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Development and Implementation of a Community-Based Health Evangelism Strategy at Fellowship Seventh-day Adventist Church in Tallahassee, Florida

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ABSTRACT

DEVELOPMENT AND IMPLEMENTATION
OF A COMMUNITY-BASED HEALTH
EVANGELISM STRATEGY AT
FELLOWSHIP SEVENTH-DAY
ADVENTIST CHURCH IN
TALLAHASSEE,
FLORIDA

by

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ABSTRACT OF GRADUATE STUDENT RESEARCH

Project Document

Andrews University

Seventh-day Adventist Theological Seminary

Title: DEVELOPMENT AND IMPLEMENTATION OF A COMMUNITY-BASED HEALTH EVANGELISM STRATEGY AT FELLOWSHIP SEVENTH-DAY ADVENTIST CHURCH IN TALLAHASSEE, FLORIDA

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Problem

The Fellowship Seventh-day Adventist church desired to reach its community but did not have a strategic plan on how to do so. The lack of a strategic plan hindered the effectiveness of the church in making an impact in its neighborhood and left the members with a sense that they were not making a difference in their community. Initial observations done through formal talks with church leaders suggested that health ministry was a focus where their church had a strength and was a means by which to reach the neighborhood.

Method

The methods used were to develop a team that analyzed data from a recent community health needs assessment, planned and implemented a health ministry initiative that targeted the local community, then tracked and evaluated the initiative whose aim was to support the church's overall mission in the neighborhood so that individuals could also be made aware of the ministry the church provided to them.

Results

Findings from the project were a list of new ideas regarding how to reach the local community; a record of community needs; a plan to prioritize and meet selected needs; a change in the health profile of participants engaged in the 8-week health series; and an increase in new members to the church.

Conclusion

The evidence showed that a strategic plan assisted the health ministry in developing a new identity and giving the church a missional direction for its community. Utilization of this ministry gift gave the church a renewed emphasis in its community outreach. The church realized it had a strength in the area of health evangelism. We can therefore conclude that the church did make an important contribution in the area of health evangelism; and that other churches can use this plan to make a similar impact in their communities.

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A Professional Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Ministry

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TABLE OF CONTENTS

LIST OF ILLUSTRATIONS

LIST OF TABLES

ACKNOWLEDGEMENTS

I would like to dedicate this book in memory of my dad, Isaac Daphnis, who served as a faithful servant in the lay ministry of his church. His superb organizational skills and duty to work served as my inspiration. Love you dad; see you in heaven!

I would like to thank my wife, Marsha Daphnis. You have sacrificed so much time to help push me forward. You always believed in me. I love you! To my kids, this was a lot of hard work and I pray God that this serves as my testimony to you that with God all things are possible! I would like to thank my mom who raised me in a Christian home and nurtured me. You and dad sacrificed a lot. Thank you for always believing in me. I love you!

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CHAPTER 1

INTRODUCTION

Description of the Ministry Context

This mission-oriented community-based project began its planning in 2012 and was implemented in 2015 at the Fellowship Adventist Church in Tallahassee, Florida. There were two distinct features of the project ministry context. These included the church and the community setting.

The Church

The project was implemented in the Fellowship Seventh-day Adventist Church located at 1540 Blountstown Street, Tallahassee, FL 32304 (hereinafter referred to as "Fellowship"). Fellowship is a part of the Southeastern Conference of Seventh-day Adventists, and where I was installed as its pastor in October, 2012. Even though the church can hold about 120 persons, the official membership was 107 (as of December 2015); however, a typical Sabbath attendance of all genders and age groups was between 35-40 persons or about one-third of the official membership. Hence there was a need to increase membership. The physical assets of the church could adequately accommodate such an increase. According to church records, the facility consisted of a large foyer, technology room, one children's classroom/mother's room, a pastor's study/office, two restrooms (one for each gender), and the main sanctuary. In addition, and prior to the new

project, the church purchased and renovated a house situated adjacent to it to host fellowship dinners; and a pool for baptisms.

Fellowship is one of four Adventist churches in the Tallahassee area. The largest has distinguished itself in campus ministries and a community service ministry, the other has a local radio station and houses the constituent Seventh-day Adventist school, and the last church caters specifically to the Hispanic community. But Fellowship was lagging behind these three churches in that it had not yet developed its area of declared interest, which was to reach out to the community. Another critical point that was considered related to the project decision was that Fellowship was not located in the immediate area of the other three churches; and hence, served an area that was not being reached by these three churches.

The Community

Fellowship is located in the state's capital which is home to a number of universities and several branch campuses. These institutions include Tallahassee Community College, Florida State University, and Florida Agricultural and Mechanical University. According to W*ikipedia* (2016) data, the population of the city was 188,107, while the metropolitan area was 375,751. In Tallahassee's 2014 Comprehensive Annual Financial Report, *Wikipedia* reported that the top two employers in the area were the State of Florida and Florida State University. The employees of these two companies are in high demand and many do not stay in the area for long.

One author makes the point that a transitional neighborhood is one that is experiencing change. He says:

> Its historic identity with a particular cultural group is breaking down as long-term residents leave . . . more and more renters move in, bringing poorer people who do

> not have sufficient extra energy, knowledge, or power to maintain a strong community structure. (Sahlin, 2004, p. 24)

Based on his statement, my conclusion is that Fellowship's neighborhood was a transitional one. While agreeing with Sahlin's statement, I have observed that many of the Caucasians who were long-standing residents in the community were leaving. Some of the newer residents are Caucasian, though most are college students and business persons with young families. I also found that the ethnic community of Tallahassee remained pretty diverse which was reflected in Fellowship. Although all members are Black, some are from the Caribbean, others from Africa, and some are Black Americans. Sahlin also says that "an 'outside' organization can play a key role in this type of situation, helping to mobilize the community, strengthen local resources and get the attention of foundations, business coalitions, government agencies, etc." (Sahlin, 2004, p. 24). I concluded that this situation presented an opportunity for Fellowship to play a key role as an outside organization to help examine a specific problem, engage the community, and make a difference.

Statement of the Problem

While discussing the key missional idea of problem-solution identification with church leaders, it became apparent that despite knowledge of the population profile, Fellowship had no effective community health evangelism strategy with which to address the health needs of the city of Tallahassee. The church was enthused with the potential this health initiative could provide to their community. The church also lacked leadership to help guide them through the process of planning and executing the mission of community transformation through health evangelism. The church is made up of a very talented group of members who are willing to commit their time to the community sector. However, there were some things that worked against the location of our church, that

being the transient nature of our community, colleges and government jobs making it so. We tried to target our ministry outreach strategies between the transient population and residents who are more stable.

I envisioned that the process of moving us together towards God's vision would be an interchange of ideas between us for the transformation of the community. First, this process consisted of forming a committee to bridge the gap between my vision from God and the members' ownership of the mission. One of my first duties after being installed in this church was to develop a timeline for my church. It offered me some invaluable insight about the church. This timeline gave an insight into the church history that included a lot of transition–moving from one place to another. There has also been a lot of in-fighting and even a split. It was also mentioned that the church seemed to have a life cycle of five years, and this could be attributed to the influx and exit of college students. And there always seemed to be the same people involved when it came to be putting on big projects.

The progress in putting together a timeline was an eye-opening experience for the membership. After going over the timeline through my formal talks with the church I was able to discover an area of interest that the church sees as its strength, and it is health evangelism. It helped me as an assessment of my church. It created a frame of reference to better understand the congregation. It was mentioned that at some point in time that the church would like to see areas in which health evangelism can be targeted to the community's specific health needs. I used individuals from the health ministry department along with some others directly involved in evangelism.

A local church member who served as a professor of nursing helped the church to acquire a health profile of the community through data from government agencies. In 2015, the researcher used the Geographic Information Systems (GIS) to locate areas of need in the church's zip code, 32304. Several areas of need were identified and the areas of health need that we homed in on were pneumonia (infections), colon health, and menta l health. Additionally, in the Leon county health improvement plan of 2012-2017 these areas of need were listed as part of the report as strategic health issues to be addressed within the county. As a result of formal talks with the members, two items were revealed in this challenging environmental context: (a) Fellowship lacked a viable community presence and relationship, and (b) there was little or no awareness of our presence by our local community.

