ABSTRACT

THE PICTURE OF HEALTH: A STUDY OF CHURCH HEALTH IN THE CENTRAL NEW YORK DISTRICT OF THE WESLEYAN CHURCH

by

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The purpose of this study was to assist the Central New York (CNY) District of the Wesleyan Church in its research of church health within the district towards the development of a sustainable church revitalization plan. From 2005-09, twenty-eight of its fifty churches experienced numerical decline in primary worship service attendance. This quantitative, quasi-experimental study utilized a causal-comparative research design to explore the state of church health within the district's churches. Twenty CNY District churches participated in the study, eleven churches that experienced primary worship service numerical increase from 2005-09 and nine churches that experienced primary worship service numerical decline during that same time period. A pastor and nine church leaders from each participating church completed the Wesleyan Church's standardized, online Church Health Profile survey.

Survey results revealed similarities and differences in the state of church health between the increase and decrease church groups. Churches in the decrease group rated the experience of health in all twelve health factors lower than those in the increase group. The greatest difference was with the *effective evangelism* factor; however, both groups scored it as the lowest health factor. The survey results also revealed no statistically significant difference in the perception of church health between pastor and church leaders in both groups. Health factor ranking revealed similarities in both the

increase and decrease group, with *pastoral leadership* ranked first and *effective evangelism* ranked last.

DISSERTATION APPROVAL

This is to certify that the dissertation entitled

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The Apostle Paul's heartfelt words to the church at Philippi reflect my own feelings as I think of the many individuals that offered encouragement and support to me throughout this dissertation project: "I thank my God every time I remember you" (Phil. 1:3 NIV). I would like to acknowledge these individuals for their contribution. First and foremost, I thank the Grace Lee Memorial Church family and leadership for allowing me the time to work on the project, for praying for me, and for encouraging me every step of the way. I also want to thank my Research and Reflection team for their wisdom and prayers. I am indebted to Pastor Greg and Sheila for their willingness to handle things in the office and cover my responsibilities when I *escaped* to work on this project.

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CHAPTER 1

PROBLEM

The Central New York District of the Wesleyan Church has a long and rich history with its roots reaching back to the Methodist Episcopal Church. In the 1840s, many churches within the Methodist Episcopal Church in America, particularly in Michigan, Indiana, Ohio, Pennsylvania, New York, and New England, were withdrawing from the denomination over the issue of slavery. In May 1843, an antislavery convention was held in Utica, New York, where, under the leadership of Rev. Orange Scott, the Wesleyan Methodist Church was organized.

The denomination was divided into six annual conferences, one of which was called the New York Conference. This conference encompassed all of New Jersey, Eastern Pennsylvania, and all of New York State south of the Adirondacks. At the first General Conference of the new denomination, the Rev. Luther Lee, from the New York Conference, was elected president.

The denomination experienced several name changes as time passed, becoming the Wesleyan Methodist Connection in 1891 and then the Wesleyan Methodist Church of America in 1947. As a result of two mergers, one in 1966 and one in 1968, the denomination embraced its present name, the Wesleyan Church (Yager 3).

The present boundaries of the Central New York District, part of the original New York Conference of the Wesleyan Methodist Church, were established in 1968, following the merger with the Pilgrim Holiness Church. Since 1968 the district has enjoyed growth and expansion to its present number of fifty churches. Over the last decade (2000-09), the Central New York District has planted six churches (*Central New York District Journal*,

2006; 2009) and is the only district within the denomination that showed an increase in primary worship service attendance each year (2009 15).

Closer analysis of these growth statistics in the Central New York (CNY) District 2008-09 conference journal however, reveals that while the worship service attendance statistics for the district's fifty churches from 2000-09 showed a 40 percent increase, a large number of churches experienced an attendance decrease during that time period. Eighteen churches showed a decrease in average worship attendance for the years 2000-09, and an additional ten churches showed a decrease in attendance from 2005-09.

This decline in worship service attendance is not unique to CNY District churches or the Wesleyan Church. Approximately two-thirds of Protestant churches in America report long-term attendance trends that are either flat or declining (Herrington, Bonem, and Furr xii). According to the long running General Social Survey study (GSS; Davis, Smith, and Marsden), the percentage of Americans that say they attend religious services regularly declined from a high in 1972 of about 41 percent to a low of about 30 percent in 2002 (Altemeyer 79; Walsh).

For the CNY District leadership, the decline in worship service attendance in the twenty-eight district churches from 2000-09 and 2005-09 has raised obvious concern. The CNY District Board of Administration has begun to research ways to improve the spiritual health not only of these churches but to contribute to the ongoing health of all the churches in the district. To aid in addressing spiritual health, the CNY District board has identified nine *church health indicators* to guide churches in self-evaluation (*CNY District Journal,* 2009). The first indicator focuses on primary worship service attendance, while the next eight focus on the following: number of individuals saved,

number of persons baptized, number of all members, number in spiritual formation groups, number called to ministry or missions, all missions giving, total giving, and per capita giving per week. District leadership has communicated these *indicators* to the district churches, but while the *indicators* may provide a snapshot of the state of health in the local church, they do not necessarily provide churches with the information and resources needed for the ongoing maintenance and restoration of health.

In November 2009 the CNY district superintendent, Rev. Wayne Wager, asked me to consider focusing the project of my dissertation upon local church health within the district. The results of the dissertation project, a survey of local churches, would help the district evaluate and refine the *church health indicators,* understand more clearly the strengths and weaknesses of its local churches, and lay the foundation for a sustainable plan to assist churches towards health. Part of this plan would include the addition of assistant superintendents to work directly and regularly with local churches. In this role, which began in the fall of 2010, one or more other district pastors and I would serve as coach/consultants with churches assigned or requesting help in maintaining or restoring health. The dissertation project survey and data would become the basis for dialogue between the assistant superintendents and the local churches they are working with. The CNY District leadership hopes that seeking the input of local church pastors and leaders through this dissertation project will help to foster a willingness at the local level to embrace help from the District.

The CNY District leadership recognizes that developing a sustainable plan to assist churches towards health will require going beyond the district *church health indicators* to factors or principles of health that are universal (Schwarz 16). Of greatest

concern is the need to differentiate between the role of the church in attaining and maintaining health and the role that only God can accomplish (Reeder 29; Schwarz 50). The ultimate goal of the district is a plan that acknowledges practices and technique not as *the* solution but as a means to position churches for health and vitality only possible through the work of the Holy Spirit.

Purpose

The purpose of this research project was to assess the church health of twenty-four CNY District churches through use of the Wesleyan Church's Church Health Profile. The district anticipates that such an assessment will guide it in establishing the foundation for a sustainable church revitalization plan for the district.

Research Questions

The following research questions were foundational to the project.

Research Question #1

What are the actual similarities and differences in overall church health, based on the Church Health Profile (CHP), among the twelve CNY District churches reporting declining worship service attendance from 2005-09 and the twelve CNY District churches reporting an increase in worship service attendance from 2005-09?

Research Question #2

What are the actual similarities and differences in perceived church health, based on the CHP assessment, among the pastors and church leaders of the twelve CNY District churches reporting declining worship service attendance from 2005-09 and the pastors and leaders of each of the twelve CNY District churches reporting an increase in worship service attendance from 2005-09?

Research Question #3

What are the church health characteristics, based on ranking resulting from the CHP assessment, that will enable the Central New York District leadership to impact the pastors and church leaders and help position district churches for revitalization?

Definition of Terms

The definitions of the following terms were used throughout the project.

Church Health

For the purpose of this study, church health is defined as consisting of twelve factors, according to the Wesleyan Church's Church Health Profile assessment tool. While the definition for each factor is provided in Chapter 2, here is a listing of the twelve factors: "Divine enablement, pastoral leadership, effective evangelism, ministries of compassion, loving community, maturing faith, personal ministry, leadership development, God-honoring stewardship, missionary spirit, and vision focused systems" (*Church Health Profile*). The experience of health will involve a balance and interplay of each of the twelve health factors.

Sustainable

The term *sustainable*, used in reference to a plan for church revitalization in the CNY District, is a plan that is capable of serving the district long-term, as opposed to a short-term, one-time intervention and a plan that positions district churches for sustainable growth.

Revitalization

The term *revitalization* focuses on leading a church to a complete measure of health, according to the CNY District church health indicators and CHP results.

Ministry Intervention

In the fall of 2010, the pastor or senior pastor and nine church leaders from each of twenty-four CNY District churches, twelve churches that reported a decrease in primary worship service attendance from 2005-09 (26 percent decline as a group) and twelve churches that reported an increase in primary worship service attendance from 2005-09 (24 percent increase as a group) were asked to complete a survey to evaluate church health. These surveys established the foundation for a sustainable church revitalization plan for the district by revealing characteristics common or associated with church health. The CNY District leadership plans for the survey data and analysis to form the basis for dialogue between district coach/consultants and churches. The coach/consultants will provide assistance and ongoing support to district churches in developing and implementing a strategic plan for addressing church health.

Context

The Wesleyan Church denomination has its roots in the Wesleyan/Holiness movement. Drawing upon its Methodist heritage, the Wesleyan Methodist Connection (later the Wesleyan Church), strongly emphasized John Wesley's doctrine of Christian perfection or holiness in its first denominational doctrinal statement in 1844 (Holdren 114). The Wesleyan Church was heavily involved in and influenced by the holiness revival of the mid-nineteenth century, with its emphasis on the present possibility of a life of "practical holiness" and the desire to spread "scriptural holiness" across the land (Dieter 4). The denominational Web site refers to these roots in its description of the denomination:

> The Wesleyan Church is an evangelical, Protestant denomination. We offer the good news that faith in Jesus Christ makes possible a wonderful

> personal relationship with God, a holy life empowered by His Holy Spirit for witness and service, and assurance of eternal life in heaven. Our ministries emphasize practical Bible teaching, uplifting worship, and special programs to meet a variety of life needs. ("Who Are the Wesleyans?")

The CNY District of the Wesleyan Church is composed of fifty churches serving throughout the center of New York and northern Pennsylvania. The general borders are the Saint Lawrence River in the north, Rochester in the west, north of Route Six in Pennsylvania and Utica in the east (*Central New York District,* Home Page). Churches range in age from over 150 years old to less than three years old and range in attendance from over 1,500 to less than twenty-five.

The twenty-four churches asked to participate in the survey reside within the boundaries of the Central New York District. Of these twenty-four churches, eleven are located in the rural context, five are located in the small town context, and eight are located in the suburban context.

Methodology

This quantitative, quasi-experimental study utilized a causal-comparative research design. The study made use of a standardized online church health survey, designed by the Wesleyan Church, called the Church Health Profile, to collect quantitative data from the survey participants on aspects of church health.

Participants

Twenty-four local churches from the CNY District received an invitation to participate in the study by completing the Church Health Profile online survey. The invitation was extended to the twelve churches that reported the greatest decline in primary worship service attendance in the district from 2005-09 and the twelve churches

that reported the highest primary worship service attendance during this same time period to make possible the causal comparison. The church pastor or senior pastor and nine church leaders from each church were to complete the survey, resulting in 240 possible participants.

Instrumentation

The instrument used in this study was a standardized, electronic, online survey designed by the Department of Evangelism and Church Growth of the Wesleyan Church called the Church Health Profile. The profile is based on twelve health factors: divine enablement, pastoral leadership, Christ-exalting worship, effective evangelism, ministries of compassion, loving community, maturing faith, personal ministry, leadership development, God-honoring stewardship, missionary spirit, and mission-focused systems. The use of the standardized survey and delivery system made possible a clean and clear correlation study impact.

Variables

The independent variables were the twelve church health factors that form the basis for the survey. The dependent variables were the participant responses to those questions. Intervening variables were the church size and demographics, the potential loss of data due to Web site difficulty, additional participants other than those selected completing the online survey, participants' lack of technological practical understanding, and participants' failure to complete the survey.

Data Collection

Participants completed the online Church Health Profile survey during a 3 ½ week time period, 11 October-3 November 2010. Each participating pastor received a

formal letter of invitation (See Appendix A), and a list of instructions (Appendix B) prior to the administration of the survey. Pastors then received a follow-up phone call to address any questions. During the data collection period, participating pastors received reminder phone calls and e-mails as necessary. Data collection ended 3 November 2010.

Data Analysis

The study utilized Microsoft Excel and descriptive statistics to analyze the data. Examination of the data included research for possible correlation related to the churches and individual groups (churches with a primary worship service attendance increase, churches with a primary worship service attendance decrease, along with pastors and church leaders from both groups). Examination of the data also included factor analysis of the level of significance of the reported scores of the twelve health factors for each church and for the whole study.

Generalizability

The Church Health Profile limited church health to twelve health factors. Other factors are possible. The study was limited to churches in the CNY District of the Wesleyan Church. This study is generalizable in two ways: (1) The church health factors utilized in the profile are generally accepted church health factors and, therefore, should be generalizable to any church in the CNY District, and (2) the study findings may be suggestive to other church district or denominational leaders.

Theological Foundation

To understand the concept of church health, the church must be viewed in its "fully biblical perspective" (Wright 15). The roots of the Church, as a community called by God, reach back into the Old Testament all the way to Genesis and the creation

account. Genesis 1 and 2 reveal that God created man and woman in his image (1:26-27). Wesley refers to this image as “original righteousness” (qtd. in Tuttle 23). In this state of original righteousness, Adam and Eve were “righteousness-prone, their innate desire for holiness made obedience easier than disobedience” (23), and they enjoyed a fellowship with God that was immanent and personal. Sadly, Adam and Eve’s rebellion resulted in the loss of original righteousness and the loss of free and open association with God (33; Gen. 3). The impact of their rebellion against this original covenant, which was achievable, was that all subsequent covenants were not achievable apart from the grace of God (30).

Following Cain’s murder of his brother Abel (Gen. 4) and the great flood (Gen. 6-8), in Genesis 11 humanity’s wickedness ultimately results in the scattering of the nations. God’s answer for Genesis 1-11 is found in the rest of the Bible from Genesis 12 through Revelation 22 (Wright 15). God’s redemptive work unfolds as he calls forth a people that begins with one man and woman, Abraham and Sarah, who “become a family, then a nation, and then a vast throng from every nation and language” (15).

In the call of Abraham and throughout the Old Testament are several marks of the people of God that inform an understanding of New Testament church health. In Genesis 12:2-3 God promises Abraham that he will bless him, make Abraham’s name great, and that through him God will bless all the peoples of the earth. Abraham responds to God’s call in obedience and faith, as he leaves his country believing in God’s promise. The concept of blessing is connected with fruitfulness in Genesis 17 as God establishes a covenant with Abraham, promising fruitfulness if Abraham and his descendents will do their part in keeping the covenant. Blessing and fruitfulness are again linked with

obedience and faith for God's people as they prepare to enter the Promised Land, as obedience to God's commands is linked with blessing and disobedience with curses (Lev. 26; Deut. 11:26-27). The prophets utilize the concept of blessing and fruitfulness to warn God's people of impending judgment as a result of their disobedience (Isa. 32; Jer. 4, 49; Ezek. 19) and also to communicate hope of redemption and restoration based on God's love and faithfulness to his covenant (Isa. 27; Jer. 23; Ezek. 36).

