Engaging the Faith Community in Promoting Community Health

By Antonia van Loon RN PhD

More than half of the leading causes of death in most western countries are largely preventable. For example alcohol, tobacco, inactivity related deaths, sexual behaviours, firearms, motor vehicle accidents, illicit drugs, toxic agents, accidents, suicide, diet, etc. The Australian Institute Health and Welfare of Health and Welfare released a report indicating there were **228,400 hospital episodes annually from smoking, drinking and illicit drug taking during 1997-98 in Australia[1].** These are preventable social diseases, which can be targeted by church based community health promotion programs.

There are many common social factors affecting the health of contemporary Australians, Martin and Davis identifies some of these.[2] They include; crisis and loss events (include life changes and transition periods); poverty; unemployment and under employment; conflict and breakdown within the family; lack of social support structures; inadequate life skills (such as communication, conflict management, parenting etc.); loneliness and isolation (particularly for the elderly); mental illness; harsh environmental conditions. These key factors are among those identified as significant contributors to illness. Many of these are capable of being addressed by our faith communities as part of a faith community nursing program, and its health and healing ministry.

Legge[3] (1997) summarised four social and cultural preconditions for health, which he noted were verified repeatedly in major research. They include;

- mutual support and discipline (the norms by which we live)
- opportunities for contribution and being valued for the contribution we make
- recognition and respect in ourselves and our contribution
- control, autonomy and security in our lives

It is not difficult to see how being part of a faith community can provide people with the social and cultural preconditions for good health. Our religious faith provides us with the guiding principles and framework upon which we as congregation members build our lives. These principles provide us with a sense of meaning and purpose in our lives. In a faith community we are supported in gaining these standards to live by through mutual networks of support, instruction and worship. People in the faith community are providing a creative contribution, which should be affirmed and the person recognised for their offering. Having a secure relationship with God and with others in our faith community, provides us with a sense of purpose, freedom and independence to grow and become, within those relationships. What a tragedy that these preconditions for good health so freely available within a faith community, are not accessed by a wider community so obviously in need. So the question is what can we do about that?

Some years ago Droege[4] identified five gaps that keep faith communities from fulfilling their potential, and these continue to be relevant for us today. They include:

1. Having the knowledge but not applying it.
2. What faith community's say about social justice and what they actually do.
3. Failing to make successful practices widely available for replication.
4. Faith communities operating in isolation from each other and health agencies.
5. Current needs/wants versus future needs/wants.

Health promotion within the faith community is about improving health conditions, providing and

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[1] AIHW (2001) The quantification of drug-caused mortality and morbidity in Australia, 1998

[2] Martin,G. & Davis,C. (1995). Mental health promotion: From rhetoric to reality? In by F.Baum (Ed) *Health for all: The South Australian experience*. Kent Town, South Australia: Wakefield Press. p. 412.

[3] Legge,D. (1997). Challenging broader social and economic inequalities. Paper presented to *South Australian Community Health Research Unit seminar.* Adelaide: South Australia, April 3rd 1997.

[4] Droege (2001) http://www.interaccess.com/ihpnet/manual.html

nurturing the relationships that sustain individuals within the faith community and beyond. Nutbeam[5] states *"...health promotion works with people, not on them".* This is best achieved through nurturing personal growth. The person does not grow in isolation; therefore community health involves strengthening relationships between family members, faith community members, wider community outreach to the geographical or cultural community that the faith community serves. Promoting health includes supporting and nurturing the individual's relationship with God and with God's created environment. This is an area of concern and challenge if the Christian church is to remain relevant as a centre for faith development and whole person health in this country. The big question is how do we mobilise our churches? What strategies can we use to connect congregations with other sectors of the health care continuum, or other faith communities to work ecumenically?

One method to build the capacity of congregations is to concentrate on developing existing assets. Gene Roehlkepartain[6], of the Search Institute notes 6 key points worth considering:

1. Focus on cultivating respectful, trusting relationships with and among the leaders you seek to engage. Rarely will people participate if someone they know and trust does not personally invite them.
2. Identify and unleash a 'champion' who is passionate, committed, and respected. This person plays a vital role in rallying people, building relationships, sharing the vision, moving to action, and celebrating progress.
3. Connect the community action to the congregation's own sense of identity. Focus first on how "asset building" can strengthen the individuals work with children, youth, and families within the congregation, then helped them take the vision outward.
4. Look for common ground and shared language that can help to build bridges across the "community."
6. The faith community must find more ways to work together respectfully despite differences.