Using data from this assessment and trying to determine next steps, members of the planning team along with the pastor set out to know if the church had adequate resources to implement a health evangelistic strategy for addressing the health needs in the community. In dialogue with the former pastor as well as the conference auditor, I was able to get a picture of the state of the church finances. Documents showed that between 2006-2010, Fellowship had its highest tithe and mission offerings returned (see Tables 1 and 2).

Table 1

Tithe for Fellowship Over a Six-Year Period and Per Capita: 2006-2012

Year	Tithe	Per Capita	Year	Tithe	Per Capita
2006	107,350	1,154	2011	69,133	743
2007	90,705	975	2012	66,208	712
2008	82,884	891			
2009	102,710	1,104			
2010	90,991	978			

Table 2

Mission Offerings for Fellowship Over a Six-Year Period and Per Capita: 2006-2012

Year	Tithe	Per Capita	Year	Tithe	Per Capita
2006	1,813	19	2011	1,249	13
2007	1,481	16	2012	613	7
2008	1,283	14			
2009	2,581	28			
2010	1,184	13			

The former pastor indicated that a lot of professional people were coming into the church at that time and the church was at its funding peak. It was also during this time that the church bought property adjacent to it as well as a house they were converting into a fellowship hall. This peak was also reflected in the evangelism reports. Table 3 reports the number of people baptized from 2006 to 2010. Up to and including 2010 the church was on its mission to evangelize the community; it had adequate resources and people to facilitate that mission.

Table 3

Membership Growth for Fellowship Over a Four-Year Period: 2006-2010

Year	Baptism	Profession of Faith/Letter	Total
2006	7	0	07
2007	11	0	11
2008	4	0	04
2009	11	0	11
2010	2	0	02

Also, the average attendance between 2006 and 2009 was high (see Table 4). Since 2010, there was a decrease in attendance, tithe, mission, and baptisms. So, what happened after 2010? One plausible explanation was that when the church was experiencing growth there was no strategic plan to sustain the growth. Second, the church was going through internal leadership challenges.

Many visitors and members stopped attending and the morale of the church was very low. This change resulted in declines in tithe/mission offerings as well as attendance. Since 2012, under my leadership, much is being done to mitigate these challenges; but

Table 4

Average Church Attendance: 2006-2012

Year	# of Persons
2006	120-130
2007	140-150
2008	140-150
2009	140-150
2010	100-120
2011	100-120
2012	100-120

without developing and implementing an effective evangelism strategy, the tithe, mission, attendance, and baptisms will remain stagnant.

Statement of the Task

The task involved a new and effective community-based health evangelism strategy for Fellowship that consisted of three phases: (a) development, (b) implementation, and (c) evaluation.

In developing a strategy for addressing the problem in 2012, the church was taken through its history from 1994-2012. The session offered me some invaluable insight about the church. One insight was transition. This showed that the church physically moved several times. It first met in members' homes and then transitioned to worshipping at St. Stephen's Lutheran Church, then to a bakery known as the Abbey. Next, a duplex was purchased and converted it into a place of worship.

The second lesson learned was about relationships. The record indicated that there was some in-fighting, and even a split that occurred in 2000; however, the church was reunited in 2002. It was also mentioned by the congregation that the church seemed to

have a life cycle of five years, probably because of the highly transient nature of the community. The college students who participate usually graduate within four and five years. There also seemed to be the same people involved when it came to be executing big projects, and those are the persons who have stayed in the church the longest.

The history series was beneficial for the members in that they learned where they came from and where they wanted to go; and that journey included a strong desire to become involved in health ministry as well as other community service ventures. This information was also invaluable for me as the pastor who was charged with moving them forward to a greater future. There was no way I could press forward with a vision if I had not understood where they had been and what they had been through.

In terms of statistics, I conducted a search in 2012 in connection with the Association of Religion Data Archives and found some interesting data on the religious profile of the county. In 2010, there were 62,952 Evangelical Protestants, 22,212 Black Protestants, 18,716 mainline Protestants, 605 Orthodox Christianity, 15,677 Catholic, 10,064 other, and 145,260 unclaimed. Fifty-two percent of the citizens in Leon County did not consider themselves Christian. This was very encouraging news as it related to evangelism, particularly health evangelism, which is a less dogmatic approach.

The data on Adventists showed that in 2012 there were four Seventh-day Adventist churches in Tallahassee. This meant that there were more than enough people in the both the city and county to reach. Between 2000 and 2010 there was an increase of 4% in the adherents' rate of church attendance in Leon County. Among Adventists there was an increase of 403 plus members. Thus, developing a strategy for community-based health evangelism would provide an opportunity to grow the church more and to improve

the strategic health concerns in the community. The implementation phase was directed by the community health evangelism team and the pastor. We focused on administering the method chosen to best meet the health needs of the community. This team consisted of local church board members and worked with the principal researcher in the project. The evaluation phase was done after the implementation phase was over. The community health evangelism team looked at the implementation and development phase of what areas of concern could be improved upon next time for the further growth of the church.

Delimitations

This study was delimited to the zip code where the church is currently located.

Description of the Project Process

There were three biblical principles that I reflected on during my project. These are Galatians 4:4, 5; Acts 20:17-21; and Numbers 21:4-9. Galatians 4: 4 (KJV) says: "But when the fullness of the time was come, God sent forth his Son, made of a woman, made under the law." Verse 5 continues, "To redeem them that were under the law, that we might receive the adoption of sons." The church should see its community as those who, by the acts of Christ, are heirs and have been adopted into the family of God. The church is commissioned to take this message to those around it and include them as part of the great family of God. Acts 20:17-21 (NIV) states:

> From Miletus, Paul sent to Ephesus for the elders of the church. When they arrived, he said to them: 'You know how I lived the whole time I was with you, from the first day I came into the province of Asia. I served the Lord with great humility and with tears and in the midst of severe testing by the plots of my Jewish opponents. You know that I have not hesitated to preach anything that would be helpful to you but have taught you publicly and from house to house. I have declared to both Jews and Greeks that they must turn to God in repentance and have faith in our Lord Jesus.'

Paul traveled many journeys to start churches, but he also went back to strengthen those individuals–particularly the leaders–so they could be strong. Presence was very important to Paul's ministry and was explored in this text, the ministry of presence. Paul also says in the text that he lived with them. This text also mentioned specifically the presence of Paul with the church.

The third and final Bible text that I looked at for my project is Numbers 21:4-9. This text highlights the importance of the church as a leader in health transformation. The church is a tool that can be used not only the salvation of souls but for the improvement of the overall health of the community it serves.

Galatians 4:4 and 5 were my focus when I was installed at the church. Our position as sons and daughters of God compels each person towards the mission of telling the world about the hope they have through Jesus and this in turn impacts the communities. This passage, along with Acts 20:17-21, focused on the presence of Paul guiding the mission projects between 2012 and 2014.

In 2012, the members and the pastor participated in a "congregational timeline." It offered me some invaluable insights about the church. After the timeline and through formal talks we mapped out some areas of interest as they relate to the church's future mission and passion for health ministry and evangelism in the community. From the information gathered as well as informal talks with members and the previous pastor, I understood that the church had a strong interest and desire for a health ministry as well as other community service ventures. The strategy was to build from having sporadic events with different focuses to having an intentional focus on an area over time.

In the next year, 2013, I believed that God was leading me to conduct an evangelistic effort with the focus on the family. This focus consisted of a four-week Bible teaching conference in October, followed by a community baby dedication, 100-praying-men anointing service of all the men in the community, individual and group family counseling in the homes, and individual Bible studies given in the community. The church membership also was interested in extending its reach into the community with restarting the Adventurer/Pathfinder club and basketball ministry; by reopening the local Adventist primary school, and becoming a constituent thereby increasing its community footprint. All of these initiatives resulted in the church being more spiritually present in the community we served. Together we felt that before we could move forward with the vision of health transformation, we needed to immediately address areas of ministry right before us. The church also voted in 2013 to start a daycare in the newly purchased and remodeled fellowship hall as there was no childcare in the immediate community. We hosted a Vacation Bible School every summer which brought 40-50 children from the immediate neighborhood. These steps during 2013-2014 were very essential in extending the next phase of the focus: community-based health evangelism.