An overriding mark of the people of God, connected with the marks of blessing, fruitfulness, obedience, faith, and covenant is the mark of holiness. God has set apart his people from the nations for his own (Lev. 11:44, 45; 19:2; 20:7, 26). While God makes them holy, God's people must demonstrate their commitment to holiness, consecrating themselves by their obedience (Lev. 20:7).

From the call of Abraham to the life, death, and resurrection of Jesus Christ, the experience of health and vitality as the people of God and as a nation was set against the backdrop of the promise to come (Heb. 11:13). For the people of God since the coming of Christ these same marks of health and vitality are understood against the backdrop of the promise fulfilled (Matt. 12:17-21).

Jesus stated during his earthly ministry that he did not come to abolish the Law or the Prophets but to fulfill them (Matt. 5:17). Jesus affirmed that Abraham had rejoiced to see his day, that Moses had written of him, and that the Scriptures, the Law, the prophets, and the writings, bore witness to him (Stott, *Basic Christianity* 30). Jesus understood and instructed his disciples that he was God's son (Matt. 11:27; John 10:30) the fulfillment of God's promise to Israel (Luke 4:18-21) and that through his death and resurrection all who believed in him would receive the gift of eternal life (John 3:16; 6:40). Following his

resurrection and before he ascended into heaven, Jesus commissioned his disciples to carry on his ministry, taking the message of repentance and forgiveness beyond Jerusalem to the nations (Luke 24:45-46; Matt. 28:16-20).

At Pentecost, the outpouring of the promised Holy Spirit marked the beginning of God's new age of salvation and blessing (Wright 20). Those who responded to the gospel in repentance and faith could now belong to the restored Israel in Christ, whether they were Jew or Gentile (Rom. 5:12-21; Gal. 3:10-14; Wright 20).

According to Jesus' teaching and instruction of the Apostles, the original marks or identifying characteristics of God's people in the Old Testament continue to be the marks by which Christ's Church is identified. To speak of church health, one must do so with an understanding of blessing, fruitfulness, obedience, faith, covenant, and holiness rooted in the Old Testament but also in light of the work of Christ and the presence and power of the Holy Spirit.

The Apostle Paul sought to explain what the healthy functioning of the New Testament Church should look like in his description of the Church as the "body of Christ" (Eph. 1:22, NIV). Paul explains that as with the human body, the body of Christ consists of many parts: feet, hands, ears, and eyes (1 Cor. 12:15-17; Eph. 4:15-16). As each part "does its work" the body is able to be "built up … and become mature, attaining to the whole measure of fullness in Christ" (Eph. 4:12-13). This growth is made possible by God (Col. 2:19) through Christ whom he has given authority over all things and placed him "head" over the Church (Eph. 1:22; 4:15; Col. 2:10). According to the Apostle Paul, Christ works to join and hold the whole body together, sustaining, empowering, and positioning the Church for growth (Eph. 4:16). With Christ as the

"head," the Church will experience health primarily as it seeks to glorify him (3:21). The Church glorifies Christ as it fulfills its mission to carry on his ministry in the world (Matt. 28:19-20) and to build up mature believers (Eph. 4:12-13).

With this biblical perspective of the Church as a backdrop, this project seeks to clarify the *work* of the Church in achieving and maintaining health and the work for which the Church must depend on God. The CNY District leadership recognizes that in order to establish the foundation for a sustainable church revitalization plan it needs to evaluate the Church Health Profile survey results through a theological lens. Clarification of the *work* of the church in achieving church health and vitality will impact the interpretation and use of the survey results.

Mark 4:26-29, Acts 2:42-47, and 1 Corinthians 3:5-17 indicate a biblical distinction between the work that only God can do and the work of the church in the experience of health and vitality. In Mark 4:26-29, Jesus introduces, through the parable of the growing seed, the "all-by-itself" growth principle (Schwarz 12). The emphasis in the parable is on the growth of the seed for which the man "does not know how" (Mark 4:27). The parable does not indicate that the man was surprised that the seed grew but that he did not play a role in its growth. The growth of the seed was hidden and mysterious. The implication of the parable points to the power of God's word to transform lives. Spiritual life and vitality are not a result of human effort but of divine provision (English 101). Acts 2:42-47 provides a description of the life of the early Church. The church experienced numerical growth daily, but Luke is clear that the Lord brought the growth. Luke's description of the church outlines practices that *positioned* the church for growth. The church's witness was effective as they enjoyed *favor* with all

the people but the witness was a reflection of the work of the Spirit in and through the church. In 1 Corinthians 3:5-17, the Apostle Paul utilizes two metaphors to describe God's work and the work of the church. In both metaphors Paul validates the work of the church but only as it builds on the foundation of Jesus Christ (Bruce, *1 and 2 Corinthians* 44). God brings the growth but works through the humble, dependent service of his Church.

Overview

Chapter 2 reviews the biblical/theological foundations of church health, the literature associated with church health, an overview of the Wesleyan Church's Church Health Profile tool, and research methods. Chapter 3 provides greater specificity for the methodology, including a restatement of the purpose, problem, research questions, hypothesis, population and participants, discussion and explanation for the design of the study, research questions, population and sample, instrumentation, data collection, variables, data analysis, and ethical procedures. Chapter 4 reports and summarizes the major findings of the study. Chapter 5 provides a discussion of the major findings of the study, unexpected observations, recommendations, limits of the study, and further study possibilities.

CHAPTER 2

LITERATURE

Introduction

I have served three churches in my fifteen years of pastoral ministry in the Wesleyan Church (the first two churches as a two-point charge). In each of these churches, I have had the privilege of celebrating with the church family historic numerical and other statistically measured growth during my tenure. This statistical growth has been cause for excitement at the local church level and has resulted in recognition at the district and denominational level. I have wrestled, however, through these years of statistical accomplishment, with measuring the true state of health in each of these churches. In addition, I have observed in the districts I served that some churches struggling statistically seem very healthy and at the same time some statistically strong churches show signs of what might be considered a lack of health.

I have found statistical measurement in ministry largely focused on numerical church growth rather than on a comprehensive measurement of church health. Numerical growth receives so much focus and attention that it has become *the* standard for evaluating a church. For example, while other denominational statistics are reported on the general secretary's departmental Web page, the first statistic highlighted is the primary worship service attendance for the Wesleyan Church in North America ("General Secretary"). The impact of this emphasis upon numerical growth is so extensive that one of the first questions a fellow clergy person will ask and one of the first questions someone asks when discovering I am a pastor is, "How large is your church?"

The measurement of numerical growth certainly has a use and place in the church. This measurement may be *helpful* in determining the state of church health, but it is not the only measure or indicator of health. Placing numerical growth within the larger picture of church health would not only serve to encourage pastors of churches of all sizes but also challenge the church in general to work towards a more biblical picture of a healthy, effective church.

Jim Herrington, Mike Bonem, and James H. Furr begin their book, *Leading Congregational Change*, with a question for leaders to ponder: "If you keep doing what you've been doing, you'll keep getting what you've been getting. Can you live with that?" (xv). The leadership of the Central New York District of the Wesleyan Church has decided that they cannot live with the status quo in the district and long to help initiate "bold transformation" (xii) in its local churches. District leadership recognizes "bold transformation" will require going beyond asking, "how large is your church?" The focus must shift, in part, to a greater understanding of *roles*—God's role and the role of the local church in achieving health and vitality. A biblical understanding of these roles will impact greatly the use and value of the CNY District's *church health indicators* and the Wesleyan Church's Church Health Profile survey.

The purpose of this research project was to assess the church health of twenty-four CNY District churches to provide the basis for a relevant, ongoing revitalization plan for the district. The goal was to develop a plan that was both reactive, addressing situations that required immediate intervention, and proactive, enabling the district to help healthy churches remain healthy.

Biblical and Theological Foundations

The Central New York District leadership sees great value in identifying church health *indicators* and utilizing the Wesleyan Church's Church Health Profile to help local churches focus on their health and growth. Clarification of the role that God plays and the role of the local church in achieving health is essential to the value of these tools for the church. Three New Testament passages are particularly informative in developing a biblical theology concerning God's role and the church's role in achieving and maintaining health: Mark 4:26-29, Acts 2:42-47, and 1 Corinthians 3:5-17.

Mark 4:26-29

Mark chapter four begins with Jesus teaching before a large crowd along the shore of the Sea of Galilee (4:1). Mark records that Jesus taught the crowd through the use of parables and that his disciples and other followers later asked him about those parables (4:10). In response to the disciples' inquiry, Jesus provided explanation and further instruction again through the use of parables, one of which is the parable of the growing seed, found in Mark 4:26-29:

> He also said, "This is what the kingdom of God is like. A man scatters seed on the ground. Night and day, whether he sleeps or gets up, the seed sprouts and grows, though he does not know how. All by itself the soil produces grain—first the stalk, then the head, then the full kernel in the head. As soon as the grain is ripe, he puts the sickle to it, because the harvest has come."

The parable of the growing seed is set in the context of five parables that form chapter four of Mark's Gospel, the parable of the seeds (vv. 3-9), the parable of the lamp (vv. 21-23), the parable of the measure (vv. 24-25), the parable of the growing seed (vv. 26-29), and the parable of the mustard seed (vv. 30-32 Gundry 286). Coupled with the parable of the wheat and the tares (Matt. 13:24-30), the parables of Mark 4:3-9, 26-29, and 30-32

form a set of four seed parables in the Gospels (Strelan 32). Each of these parables reveals truth about the kingdom of God and serve as “pointers, signposts, or avenues”, pointing to the “secret” (Mark 4:11) of the kingdom, the person of Jesus (English 98).

While the parable of the growing seed is unique, it is a continuation of the teaching of the parable of the seeds (Gundry 219). Both parables have in common sowing, soil, seed, and fruit bearing. In the parable of the growing seed attention shifts, however, from the bad soils to an expansion of the description of the growth on good soil. The point of the parable also shifts from the “need to hear well to the incomprehensibility of marvelous growth” highlighting the power of the word of God (219).

According to John Strelan, interpretation of the parable of the growing seed typically focuses one of four approaches (32). The first approach sees the kingdom of God like the seed that develops or grows internally, both on an individual level, resulting in character transformation, and on a corporate level, the Church conforming to God’s will. The second approach equates God’s kingdom to the process of growth as a whole. God’s power or “divine energy” brings about the gradual accomplishment of his purposes in the world. The third approach focuses on the end result, or the harvest. In this approach Jesus is presently harvesting, taking active steps to “put in the sickle” (33). The fourth approach interprets the parable as “presenting a contrast” though opinions differ in what is contrasted. One interpretation views the contrast between the farmer’s ignorance before the “mystery of the harvest” and his ability to take right action at the right time (Pavur 22). The most common interpretation views the contrast between the seed sown and the harvest (Strelan 33). In this view, the seed sown represents the person of Jesus Christ and the harvest represents the kingdom of God which will be harvested in “due course” (33).

Any interpretation of Mark 4:26-29 must take into consideration the main theme that unites this parable with the three earlier parables in the chapter, the hearing of the word. The parable of the seeds focused on different ways of hearing the word, the parable of the lamp focused on the light received by those who hear, the parable of the measure focused on the understanding possible to those who hear well, and the parable of the growing seed follows with a focus upon fruit bearing that comes by hearing the word and its explanation (Gundry 221). While Jesus' reference to fruit bearing and the harvest (4:29) has been interpreted as an eschatological reference, the context points more to a focus upon the impact of word heard well in the lives of Jesus' disciples and followers (221). The emphasis in 4:28 upon the process or progression of the growth of the seed from leaf blades to heads of wheat to ripened grain highlights the "power of the taught word" (220).

Any attempt to identify a contrast in the parable of the growing seed must center on the context and parables' emphasis upon the power of the word. The contrast may lie between the activity of the person and the activity of the word in the process of discipleship. Jesus seemed to deemphasize the contribution of the farmer or "man," according to the Greek, and emphasize his ignorance, but in doing so joins together the growth of the seed as the object of the man's not knowing (Gundry 220). The contrast does not paint the man's inactivity negatively but celebrates the mystery of the power of the word at work in those that have heard and received it. Participation in God's rule involves activity but the larger context, particularly the parable of the seeds, defines that activity as hearing. Hearing entails receiving the word deeply, exclusively, and at a level that touches conduct and evokes commitment and devotion (206).

The contrast in Mark 4:26-29 between the activity of the man and the word is informative to the issue of church health and growth. First, the parable highlights a distinction between the kingdom of God and the Church. While the Church, entrusted with the word and witness to the gospel of the kingdom, is a sign of the presence of the kingdom, the Church and the kingdom of God are not identical (Strelan 35). The parable of the growing seed portrays the kingdom as mysterious or hidden, working, but visible only to those with the eyes to see, the eyes of faith (35). Viewed negatively, this distinction raises the possibility that a church could be busy at *ministry,* even grow numerically, apart from the working of God's kingdom. A church could by statistical measure be considered a *healthy* organization and yet be lacking in fruit consistent with obedience to the word of the kingdom (Gundry 206). Viewed positively, the distinction between the Church and the kingdom of God gives purpose, comfort, and inspiration. The Church's calling and privilege is to serve as "both as a model and a deliverer of God's message of redemption and God's rule" (Jones 1.3). As the Church embraces its God-designed role, it discovers a purpose bigger than itself, advancing the cause of the kingdom as ambassadors of the Gospel (2 Cor. 6:16-21). The Church is also comforted by the fact that it is called to participate in God's kingdom purposes by carrying on Christ's ministry. The Church enjoys and serves with the knowledge that the gates of hell will not overcome it (Matt. 16:18) and the power of Christ's resurrection is available to it (Phil. 3:10). The distinction between the Church and the kingdom of God brings inspiration to the Church as well. God will always be at work in the faithful proclamation of his word. While the hidden or mysterious nature of the power and work of his word may at times defy statistical measure, God's word will never return void (Isa. 55:8-13).

Secondly, the parable of the growing seed sheds light on the measurement of Church health. While not dismissing the value of statistical measure that speaks to the organizational health of a church, this type of measurement must be secondary to a measurement of health that takes into account the ministry of the word of God. According to the parable, God's word transforms lives. In light of this truth, health and vitality in the Church will necessarily revolve around the church's proclamation of and witness to the word. While the Church does not ultimately *make* disciples it is to cultivate the growth of believers through discipleship (Gundry 206).

Lastly, the parable of the growing seed raises a note of caution for the Church in its effort to measure church health. The contrast between the role of the man and the role of the word in the parable serves, in part, as an encouragement to the Church (Tuckett 25). While the work of the word may not always be *visible*, the word is nonetheless at work when faithfully proclaimed and obeyed. Expectations and assessment of church health must acknowledge this truth, avoiding the possibility of unnecessarily discouraging pastors and churches.

Acts 2:42-47

Acts 2:42-47 paints an informative picture of the life of the early Church. Luke's concise description provides insight into the priorities and practices of the Church that contribute to its growth:

> They devoted themselves to the apostles' teaching and to the fellowship, to the breaking of bread and to prayer. Everyone was filled with awe, and many wonders and miraculous signs were done by the apostles. All the believers were together and had everything in common. Selling their possessions and goods, they gave to anyone as he had need. Every day they continued to meet together in the temple courts. They broke bread in their homes and ate together with glad and sincere hearts, praising God

> and enjoying the favor of all the people. And the Lord added to their number daily those who were being saved.

