 2002 to 2007. Cases of hypertension and diabetes were lower for African American Adventists than comparable national rates for both African Americans and non-African Americans, a noteworthy finding. Also, obesity prevalence was 10% lower than the prevalence reported among African Americans in the 2003-2004 National Health and Nutrition Examination Survey (NHANES). In addition, the lifestyle of African American Adventists placed them at lower risk for heart disease, several cancers, and arthritis. Thus, incorporating health-related policies or beliefs within a religious denomination or church can decrease health disparities.

Eighty-three percent (Langer, 2013) of Americans identify themselves as Christians. Most of the rest, 13 percent, have no religion. That leaves just 4 percent as adherents of all non-Christian religions combined — Jews, Muslims, Buddhists and a smattering of individual mentions. Michael Lipka (2013), assistant editor at the Pew Research Center's Religion and Public Life Project, reported that approximately 37% of these persons attend church weekly or more often, 33% attend monthly or yearly, and 29% attend seldom or never. Among those who attend worship services no more than a few times a year, 24% cite personal priorities – including 16% who say they are too busy – as reasons they do not attend more often. Another 24% mention practical difficulties, including work conflicts, health problems or transportation difficulties. Nearly four-in-ten (37%) point to an issue directly related to religion or church itself. The most common religion-related responses include disagreements with the beliefs of the religion or their church leaders, or the belief that attending worship services is not important. Given the prevalence of churches and religious denominations in America, their incorporation of health-related polices or beliefs have the potential to reduce health disparities, especially in urban communities.

In a recent study, titled, "Health among Elderly Hispanics: Is there a Role for Spirituality?", (G. Billingsley and M. Davis, personal communication, 2014) used data from the Sacramento Area Latino Study on Aging (SALSA Study), 1996-2008 (University of Michigan Inter-University Consortium for Political and Social Research, n.d.). They concluded that the Latino elderly persons in the study had compartmentalized their lives into two spheres: the spiritual and the physical or natural. This compartmentalization is antithetical to the interrelationship of religion and spirituality presented in the literature. Seventeen items about the respondents' relation to religion or God, which explained 91% of the variance of the underlying construct, failed to correlate

with stroke, diabetes, atrial fibrillation, smoking, and kidney problems. However, their level of physical activity correlated significantly with these variables. Thus, spirituality is not a driving force for their health maintenance behaviors. Stated another way, health-related beliefs or policies are not dominant in their religious denomination.

While the exact role spirituality plays in driving health behaviors is debatable, one point beyond question is the expanding role churches are performing regarding health and wellness activities. The recent healthcare debate provided an opportunity for many churches to offer input regarding the many policy aspects of healthcare in this country. Policy issues ranging from the availability of wellness exams to community health clinics to employer-provided contraceptives all received policy input from various church organizations (Mihut, 2011; Smedley, 2012).

While this involvement might be surprising given the "separation of church and state" language often discussed in civics classes, religious organizations have a long history of participating in health policy decisions through such activities as establishing hospitals, nursing homes, community clinics, feeding the poor, and supporting/opposing governmental policies (Cochran, 1997). A policy in its simplest terms can be viewed as an official course of action used to guide and direct activities in a given area. Churches pre-dating the birth of Christ have long-established beliefs, practices, and policies to guide the health and behavior of their members through such doctrines as following moral codes (e.g., the Ten Commandments); conducting periodic fasting; and practicing daily meditation/prayer (Singh, 2009). These beliefs, practices, and policies, when viewed through an institutional model of policy making, offer opportunities for churches to reduce health disparities due to their legitimacy, authority, structure, constituencies, and available resources (Dye, 2008). Indeed, many national church organizations are beginning to use their institutional presence to adopt and implement policies designed to improve the health of their members. For example, The National Baptist Convention, USA, Inc.; the Episcopal Church Foundation, the United States Conference of Catholic Bishops, The Church of Jesus Christ of Latter Day Saints, and the United Church of Christ have all utilized various policy tools (e.g., adopting official resolutions, publishing position and policy papers, lobbying for or against certain laws or regulations, developing organizational policy handbooks directing behavior and allowable activities, and developing and implementing programming activities) to address health and wellness issues impacting their memberships and the nation (Episcopal Church Foundation, n.d.; The Church of Jesus Christ of Latter Day Saints, n.d.; The National Baptist Convention, USA, Inc., n.d.; United Church of Christ, 2014; United States Conference of Catholic Bishops, n.d.).

There is growing evidence that churches overall, and the African American church in particular, are playing larger roles in developing and implementing health-related policies designed to reduce health disparities (Levin, 2014; Butler-Ajibade, Booth, & Burwell, 2012; North Carolina Division of Public Health, 2004).

Given the historical role the African American church has performed in improving the quality of life for its members since post-slavery, and the growing health crisis levels existing in many urban areas, the emergence of the church in addressing the health disparity crisis should not come as a surprise. Many African American churches across the country are adopting policies, practices, and programs such as supporting healthy school food choice policies; conducting community health fairs; promoting exercise programs; operating local food banks; and conducting public health advocacy activities (Butler-Ajibade, et al., 2012; North Carolina Division of Public Health, 2004). But, are they incorporating into their doctrines/beliefs/policies total abstinence from

tobacco and other harmful drugs, and unclean meat (animals and sea life that are scavengers); adequate exercise, water, sunshine, air, and rest; good nutrition, temperance, and trust in their Creator? These comprise the eight natural laws of health, and obedience to them will eliminate health disparities.

Recently, after spending 14 days at a Life Style Center and adjusting his life to the eight natural laws of health, a person shared the drastic improvement in his lab results (e.g., glucose, triglycerides, cholesterol, etc.) with his pastor who was on his third cup of coffee at 9:00 a.m. When the "converted" member spoke to his pastor about the coffee, the pastor responded that God did not mean for us to stop doing all the things we enjoy, exclaiming, "He understands! Just pray!!" (D. Ware, personal communication, February 14, 2014). Clearly, this pastor did not validate that his church has doctrines/beliefs/policies that encourage total abstinence from tobacco and other harmful drugs. Organizational culture begins with leadership and impacts how quickly organizational change takes place. African American church culture, if properly harnessed, can be used as a strategy for action in dealing with the myriad social and health-related issues in the black community (Pattillo-McCoy, 1998).

The current authors applaud the churches for the work they are doing to reduce health disparities, but these efforts are not enough; especially given the influential role of these churches in the community. The time has come for churches to incorporate doctrines/beliefs/policies that encourage total abstinence from tobacco, other harmful drugs, and unhealthy meat; and adequate exercise, water, sunshine, air, rest, good nutrition, temperance, and trust in their Creator. Incorporation of these health-related doctrines/beliefs/policies has the potential to significantly reduce health disparities; especially in African American and Hispanic communities where the church occupies a dominant position.

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