In 2015, the team concept of Numbers 21:4-9 began to take shape in the development of a community health evangelism team and looking at the health concerns in our zip code. The community health evangelism team consisted of eight persons–five males and three females. This team worked with the pastor to clarify the church's vision and included lay members from personal ministries, health ministries, board of elders, and healthcare professionals in the church. The team reported to the church board and agreed that a preventative health ministry would be more effective than a treatment-based

health ministry for our area. The team along with the pastor focused our church to stress the importance of prevention rather than cure. The health evangelism team also worked with one of the members who is a professor of nursing, to analyze data from local health agencies.

As the pastors and members began to implement the strategy in July, 2015, we noticed an increase in the involvement of non-Adventist families from our local zip code, and even some outside of it, participating at our local church activities. This trend reinforced Acts 20:17-21. We wanted to practice Christian hospitality to those who were coming and invite them to become a part of our church family. The implementation phase had three sites: (a) the church property, (b) local health and fitness track, and (c) individuals' homes for Bible study. The implementation phase lasted from July–December, 2015. At the end of the implementation phase to the summer of 2016, we noticed a growth in the attendance of 30 non-Adventist persons added to our church from within and outside of our zip code.

Definition of Terms

Congregational timeline—"the goal in constructing a time line is to understand how the congregation is situated within an inclusive conception of its history, that is local, denominational, national, and global history" (Ammerman, Carroll, Dudley, & McKinney, 1998, p. 43).

Congregation—"an assembly of persons: GATHERING; especially: an assembly of persons met for worship and religious instruction (b) a religious community: such as (1): an organized body of believers in a particular locality" (*Merriam-Webster*, 2018).

Community—"a complex web of people, meanings, and relationships that consist on three levels-demography, culture, and organization" (Ammerman et al., 1998, p. 42).

Culture—"all things a group does together–its rituals, its ways of training newcomers, its work, and its play." It also includes artifacts, "and the accounts it gives of itself–its stories and heroes, its symbols and myths, its jargon, and its jokes" (Ammerman et al., 1998, p. 15).

Leadership–"as an activity, leadership involves (1) helping the congregation gain a realistic understanding of its particular situation and circumstances; (2) assisting members to develop a vision of their corporate life that is faithful to their best understanding of God and God's purposes for the congregation in this time and place; and (3) helping members embody that vision in the congregation's corporate life" (Ammerman et al., 1998, p. 42).

Disease–"a condition of the living animal or plant body or of one of its parts that impairs normal functioning and is typically manifested by distinguishing signs and symptoms" (*Merriam-Webster,* 2018).

Evangelism–"activities–public and personal, large-group, small-group, and one-on-one–which involve bringing people to accept Christ and studying His message from the Bible" (Sahlin, 2004, p. iii).

Intervention–"the act or an instance of intervening . . . a: the act of interfering with the outcome or course especially of a condition or process" (*Merriam-Webster,* 2018).

Transformational leadership–"is the process whereby a person engages with others and creates a connection that raises the level of motivation and morality in both the leader and the follower" (Northouse, 2016).

Outcomes–"something that follows as a result or consequence" (*Merriam-Webster,* 2018).

CHAPTER 2

PASTOR AND CHURCH AS A LEADER IN COMMUNITY HEALTH TRANSFORMATION

Chapter 2 will be reflecting on the theological support for the pastor and church as a leader in community health transformation through planning and implementing the health evangelism strategy. The actions of the pastor and church, engaging in community health transformation, are based on the principles of love, servanthood, and transmitting teachings. These biblical principles, as will be mentioned in the text, were first adopted and expressed by the church's forefathers, including Moses, Elijah, and Paul, and are also by modern day literature supporting the actions of the church who are propelled by love and servanthood. Thus, leadership is built on a concept of love and sacrificial covenant to its community.

What is the Church?

But what is the church? Is it the building where the community resides? Or is it the members that come into the building? The *Oxford Living Dictionary* (2019) describes church as the building for public worship, especially Christian in its first definition. Many today see the church as such, just a building. However, Kidder (2011) in his description of a dream church, a building is nowhere mentioned. He says that the church is a community

> living by the values of Jesus Christ as outlined in Acts 2:42-47–a studying, worshipping, praising, fellowshipping, and praying church. It is a church filled with joy and unity and yet able to perform miracles. While a safe place to be, it is yet challenging enough to inspire people to do ministry and evangelism. (p. 16)

Meanwhile, Cosgrove and Hatfield (1994) see church as a family. They state that churches starting in "households" may have pre-dated their theological understanding as the church as a family because "the first believers were already organizing themselves in family settings and along family-like lines" (p. 14). Ferguson (1993), in speaking of marriage and family, states:

> The family consisted of the entire household, including husband, wife, children, sometimes other relatives, and slaves. It was the basic unit of society in all of the cultures that provide the background for early Christianity. The family was united by common religious observances as well as by economic interdependence. (p. 65)

However, this sense of family which helped to frame the background for early Christianity was not the genesis of the family. We see how the family, from the beginning of human existence on earth, has been utilized as a tool by God to show his love. The family has helped to create margin. Swenson (2004) reminds us that margin is the space between our load and our limits. It is the amount allowed beyond that which is needed. It is something held in reserve for contingencies or unanticipated situations. Margin is the gap between rest and exhaustion, the space between breathing freely and suffocating (p. 69).

Christian Schwarz (1996), speaking on quality characteristic holistic small groups, says that "they must be holistic groups which go beyond just discussing Bible passages to be applying its message to daily life. In these groups, members are able to bring up those issues and questions that are immediate personal concerns (p. 32).

Schwarz (1996) believes that one of the eight characteristics of healthy churches is the ability to relate well to one another. Churches are more than just theological centers; they are places where persons' lives are changed through relationship with each other and with God. Through this relationship with each other members act as a support system to each other as well as to the community. In *New issues facing Christianity today*, the author states there should never be a question as to whether there is a relationship between evangelism and social responsibility (Stott, 1999). Oyinloye (2014) states,

> evangelism is a spiritual endeavor that gets effectively carried out through social involvements. So, there should be no dichotomy or separation of evangelism from social involvements. In planning and carrying out evangelism, the Christian needs to reflect on how God carried this through in the past so that we can be rightly guided. (pp. 22, 23)

In the forming of the new nation, God instructed the people concerning ceremonial and health laws that if followed would be for their blessing. In Leviticus 11 he describes foods that are to be eaten and forbidden; in Leviticus 13 there are procedures on how to deal with a contagious skin disease known as leprosy; and in Leviticus 15, there are protocols on how to deal with bodily discharges to prevent the spread of disease. In Matthew 4:23, the Bible says, "And Jesus went about all Galilee, teaching in their synagogues, and preaching the gospel of the kingdom, and healing all manner of sickness and all manner of disease among the people." In Matthew 1:21, "And you shall call his name Jesus, for he will save his people from their sins." Oyinloye (2014) states, "the name Jesus is a Greek derivative- a direct transliteration of the Hebrew name Joshua (Jehovah is salvation). The name itself is related to the name Hosea (salvation)" (p. 35). Oyinloye states that "God has always been involved in giving services and rendering justice" (p. 23). The word "save" in the Greek literally means to heal, preserve, and save,

be whole (Oyinloye, 2014). In Matthew 1:21, it reads, “and you shall call His name, Jesus (Healer), for he will heal his people from their (ailments) sins” (Oyinloye, p. 36). The idea of God as a healer is clearly seen in the scriptures. Oyinloye states,

> Jesus lived and worked in a social environment to show in loving ways God’s concern for humanity so they would also desire healing from sin and desire to be restored to a holistic relationship with God. Healing was the keyword to describe His ministry, and Jesus used healing as a redemptive analogy. (p. 36)

Leadership is Love

In his dealings with Adam and Eve in the Garden of God to the earth made new in Revelation we behold the leadership style of God. Leadership is love but as broken human beings, God has revealed to the human race its depth. Philippians 2:5-8 says,

> Let this mind be in you, which was also in Christ Jesus: Who, being in the form of God, thought it not robbery to be equal with God: But made himself of no reputation, and took upon him the form of a servant, and was made in the likeness of men: And being found in fashion as a man, he humbled himself, and became obedient unto death, even the death of the cross.