Luke gives this description of the life of church in following his account of Pentecost (2:1-12) and Peter's sermon to the crowd that witnessed the event (2:13-39). About three thousand who believed Peter's message were baptized and added to the church (2:41). While the church as the people of God goes back to Abraham, the Church at Pentecost became the spirit-filled body of Christ (Stott, *Message of Acts* 81). Acts 2:42-47 describes the impact of the Holy Spirit upon the church, the evidence of his presence and power.

The first evidence of the impact of the Holy Spirit upon the church was the community's commitment to the apostles' teaching (Bruce, *Book of Acts* 79). The apostles' witness to Jesus' life, teaching, death, and resurrection, directed by the Holy Spirit, grounded the early Church doctrinally and "enriched every aspect of this church's life" (Lawson 200). The early Church's demonstration of devotion to one another through fellowship was also a sign of the impact of the Holy Spirit. The believers enjoyed new family relationships in Christ and a fellowship marked by unity, mutuality, and generosity (Gangel 472). Luke defines this experience of fellowship as *koinōnia*. The church enjoyed *koinōnia* as a result of their "common share in God the Father, Son, and Holy Spirit" and in their willingness to share their possessions for the common good (Stott, *Message of Acts* 83). As a result of the impact of the Holy Spirit, the life of the church also experienced an "awareness of God's presence and power" that resulted in prayer, worship, and praise (Gangel 469). The worship of the early Church, marked by joy and sincerity, was both formal (in the temple courts) and informal (in homes). These regular worship gatherings focused on the celebration of the Lord's Supper and prayer

(Stott, *Message of Acts* 85). Finally, the Spirit's impact empowered the witness of the early Church. Luke comments that the church gained favor with those outside the church and that the Lord added "daily to their number" those saved (Acts 2:47).

The description of the Spirit-filled church in Acts 2:42-47 is integral to a biblical definition of church health. According to Luke, the early Church was clearly a growing church, it grew both spiritually and numerically (Carver 478), yet Luke's description indicates numerical growth as a result of the life of the church, not in reverse order. In other words, growth was an outcome or fruit of the health and vitality of the church. Luke does not indicate that this experience of health and growth in the church was automatic; rather, he outlines the practices of the church that *positioned* it for health and growth. Wesley, in his message entitled "The Means of Grace" defines these practices; prayer, searching the Scriptures, the Lord's Supper, fasting, and fellowship, as "ordinances," means ordained of God as the "usual channels of his grace." Wesley carefully and clearly points out that the ordinances themselves have no power nor is there merit in the discipline of practicing them. Rather, the believer, "in and through every outward thing, is to look singly to the *power* of his Spirit; and the *merits* of his Son" (original emphasis). Seeking God alone through the means of grace, positions the believer for the ministry of his grace, the renewal of the soul in "righteousness and true holiness." Viewed through a corporate lens, the means of grace define church health in practical and spiritual terms. The church with its life centered on the pursuit of God through his word, prayer, and the Lord's Supper, positions itself for the ministry and blessing of God's grace. According to Luke's description of the church in Acts any discussion of church health and vitality will necessarily focus on these practices. Luke did speak in numerical terms when he noted

that the Lord added to the church's numbers each day, but the addition is a reflection and result of God's work of grace and power in and through the church.

Luke's description of the growth of the church in Acts 2:42-47 gives further insight on the definition of a healthy church. Luke adds a qualifier in noting the daily numerical growth of the church by stating that the numbers represented those "who were being saved" (2:47). The witness of the early Church is apparent in the favor they enjoyed with all the people (2:47), but those "added" to the fellowship believed the message of the Apostles and placed their faith in Jesus Christ. In matters of church health then, according to the church in Acts, numerical growth in and of itself is neutral. Numerical growth is healthy growth when the increasing numbers are a result of conversions. Also, absent from Luke's description of the church in Acts 2:42-47 is any indication of a link between church size and health. Any definition or assessment of health built upon the example of the church in Acts 2 will focus on spiritual factors, not numerical size. Luke's emphasis on the growth of the church is not upon size but the fact that the "Lord added to their number daily" (2:47). The healthy church will be a growing church but the matter of numerical growth is ultimately in the hands of the Lord. The Church participates in God's ministry of grace to those outside a relationship with him by its faithful witness to God's redemptive plan and power (Gangel 471). Further still, the picture of church health outlined in this passage infers that the experience of the early Church is the norm. Nowhere does the passage suggest that the early Church was extraordinary or that their experience was unique as compared to the expectations of the church from that point forward. The Holy Spirit did come at Pentecost and has never left the church (Stott, *Message of Acts* 87).

First Corinthians 3:5-17

In 1 Corinthians 3:5-17, the Apostle Paul clearly identifies the true cause of growth in the church, putting in perspective the work of those that serve the church as assigned by Lord:

> What, after all, is Apollos? And what is Paul? Only servants, through whom you came to believe—as the Lord has assigned to each his task. I planted the seed, Apollos watered it, but God made it grow. So neither he who plants nor he who waters is anything, but only God, who makes things grow. The man who plants and the man who waters have one purpose, and each will be rewarded according to his own labor. For we are God's fellow workers; you are God's field, God's building.
>
> By the grace God has given me, I laid a foundation as an expert builder, and someone else is building on it. But each one should be careful how he builds. For no one can lay any foundation other than the one already laid, which is Jesus Christ. If any man builds on this foundation using gold, silver, costly stones, wood, hay or straw, his work will be shown for what it is, because the Day will bring it to light. It will be revealed with fire, and the fire will test the quality of each man's work. If what he has built survives, he will receive his reward. If it is burned up, he will suffer loss; he himself will be saved, but only as one escaping through the flames.
>
> Don't you know that you yourselves are God's temple and that God's Spirit lives in you? If anyone destroys God's temple, God will destroy him; for God's temple is sacred, and you are that temple.

The Apostle Paul's words are set in the context of an effort to confront division in the church at Corinth. Paul reveals that the divisions are based on a wrong view of Christian leadership (1:12, 3:4) rooted in their spiritual immaturity (3:1-3; Pryor 55).

Divisions arose as church members formed parties aligning themselves with the leadership of Paul, Apollos, Peter, and even Christ. At the heart of this crisis, for which Paul's authority and gospel at Corinth were at risk, was the Corinthians' fascination with "wisdom" (Rhyne 174). Some in the church at Corinth were unimpressed with Paul and his message of the cross (1:17-3:4). Paul countered the Corinthian's unspiritual view of wisdom by stressing that when he came to them he spoke plainly that they might trust the

power of God rather than human wisdom (2:4-5). Because of God they were in Christ Jesus, who "has become for us wisdom from God—that is, our righteousness, holiness and redemption" (1:30). Paul turned the accusations against him back on those questioning his wisdom and gospel by declaring that he had "the mind of Christ" (2:16). The Spirit revealed the "secret wisdom of God" to him—Christ crucified (2:10) and the Spirit speaks through him (2:13). As a result, the inability of some members of the church at Corinth to comprehend his wisdom was a sign of their being unspiritual. Paul contends that he was not previously, and was still not able at the time of his writing, to speak to the Church at Corinth as he would to "mature Christians" (3:10). As much as the church wanted to speak of "wisdom" and spiritual matters, Paul pointed to their behavior as immature and worldly; they were acting like "mere men" (3:1).

Paul addresses the division in the church at Corinth and the spiritual immaturity; underlying it in 3:5-9a with a metaphor of farmers in a field and in 3:9b-17 with a metaphor of construction workers on a building (Blomberg 72). In both metaphors Paul seeks to put into perspective the role that he and Apollos had played with the role that God played in establishing and building the church at Corinth (Pryor 58). Through these metaphors Paul also offers valuable insights on the topic of church health as well as the distinction between the Church's role and God's role in the growth of the Church.

In 3:5-9a, Paul describes himself and Apollos as "servants" (*diakoni*), performing the tasks assigned to them by the master. They both have allotted and assigned work to do in the "field" and their work is of equal value. Paul "planted" the gospel seed, Apollos "watered," and God "made it grow" (3:6). Both Paul's and Apollos' roles are vital but are insignificant apart from God's role (Bruce, *1 and 2 Corinthians* 43). In 3:9b-17 Paul

transitions to a building metaphor, describing himself as an “expert builder” or “architect” (Pryor 59). Paul laid the foundation for the church in Corinth through his preaching of Jesus Christ and the cross. Others were building on that foundation. Like the workers in the field the work of the builders was vital, but only work that contributed to the growth of the church in Christ will last on that “Day.” Paul emphasizes that God will test each person’s work by “fire” to reveal the quality of materials, whether the work was done in and through the power of the Holy Spirit or with human resources and selfish motives.

Paul’s recognition in 3:5-17 of his work and the work of others in building the church sheds light on the role of the Church in attaining and maintaining health. His use of the metaphors in this passage anticipate the metaphor of the body in chapters twelve through fourteen with all Christians using their spiritual gifts for the building of the church (Blomberg 84). Paul later emphasizes his own hard work by the grace of God (15:10) and encourages the church at Corinth to give themselves “fully to the work of the Lord” (15:58). Paul highlights the validity, the value, and the equality of his and the work of others. This work, however, is valid only as it builds upon the foundation of Christ, is of value only when accomplished in the power of the Holy Spirit, and is equal only when performed in an attitude of humility and service. Far from a passive role, Paul stresses that the church is to take a very active role in its growth and development. This role is subordinate, however, to God’s role, as he brings growth and is the source of the life and vitality of the church.

When Paul draws a distinction in 3:12-14 between work that will last, work with an eternal value, and work that will be “burned up,” work with only temporary value, he

states that the distinction will be revealed on that "Day," in reference to the Judgment (Blomberg 74). Until that Day discerning the authenticity of church growth and health will require strict attention to the spiritual tests or marks such as those Paul gave the church at Corinth: unity in the faith (1:10), holiness (1:2, 30), and humble service in the grace and power of God (3:5).

A Healthy Church

Church growth and health have been *buzzwords* in the Church for some time. A review of both movements will be helpful in understanding the foundation for the Wesleyan Church's Church Health Profile, the tool used for this project. The review will also enable critical biblical-theological analysis of the movement necessary for the creation of the health revitalization plan desired by the CNY District.

The Church Health Movement

The current focus upon health in the church today can at the same time be said to have its roots in the church growth movement and yet also be the result of a reaction to it (Walker 6-7). The foundational concern of the church growth movement, based on the work of Donald McGavran in the 1960s, enabled the church to reach people outside of a relationship with God more effectively (Stetzer 7). Through disciplines such as the social sciences and statistics, the church growth movement utilized tools to evaluate the effectiveness of church growth methods carefully and accurately and to study church growth worldwide (8). The movement effectively called the church to a focus upon the "church not individual conversions, on integrity not on excuses, on the main task not on secondary tasks, on principles not pragmatics, and on sociological tools not traditional correctness" (Walker 5).

The movement's focus upon numerical growth in the church was and is reflective of a commitment to the Great Commission and God's call for fruitfulness (Walker 4; Ellis 8). The definition of church growth used by the American Society for Church Growth expresses this balance between spiritual and technical factors:

> Church growth is that careful discipline which investigates the nature, the function, and the health of Christian churches, as they relate to the effective implementation of the Lord's Great Commission to make disciples of all people (Matt. 28:19-20). It is a spiritual conviction, yet it is practical, combining the eternal principles of God's Word with the practical insights of social and behavioral sciences. (Ellis 6)

The emphasis of the church growth movement upon the application of principles of mission to the context of evangelistic growth (Stetzer 12) challenged churches to consider church *health* through the lens of growth and outreach.

Your Church Can Grow and *The Healthy Church* by prominent church growth author C. Peter Wagner further expresses the connection between church health and church growth. With the identification of church health vital signs and "diseases" that can afflict a church and prohibit growth, Wagner's research highlights that health is essential to growth and so introduces a new paradigm, "health before growth" (Walker 6; Wagner, *Healthy Church* 9).

While church health was foundational to the church growth movement, it eventually became the focal point of one of the greatest perceived criticisms of the movement (Stetzer 8). With its emphasis upon technique, the church growth movement was criticized for being more focused upon growing churches numerically than it was upon the biblical and spiritual aspects of growth (Dever 11; Malphurs 27; Macchia 15; Schwarz 7). Health was being measured in numerical terms rather than in spiritual terms (Gangel 468). This criticism further leveled that the movement's emphasis upon

technique created a *one-size-fits-all* approach to growth, which resulted in an uncritical application of methods in the local church's context (Stetzer 5).

Proponents of church health maintained that nowhere in Scripture is the measure of church health based on size alone (Gangel 469). Just as a large person can be unhealthy or a small person can be healthy, a large church could be unhealthy and a small church healthy. While healthy churches do grow in size and numbers, "they do not only grow" (Steinke xiii). Regardless of size, the focus must be upon the health of the church, leaving the issue of growth to God (Reeder 29; Schwarz 10). Church health is to be understood in "organic" terms (Steinke xii) and not linear, but progressive or expansive (Reeder 29; Schwarz 12). The process of improving the health of a local church is ongoing and will continue to be necessary while the church remains (Walker 12).

The Marks of a Healthy Church

Church health proponents, in contrast to the church growth movement, focus upon principles or marks of health rather than technique (Macchia 14; Schwarz 16; Walker 9). These principles are universal and meant to be "fashioned" and "lived out" in each church's unique setting (Macchia 15). While the concept of *maintenance* is viewed negatively in the church growth movement, in the context of church health it is a positive concept (Steinke xii). As with the human body, health in a church requires maintenance. The attention and energy a church spends on the marks or principles of church health positions a church to optimize its health and advance its mission (xiv).

While lists of marks or principles of church health abound, some based on research and others on experience and opinion, a general list of recurring marks or principles that is representative of the movement can be identified (see Table 2.1)

Table 2.1. General Marks or Principles of Church Health

Marks or Principles	Authors
God-exalting, inspiring worship services	Bickers; Callahan; Gibbs; Macchia; Schwarz
Lay ministry with a focus on spiritual gifts	Bickers; Gibbs; Macchia, Schwarz; Wagner, *Your Church Can Grow*; Warren
A clear mission and vision	Bickers; Gibbs; Macchia; Reeder
Gospel-driven and Christ-centered ministry	Dever; Gangel; Reeder; Spader and Mayes
A commitment to discipleship	Callahan; Bickers; Dever; Gangel; Gibbs; Macchia; Reeder; Schwarz; Spader and Mayes; Wagner, *Your Church Can Grow*; Warren
An authentic, loving, growing community	Callahan; Bickers; Dever; Gangel; Gibbs; Macchia; Schwarz; Spader and Mayes; Warren
Empowered and empowering leadership	Callahan; Bickers; Dever; Gangel; Gibbs; Macchia; Reeder; Schwarz; Wagner, *Your Church Can Grow*; Warren
Leadership development	Callahan; Dever; Gangel; Gibbs; Macchia; Reeder
A commitment to prayer	Callahan; Bickers; Dever; Gibbs; Macchia; Schwarz; Reeder; Spader and Mayes; Warren
A commitment to the Great Commission	Bickers; Dever; Gibbs; Macchia; Schwarz; Reeder; Spader and Mayes; Wagner, *Your Church Can Grow*; Warren
Stewardship and generosity	Callahan; Bickers; Macchia; Warren
Vision-focused and functional structures	Bickers; Callahan; Dever; Gangel; Gibbs; Macchia; Wagner, *Your Church Can Grow*; Warren; Schwarz

Recent research in the field of church health has shown that focus upon these church health factors can result in a recovery of church health and lead to revitalization (Salsburey 5; Sloan 7). Lay leadership can also be trained to be *pulse takers*, enabling them to access, identify, develop, and address a church's organizational system in ways that seek to maintain and promote church health (De Noyelles 57).