Recognize and accept that engaging congregations in community action is slow, time-consuming, and at times, frustrating work. There aren't perfect formulas, strategies that always work, or guarantees. Stay connected to others who are seeking to do similar work in other communities (such as the Australian Faith Community Nurses Association) as they can offer perspective, new ideas, support, and renewal.

One of the biggest hurdles we have is visioning ourselves as a *community,* rather than a gathering of people. I like Peck's[7] definition of community as "...*a group of individuals who have learned how to communicate honestly with each other, whose relationships go deeper than their masks of composure, and who developed some significant commitment to "rejoice together, mourn together," and to "delight in each other, make others' conditions their own"*. Isn't that the sort of congregation we all want to be? I believe that is what people are really looking for in our community. Depression and loneliness are anticipated to become our number one health issue in the next decade. People need meaningful relationships with other people and with God, and this is the key to where the faith community's energy must be spent.

Secondly, Churches need to see themselves as an integral part of a larger community of faith and a larger cultural community with responsibilities toward improving the social situation for everyone in the community not just 'their own'. I am disappointed when I see the unwillingness of people within Christian churches of the same denomination to work together, let alone considering working with other denominations. As churches we don't have a good track record of being a universal Christian community. In fact, we often don't even know each other, much less trust each other. Therefore discovering how to work together across faith traditions around common goals is vital. I believe we have learned something about working ecumenically at the AFCNA that can be useful for everyone. We started out by finding our common ground without losing the richness of our diversity. We set aside 'religious language' and 'agendas' so we could dialogue in a spirit of understanding with others. As Christians we have the death and resurrection of Jesus Christ as our common ground and this was the place where we began.

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[5] Nutbeam,D. (1986). Health promotion glossary, *Health promotion*. 1(1), p115.

[6] Roehlkepartain (2001) IHP-NET March 2001

[7] Peck, S. (1988) *The different drum: Community making and peace*. Touchstone, New York. P. 59

In terms of engaging the faith community the congregation is no different from any other community group. All groups have their overt and covert ‘regulations’ that need to be considered. In my experience it is really worth spending some time trying to identify these principles because they will be a major influence on how you progress your future plans. Every group is motivated by a core set of values that are usually shared within that group. I believe time should be spent helping people vision the possibilities of the program. I like to focus on strengths and do something that will have a positive outcome which affirms rather than focusing on negatives and problems we cannot easily address as this leaves people feeling overwhelmed and disempowered. That is not to say that these should be ignored, simply kept in focus.

I recommend moving slowly and building trust by proving your reliability for the long haul. People want to see your motivation is for the common good and not just the promotion of your own agenda. Don't assume that your shared faith, or your appointed position will proffer you automatic trust, because people want to see your intent is ‘pure of heart’. All groups have their appointed and their unofficial leaders, who can prove to be either an asset or a hindrance depending on where they sit on the issue. There will always be the cynics and the ‘log throwers’ who will disagree with what you are proposing to do. I have found courting these people by letting them air their questions and issues, and then genuinely trying to consider their viewpoint goes a long way to ameliorating their negative effect. In fact some of these people have become my best allies! Far more difficult are the large apathetic majority who have no desire to serve and avoid all contact for fear of ‘landing a job’! My only strategy is to pray for them, that the Holy Spirit may inspire them and to protect me from the negative effects of their disinterest so that I can continue to keep my eyes fixed on the goal “Christ Jesus and His healing ministry”.

Finally, I strongly recommend celebrating together. Every high point in your community’s life should be acknowledged in an effort to connect people in times of joy and celebration. It is difficult to be there for someone in his/her time of sadness when you have not been together in your times of joy. The challenges of community building in our churches are so important to the health and wellbeing of our whole community that we must continue to be fired up with passion for this God given work. May God bless you all as you build relational bridges within your community and beyond.

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