Leadership involves trust and this takes time. This goes back to the saying of Jesus Christ in Matthew 11:27 (NIV), “All things have been committed to me by my Father. No one knows the Son except the Father, and no one knows the Father except the Son and those to whom the Son chooses to reveal him.” The task of leadership is to get human beings with the freedom of choice to decide to follow the leader. There must be a relationship building experience that the leader engages with those whom he chooses to lead.

> In psychology and ethology, **imprinting** is any kind of phase sensitive learning (learning occurring at a particular age or a particular life stage) that is rapid and apparently independent of the consequences of behavior. It was first used to describe situations in which an animal or person learns the characteristics of some stimulus, which is therefore said to be “imprinted” onto the subject. Imprinting is hypothesized to have a critical period. (*Wikipedia,* 2019)

I believe that leaders have an imprinting opportunity upon the organization they lead. Through the life of the leader, the followers can catch a vision of the culture that is to be emulated. Greenleaf (1977) taught that there is a selflessness to leadership. As selfish and broken beings, it is hard to emulate others but in leadership, theorists are learning that leadership which is based on this principle brings out the best not only in leaders but also in those whom they lead. In reciting American history one can recount the story of our founding fathers and those soldiers who were brave and gave their lives for this country. These ideals have been placed to music in such songs as "God Bless America," "I'm Proud to be an American," and "The Star-Spangled Banner." These lyrics magnify how we as present-day Americans stand on the sacrifices of others.

In recounting the history of America, we also think about the countless Black Americans who served in the Civil War, World War I and II, yet were denied freedom in their own country. These examples and countless others served as selfless acts that allowed this country to reach its destiny of becoming the greatest nation in the world. We have become great because of those who served selflessly.

White (2012) writes, "As the tidings spread through the countries of Europe, of a land where every man might enjoy the fruit of his own labor and obey the convictions of his own conscience, thousands flocked to the shores of the New World" (p. 222). America has been blessed because of her religious freedom that she has allowed to her citizens. The country honors freedom of conscience and so does our God.

But what happens when human beings do not always choose what is best for them? This is what makes the leadership of God so special. When people sin, not only does God provide a means of restoration; but he is also healing their brokenness and

restoring them physically, spiritually, and emotionally back into relationship with Him and each other. This is evidence of God's perfect leadership of love. In Joshua 24: 14, 15 the Bible states,

> Now therefore fear the Lord and serve him in sincerity and in truth: and put away the gods which your fathers served on the other side of the flood, and in Egypt; and serve ye the Lord. And if it seem evil unto you to serve the Lord, choose you this day whom ye will serve; whether the gods which your fathers served that were on the other side of the flood, or the gods of the Amorites, in whose land ye dwell: but as for me and my house, we will serve the Lord.

There is a choice that we as individuals get to make about our destiny that God will not force upon us or others. However, He seeks to enter into relationship with us so that we can see evidences of His love for us and enter into a relationship with Him.

Restoration in Love

The first biblical text that will be examined to support the relationship concept is Galatians 4:4, 5: "4But when the fullness of the time was come, God sent forth his Son, made of a woman, made under the law, 5To redeem them that were under the law, that we might receive the adoption of sons." The context of this scripture can be found in Galatians 4:1-7 (KJV):

> Now I say, That the heir, as long as he is a child, differeth nothing from a servant, though he be lord of all; 2 But is under tutors and governors until the time appointed of the father. 3 Even so we, when we were children, were in bondage under the elements of the world:4 But when the fullness of the time was come, God sent forth his Son, made of a woman, made under the law, 5 To redeem them that were under the law, that we might receive the adoption of sons. 6 And because ye are sons, God hath sent forth the Spirit of his Son into your hearts, crying, Abba, Father. 7 Wherefore thou art no more a servant, but a son; and if a son, then an heir of God through Christ.

"In Roman law the heir, until he came of age at fourteen, was under the control of a tutor, nominated by the father in his will" (Bruce, 1982, p. 192).

> By being born of a Jewish mother, Jesus was born a Jew and, as such, ὑπὸ νόμον. He entered into the prison-house where His people were held in bondage so as to set

> them free. It is implied that He Himself was not enslaved to the bondage in which they were held, and while Paul does not say so here explicitly, the reason must be that He remained free from sin–while ὑπὸ νόμον, He was nevertheless not ὑπὸ ἁμαρτίαν (cf. 2 Cor. 5:21, τὸν μὴ γνόντα ἁμαρτίαν). He Himself had no need of slave-attendant, guardian or steward, and He came to bring His people to the point where they too could dispense with their services. Christ entered by birth into an inherited obligation to obey the will of God, but to Him such obedience was no mere obligation but a spontaneous joy. In Paul's thinking, for the Son of God to be born under that law which He rejoiced to fulfill involved His voluntarily taking on Himself the curse which others, by their failure to fulfill it, had incurred. Only so could He accomplish the purpose of redeeming those who were 'under law' (v 5). (Bruce, 1982, p. 196)

This concept of redemption is important in the scripture text. Jesus came to restore those things which were lost when sin entered into the world. In leadership, there should always seek to be some form of redemption especially in the context of relationships. God has come to restore the brokenness that has occurred over time. Leaders need to be about mending broken relationships and the most important broken relationship is the one that is between God and humanity. The Scripture text also talks about the principle of adoption.

> By contrast with Jewish law, Greek and (especially) Roman law were well acquainted with the institution of adoption. In Paul's day, it played an increasingly important part in Roman life; for example, from the late first century to the mid-second century AD and beyond successive Roman emperors adopted men not related to them by blood with the intention that they should succeed them in the principate. . . If the son to be adopted was not yet of age, his original father conveyed him into the *potestas* of his adoptive father by a pretended sale. Once adopted into the new family, the son was in all legal respects on a level with those born into that family. If the son to be adopted was of age, he was adopted by his new father in the ceremony of *adrogatio*, in which the pontifex maximus and the augurs were involved. It was also possible, later, for a testator to adopt someone in his will. (Bruce, p. 197)

We have been adopted into the family of God because of the redemption of God's son, Jesus Christ. Adam is mentioned as the son of God in Luke 3:38. However, because of sin he lost his place. Romans 5:8 also refers to the restoration principle. It says that "while we were still sinners, Christ died for us." At the beginning of time there was no

separation in the relationship between Adam and the Creator. Thus, it shows that there were no effects of sin because the relationship was intact. At the foundation of humanity's ills are people's disconnected relationship with their Creator. As a person seeks to mend the brokenness of others there must first be an amending of his or her brokenness, individually. As Scazzero (2003) states, "We all come into the family of Jesus with broken bones, wounds, and legs shot up in the war of life. God's intention is to heal our brokenness and patch up our wounds (p. 99).

According to Richard Davidson (1992), there are several kinds of brokenness shown in Genesis 3:9-14: A "rupture in interhuman (husband-wife), divine-human relationship, and the conflict with humanity and their environment (p. 8). Adam blames Eve for eating the fruit of the tree. He takes no responsibility for his actions and shifts the burden of responsibility somewhere else. Seamands (1991) writes, "Some of the most powerful weapons in Satan's arsenal are psychological. Fear is one of these" (p. 48). When God comes walking in the garden, Adam and Eve hide themselves because they were now afraid. Their sin has now ultimately brought a broken relationship between themselves and God. Psalm 5:4-6 (NIV) says, "For you are not a God who is pleased with wickedness; with you, evil people are not welcome. The arrogant cannot stand in your presence." It could have been that their nakedness could not handle the brightness of light that shone around them or that their shame of nakedness literally just kept them away. A serpent was used to deceive Adam and Eve, leaves had become their coverings, and animal skins would now become their coverings. And eventually all of nature itself would turn hostile to them. The environment they had once tended and cared for is now hostile to them. Nature is being exploited because of Adam and Eve's nakedness and shame.

White (2000) says, “Through the things of nature, and the deepest and tenderest earthly ties that human hearts can know, He has sought to reveal Himself to us. Yet these but imperfectly represent His love” (p. 2).

Ultimately, when people sin it is against God. Adam and Eve disobeyed God’s command and when He came walking in the cool of the day to meet with them; they were hiding among the trees of the garden. Thus, there is a need for healing in our communities. Restoration of a broken relationship started right there in the garden. God met Adam and Eve where they were and came up with a solution to address not only their immediate needs but also their future salvation. In the text that is why there is an emphasis on the fullness of time.