Natural Church Development

The most significant and extensive research into church health, Natural Church Development (NCD), was conducted by Christian A. Schwarz. From 1994-96, one thousand churches in thirty-two different countries and six continents were surveyed to

determine, “What church growth principles are true, regardless of culture and theological persuasion?” (19). Based on this research, Schwarz identified eight principles or *quality characteristics* for natural church growth and development. No one of these characteristics leads to church growth in and of itself; rather, each of these eight characteristics must be in a “harmonious interplay” for growth to take place (39; see Table 2.2).

Table 2.2. NCD Eight Quality Characteristics of Church Growth

Characteristic	Description
Quality characteristic #1	Empowering leadership
Quality characteristic #2	Gift-oriented ministry
Quality characteristic #3	Passionate spirituality
Quality characteristic #4	Functional structures
Quality characteristic #5	Inspiring worship service
Quality characteristic #6	Holistic small groups
Quality characteristic #7	Need-oriented evangelism
Quality characteristic #8	Loving relationships

These eight quality characteristics are to be understood as principles, not a model (Schwarz 17). The focus of NCD is to release the “biotic potential” that God has put in every church (10). Over against the “technocratic” approach of attempting church growth in one’s own strength, and a “spiritualistic” paradigm that underestimates the significance of institutions, programs, and methods, the goal is to let God’s growth “automatisms” bring growth (14). The responsibility of the church lies in removing obstacles to growth, quality characteristics least developed or “minimum factors,” both inside and outside the church (50). Church energies should be invested in the “institutional pole of church life,”

ensuring that they are in harmony with God's principles so that the "organic pole" can develop "unhindered and healthy" (99).

NCD utilizes a scientifically validated tool to measure a church's qualitative growth by way of a "quality index" or QI based on the NCD eight quality characteristics (Schwarz 20). Utilizing this qualitative data along with quantitative data (numerical growth or decline), Schwarz identifies four categories of churches and the "typical real life behavior" of these churches in various areas (21; see Figure 2.1).

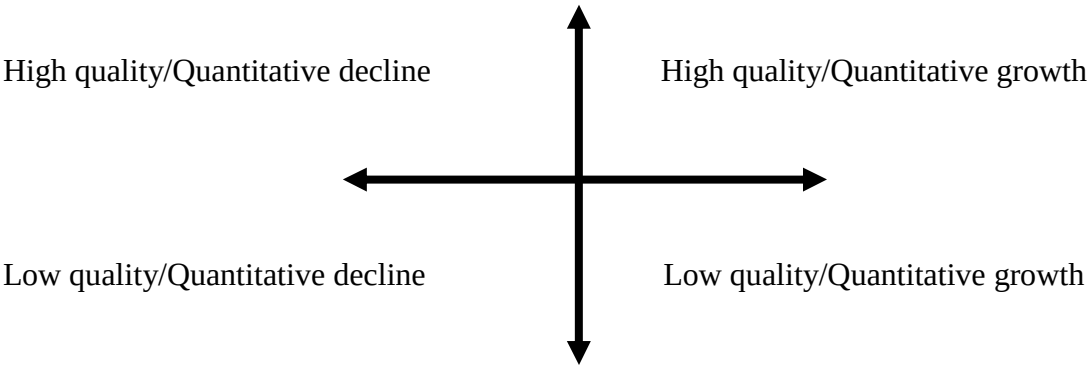

Figure 2.1. NCD four categories based on church quality and quantity.

The overarching results of this research reveals that not all growing churches are healthy (based on the quality index) but that every church that reached a quality index of sixty-five or more in each of the eight quality characteristics was a growing church (Schwarz 39).

Criticism of NCD and Church Health Movement

NCD has not been without its critics. Many from the church growth movement object to Schwarz's characterization of the movement's presenting "simplistic rules and principles that don't work in the real world" and that the eight principles for church

health presented by Schwarz are not new (Ellis 7). Critics from the church growth movement also point out that Schwarz did not follow scientific methods and that his work was, therefore, pseudo-scientific and flawed (Stetzer 14).

Probably the greatest criticism of NCD and the church health movement as a whole was the almost exclusive focus upon ecclesiology, or *how to do church,* in order to be healthy and grow. Criticism centered upon the fact that the attention to the internal life of a church resulted in a neglect of "matters of culture and context" (Stetzer 15). In other words, if churches focused entirely on doing church better they would be in danger of losing sight of their mission to reach their communities for Christ.

The Wesleyan Church's Church Health Profile

The CHP was chosen as the tool for this research project because it is a denominational tool readily available to districts and local churches of the Wesleyan Church. As a denominational tool, it provides the opportunity not only for data but also for ongoing accountability and growth. In reviewing the CHP background material available on the denomination's evangelism and church growth (ECG) Web site and material made available to me through that office, a brief summary is offered on the creation and development of the CHP tool.

Over two years in the making, the CHP is an online assessment instrument that helps measure a church's health by evaluating behavioral outcomes within twelve factors. Under the leadership of Rev. Richard Meeks, the Director of ECG for the Wesleyan Church, the CHP became the centerpiece of the Church Health Fitness Center, a Web site that serves pastors and other church leaders by resourcing them as they address health and growth issues within their churches.

The CHP was designed to be a “denominationally sensitive tool,” which means it speaks to churches within denominational systems with “corporate identity and certain accountability” (“CHP What and Why” 1). Its goal was not to invent a replacement for the NCD survey but to provide an excellent alternative that serves the broad range of Wesleyan churches.

Accompanying the CHP diagnostic tool on the Church Health Fitness Center Web site are resource articles to assist pastors and other church leaders in taking steps to enhance their strengths and address specific areas of concern.

The twelve health factors of the CHP were developed through review of church growth and church health literature with the assistance of expert consultation and with the help of a think tank and focus group made up of select pastors, denominational leaders, and professors.

An overview of the twelve factors is provided in Table 2.3. The CHP takes the participants’ responses and averages the totals in each health factor to determine an overall score. The overall score is then used as an indicator of general health within the church. The CHP also takes the overall score and places the church in one of three predetermined developmental categories: reproduce, refocus, or return.

The results of the CHP are to be interpreted as a general conclusion, intended to be instructive and helpful, to be used as a guide in leading the church toward greater health and vitality.

Table 2.3. The CHP Twelve Health Factors

Health Factor	Description
1. Divine enablement	The healthy church recognizes God's sovereign role in building the kingdom and joyfully seeks and expects his Holy Spirit's work in and through the body of Christ.
2. Pastoral leadership	The healthy church is led by a pastor who demonstrates the calling, character, and competence to help the church achieve its God-given purpose and shared vision.
3. Christ-exalting worship	The healthy church magnifies Christ by providing worship experiences that engage the whole person and lead the congregation into God's empowering presence.
4. Effective evangelism	The healthy church embraces its Great Commission responsibility by multiplying passionate followers of Jesus Christ and healthy churches.
5. Ministries of compassion	The healthy church actively expresses the love of Christ through generosity and service to those in need.
6. Loving community	The healthy church practices genuine care for one another while embracing new people and valuing their inclusion in the fellowship.
7. Maturing faith	The healthy church nurtures spiritual maturity that shapes biblical beliefs and transforms behaviors consistent with a holy life.
8. Personal ministry	The healthy church expects and equips its members to discover, develop, and use their gifts for fruitful ministry.
9. Leadership development	The healthy church identifies, trains, and empowers persons called to and gifted for servant leadership.
10. God-honoring stewardship	The healthy church teaches biblical stewardship and provides opportunities for generosity.
11. Missionary spirit	The healthy church replicates itself by reaching into its community and world as compassionate, culturally responsive, disciple-making ambassadors of Jesus Christ.
12. Vision-focused systems	The healthy church has its varied ministries focused and working together around the central purpose of fulfilling its vision.

Research Design

In order to provide the necessary data concerning the state of church health within twenty-four of the CNY District's fifty churches, this study utilized a quantitative, quasi-experimental, causal-comparative research design. The quantitative research approach was chosen in order to provide the CNY District quantifiable data that revealed

similarities and differences between churches, pastors, and lay leadership concerning church health (Creswell 51). This data was made possible by the use of a standardized survey. A quasi-experimental approach was necessary in selecting the churches to participate in the CHP survey so that the study would incorporate an equal number of churches that had shown primary worship service growth or decline.

The causal comparative aspect of the research enabled comparison of the different groups from which the data was derived: churches showing primary worship service attendance decline, along with their pastors and leaders compared with the churches that showed primary worship service attendance increase and their pastors and leaders ("Causal Comparative Research" 2). The use of the standardized CHP survey and delivery system also made possible a clean and clear correlation analysis of the possible relationships between primary worship service decline or increase and the church health factors focused on as part of the CHP survey (Hawkins and Parkinson 105).

Summary

Both the church growth and the church health movements have made a contribution to the Church in its mission to fulfill the Great Commandment. Part of that contribution has been the development of tools, such as the Wesleyan Church Health Profile, to enable churches to assess and address matters of health and growth. While acknowledging this contribution, a biblical definition of health based on passages such as Mark 4:26-29, Acts 2:42-47, and 1 Corinthians 3:5-17, reveal guidelines for the creation of and limitations for the use of these diagnostic tools. These guidelines and limitations center on the clarification of *roles,* God's role, and the role of the church in achieving and maintaining health.

An overarching theme that joins Mark 4:26-29, Acts 2:42-47, and 1 Corinthians 3:5-17 together is the message and power of the gospel of Jesus Christ. In Mark's record of Jesus' parable of the growing seed, the word transforms or bears fruit in the lives of those who hear it well. In Acts 2:42-47 the word is central to the life of the church. As a result of their faith and obedience to the word, *hearing well*, the church positions itself for the ministry of God's grace, leading to spiritual and numerical growth. In 1 Corinthians 3:5-17 "Christ crucified" is the power and wisdom of God. Faith in the crucified Christ will evidence itself in the spiritual fruit of unity, holiness, and humble service.

The focus upon the message and power of the gospel of Jesus Christ in Mark 4:26-29, Acts 2:42-47, and 1 Corinthians 3:5-17 reveals that God's role and the role of the Church in achieving and maintaining health are not equal. The power of the gospel transforms lives. Spiritual and numerical growth is a result of the power of God at work in and through the Church. Accordingly, the experience of health in the Church will be in direct correlation to the preeminence of the gospel. The Church's role then is to participate in the building of the Church through the faithful witness and proclamation of the gospel. Essential to this role is the ordering of the life of the Church around the means of grace, such as the study of Scripture, prayer, and celebration of the Lord's Supper. God's role precedes and enables the Church's role.

One result of this clarification of roles is that it places the evaluation of health and vitality in the Church in the context of relationship rather than in a technical context. Numbers and methodologies may play a secondary role but only as they serve the primary factor in church health, the state of the Church's relationship with the Lord.

Attention to relationship with Christ then impacts relationships within the body of Christ and those outside the Church. Another result of the clarification of God's role and the role of the Church is the priority of discipleship in achieving and maintaining health. While the working of the word is by God's power, *hearing well* entails commitment and devotion. The work of the Church, to build up the body of Christ in his "fullness" (Eph. 4:13) is vital. A third result of the clarification of roles is that it puts into perspective God's power and the Church's dependency in the experience of health. Every church, regardless of size, is dependent upon God, and by his power, can experience health and vitality. Churches can, therefore, avoid chasing after the *latest and greatest* church health fad or wishing they were more like another church. God is able, with even the smallest of beginnings, to accomplish his kingdom purposes through the Church.

The data made possible through this project, by the use of the Wesleyan Church's Church Health Profile, will give the CNY District valuable insight into the health of the participating churches. The development of a sustainable revitalization plan for the district, however, will need to go beyond the survey results. Tools such as the Church Health Profile provide a snapshot or barometer of church health and as such are secondary to the principles and spiritual practices that lead to health.

CHAPTER 3

METHODOLOGY

Problem and Purpose

In 2006, the general superintendents and district superintendents of the Wesleyan Church spent several months working together to identify the fundamental indicators of church health. As a result of that discussion, the Central New York District Board of Administration developed a top ten list of church health indicators for district use. These indicators were to be used to aid churches in self-evaluation and to aid the district in monitoring and encouraging churches (*Central New York District Journal*, 2006 4). Based on the first of these indicators, primary worship service attendance, twenty-eight of the fifty district churches have shown a numerical decline from 2000-09 or 2005-09. While only one indicator of the now nine health indicators (*Central New York District Journal*, 2009), the decline in primary worship service attendance has raised concern with district leadership and awareness for the need to seek effective ways to help district churches.

The purpose of this research project was to assess the church health of twenty-four CNY District churches through use of the Wesleyan Church's Church Health Profile. The district anticipates that such an assessment will guide it in establishing the foundation for a sustainable church revitalization plan for the district.

Research Questions and/or Hypotheses

To provide the data necessary for the creation of such a plan, the following research questions provided focus for the research. These questions as a whole were designed to enable the district to understand the state of church health from the

perspective of the local churches themselves. The ultimate goal was to allow this data to drive the creation of a church revitalization and health maintenance plan.

Research Question #1

What are the actual similarities and differences in overall church health, based on the Church Health Profile, among the twelve CNY district churches reporting declining worship service attendance from 2005-09 and the twelve CNY District churches reporting an increase in worship service attendance from 2005-09?

The intention behind this comparison was to seek to identify what, if any, connection might exist between church health and numerical growth or decline. The comparison also made possible the identification of any church health factors, or combination of church health factors, that might contribute to church numerical growth. Comparison analysis included each church's overall health factor scores and the analysis of health factor scores by grouping (primary worship service attendance increase, primary worship service attendance decrease).

Research Question #2

What are the actual similarities and differences in perceived church health, based on the CHP assessment, among the pastors and church leaders of the twelve CNY District churches reporting declining worship service attendance from 2005-09 and the pastors and leaders of each of the twelve CNY District churches reporting an increase in worship service attendance from 2005-09?

With the recognition of possible differences between actual church health and *perceived* church health, this second research question focused not only on a comparison of groups (numerical growth and numerical decline) but also sought to compare the

pastors' and church leaders' assessment of church health in each church. The goal was to identify any similarities or differences among clergy's and lay leaders' perceptions of church health, by church and by group, that might contribute to or detract from the actual experience of health.

Research Question #3

What are the church health characteristics, based on ranking resulting from the CHP assessment, that will enable the Central New York District leadership to impact the pastors and church leaders and help position district churches for revitalization?