We believe that relationship takes time; God could not just send his Son in the flesh at any time. According Riddle and Starbuck, (2008, p. 96), there had to be a relationship development over time before humanity could be prepared for the gift. “The Gospel was withheld until the world had arrived at mature age; law had worked out its educational purpose and now was superseded” (p. 97). God sends forth his Son at the appropriate time and the purpose of the sending was to restore relationship. The Bible uses the terminology “adoption as sons.” Church is about extending its reach of those who choose to be restored in this relationship, thus receiving the adoption of sons.

Leaders Presence Among the People

The leadership of Paul in the early church and community is instructive. Paul was executing the call of Jesus to evangelize and raise up churches. He traveled to start churches, but he also went back to strengthen those individuals–particularly the leaders,

so they could be strong. Presence was very important to Paul's ministry. He says in Acts 20:17-21,

> And from Miletus he sent to Ephesus and called the elders of the church. And when they were come to him, he said unto them, Ye know, from the first day that I came into Asia, after what manner I have been with you at all seasons, serving the Lord with all humility of mind, and with many tears, and temptations, which befell me by the lying in wait of the Jews: and how I kept back nothing that was profitable unto you, but have shewed you, and have taught you publicly, and from house to house, testifying both to the Jews, and also to the Greeks, repentance toward God, and faith toward our Lord Jesus Christ.

He said that he lived with them the whole time he was there.

When the children of Israel were wandering through the wilderness, God commanded Moses to make him a sanctuary that he may dwell with them. After Adam and Eve sinned, God walked through the garden as before to look for them. Paul's example was one that he learned from God. Leaders are not just called to lead people, they are called to be with them. As they experience their ups and downs, that is why Paul would say in Romans 12:15, "rejoice with those who rejoice, weep with those who weep."

Leader as Servant

Polhill (1992) notes that there were three basic characteristics of Paul's ministry while he lived with the people (p. 424). The first one was humility. He often spoke of "serving" (*douleuō*) the Lord (cf. 1 Thess 1:9; Col 3:24) and described himself as a servant or "bond-slave" (*doulos*) of Christ (cf. Rom 1:1; Gal 1:10; Phil 1:1). In the Bible, Paul frequently points to this quality as the "major hallmark of the Christian life" (Phil 2:3; Col 3:12; Eph 4:2).

Leslie Pollard picks up this striking discussion of the *doulos*-slave narrative in Pauline theology. In the culture of the New Testament the word was despised for many reasons.

> Slaves lost autonomy, respect, dignity, and independence due to war, kidnapping, sale, and a variety of other reasons. But biblical writers, such as the apostle Paul, consciously labeled themselves as *douloi* (slaves) of Jesus Christ and His people (Romans 1:1 and 6:22; 1 Corinthians 9:19; 2 Corinthians 4:5; and Galatians 1:10). Make no mistake about it; biblical writers were bold in their decision to transform a term–a term often accompanied by social derision–into a term that captures the dignity of and calling to selfless service to God and for others. (Pollard, 2014, p. 310)

Pollard (2014) mentions that the idea of slave included "the complete and degrading loss of personal autonomy, with possible horrific treatment." In the Bible promotion often comes as one may be experiencing tough times. In the story of Joseph, the beauty of this can be seen. The Bible says that the Lord was with Joseph when he was sold as a slave and went down to Egypt. The Bible also says that when he went to prison being falsely accused, the Lord was with him.

In today's society, there is a false relationship that exists between upward mobility and independence; however, in the cross of Christ greatness is seen in terms of loss. That is why Paul exclaims in Philippians 3:7-11,

> But whatever gain I had, I counted as loss for the sake of Christ. Indeed, I count everything as loss because of the surpassing worth of knowing Christ Jesus my Lord. For His sake I have suffered the loss of all things and count them as rubbish, in order that I may gain Christ and be found in Him, not having a righteousness of my own that comes from the law, but that which comes through faith in Christ, the righteousness from God that depends on faith—that I may know Him and the power of His resurrection, and may share His sufferings, becoming like Him in His death, that by any means possible I may attain the resurrection from the dead.

Pollard (2014) gives six leadership principles of Paul and its relationship to servant leadership:

1. The voluntary use of leadership influence is subordinated to the saving purpose of God.
2. Christian leaders engage in a reformulation of personal identity.
3. Leaders cross ethnic, racial, and cultural boundaries in service to God and Jesus Christ.
4. Leadership is inseparably connected to stewardship.
5. Leadership is grounded in love.
6. Leadership imitates the slave-leadership of Jesus Christ (p. 319).

Openness of the Leader

Polhill (1992) then goes on to describe the second characteristic of Paul's ministry and that was the openness of his proclamation. He states that Paul "kept no secrets, held nothing back. Whatever was true to the gospel and helpful to the faithful, Paul preached both publicly and from house to house" (p. 424). The scripture text refers to houses and probably has to do with the house-church meetings of the Ephesian Christians. Paul warned against those who advocated things in secret such as the Gnostic heresy. "In contrast, some were not so open in their witness, i.e., false teachers who advocated hidden and secret doctrines. Paul warned the Ephesian leaders later in his speech that such would arise to plague their own church" (Polhill, 1992, p. 424).

Paul admonished the leaders in Ephesus, especially in Acts chapter 20 verse 29, that "savage wolves will come in among you, not sparing the flock." Paul reminded them of the example of his life that was filled with "honesty and openness of his own preaching" (Polhill, 1992, p. 424). I think this is very important in terms of evangelism. I believe that in the ministry of the Adventist church leaders should be very clear and

upfront with the people. I believe that because of prejudice, many have chosen to hold back on certain elements of the church's identity in evangelism. The final characteristic of Paul's ministry according Polhill was the inclusiveness of his witness. Paul had preached to everyone, both Jews and Greeks (v. 21). "The final characteristic of Paul's ministry was the inclusiveness of his witness. He had preached to everyone, both Jews and Greeks (v. 21). No one had been left out. This had indeed been the case in Ephesus" (19:10).

Paul saw his own special calling as being the apostle to the Gentiles, but he never abandoned the synagogue. Perhaps more clearly than anyone else in the church of his day, Paul saw the full implications of his monotheism. God is the God of all. In Christ he reaches out for the salvation of all who will trust in him. There is no distinction (cf. Rom 3:29f.). There is no room for exclusivism in the gospel in the sense that the gospel is for Gentiles and Jews, slaves and free, and men and women. The gospel itself is, however, exclusive in its claims, "for there is no other name under heaven . . . by which we must be saved" (Acts 4:12). Salvation is available only in the name of Jesus (Polhill, 1992, p. 424).

According to Pollard (2014), when Paul says, "To the Jew, I became as a Jew," Paul is saying that he has experienced a reformulation of his base identity. He is a new creature with a new identity (2 Cor. 5:17). The convert Paul, the former persecutor who loved Judaism enough to kill to protect it, now refuses to be enslaved to the identity politics of either his times or his culture of origin. Paul is free in Christ! At Damascus, Paul received an identity transplant (Acts 9:1-6).

I believe that this is necessary especially when dealing with leaders of the church

and evangelism. Often those who participate in the evangelism process have not been deconstructed from all their personal biases and opinions. This is a significant challenge that I faced in my project. There are some individuals who may have not deconstructed, and they may be attempting to place their own views of "identity idolatry" in others that will not be of Christ. Polhill (1992) believes that Paul in his case about how he lives was not meant to be on the defensive but was set up as an example to Ephesian leaders as one that they could emulate. Polhill also writes, "It is a worthy example for every servant of the Lord: a ministry marked by humility, openness, and inclusiveness and rooted in the gospel" (p. 424).

The next text to focus on is found in Numbers 21:4-9:

> 4And they journeyed from mount Hor by the way of the Red sea, to compass the land of Edom: and the soul of the people was much discouraged because of the way. 5And the people spake against God, and against Moses, "Wherefore have ye brought us up out of Egypt to die in the wilderness? For there is no bread, neither is there any water; and our soul loatheth this light bread." 6And the Lord sent fiery serpents among the people, and they bit the people; and much people of Israel died. 7Therefore the people came to Moses, and said, "We have sinned, for we have spoken against the Lord, and against thee; pray unto the Lord, that he take away the serpents from us." And Moses prayed for the people. 8And the Lord said unto Moses, "Make thee a fiery serpent, and set it upon a pole: and it shall come to pass, that every one that is bitten, when he looketh upon it, shall live." 9And Moses made a serpent of brass, and put it upon a pole, and it came to pass, that if a serpent had bitten any man, when he beheld the serpent of brass, he lived.