Based on the first two research questions, the focus of this third question was to review the ranking of church health factors by both church groups (numerical increase and decline) and the pastors and lay leaders from both groups. Identifying the least ranked (evident) factors and the most ranked (evident) factors helped to identify those health characteristics on which the CNY District must focus to restore or maintain health in its churches and to see if the comparisons might give direction as to priority (which, if any, health factors need to be addressed first and in what order), method (how to address health factors), and target group (who needs to be addressed—church, clergy, lay leaders).

Population and Participants

The churches chosen for the study were selected from a larger group of fifty churches that comprise the Central New York District of the Wesleyan Church.

The twenty-four churches chosen for the study were selected based on the first of nine CNY Church Health Indicators—primary worship service attendance. The first group consisted of the twelve churches in the district that reported the highest numerical

increase in primary worship service attendance from 2005-09. The second group consisted of the twelve churches that reported the greatest numerical decrease in primary worship service attendance for the same time period (see Table 3.1).

Table 3.1. Participant Primary Worship Service Attendance 2005-09

Twelve CNY District churches with highest numerical increase				
CHURCH	**2005**	**2009**	**# increase**	**% increase**
Victory Highway	1294	1373	79	5.75
Avon	205	270	65	24.07
Lyncourt	80	141	61	43.26
Pulaski	295	344	49	14.24
Chambers	164	206	42	20.38
Wallace	35	77	42	54.54
Wayland	120	160	40	25.00
Buena Vista	266	301	35	11.62
Horseheads	200	232	32	13.79
Herrickville	85	113	28	24.77
Canisteo	145	170	25	14.70
Sandy Creek	40	64	24	37.50
Twelve CNY District churches with the greatest numerical decrease				
CHURCH	**2005**	**2009**	**# decrease**	**% decrease**
Athens	337	232	105	31.15
Canandaigua	1226	1121	105	8.56
Gates	181	110	71	39.22
Penfield	131	91	40	30.53
Haskinsville	95	60	35	36.84
Cortland	69	40	29	42.02
North Rome	209	192	17	8.13
Mt. Pisgah	160	144	16	10.00
Rome	35	19	16	45.71
Spencerport	143	127	16	11.18
Bentley Creek	244	230	14	5.73
Sunshine Valley	52	40	12	23.08

Design of the Study

To provide the necessary data for an assessment of church health in these twenty-four churches, each of the church's senior or solo pastor and nine church leaders were asked to complete a standardized church health survey. The survey results were then evaluated with a focus on similarities or differences that might provide the CNY District leadership with an objective picture of the state of health within each church and inform the development of a plan to revitalize and maintain church health within the district.

This was a pre-intervention study that utilized a quantitative, causal-comparative, quasi-experimental design. The use of the standardized Wesleyan Church's Church Health Profile allowed for a clean and clear statistical analysis of individual church and district church health factors. The profile also allowed for comparison of the two groups, churches reporting an increase in primary worship service attendance from 2005-09 and those that reported a decline, as well as comparison of the pastor and church leader responses.

The entire study took place over a four-month time period. The administration of the Church Health Profile took place during the first two weeks of October 2010. Any churches failing to complete the requested number of surveys received follow-up during the last two weeks of October. Analysis of surveys took place during November and December 2010 and January 2011.

Instrumentation

The Department of Evangelism and Church Growth of the Wesleyan Church created the instrument utilized in this study, the Church Health Profile, to provide churches with a measurement of overall church health (*Church Health Profile*).

Launched in 2004, the Church Health Profile is a standardized tool, consisting of 120 statements, with each statement being part of a grouping of ten, focusing on one of twelve church health factors. Participants are asked to respond to each statement, identifying the extent to which the statement is true of their church by use of a scale (consistently, occasionally, or never).

Variables

The independent variables in this research involved the twelve church health factors that form the basis for the survey. The twelve health factors, divine enablement, pastoral leadership, Christ-exalting worship, effective evangelism, ministries of compassion, loving community, maturing faith, personal ministry, leadership development, God-honoring stewardship, missionary spirit, and mission-focused systems, were identified using the best research available on the subject of church health, independent of this research project. The tool utilized a scaling format to provide solid data on the perception of health in the participants' churches. The design of the standardized tool allowed the results to be stored and then tabulated electronically.

The dependent variables in this project were the participant responses to the CHP questions assessing the health of their church. Within the tool, the twelve health factors were dependent variables, resulting from the participants' perception of the health of their churches in each of those twelve areas.

The intervening variables in this research project were the church size and demographics, the potential loss of data due to Web site difficulty, additional participants other than those selected completing the online survey, participants' lack of technological

practical understanding, participants' failure to complete the survey, and participants' concern as to whether or not their survey information would be reported anonymously.

While some intervening variables are beyond control, efforts were made to limit these variables. To help with the technological component of completing the survey online, participating churches received detailed instructions. Participating churches also received follow-up during the survey process for encouragement and to address any issues. In situations where the required number of surveys was not completed by mid-October, churches received further assistance. In the information packet, pastors and church leaders received assurance that results would be confidential.

Reliability and Validity

The Wesleyan Church Department of ECG has not calculated the reliability coefficient of the CHP survey. The tool was designed, however, to assure stability and reliability. The tool enables participants to assess the overall health of their churches by responding to questions based on twelve health factors. The tool consists of ten questions for each health factor, totaling 120 questions, asking the participants to respond by ranking their perception of church health according to a scale for each question.

To assure the validity of the CHP instrument, the designers utilized a think tank of denominational, district, and pastoral leaders during March 2003 to help develop the list of health factors and contribute to the overall development of the instrument and process. The designers also utilized a focus group during the months of April and May 2003 to refine the instrument and online format further. The designers then performed a pilot test of the CHP in April 2004 and then again in May 2004 before making the CHP available online for use. Finally, the designers also sought feedback and consultation from church

growth expert Dr. Gary McIntosh, Professor of Christian Ministry and Leadership at Talbot School of Theology, during the fall of 2003.

Data Collection

The research component of this dissertation utilized the standardized CHP instrument designed by the Department of Evangelism and Church Growth of the Wesleyan Church. The pastor (senior pastor if applicable) and nine church leaders from twenty-four CNY District churches were asked to complete the online survey. Twelve of these district churches were chosen based on the primary worship service attendance decline from 2005-09 and the other twelve based on primary worship service attendance increase during this same time period.

The research portion of this project took place from September 2010 through November 2010. It began with an introductory letter sent to each of the churches asked to participate and came to a conclusion with the follow-up and completion of surveys on 3 November 2010.

A formal letter was sent the fourth week of September 2010 to the pastors of the churches asked to participate in the project. The letter provided an invitation to participate, a general overview of the project, and complete instructions for taking the CHP. These instructions also enabled the pastors to enlist church leaders to take the survey. This letter was followed with a phone call during the first week of October 2010 to provide a more personal connection with each pastor and to answer any questions they might have.

Participants completed the online Church Health Profile between 11 October and 3 November 2010. Reminder phone calls were made, as necessary, during the data collection period, with the goal of increasing the level of participation.

Data analysis took place during November and December 2010. Scott Vandegrift, president of LeaderLadder, and Dean Neubauer, a statistician with Corning Incorporated, helped with the statistical analysis and development of the presentation of the findings.

Funding was not a major issue for the research project. The CHP instrument was available as a denominational tool at no cost to me or the district. I carried the expense of the cost of postage, materials for mailings, long-distance phone call charges, as well as an honorarium for the help with the statistical work.

Data Analysis

The study utilized Microsoft Excel and descriptive statistics to analyze the data provided by the CHP instrument. Disaggregation of the data by demographics (pastor, church leader, churches in the primary worship service attendance decline group, and churches in the primary worship service attendance increase group) divided the data into subgroups for detailed analysis. Examination of the data included research for possible correlation related to the churches and individual groups. Factor analysis provided the level of significance of the reported scores of the twelve health factors for each church and for the whole study.

Ethical Procedures

Due to the design of the online CHP instrument, data collection is anonymous apart from the distinction between pastor and church leader. Church leaders also have the option, and were given the option with this project, of providing their name or completing

the survey anonymously. The distinction between pastor and church leader and access to participants' identification is only available to the Web site administrator, LeaderLadder, an outside contractor employed by the Wesleyan Church. The summary information available to participating churches and the CNY District only reveals the number of participants in each church and the average of all completed survey scores. The Wesleyan Church granted administrative access to the survey data for this project to enable research that goes beyond the basic CHP format. Participants' identification, where given, remained confidential throughout the project.

Each of the participating pastors received assurance in the introductory letter and personal conversation that the goal of the research was to provide the basis for a district church revitalization and health maintenance plan. While district leadership was involved in determining the list of participating churches, the leadership does not have access to and does not need individual and church names to utilize the data. The district has received and is using the data in a statistical format, focusing on the district-wide component of the research.

The Wesleyan Church, through its outside contractor, LeaderLadder, does maintain record of the raw data for all of the CHP surveys completed. While access to the level of data received was granted by special permission and required a great deal of work on the part of LeaderLadder, due to the electronic, online nature of the survey an absolute promise of confidentiality is not realistic. The assurance that participating pastors and churches did receive was that individual and church names would be held in confidence in the CNY District's utilization of the data.

CHAPTER 4

FINDINGS

Problem and Purpose

The Central New York District of the Wesleyan Church recently celebrated the distinction of being the only Wesleyan District in North America to have ten consecutive years (2000-09) of increase in primary worship service attendance as a district. However, eighteen of the district's fifty churches showed a decrease in average worship attendance from the years 2000-09, and an additional ten churches showed a decrease in attendance from 2005-09. The district recognizes the need to explore the health of its churches and to be proactive in offering help and support to those who need it.

The purpose of this research project was to assess the church health of twenty-four CNY District churches through the use of the Wesleyan Church's Church Health Profile. The district anticipates that such an assessment will guide it in establishing the foundation for a sustainable church revitalization plan for the district.

Participants

Twenty-four churches were asked to participate in the study, the twelve CNY District churches with the highest primary worship service numerical increase from 2005-09 and the twelve CNY District churches with the highest primary worship service numerical decrease during that same time period. Table 4.1 provides a summary of the actual church participation in the project. Twenty of the twenty-four churches asked to participate in the project actually completed surveys. The greatest level of participation was in the primary worship service attendance increase group.

Table 4.1. Actual Church Participation Summary (N=20)

Category	Possible Participants	Actual Participants	Participation %
Primary worship service Increase group churches	12	11	91.67
Primary worship service Decrease group churches	12	9	75.00
Total # of participants	24	20	83.33

In each of the twenty-four churches asked to participate in the study, one pastor and nine church leaders were asked to complete the Church Health Profile survey. This would result in a total of ten surveys for each church and a possible total of 240 surveys overall. Table 4.2 details the actual number of surveys completed by the primary worship service attendance groups as well as pastor and leader participation within both groups. A total number of 122 surveys were completed out of a possible 240 surveys, resulting in 50.83 percent participation. The primary worship service increase group as a whole, as a pastors group and church leader group, had the highest percentage level of participation.

Table 4.2. Actual Participation by Primary Worship Service Attendance Group (N= 122)

Category	Possible participants	Actual participants	Participation %
Increase pastor group	12	11	91.66
Increase leader group	108	55	50.93
# increase participants	**120**	**66**	**55.00**
Decrease pastor group	12	9	75.00
Decrease leader group	108	47	43.52
# decrease participants	**120**	**56**	**46.67**
Total # of participants	240	122	50.83

Research Question #1

What are the actual similarities and differences in overall church health, based on the Church Health Profile (CHP), among the twelve CNY District churches reporting declining worship service attendance from 2005-09 and the twelve CNY District churches reporting an increase in worship service attendance from 2005-09?

The CHP instrument consists of 120 statements, with each statement part of a grouping of ten focusing on one of twelve church health factors. Participants were asked to respond to each statement, identifying the extent to which the statement is true of their church by use of a scale (consistently, occasionally, or never). The instrument assigns a value to the responses as shown in Table 4.3. If each of the ten responses for a given health factor were *never* then the total score for that factor would be ten. If each of the ten responses for a given health factor were *consistently,* then the total score would be thirty. These values create a score range for each church health factor of ten to thirty.

Table 4.3. Church Health Profile Scoring

Response	Response Value	Possible Score Range
Never	1	10
Occasionally	2	20
Consistently	3	30

Figure 4.1 provides an overview of the CHP results for the entire project. The columns in the chart represent the combined average scores of both the increase and decrease groups for each church health factor. The chart reveals that the lowest scoring health factor for the project was *effective evangelism*. The *effective evangelism* average

score of twenty was 26 percent lower than the highest average scoring factors of *God-honoring Stewardship* and *pastoral leadership* with an average score of twenty-seven. *leadership development, missionary spirit, personal ministry* and *vision-focused systems* each had an overall average score of twenty-four, which was 11 percent lower than the highest scoring factors.

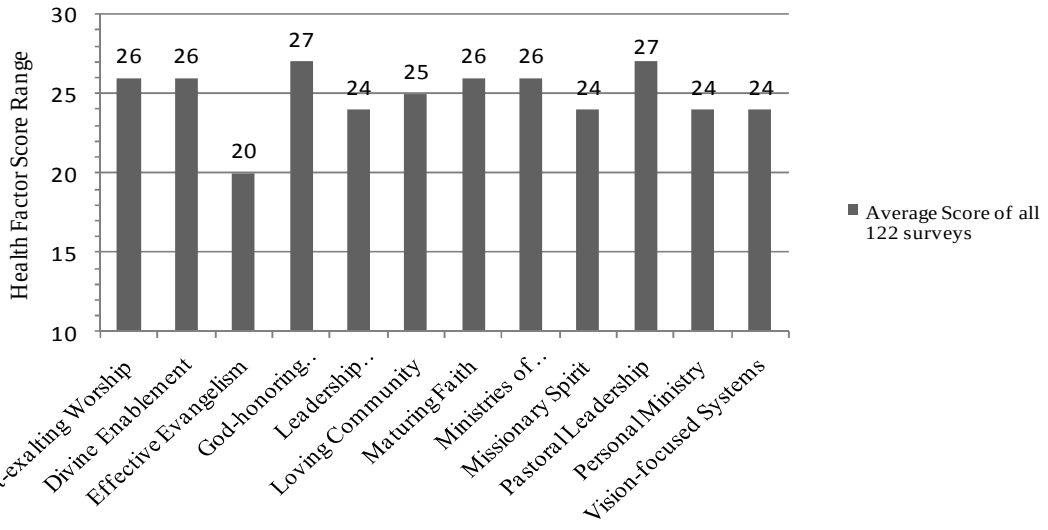

Figure 4.1. Church health profile survey results overview.

The similarities and differences between the primary worship service increase and decrease groups are visible in Table 4.4. Based on the average score by group and by factor, the most significant difference involves *effective evangelism*. The decrease group scored *effective evangelism* 14 percent lower than the increase group. Three other health factors, *divine enablement, missionary spirit,* and *vision-focused systems,* were scored 8 percent lower than the increase group's scoring for the same health factors. The greatest

similarity occurred with the *God-honoring stewardship* health factor; only a 1 percent difference in scoring average separated the two groups. The *Christ-exalting worship*, *ministries of compassion,* and *pastoral leadership* health factors were each scored lower by the decrease group but with 3 percent or less difference in scoring than the increase group. Table 4.4 also reveals that while not always statistically significant, the decrease group's scores were less than the increase group's scores for all twelve church health factors.