This text highlights the leadership response. The people were speaking against God and Moses because they did not like the way he was leading them. First, based on our biblical understanding of leadership we believe that God's leadership style is ultimately couched in love. However, here we have individuals with the freedom of choice who have decided against that belief. And they start to complain about the way they are being led. Spence and Excell (1910) note,

> This season would be one of the hottest and most trying for marching. . . The Arabah is a stony, sandy, almost barren plain shut in by mountain walls on either side, and subject to sand-storms. It was not only, however, merely the heat and drought and ruggedness of the route which depressed them, but the fact that they were marching directly away from Canaan and knew not how they were ever to reach it. (p. 272)

In the leadership style of God there is always room for dissent. However, it is not productive since God is all knowing and to argue against the principles of his kingdom will only bring death and disease.

The mention of death and disease introduce people to certain outcomes of human actions. Factors seen as influencing group physical outcomes were eating of clean and unclean animals (Lev 11, Deut 14), proper hygiene of human waste and sanitation (Deut 23:12, 13) that had it been heeded properly would have hindered disease and death in history as well as today. The choice to argue against the principles of health resulted in curses. And the Bible says that the Lord sent fiery serpents that bit the people and many of them died. They rejected God's protection by rejecting his leading. But the command was given to Moses to make a serpent out of brass and as the people looked, they would be healed.

> The Lord graciously responded to the pleas of Moses and the people by giving instructions for preparing a homeopathic antidote for the snakes' venom. Yahweh's response commences with the secondary formula for divine instruction, *wayyōʾmer YHWHʾel-mōšeh*, and the message was that Moses should produce a *sārāp* ("winged serpent" or "fiery serpent") and mount it on a signal pole (*nēs*, "sign, banner, placard") for people to see. Anyone who had been bitten by the snakes could then look at the serpent-bearing sign and would live rather than die. The verb translated "look" *(rāʾâ)* often carries with it the idea to see with belief or understanding, and it is to be so interpreted in this context. The function was a form of homeopathic and apotropaic ritual whereby a votive form of the source of the disease (homeopathic element) is used in a ritual to ward off evil (apotropaism), or in this case death from snake bite. (Cole, 2000, p. 349)

The church had a responsibility along with God's leading to provide for healing to the community. It can be argued that exercising their choice resulted in sickness and

death. The challenge for the church was not to withhold their God-given mandate to provide healing and comfort to the people.

> When Christ sent out the twelve disciples on their first missionary tour, He bade them, "As ye go, preach, saying, 'The kingdom of heaven is at hand.' Heal the sick, cleanse the lepers, raise the dead, cast out devils: freely ye have received, freely give." Matthew 10:7, 8. (White, 1942, p. 139)

Today, there are individuals in our communities who are just like the children of Israel. The church has a God-given mandate to lift up the serpent so that individuals may look and live. Jesus in his Gospel presentation to Nicodemus compared himself to this serpent and said in John 3:14, 15, "And as Moses lifted up the serpent in the wilderness, even so must the Son of man be lifted up: That whosoever believeth in Him should not perish, but have eternal life."

> The type of the brazen serpent lifted up in the wilderness is the only one which our Lord directly claims for himself as a type of his own crucifixion. No one can doubt that many other types, hardly less wonderful and instructive, exist; but this one will always have a certain pre-eminence of regard, because our Lord in his own words applied it to himself. (Thomas, 1910, p. 273)

Through this analogy, Jesus brings out a very important relationship between health and salvation. For Jesus, the serpent that saved from physical death was a type of the Savior who would save from spiritual death. Today, churches have a mandate to focus on both the spiritual and physical needs of its communities. Many times, a lopsided Gospel is preached. However, in the ministry of Jesus we see him not only preaching and teaching, but also healing all manner of diseases. Today, churches must be a leader not just in the spiritual health of its members, but it also must follow its mandate to promote the physical well-being of its members and communities. White (2001) says: "There is great need of instruction in regard to dietetic reform. Wrong habits of eating and the use of unhealthful food are in no small degree responsible for the intemperance and crime

and wretchedness that curse the world" (p. 441).

The principles of health should be biblically based and scientifically proven to work towards the health of our communities. This concept of God as a healer is clearly represented in Scripture. Malachi 4: 1, 2 says,

> For, behold, the day cometh, that shall burn as an oven; and all the proud, yea, and all that do wickedly, shall be stubble: and the day that cometh shall burn them up, saith the Lord of hosts, that it shall leave them neither root nor branch. But unto you that fear my name shall the Sun of righteousness arise with healing in his wings.

The serpent which had bitten the people clearly represented death; however, it was the bronze serpent which Moses used that clearly represented life. This proved how the same homeopathic solution meant different things to the people who chose either to accept or reject it.

In leadership there is always the concept of free will and choice. In Exodus 15:26, the Bible says,

> And said, If thou wilt diligently hearken to the voice of the Lord thy God, and wilt do that which is right in his sight, and wilt give ear to his commandments, and keep all his statutes, I will put none of these diseases upon thee, which I have brought upon the Egyptians: for I am the Lord that healeth thee.

This promise is conditional. Salvation has been offered to all but will only benefit those who choose to receive it. John 3:16 says, "For God so loved the world that he gave his only begotten son that whosoever believes in him should not perish but have everlasting life." We must choose to be saved just like we must choose to be healed.

I believe that the three texts I have chosen, Galatians 4:4, 5; Acts 20:17-21; and Numbers 21:4-9, support leadership principles and the role of leaders in addressing community needs. This type of leadership is built on love, and God has revealed to the human race the depth of that love. White (2012) states:

> There, immortal minds will contemplate with never-failing delight the wonders of creative power, the mysteries of redeeming love. There will be no cruel, deceiving foe to tempt to forgetfulness of God. Every faculty will be developed, every capacity increased. The acquirement of knowledge will not weary the mind or exhaust the energies. There the grandest enterprises may be carried forward, the loftiest aspirations reached, the highest ambitions realized; and still there will arise new heights to surmount, new wonders to admire, new truths to comprehend, fresh objects to call forth the powers of mind and soul and body. All the treasures of the universe will be open to the study of God's redeemed. Unfettered by mortality, they wing their tireless flight to worlds afar–worlds that thrilled with sorrow at the spectacle of human woe and rang with songs of gladness at the tidings of a ransomed soul. With unutterable delight the children of earth enter into the joy and the wisdom of unfallen beings. They share the treasures of knowledge and understanding gained through ages upon ages in contemplation of God's handiwork. With undimmed vision they gaze upon the glory of creation–suns and stars and systems, all in their appointed order circling the throne of Deity. Upon all things, from the least to the greatest, the Creator's name is written, and in all are the riches of His power displayed. And the years of eternity, as they roll, will bring richer and still more glorious revelations of God and of Christ. As knowledge is progressive, so will love, reverence, and happiness increase. The more men learn of God, the greater will be their admiration of His character. As Jesus opens before them the riches of redemption and the amazing achievements in the great controversy with Satan, the hearts of the ransomed thrill with more fervent devotion, and with more rapturous joy they sweep the harps of gold; and ten thousand times ten thousand and thousands of thousands of voices unite to swell the mighty chorus of praise. ‘And every creature which is in heaven, and on the earth, and under the earth, and such as are in the sea, and all that are in them, heard I saying, Blessing, and honor, and glory, and power, be unto Him that sitteth upon the throne, and unto the Lamb for ever and ever.’ Revelation 5:13. The great controversy is ended. Sin and sinners are no more. The entire universe is clean. One pulse of harmony and gladness beats through the vast creation. From Him who created all, flow life and light and gladness, throughout the realms of illimitable space. From the minutest atom to the greatest world, all things, animate and inanimate, in their unshadowed beauty and perfect joy, declare that God is love. (pp. 677, 678)

Leaders follow His example of love in serving their communities. Tutsch (2008) states,

> Humanity’s desire is to know God; God’s desire is to restore in humanity the image of God. This restoration enables the Godhead to achieve intimacy of companionship and communication with Their created beings. This kind of companionship includes humanity’s loving obedience as a response to His love and grace. (p. 10)

White (2010) says, “We may never know until the judgment the influence of a kind, considerate course of action to the inconsistent, the unreasonable, and unworthy.” (p. 11). This service of health transformation actions; however, take time and trust.