Table 4.4. Church Health Factor Score Comparison of Study

Health Factor	Increase Group	Decrease Group	% Difference
Christ-exalting worship	26.5	26.0	2
Divine enablement	27.4	25.3	8
Effective evangelism	21.8	18.8	14
God-honoring stewardship	26.7	26.4	1
Leadership development	24.7	23.5	5
Loving community	26.2	24.6	6
Maturing faith	26.5	25.3	4
Ministries of compassion	25.9	25.0	3
Missionary spirit	25.0	23.0	8
Pastoral leadership	27.8	26.9	3
Personal ministry	24.2	23.2	4
Vision-focused systems	25.1	23.0	8

A two-staged nested analysis of means (ANOM) of the average CHP score of each participating church by category reveals further similarity between the increase and decrease groups. The analysis reveals sixteen ANOM effects, scores outside the average CHP score range, with at least 99 percent confidence. Of the effects, thirteen fall below

the .01 lower decision limit, representing lower than average scores. Twelve of those thirteen effects are a result of *effective evangelism* scores, with seven scores from decrease group churches and five from increase group churches.

Research Question #2

What are the actual similarities and differences in perceived church health, based on the CHP assessment, among the pastors and church leaders of the twelve CNY District churches reporting declining worship service attendance from 2005-09 and the pastors and leaders of each of the twelve CNY District churches reporting an increase in worship service attendance from 2005-09?

Table 4.5 contains the comparison of the scores of pastors and church leaders in the primary worship service attendance increase group. The largest percentage difference between average scores was in the *effective evangelism* category. The pastors in the increase group scored *effective evangelism* 7 percent lower than the increase leaders. The comparison of the scoring for the other eleven church health factors revealed no significant statistical difference.

Table 4.5. Church Health Factor Score Comparison of Increase Group

Health Factor	Increase Leader	Increase Pastor	% Difference
Christ-exalting worship	26.5	26.5	0
Divine enablement	27.4	27.4	0
Effective evangelism	22.1	20.5	7
God-honoring stewardship	26.6	27.0	-2
Leadership development	24.7	24.7	0
Loving community	26.2	25.8	2
Maturing faith	26.5	26.7	-1
Ministries of compassion	25.9	25.7	1
Missionary spirit	25.0	24.5	2
Pastoral leadership	27.7	27.8	0
Personal ministry	24.2	24.4	-1
Vision-focused systems	25.2	24.9	1

Similar to Table 4.5, Table 4.6 contains a comparison of scores, but the comparison is of the scores of pastors and church leaders of the primary worship service attendance decrease group. The only statistically significant difference in scoring average concerned the *effective evangelism* health factor with the decrease pastors scoring an average 8 percent less than the church leader scoring average. The other eleven health factor scores revealed very little percentage difference.

Table 4.6. Church Health Factor Score Comparison of Decrease Group

Health Factor	Increase Leader	Increase Pastor	% Difference
Christ-exalting worship	25.8	26.8	-4
Divine enablement	25.2	25.8	-2
Effective evangelism	19.1	17.6	8
God-honoring stewardship	26.3	26.9	-2
Leadership development	23.5	23.8	-1
Loving community	24.7	24.2	2
Maturing faith	25.5	24.7	3
Ministries of compassion	25.0	25.2	-1
Missionary spirit	23.1	22.7	2
Pastoral leadership	26.9	26.7	1
Personal ministry	23.2	22.8	2
Vision-focused systems	23.0	23.3	-1

A two-staged nested analysis of means (ANOM) used to identify any further similarities or differences between the pastors and church leader's perception of church health, by church and by group, revealed no statistically significant difference between the two groups' scores. The analysis, based on the pastor and church leader average scores, revealed only four ANOM effects showing a difference in perceived church health between pastor and leader, with at least 95 percent confidence. Of the effects, the two factors where the leaders' perception of health is greater than that of the pastors above the .05 decision limit are *effective evangelism* and *personal ministry*. The two factors where the pastors' perception of health is greater than that of the leaders and above the .05 decision limit are *ministries of compassion* and *Christ-exalting worship*.

Research Question #3

What are the church health characteristics, based on ranking resulting from the CHP assessment, that will enable the Central New York District leadership to impact the pastors and church leaders and help position district churches for revitalization?

Averaging average scores for each health factor accomplished ranking of the church health factors. Table 4.7 lists the ranking in descending order for the whole study. According to the average of average scores, *pastoral leadership* was the highest ranked health factor of the twelve health factors for both the increase and decrease groups, and *effective evangelism* was the lowest.

Table 4.7. CHP Factor Ranking for Whole Study

Health Factor	Average of Avg. Score	Rank
Pastoral leadership	2.734	1
God-honoring stewardship	2.653	2
Divine enablement	2.643	3
Christ-exalting worship	2.625	4
Maturing faith	2.599	5
Ministries of compassion	2.550	6
Loving community	2.546	7
Leadership development	2.419	8
Vision-focused systems	2.416	9
Missionary spirit	2.407	10
Personal ministry	2.375	11
Effective evangelism	2.044	12

Table 4.8 lists the ranking of the church health factors for the primary worship service attendance increase group according to the average of average scores for each

factor. Dividing the list in half, the lowest ranked factors and the six identified as in need of the most immediate attention are *maturing faith, vision-focused systems, missionary spirit, leadership development, personal ministry,* and *effective evangelism*. The only factors not ranked in the bottom six in both Table 4.7 and Table 4.8 are *maturing faith* and *loving community*.

Table 4.8. CHP Factor Ranking of Increase Group

Health Factor	Average of Avg. Score	Rank
Pastoral leadership	2.776	1
Divine enablement	2.741	2
God-honoring stewardship	2.667	3
Christ-exalting worship	2.650	4
Loving community	2.617	5
Ministries of compassion	2.589	6
Maturing faith	2.545	7
Vision-focused systems	2.514	8
Missionary spirit	2.495	9
Leadership development	2.474	10
Personal ministry	2.423	11
Effective evangelism	2.182	12

Table 4.9 lists the ranking of the church health factors for the primary worship service attendance decrease group according to the average of average scores for each factor. The six lowest ranked factors in Table 4.9 compared to the ranking of the last six in Table 4.8 reveals a shared list of factors with similar ranking. The only difference is the ranking of *maturing faith* and *loving community*. *Maturing faith* is ranked seventh by

the increase group and fourth by the decrease group. *Loving community* is ranked fifth by the increase group and sixth by the decrease group.

Table 4.9. CHP Factor Ranking Decrease Group

Health Factor	Average of Avg. Score	Rank
Pastoral leadership	2.686	1
God-honoring stewardship	2.638	2
Christ-exalting worship	2.596	3
Maturing faith	2.534	4
Divine enablement	2.527	5
Ministries of compassion	2.504	6
Loving community	2.463	7
Leadership development	2.354	8
Personal ministry	2.320	9
Vision-focused systems	2.302	10
Missionary spirit	2.304	11
Effective evangelism	1.882	12

Incidental Observations

The similar ranking of health factors between the primary worship service increase and decrease groups reveals potential church health factor clusters. For instance, the cluster of lower ranked factors may be systemic of issues related to the lowest ranked factor, *effective evangelism*. The cluster of highest ranked factors may also be systemic of issues related to the highest ranked factor, *pastoral leadership*.

Summary of Major Findings

Based upon the statistical analysis of the Church Health Profile survey results the following major findings are discussed further in Chapter 5:

1. Churches in the primary worship service attendance decrease group rated the experience of health in all twelve health factors lower than those in the primary worship service attendance increase group.

2. *Effective evangelism* stands out as the lowest ranked church health factor of the twelve Church Health Profile factors across the study.

3. The study analysis revealed no significant difference between the perception of church health between pastors and church leaders in both the primary worship service attendance increase and decrease groups.

4. The ranking of church health factors revealed a similar ranking of health factors for both the primary worship service increase and decrease groups.

CHAPTER 5

DISCUSSION

Major Findings

Primary worship service attendance statistics in the Central New York District of the Wesleyan Church from 2000-09 reveal that eighteen of the district's fifty churches showed a decrease in average worship attendance during this time period and that an additional ten churches showed a decrease in attendance from 2005-09. These twenty-eight churches represent a significant percentage of the district's fifty churches. Taking a proactive approach to this attendance decline, the CNY District leadership is striving to research the state of health of its churches and offer help and support.

The purpose of this research project was to assess the church health of twenty-four CNY District churches through use of the Wesleyan Church's Church Health Profile. The district anticipates that such an assessment will guide it in establishing the foundation for a sustainable church revitalization plan for the district.

Primary Worship Service Attendance and Church Health

According to the survey results, the primary worship service attendance decrease group rated their assessment of church health lower than the increase group's assessment of church health in each of the twelve church health factors. The percentage difference between the two groups in their assessment of church health by factor, while not always statistically significant, is an important finding for the project as a whole. The decrease group's lower assessment of church health in comparison to the increase group's assessment of health indicates that a decline in primary worship service attendance can be a valid indicator of church health issues.

The connection between numerical decline and church health, while valid, must not be overstated. Numerical decline does not automatically mean that a church is lacking in health, as a church could experience numerical decline for various reasons. A church may experience numerical decline even as church health improves. According to this study, however, numerical decline *can* indicate a lack of health or issues that reflect on the health of the church.

The church health movement, in response to a perceived overemphasis on numerical growth within the church growth movement, promotes the measuring of church health in spiritual terms, not numerical terms (Gangel 468). The church health movement views this shift away from equating church health with numerical growth as a more biblical approach to church health (467). The emphasis upon measuring health in more qualitative terms such as spiritual growth and maturity, though biblical, has its challenges. Just as overemphasis on numerical growth is possible church health can be over-spiritualized (Schwarz, 90). In the absence of quantitative measurement, a church may rationalize a lack of numerical growth and even numerical decline. Numerical decline does not necessarily mean a church is experiencing health issues, but numerical decline must receive consideration as a possible indicator of issues related to church health.

Luke's description of the life of the church as recorded in Acts 2:42-47 includes both qualitative and quantitative measurement. Luke describes the spiritual growth of the church in terms of attention to the Apostle's teaching, prayer, worship, the breaking of bread, fellowship, and the sharing of resources. Luke also notes the fact that the Lord brought growth, adding new believers to the fellowship, and Luke records the actual

number of those saved (2:47). Luke's description seems to emphasize spiritual principles essential to church health and also to growth. The Lord may have been the agent in the church's growth, but attention to the spiritual disciples positioned the church for growth. Quantitative growth followed the church's attention to the more qualitative spiritual disciplines. Numerical growth was an indicator of the health and vitality of the church.

The CNY District has taken steps to identify church health indicators for use in assessing the health of the district and local churches, one of which is primary worship service attendance. Based on the results of this study, primary worship service attendance decrease is a valid indicator for identifying churches with a declining experience of church health. Used sensitively, the primary worship service attendance decrease indicator can guide district leadership in the identification of churches in need of intervention and form the basis for dialogue with local church pastors and leaders.

Effective Evangelism

The project data revealed that the churches that experienced numerical growth in the CNY District from 2005-09 ranked *effective evangelism* as the factor most in need of health improvement along with the churches in the numerical decline group. This finding points to the need for careful evaluation of numerical growth and the emphasis it receives. Numerical growth may or may not be an indicator of church health. Some churches may experience growth as a result of social, contextual, or other phenomena. Health factors other than *effective evangelism* may lead to numerical growth.

This finding may also point to the need for clarification of the biblical definition of evangelism. Numerically growing and declining, large and small churches in the CNY District identify evangelism as an area in great need of development. This spectrum of

churches certainly must represent a wide range of perspectives on evangelism and a variety of resources, methods, and tools used. The answer may not be more resources and better tools; the answer may be a more foundational concern.

The project data also revealed that while the primary worship service decrease group's *effective evangelism* score was the lowest of the study, the group ranked *maturing faith* fourth. This ranking was three factors higher than the primary worship service increase group's ranking of the same factor. Redefining evangelism may also require exploring the disconnect between what is viewed as a growing maturing faith and the health factor of evangelism.

Looking back on the development of the church growth movement, the application of foreign missions principles to ministry in the local church resulted in its fundamental premise, "How can we be more effective at reaching people?" (Stetzer 7). The term *church growth* was used rather than *evangelism* because evangelism had come to mean social action in the mainline church of the 1960s (9). *Church growth* was meant to describe the addition of converts to a church. Criticism of the movement arose, however, when focus shifted from spiritual growth to numerical growth with an overemphasis on methodological "tricks and techniques" (8). The movement presented many of these techniques in the following manner: "If you do it this way, growth is inevitable" (Walker 6).

The low ranking of *effective evangelism* by the churches participating in this study may be a reflection of the influence of the church growth movement and its overemphasis on technique. Obviously the survey data is not able to provide insight into this possibility, but at the very least, the CNY District must take this possibility into consideration as it

develops its church health revitalization plan. The plan should distinguish between true evangelism principles and methods, equipping churches for effective outreach in their local context (Schwarz 34).

The *all-by-itself* principle of Mark 4:26-29 and 1 Corinthians 3:5-7 reminds the Church that much about growth is in God's hands. The Church can participate in the growth of God's kingdom but not manipulate growth in its own power and resources. The picture of the church in Acts 2:42-47 is a reminder that effective evangelism begins in the work of God's grace in and through the life of the Church, empowering its witness to the life-changing power of the gospel.

The *effective evangelism* ranking of the CNY District churches participating in the study gives the district insight into the greatest perceived health weakness of its churches. The insight enables the district to direct the focus of its churches away from *one-size-fits-all* programs and methods of evangelism. Instead the district can assist churches in cultivating an environment where the local church can discern God's direction and activities in their local communities and participate in the "Spirit's creative, world changing activity" (Roxburgh and Romanuk 16).

Pastors and Church Leaders Shared Perception of Health

I hypothesized prior to the study a difference in the perception of church health between pastor and church leaders in the participating CNY district churches and perhaps an even greater difference in the churches that experienced a primary worship service decline from 2005-09. The survey data indicated no significant difference in the perception of health between pastor and church leaders for both the decrease and increase group. The survey data seems to indicate that district pastors and church leaders share a

similar assessment of their churches' state of health and are aware of strengths and weaknesses. This finding suggests that addressing and improving health according to the Church Health Profile factors will not require getting pastors and church leaders *on the same page* as far as the current state of church health is concerned.

A shared assessment of health, however, could reflect a shared inability to see health deficiencies. Intentionally or unintentionally a leadership team of like-minded leaders can often surround pastors. Participants' perceptions may reflect what they believe *should* be true more than what is *actually* true. The shared assessment of health may further reveal that the church leader's perception of health is more a reflection of the church pastor than of the life of the church. In light of these possibilities, the shared assessment of health between church leaders and pastors may reveal a limitation to the use of assessment tools such as the Church Health Profile.

According to the church health movement, the attention and energy a church spends on the marks or principles of church health positions a church to optimize its health and advance its mission (Steinke xiv). The church health movement has faced criticism, however, for the almost exclusive focus upon ecclesiology, or *how to do church*, in order to be healthy and grow, to the neglect of "matters of culture and context" (Stetzer 15). In other words, the focus upon *how to do church* may result in blindness to larger church health realities. The shared assessment of health between church leaders and pastors in this study may be reflective of this criticism.