The pastor and members of the Fellowship Adventist Church definitely had a desire to reach the community. The pastor had been given a vision by God to focus on health evangelism. The church had served the community throughout the years. We believed that we have been placed by God in our neighborhood to make a difference in the lives with whom we made contact. However, there needed to be a more strategic effort to our approach. Mintzberg (1994) quotes Koontz stating that planning is “the conscious determination of courses of action designed to accomplish purposes” (p. 9). “Strategy is viewed as an ‘operator’ which is designed to transform the firm from the present position to the position described by the objectives, subject to the constraints of the capabilities and the potential” (Mintzberg, p. 43). We wanted to take a more strategic approach to accomplish the mission that we believe God has gifted to us.

According to Dick and Miller (2011), when it came to using our gifts there was no overarching them or order to what we did, and gifts were carried out independently witho ut any connection to the other ministries. The experience we went through of constraining ourselves to specific objectives freed us to be more intentional and developing needs on a deeper level in our relationships. It opened up the possibility of imprinting on the church’s DNA a new model for ministry.

Brantley, Jackson, and Cauley (2015) outline several kinds of churches in terms of function. They state that many churches have become event-driven, leader-driven, and crisis-driven churches. As we look at our history as a church, we have seen how these

models have impacted our church. However, the authors argue for mission-driven churches and this focus was the desire of Fellowship Seventh-day Adventist Church. We wanted to become a church that placed its priority on others and the mission that God had given to us.

CHAPTER 3

LITERATURE REVIEW

Leadership Theory History

A search of non-biblical and non-theological sources have found additional support for many of the leadership principles previously mentioned (Chapter 2) as well as for the pastor and church as leader of certain aspects of community life. Burns (1978) is widely viewed as one who has influenced the thinking on leadership. In his first known works on leadership, he is quoted as saying that

> the crisis of leadership today is the mediocrity or irresponsibility of so many of the men and women in power, but leadership rarely rises to the full need for it. The fundamental crisis underlying mediocrity is intellectual. If we know all too much about our leaders, we know far too little about leadership. We fail to grasp the essence of leadership that is relevant to the modern age and hence we cannot agree even on the standards by which to measure, recruit, and reject it. Is leadership simply innovation-cultural or political? Is it essentially inspiration? Mobilization of followers? Goal setting? Goal fulfillment? Is a leader the definer of values? Satisfier of needs? If leaders require followers, who leads whom from where to where, and why? How do leaders lead followers without being wholly led by followers? Leadership is one of the most observed and least understood phenomena on earth. (Burns, 1978, pp. 1-2)

There are more than 850 published definitions of leadership (Bennis & Nanus, 1997), and many theories on leadership. One of the earliest theories on leadership is the great man theory. In 1841, Thomas Carlyle brought this view to front in his work *On Heroes, Hero-Worship, and the Heroic in History* (cited in R. A. Heifetz, 1994). It focused upon the belief that great leaders are born not made. Many persons still hold to

that kind of leadership today. If we continue to look for leaders like this we will continually be disappointed because they are made up to be more than human (Moxley, 2000).

In reaction to the great man theory, social theorists like Herbert Spencer in 1884 suggested that it was not the leaders themselves but the circumstances that called for the greatness of the individual (R. A. Heifetz, 1994). Through the process of time, it was determined that if it were traits that allowed the leader to excel then we would better understand leadership. The trait theory which developed in the 1930s-1940s focused on the analysis of mental, physical, and social characteristics (Central.com, 2013). The goal of this theory was to pinpoint the common characteristics among leaders. However, the context of the leader was not considered (Central.com, 2013). In reaction to the trait leadership theory, around the 1940s-1950s the behavioral theories began to focus upon the behaviors of the leaders as opposed to their mental, physical or social characteristics (Central.com, 2013). At this time in history, notably with the advancement of factor analysis, researchers were able to measure the cause and effects relationship of specific human behaviors from leaders (Central.com, 2013). The results from this theory wanted to prove that leaders are not born but made. It was their belief that anyone wanting to be a gifted leader could just learn the behavior with right conditioning.

In the 1960s the contingency leadership argued that different styles of leadership and personalities are needed depending on the situation. It is believed that depending on the situation differing styles of leadership maybe applied. In contingency theories it is believed that that leaders are more likely to express their leadership if they feel that their followers will be responsive (Central.com, 2013).

Then in the 1970s, transactional theories, also known as exchange theories of leadership, gained ground. They are characterized by a transaction made between the leader and the followers (Central.com, 2013). This theory valued a positive and mutually beneficial relationship (Central.com, 2013). According to theory, in order for the leader to have motivational value, the leader must find a way "to adequately reward (or punish) his follower, for performing leader-assigned task" (Central.com, 2013). "The transactional theorists state that humans in general are seeking to maximize pleasurable experiences and to diminish un-pleasurable experiences" (Central.com, 2013). Therefore, we tend to "associate ourselves with individuals that add to our strengths" (Central.com, 2013). According to this theory "leaders not only influence followers but are under their influence as well" (R. A. Heifetz, 1994). A leader gains the influence of his or her followers by giving them what they want. According to Heifetz these all of these theories are considered to be value-free. While many may see leadership as neutral and value-free, he argues that in many societies leadership is a normative idea that "represents a set of orienting values, as do words like 'hero' and 'champion'" (R. A. Heifetz, 1994).

In his opinion, Heifetz believes that values-free leadership can become pretty dangerous because it can foster "self-delusion and irresponsibility." He argues that a leader is more likely to produce outcomes that are beneficial for society if the goals are set by both leaders and followers. Burns "suggested that socially useful goals not only have to meet the needs of followers, they also should elevate followers to a higher moral level" (as cited in R. A. Heifetz, 1994). He agrees that most of the relationships between leaders and their followers are transactional, but argues for transforming leadership as something that has more potential because in it the leader not only recognizes and meets

an existing need of the follower; but he looks for "potential motives," seeks to satisfy higher purposes, and totally engages the "full person" of the follower (Burns, 1978). He terms this "moral leadership."

Theorists assert that transformational leadership creates a "solid relationship that results in a high percentage of trust, that will later result in an increase of motivation, both intrinsic and extrinsic, in both leaders and followers" (Central.com, 2013). According to Burns, he believes that leaders not only have a relationship of power with their followers but also of "mutual needs, aspirations, and values." He believes that followers should have adequate knowledge about their leaders, as well as other leaders, so that they can make the best choice in whom to follow. And lastly, he feels that if leaders make promises, they have an obligation to make that change in their leadership. However, this view has garnered some criticism. Those who support transformational leadership believe that the leader's agenda is "inseparable from the follower's needs"(Harrison, 2011).

Relationship as an Aspect of Leadership

In introducing the concept of relationship as a critical aspect to leadership, Burns is quoted as saying that most of the relationships between leaders and their followers are transactional. Furthermore, transforming leadership is something that has more potential because in it the leader not only recognizes and meets an existing need of the follower. He also believes that

> the essential strategy of leadership in mobilizing power is to recognize the arrays of motives and goals in potential followers, to appeal to those motives by words and action, and to strengthen those motives and goals in order to increase the power of leadership, thereby changing the environment within which both followers and leaders act. (Burns, 1978, p. 40)

Heifetz (1994), citing Burns, argues that "socially useful goals not only have to meet the needs of followers, they also should elevate followers to a higher moral level" (p. 21).

According to Pearce and Conger (2003), historically leadership has been centered on an individual and that person's connection to those under him or her. However, the 21st century saw a gradual shift in leadership theory over time from the greatness of the individual to the leader in more interaction with the community.

Greenleaf, in his seminal work, *Servant Leadership,* talks about the importance of being a servant leader to create unity within an organization. Servant leadership is more of a leadership style than it is theory; however it places an emphasis on the leader being the humble servant to his followers. This is the direction that leadership theory has been headed towards; its focus is not just on the power holder but also the followership. In the book, *Theory and Practice of Leadership,* the author states "one talent all leaders must possess [is] the capacity to perceive needs of followers in relationship to their own, to help followers move toward fuller self-realization along with the leaders themselves" (Gill, 2006).