According to Mark 4:26-29, Acts 2:42-47, and 1 Corinthians 3:5-17, the assessment of church health must go beyond the health factors or marks that are so prevalent in church health literature and focus on the principles and practices of church

health. Church health marks or factors have value, but only as they direct attention back to the principles and practices essential to health and growth. For example, recognition of God's necessary role in bringing growth and humanity's dependence upon him guards a church against an unhealthy inward focus or from trusting in technique alone.

The shared assessment of church health between the pastors and church leaders that participated in the study presents these churches with an opportunity to move forward from a position of agreement. The CNY District leadership and coach consultants can build on this agreement by helping churches foster deeper spiritual growth and unity. By utilizing material such as Wagner's list of church diseases in *The Healthy Church* and directing churches towards the principles and practices of church health, the coach consultants can help churches identify blind spots and facilitate growth.

Church Health Factor Ranking

The similar ranking of church health factors between the primary worship service increase and decrease groups is perhaps the most interesting finding of the study. It seems to indicate that regardless of church size and presence or absence of numerical growth the CNY District churches participating in the study share similar health strengths and weaknesses. The ranking will not only be helpful in resourcing individual churches but it also enables district leadership to make district-wide observations.

The similar ranking of church health factors makes possible the identification of church health factor clusters. Viewed as clusters, the highest and lowest ranked factors provide insight into the state of church health in the CNY District valuable for the formation of a church health revitalization plan. The church health factor rankings place *effective evangelism, missionary spirit, vision-focused systems, leadership development,*

and *personal ministry* as the lowest ranked factors. These rankings seem to indicate a lower measure of health in matters related to mission and vision. As a cluster, the data indicates that the CNY District leadership must reflect on the connection between the health factor of *effective evangelism* and factors related to mission, vision, and both lay leadership and ministry. The absence of health in the area of evangelism, which is essential to the Great Commission (Matt. 28:16-20), may be the result of a lack of vision and ministry opportunity for many church members. The church health factor rankings also place *pastoral leadership, divine enablement*, *Christ-exalting worship*, and *God-honoring stewardship* as the highest ranking church health factors. As with the lowest ranking factors, as a cluster, these highest ranked factors highlight the need for the CNY District to explore the impact of pastoral leadership upon the state of church health in the district. The highest ranked factors may represent a reflection of the pastor's spiritual life more than the health of the church or point to the leadership strengths of the participating church pastors. The lower ranking factors may then be representative of areas of weakness or receiving less priority in CNY District pastoral leadership.

The ranking of the *maturing faith* health factor, particularly by the primary worship service decrease group (ranked fourth), also deserves reflection and research. The ranking may reveal a possible disconnect between the inward experience of maturing faith and the outward fruit or expression of that faith in the form of personal ministry and evangelism. Both factors ranked low in the study. Against the backdrop of Wesleyan heritage, this disconnect stands in contrast to a view of holiness that impacts both heart and life. Wesley defines Christian perfection or holiness as perfection in love, a pure love that fills the heart and governs all words and actions (*Plain Account* 60). This love is

expressed vertically in love for the Lord and horizontally in the love of one's neighbor. In other words, a faith that is maturing will be marked by service to the body of Christ and concern for those living outside of a relationship with God.

Schwarz recommends that in order to improve church health, churches begin by focusing on their "minimum factors," the lowest ranked church health categories (108). Churches should set qualitative goals toward increasing quality and effectiveness in those factors. The goal-setting process is essential for moving from the health assessment and rankings to concrete things the church should do to increase health (110). Schwarz's premise of focusing on the *minimum factors* is true of the larger church health movement. The project data, however, indicates that this approach might not enable the CNY District leadership to help district churches address the systemic issues affecting church health. While Peter L. Steinke's *Healthy Congregations* would help district leadership reflect on systemic issues impacting the Church Health Profile data, district leadership must also reflect on the relationship of the health factors as seen through the lens of the denomination's Wesleyan heritage.

Mark 4:26-29 identifies *the* factor in the health and growth of the Church, hearing well the word of God. Growth, which only God can bring, is the blessing and fruit of discipleship. While over-spiritualizing the pursuit of health in the Church may be possible it is impossible to over-emphasize the central role of the Living Word in the experience of church health. God transforms lives and churches; he brings the growth. Any attempt to address church health must acknowledge God's foundational role as the source of life and power in the Church. First Corinthians 3:5-7 does stress the value and significance of the work of the Church. In a spirit of humility, the Church is to work

according to its spiritual gifting to build the body and witness in the world. Working to improve church health according to the factor rankings and setting qualitative goals is a legitimate, biblical use of the church's time and resources. The church must, however, never forget its dependence on the Lord for growth and substitute the reliance upon God's power with reliance upon the church's efforts.

Mark 4:26-29, Acts 2:42-47, and 1 Corinthians 3:5-17 each in their own way direct the Church back to the word of God for the definition and experience of church health. The health factor rankings and survey data present the CNY District leadership with an opportunity to develop a church revitalization plan that reflects the emphasis of Wesleyan heritage upon scriptural holiness. This focus will keep the plan from dealing with church health merely at the factor level and call churches to engage with Scripture and Wesleyan theology.

The CNY District can utilize the church health factor rankings of the churches participating in the study to resource churches on an individual basis through the coach/consultants and in district-wide venues. The rankings also present district leadership with information beneficial for assessing and developing the future direction and focus of the district. The district's response to the Church Health Profile survey results can be a model for district churches to follow.

Implications of the Findings

The Wesleyan Church's Church Health Profile survey results provide reliable data for the CNY District leadership to utilize in the development of its church health and revitalization plan. The findings not only provide the district with insight into the state of health of twenty of its churches but also provide priority and direction for resourcing

churches according to the health factors. The comparison of the primary worship service increase and decrease groups and the overall ranking of health factors enables the district to resource at the district level, with groupings of churches (primary worship service increase and decrease), and individual churches.

The biblical/theological focus of the study puts the church health factors and survey results into perspective. The church health factors are *indicators* of health. The improvement of health requires going beyond the indicators to the church health *principles* and *practices* as defined by Scripture. These principles and practices are universal and define God's role and the role of the Church in achieving and maintaining health. God's working results in growth. The work of the church must center on the faithful proclamation and witness to the gospel. The district can support and encourage churches to build upon the Church Health Profile survey results by focusing on their devotion to Christ and the transforming power of the gospel through the means of grace: prayer, searching the Scriptures, the Lord's Supper, fasting, and fellowship.

Limitations of the Study

Looking back, the data collection method for the project limited the opportunity for follow-up to increase the level of participation. Asking the church pastors to register the church for the survey, to enlist church leaders to take the survey, and then to provide those leaders with the instructions and church survey code required a significant commitment on their part. I was only able to follow up with the pastors, and as the actual church leader participation for both groups indicates, follow up may have resulted in greater participation. If I had the opportunity to go back and conduct the project again, I would register the churches in advance and pass along the code to each pastor. I would

then ask the pastors for a list of church leaders and enlist their participation. Also, the data collection method allowed the pastor to choose the church leaders to participate in the survey which could have impacted the survey results.

The online Church Health Profile had its advantages but also limitations. The greatest limitation was the accessibility of the survey data. The Web site contractor that oversees the profile was very helpful in providing the data, but access to the raw data would have enabled me to review the responses to each of the 120 statements and perhaps add to the depth and breadth of the findings.

Unexpected Observations

Through the process of data collection, I had the privilege of talking extensively with many of the pastors of the district. I did not expect how willing pastors were to initiate conversation concerning the health of their church. I was reminded that behind the surveys and statistics are people and churches working diligently in service to the Lord. The survey results and subsequent work toward developing a district health revitalization plan must be sensitive to the pastors and churches of the district. Every effort, on the part of district leadership and coach consultants, must be made to avoid any notion of *we are here to fix you and your problems*; rather, every pastor and church must be approached respectfully and compassionately and treated with Christ-like care.

Recommendations

I have the unique opportunity, in my role as an assistant district superintendent, to serve as a coach/consultant for churches within our district. The data and findings are to serve as a foundation for this work and the development of a district church health revitalization plan. With this opportunity I plan to enlist the help of the other

coach/consultants to develop a list of qualitative assessment questions designed to help pastors and church leadership glean insights from the Church Health Profile data and focus in on the spiritual life of the church. The goal will be to help churches lay a foundation for the experience of health by focusing on the principles and means of grace essential to the church's growth in Christ and witness. The coach consultant role will allow district churches to work on church health in the context of relationship. Instead of simply presenting churches with a *one-size-fits-all* program, the coach consultant can work with churches to journey toward health and vitality in a way that affirms the local church and pastor, acknowledges the local context, and is built upon the foundation of the church's relationship with the Lord of the Church, Jesus Christ.

Postscript

The characters in C. S. Lewis' *The Chronicles of Narnia* series often make reference to the fact that the great lion Aslan, who represents Christ in the stories, is not a "tame lion." As I reflect back on this project and the Church Health Profile survey results I am reminded afresh that no tool, method, or even movement in the Church can *contain* God. The *all-by-itself* principle of Mark 4:26-29 and 1 Corinthians 3:5-7 means that in spite of efforts to package growth and health in the Church, kingdom growth will always contain a hidden and even mysterious work of God.

At the conclusion of the project, I find myself less focused upon the tools of ministry and more focused upon devotion to the Lord in my life and in my role as pastor. Living a life of devotion to the Lord has always been a priority, but through my Doctor of Ministry studies and dissertation work, I have come to realize that I have equated the work of ministry and growing the church *as* devotion to the Lord. This substitution

removed an element of *relationship* from my life and ministry that I look forward to rediscovering. I also look forward to my role as a coach/consultant with the CNY District. The opportunity to build relationships with pastors and churches, offer encouragement, and assist them in matters of church health and growth is both humbling and exciting. In the spirit of 1 Corinthians 3:5-17, I am praying that in this partnership with local churches the Lord will enable us to build upon the foundation of Jesus Christ, positioning these churches for the renewed health and grow that only he can bring.

APPENDIX A

INVITATION LETTER TO PARTICIPANTS

Dear _____,

My reason for writing is to ask for your participation in a project I am conducting as part of a doctoral dissertation, on behalf of the CNY District. The overall goal of the project is to provide data that will better position district leadership to understand the health of churches within the district toward greater effectiveness in assisting churches with the maintenance of health or revitalization.

To provide the data necessary, I am seeking the participation of twenty-four district churches in a survey of church health, utilizing the Wesleyan Church's online Church Health Profile. Participation in the survey as a church will not only assist me in this project but will also provide each church with a useful church health summary.

Our district has identified and promoted nine *church health indicators,* one of which is primary worship service attendance. To establish an objective data pool, I've chosen for the project to survey the twelve churches that showed the most numerical gain in primary worship service attendance from 2005-09 and the twelve churches that showed the most numerical decline during that same time period. My research will focus on these groups, not individual churches, and will compare the perception of health among pastors and leaders within and across these two groups. Individual names and individual churches will not be identified in the findings, and confidentiality will be maintained.

I have provided, along with this letter, a detailed sheet of instructions for participation in the project. The timeframe for the surveys to be completed is the first two weeks of October 2010. I will call you in the next several days to follow up on this letter, to speak personally with you about the project, and to answer any questions you may have. Of course you can call me at anytime at the numbers listed below or contact me by e-mail.

My sincere hope for this project is that it will be of benefit to your church, to our district, and ultimately to the kingdom of God. I appreciate your willingness to assist me, as completing the project will be impossible without your help.

In His Service,

Matthew Pickering

APPENDIX B

PARTICIPANTS SURVEY INSTRUCTIONS

Church Health Profile Survey Instructions

Getting Started

1. The first step is for you to log on to www.churchhealthprofile.com and sign your church up for the survey.
   - Once you are on the Web site, click on Survey (found on the red option bar)
   - Under Survey click on the third option, Sign Up
2. On the sign-up page, you will be asked to give your church name, district, your name (Pastor), church address, average attendance, age of church, and community type and to create a username and password. It is critical that you
   - Choose "Wesleyan—Central New York District" from the District list provided
   - Preface your church User name with "2010." For example, "2010 Grace Lee Memorial Wesleyan Church." Prefacing your church name with 2010 will allow me to distinguish the surveys completed for this project from those that may have been completed previously.
3. Once you click on the Sign-Up tab at the bottom of the Sign-Up page, an e-mail will be sent to the e-mail address you provided, with the survey code that each church leader will need to complete a survey for your church.
4. As pastor, you will be able to use the church username and password to view the survey summary and details for your church. The survey completed by yourself and those completed by your leaders will be summarized and available to you in the form of a church health profile.

Taking the Survey

1. In order to take the survey, you, and your church leaders, will need to go to the Church Health Profile Web page, www.churchhealthprofile.com.
2. Once on the Web page, click on click here under Step 2: Members take the survey. You will then be directed to a page that will give you the option to login or register. On this page, you and your leaders will need to click Register.
3. The registration page asks for the participant's name, for each participant to create a personal username and password, for an e-mail address, and for the church's survey code, which you as pastor will need to provide them with in advance.
4. Once this information has been filled in, click on Register and the survey will begin.
5. The survey consists of 120 questions, ten questions for each of twelve church health factors. Each question is answered by scale, clicking on one of three options, consistently, occasionally, or never.
6. The Church Health Profile will take approximately 20-30 minutes to complete.

Time Frame

1. As stated in the accompanying letter, the timeframe for survey completion is the first two weeks of October 2010.
2. While the survey results for your church will be available to you as soon as the surveys are completed, a summary of the district-wide results will be available in the late winter/spring of 2011.

APPENDIX C

CHURCH HEALTH PROFILE INSTRUMENT

Divine Enablement … *The healthy church recognizes God's sovereign role in building the Kingdom and joyfully seeks and expects His Holy Spirit's work in and through the Body of Christ.*

1. Our leaders admonish us to align our church's plans with God's purposes.

   ☐ Consistently ☐ Occasionally ☐ Never

2. Our church obeys the leading of the Holy Spirit, even when doing it seems difficult or costly.

   ☐ Consistently ☐ Occasionally ☐ Never

3. Our congregation works together in unity to fulfill our church's vision.

   ☐ Consistently ☐ Occasionally ☐ Never

4. Our church prays for the Holy Spirit's guidance as we seek to draw lost people to Christ through our ministries.

   ☐ Consistently ☐ Occasionally ☐ Never

5. Our leaders submit to the Headship of Christ by humbly seeking His will for our church.

   ☐ Consistently ☐ Occasionally ☐ Never

6. Our congregation celebrates answers to our prayers.

   ☐ Consistently ☐ Occasionally ☐ Never

7. Our members seek God's will through prayer when we make significant church-wide decisions.

   ☐ Consistently ☐ Occasionally ☐ Never

8. Our church relies on faith to pursue vision beyond our current resources.

   ☐ Consistently ☐ Occasionally ☐ Never

9. Our congregation takes bold steps, when needed, to trust God as we do His will for our church.

   ☐ Consistently ☐ Occasionally ☐ Never

10. Our church reports ministry results that can only be explained as God at work.

    ☐ Consistently ☐ Occasionally ☐ Never

Pastoral Leadership … *The healthy church is led by a pastor who demonstrates the calling, character and competence to help this church achieve its God-given purpose and shared vision.*

11. Our pastor helps us know and fulfill God's vision for our church.

    ☐ Consistently ☐ Occasionally ☐ Never

12. Our pastor demonstrates a clear call from God to minister in this church.

    ☐ Consistently ☐ Occasionally ☐ Never

13. Our pastor takes advantage of opportunities for personal and professional growth.

    ☐ Consistently ☐ Occasionally ☐ Never

14. Our pastor exhibits the professional skills and abilities necessary for leading a church our size.

    ☐ Consistently ☐ Occasionally ☐ Never

15. Our pastor motivates our congregation so that our church can confidently move forward with its vision.

    ☐ Consistently ☐ Occasionally ☐ Never

16. Our pastor teaches and supports the doctrinal positions of our denomination.

    ☐ Consistently ☐ Occasionally ☐ Never

17. Our pastor fosters unity in our church by managing conflict well.

    ☐ Consistently ☐ Occasionally ☐ Never

18. Our pastor models integrity and godly character for our congregation.

    ☐ Consistently ☐ Occasionally ☐ Never

19. Our pastor guides us in making changes that will fulfill our church's vision.

    ☐ Consistently ☐ Occasionally ☐ Never

20. Our pastor helps our church participate in denominational activities and programs.

    ☐ Consistently ☐ Occasionally ☐ Never

Christ-Exalting Worship … *The healthy church magnifies Christ by providing worship experiences that engage the whole person and lead the congregation into God's empowering presence.*

21. People in our congregation actively participate in the prayer times in our worship experiences.

    ☐ Consistently ☐ Occasionally ☐ Never

22. The persons leading our worship experiences engage us in personal responses to God.

    ☐ Consistently ☐ Occasionally ☐ Never

23. Scripture is used in a variety of ways when we worship together.

    ☐ Consistently ☐ Occasionally ☐ Never

24. A variety of elements engage our hearts, minds and senses in our corporate worship experiences.

    ☐ Consistently ☐ Occasionally ☐ Never

25. Our worship experiences appeal to people from more than one generation or culture.

    ☐ Consistently ☐ Occasionally ☐ Never

26. People actively participate in our worship experiences rather than sit as passive spectators.

    ☐ Consistently ☐ Occasionally ☐ Never

27. The musicians in our worship experiences focus our attention on exalting God through their musical selections.

    ☐ Consistently ☐ Occasionally ☐ Never

28. Our pastor's sermons apply the Bible in practical ways to life in today's world.

    ☐ Consistently ☐ Occasionally ☐ Never

29. The sacraments of communion and baptism are observed with meaning and freshness in our services.

    ☐ Consistently ☐ Occasionally ☐ Never

30. Our worship experiences preserve and pass on the rich heritage of historical Christianity.

    ☐ Consistently ☐ Occasionally ☐ Never

Effective Evangelism … *The healthy church embraces its mandate to multiply passionate followers of Jesus Christ and healthy churches.*

31. Our church trains Christians to share their personal faith with others.

☐ Consistently ☐ Occasionally ☐ Never

32. Conversions to Christ are the primary source of our church's growth.

☐ Consistently ☐ Occasionally ☐ Never

33. Our church offers intentional activities and services as evangelism opportunities for us to invite unsaved friends.

☐ Consistently ☐ Occasionally ☐ Never

34. Our church baptizes believers as an intentional part of the discipleship process.

☐ Consistently ☐ Occasionally ☐ Never

35. Our church receives new believers as members by their profession of faith.

☐ Consistently ☐ Occasionally ☐ Never

36. Our leaders communicate plans for our congregation to help start new churches.

☐ Consistently ☐ Occasionally ☐ Never

37. Our church identifies church planting opportunities among the unreached people in our area.

☐ Consistently ☐ Occasionally ☐ Never

38. We pray for God to raise up individuals from our congregation who will help plant other churches.

☐ Consistently ☐ Occasionally ☐ Never

39. We intentionally release resources—people and/or money—to establish new ministries outside our local church.

☐ Consistently ☐ Occasionally ☐ Never

40. Our members support our denomination's cooperative church planting initiatives.

☐ Consistently ☐ Occasionally ☐ Never

Ministries of Compassion … *The healthy church actively expresses the love of Christ through generosity and service to those in need.*

41. Our leaders alert us to specific needs for compassion ministry.

☐ Consistently ☐ Occasionally ☐ Never

42. Our church's preaching and teaching gives us a biblical view of compassion and service.

☐ Consistently ☐ Occasionally ☐ Never

43. Our members demonstrate Christ's love to each other in practical ways.

☐ Consistently ☐ Occasionally ☐ Never

44. Our community looks to our church as an advocate for the poor and hurting.

☐ Consistently ☐ Occasionally ☐ Never

45. Our church responds in tangible ways to global humanitarian needs.

☐ Consistently ☐ Occasionally ☐ Never

46. Our church's budget designates specific funds for compassion ministries.

☐ Consistently ☐ Occasionally ☐ Never

47. Our church recruits and trains people for involvement in specific compassion ministries.

☐ Consistently ☐ Occasionally ☐ Never

48. Our congregation recognizes and supports members who engage in ministries of compassion.

☐ Consistently ☐ Occasionally ☐ Never

49. Our church publicly states its biblical positions on moral and social concerns.

☐ Consistently ☐ Occasionally ☐ Never

50. Our congregation partners with others to meet compassion needs beyond the resources or reach of our own local church.

☐ Consistently ☐ Occasionally ☐ Never

Loving Community … *The healthy church practices genuine care for one another while embracing new people and valuing their inclusion in the fellowship.*

51. People, other than our pastor, are directly involved in providing care to our congregation.

☐ Consistently ☐ Occasionally ☐ Never

52. The atmosphere of acceptance and belonging causes people to stay connected to our church.

☐ Consistently ☐ Occasionally ☐ Never

53. Our leaders handle conflict in a responsible, biblical manner.

☐ Consistently ☐ Occasionally ☐ Never

54. We systematically follow-up visitors to encourage them into our church family.

☐ Consistently ☐ Occasionally ☐ Never

55. Our church intentionally creates new groups or classes so more people can build relationships and receive care in our church.

☐ Consistently ☐ Occasionally ☐ Never

56. People in our church feel safe to share their personal issues of life with each other.

☐ Consistently ☐ Occasionally ☐ Never

57. Newcomers report that they are warmly welcomed during their initial visits to our church.

☐ Consistently ☐ Occasionally ☐ Never

58. People in our church talk to the right people to address problems in a timely manner.

☐ Consistently ☐ Occasionally ☐ Never

59. Our church provides opportunities for people to get together for fellowship with one another.

☐ Consistently ☐ Occasionally ☐ Never

60. Members talk positively about the level of spiritual care they receive in our church.

☐ Consistently ☐ Occasionally ☐ Never

Maturing Faith … *The healthy church nurtures spiritual maturity that shapes biblical beliefs and transforms behaviors consistent with a holy life.*

61. A majority of our people participate in Sunday School or other small group Bible studies that develop spiritual maturity.

    ☐ Consistently ☐ Occasionally ☐ Never

62. Mature members mentor new believers and other members in living a sanctified life.

    ☐ Consistently ☐ Occasionally ☐ Never

63. Our church connects people with opportunities to serve others, both inside and outside our local church.

    ☐ Consistently ☐ Occasionally ☐ Never

64. Our members learn the doctrinal positions of our denomination.

    ☐ Consistently ☐ Occasionally ☐ Never

65. Our church teaches believers to apply the Bible's teachings to all matters of life.

    ☐ Consistently ☐ Occasionally ☐ Never

66. Believers are taught how to handle adversity with deeper trust and joy in God.

    ☐ Consistently ☐ Occasionally ☐ Never

67. Our church encourages members to practice spiritual disciplines (prayer, personal Bible study, giving and fasting, etc.).

    ☐ Consistently ☐ Occasionally ☐ Never

68. Our church takes new people through a systematic process to become members.

    ☐ Consistently ☐ Occasionally ☐ Never

69. Our congregation accepts and implements changes that fulfill our church's vision, even if doing so causes discomfort.

    ☐ Consistently ☐ Occasionally ☐ Never

70. Our church emphasizes the fruit of the Spirit, above His gifts, as the evidence of a Spirit-filled life.

    ☐ Consistently ☐ Occasionally ☐ Never

Personal Ministry … *The healthy church expects and equips its members to discover, develop and use their gifts for fruitful ministry.*

71. Our leaders teach people our church's doctrine regarding the exercise of spiritual gifts by believers.

☐ Consistently ☐ Occasionally ☐ Never

72. Our church helps believers discover their unique purpose and contribution to God's kingdom.

☐ Consistently ☐ Occasionally ☐ Never

73. Our church equips people to use their spiritual gifts and abilities in ministry.

☐ Consistently ☐ Occasionally ☐ Never

74. Our church places people in ministries that match their passions and gifts.

☐ Consistently ☐ Occasionally ☐ Never

75. The majority of our church members are involved in personal ministry.

☐ Consistently ☐ Occasionally ☐ Never

76. Our church helps individuals evaluate and increase the fruitfulness of their ministries.

☐ Consistently ☐ Occasionally ☐ Never

77. People doing ministry in our church are each held accountable by someone in leadership.

☐ Consistently ☐ Occasionally ☐ Never

78. Our church provides ongoing training for people doing ministry.

☐ Consistently ☐ Occasionally ☐ Never

79. New ministries are strategically launched within our church, based on members' gifts.

☐ Consistently ☐ Occasionally ☐ Never

80. Our church appreciates and publicly recognizes people serving in ministries.

☐ Consistently ☐ Occasionally ☐ Never

Leadership Development … *The healthy church identifies, trains, and empowers persons called to and gifted for servant leadership.*

81. Our church builds our leadership pool by identifying young people gifted and called to leadership.

☐ Consistently ☐ Occasionally ☐ Never

82. Our church intentionally seeks specifically gifted and God-called believers to fill leadership roles.

☐ Consistently ☐ Occasionally ☐ Never

83. Our leaders participate in ongoing training to enhance their skills and effectiveness.

☐ Consistently ☐ Occasionally ☐ Never

84. Our church delegates authority and responsibility to our leaders to serve in their assignments.

☐ Consistently ☐ Occasionally ☐ Never

85. Our leaders recruit capable newcomers to participate in ministry leadership roles.

☐ Consistently ☐ Occasionally ☐ Never

86. Our church holds its leaders accountable to clearly defined and communicated expectations.

☐ Consistently ☐ Occasionally ☐ Never

87. Our leaders exhibit integrity and godly character in their decisions and actions.

☐ Consistently ☐ Occasionally ☐ Never

88. Our members confidently follow the direction set by our leaders.

☐ Consistently ☐ Occasionally ☐ Never

89. Our church recognizes and honors individuals for their effective leadership.

☐ Consistently ☐ Occasionally ☐ Never

90. Ministry leaders in our church are given intentional evaluation and feedback about their performance.

☐ Consistently ☐ Occasionally ☐ Never

God-Honoring Stewardship … *The healthy church teaches and practices biblical stewardship and provides opportunities for generosity in time, talents and treasures.*

91. Our church teaches people to manage every aspect of life—time, talent and treasure—to glorify God.

☐ Consistently ☐ Occasionally ☐ Never

92. Our church offers us programs that systematically develop good personal financial management in accountability to God.

☐ Consistently ☐ Occasionally ☐ Never

93. Our members receive regular, accurate reports about our church's financial resources.

☐ Consistently ☐ Occasionally ☐ Never

94. Our church plans and schedules ministries as a model of good time management**.**

☐ Consistently ☐ Occasionally ☐ Never

95. Our church encourages believers to use their talents and gifts for volunteer service.

☐ Consistently ☐ Occasionally ☐ Never

96. Our church provides opportunities for members to support cooperative denominational initiatives.

☐ Consistently ☐ Occasionally ☐ Never

97. Our leaders align the annual budget with the church's vision and priorities.

☐ Consistently ☐ Occasionally ☐ Never

98. Our leaders realistically stretch our congregation's faith when establishing the annual budget.

☐ Consistently ☐ Occasionally ☐ Never

99. Our church fulfills its district and denominational financial obligations.

☐ Consistently ☐ Occasionally ☐ Never

100. Our church communicates the expectation of every member tithing time and treasure.

☐ Consistently ☐ Occasionally ☐ Never

Missionary Spirit … *The healthy church reaches into its community and the world as compassionate, culturally responsive, disciple-making ambassadors of Jesus Christ.*

101. Our church deliberately studies our community to make informed decisions about planning culturally-relevant outreach.

☐ Consistently ☐ Occasionally ☐ Never

102. Our church encourages its members to participate in local civic affairs and community life.

☐ Consistently ☐ Occasionally ☐ Never

103. Our church makes significant sacrifices to fund and resource our global ministry.

☐ Consistently ☐ Occasionally ☐ Never

104. Our church develops intentional plans and goals to bring the gospel to the unreached within our community.

☐ Consistently ☐ Occasionally ☐ Never

105. The process for planning our outreach ministries specifically addresses the cultural diversity of our community.

☐ Consistently ☐ Occasionally ☐ Never

106. Our ministries are designed to reach a broader cross-section of people than currently attend our church.

☐ Consistently ☐ Occasionally ☐ Never

107. We send and support Christian workers for inter-cultural ministries from our own congregation.

☐ Consistently ☐ Occasionally ☐ Never

108. Our church gives highest priority to denominational partnerships in our global outreach plans and activities.

☐ Consistently ☐ Occasionally ☐ Never

109. Our church reminds us that every believer is sent into the world to help make more disciples for Christ.

☐ Consistently ☐ Occasionally ☐ Never

110. Our church encourages and helps people from our congregation participate in short-term and vocational missions.

☐ Consistently ☐ Occasionally ☐ Never

Vision-Directed Systems … *The healthy church has its varied ministries focused and working together around the central purpose of fulfilling its vision.*

111. Our leaders involve a variety of people beside themselves in our church's vision planning process.

☐ Consistently ☐ Occasionally ☐ Never

112. Our church allows decisions to be made by the people most directly responsible for carrying them out.

☐ Consistently ☐ Occasionally ☐ Never

113. Our leaders evaluate and adjust our church's ministry structures for sustaining growth.

☐ Consistently ☐ Occasionally ☐ Never

114. Our church resources people to start new ministries that fit our vision.

☐ Consistently ☐ Occasionally ☐ Never

115. Our church measures a ministry's effectiveness using previously determined standards.

☐ Consistently ☐ Occasionally ☐ Never

116. Existing ministries are discontinued when they no longer fulfill their purpose in our church.

☐ Consistently ☐ Occasionally ☐ Never

117. Our leaders evaluate our church's overall ministry-effectiveness in light of our shared vision.

☐ Consistently ☐ Occasionally ☐ Never

118. Our church puts systems in place to ensure there's clear communication on all levels.

☐ Consistently ☐ Occasionally ☐ Never

119. People stay with our church through transition and change.

☐ Consistently ☐ Occasionally ☐ Never

120. Our varied ministries are each focused on cooperatively fulfilling our church's vision.

☐ Consistently ☐ Occasionally ☐ Never

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