It is actually believed that "the smartest groups . . . are made up of people with diverse perspectives who are able to stay independent of each other" (Surowiecki, 2005, p. 39). Gill (2006) states that "one talent all leaders must possess [is] the capacity to perceive needs of followers in relationship to their own, to help followers move toward fuller self-realization along with the leaders themselves" (p. 11).

The assertion is that transformational leadership creates "solid relationship that results in a high percentage of trust, that will later result in an increase of motivation,

both intrinsic and extrinsic, in both leaders and followers" (Leadership-Central.com, 2013). Other new approaches to leadership include

> Authentic leadership, in which the authenticity of leaders and their leadership is emphasized; spiritual leadership, which focuses on leadership that utilizes values and sense of calling and membership to motivate followers; servant leadership, which puts the leader in the role of servant, who utilizes 'caring principles' to focus on followers' needs to help those followers become more autonomous, knowledgeable, and like servants themselves; and adaptive leadership, in which leaders encourage followers to adapt by confronting and solving problems, challenges, and changes. (Northhouse, 2015, pp. 4-5)

Pastor as Adaptive Leader

My aim is to focus on the adaptive model of leading. There is a mistake often made in organizations "to address change as purely technical through the use of authoritative expertise while ignoring the adaptive work that the stakeholders must do for themselves" (Adams, Bailey, Anderson, & Galanos, 2013, p. 4, chart 1). So, the question may be asked: What is adaptive leadership?

> According to management professor and consultant Dr. Charles Albano, an advocate for individual self-growth programs, it is not a passive effort merely to adjust circumstances. Instead, adaptive leadership encourages and builds upon the circular and interactive relationships that exist among the people within an organization. Dr. Albano describes adaptive leaders as those who see organizations as living–not mechanical–systems. Adaptive leaders seek to shape the roles of subordinates by using their ability to tap into human potential to make positive change. Dr. Gary Yukl and Dr. Ruma Mahsud, professors of management from the University of Albany, state that adaptive leadership involves changing behavior in appropriate ways as the situation changes. Yukl and Mahsud argue that as the pace of change increases, adaptive leaders become more critical to its success. Adaptive leaders succeed because they are able to accurately diagnose the situation and vary their behavior and the behavior of their subordinates accordingly. Albano, Yukl, and Mahsud define adaptive leadership as it applies to the success in commercial organizations. In these organizations, change is a constant created by external variables such as the Internet, diversity, the environment, and the economy. Organizations that succeed are led by leaders who recognize that change is occurring, or imminent, and who are willing to adapt. They effectively communicate to their subordinate leaders and workforce the purpose for change, the outcomes of change, and the organizational way ahead. In doing so, the adaptive leader builds the understanding, consensus, and collaboration

> necessary for a workforce to adapt and embrace the organization's roadmap for what businesses define as success–profit. (Sharpe & Creviston, 2013, p. 5)

It is noted that the practice of adaptive leadership is to mobilize people to take on the tough challenges of leadership and to thrive (Heifetz, Grashow, & Linsky, 2009). In this form of leadership, the authors define adaptive leadership as being in a "the state of disequilibrium" (Heifetz et al., 2009). Conflict is not something bad; however, the state of disequilibrium can become quite disenabling if the conflict reaches to a level where it becomes unproductive. The *Harvard Business Review on Culture and Change* (2002) mentioned resistance in the change process does not mean opposition. A leader needs to know the balance between enough and not enough conflict to bring the organization to the state of disequilibrium (Heifetz et al., 2009). Friedman (2007) lays out that for change to occur in an organization there must be a method in place to produce leaders who will stand against the tide of resistance ingrained within the current organizational culture and break down the old ways of doing business and set a new path.

Before applying the principles of adaptive leadership, there has to be a time of problem diagnosing (Heifetz et al., 2009). In adaptive leadership, there are basically two kinds of problems: technical and adaptive; and the challenge lies in discerning the nature of the problem. The tenets of this leadership philosophy postulates that if the problem lies in the people; therefore, the solution lies there too (Heifetz et al., 2009). Adaptive leaders also try to place themselves in the shoes of those who are being affected. The authors believe that adaptive leaders are more correctly assessed by their actions than by their words (Heifetz et al., 2009). Adaptive leadership pays a lot of attention to oneself or understanding the person as a system. Everyone has their loyalties, strengths, and weaknesses. Adaptive leadership focuses on the tuning in of their personality, to broaden

their bandwidth, develop better skills in dealing with situations that in which they may be weak. People are encouraged to identify their hungers; intimacy needs to be addressed within the proper social context such as their families so that they do not do something irrational and thus compromise the mission of the organization in which they are leading the adaptive change.

Heifetz et al. describe the difference between adaptive leadership that supports innovation and organizational creativity and more technical approaches that attempt to solve problems quickly with whatever is handy, often utilizing material resources. Technical approaches to significant challenges may be more immediately satisfying and more reflective of the changes in political climates, but they ultimately fail in the face of repeated stress and workplace fatigue. Organizations that wish to thrive under these current circumstances must establish a framework for healthy, interactive communication that allows crucial conversations to occur, simultaneously cultivating resilience and flexibility in the workplace environment by remaining open to change and growth. Choosing the thorny–but essential–path of adaptive leadership, coupled with mindfulness practices, is a requisite element in the process of managing organizational obstacles and accessing the most creative possibilities for change. Again, a critical component of this effort is the leaders' participation in the process. It is an essential element of adaptive leadership that "the teacher [administrator in this paper] is a co-learner and at the same time a model, practicing authority and leadership in public so that others may eavesdrop, watch, contend with, and learn" (Parks, 2005, p. 232). Thus, without demonstrable support and a clear sense of mutuality, this effort cannot succeed (Raney, 2014).

The leaders in this relational leadership style are not just concerned with getting the task done. There is a major focus on individual fulfillment. In the book, *Spiritual Leadership,* the authors mentioned that God is not just concerned with accomplishing goals. He is concerned with how the goal is reached. Conflict is not something bad; however, the state of disequilibrium can become quite disenabling if the conflict reaches to a level where it becomes unproductive (Heifetz, Grashow, & Linsky, 2009). A leader needs to know the balance between enough and not enough conflict bring the organization to the state of disequilibrium (Heifetz, Grashow, & Linsky, 2009). In adaptive leadership there is the mentioning of getting on the balcony of the organization and off the dance floor. This is an attempt to catch the big picture of your organization. Adaptive leaders also try to place themselves in the shoes of those who are being affected. Adaptive leadership plays a lot of attention to paying attention oneself or understanding yourself as a system. Adaptive leadership focuses on our tuning in of our personality, to broaden our bandwidth, develop better skills in dealing with situations in which we may be weak.

Relational leadership theory believes that influence is not based upon authority or coercive but shared persuasion and values. In this kind of leadership where everyone leads and everyone follows, relational leadership is more about one's character as a leader and how one live the vision that one's preaches. There has been much abuse sustained throughout the years with various leadership theories. However, this abuse has not been done by the leader alone.

In his book, *Leadership without Easy Answers,* Heifetz suggests that many times we have seen leadership as influencing the community to follow the leader's vision. This

has been the wrong starting point because when something goes wrong the leader is to blame. However, he sees leadership as the leader marshalling the people to address challenges (R. A. Heifetz, 1994). This is a better approach because when something goes awry both leadership and the community are at fault. He mentions that the difference between leadership and management is that leadership helps to provide a vision and influence others through non-coercive means. I believe that this is one of the best models because when people can buy into the vision they take ownership and responsibility for the vision. My belief is that the relational model helps to create a sense of dignity within the workplace and high level of respect between employer and employee. However, I disagree with Heifetz on his concept of values-free leadership. I do agree that the relational model places a high priority on the leader's character. As mentioned in the book *Spiritual Leadership*, there is an emphasis upon not so much as what the leader does but more on who the leader is as a person.

According to *Soul at Work*, the values and vision of the company has to be lived throughout the leader's life. However, there is a vulnerability especially in the trait theory of leadership, that leaders use their charisma to influence others but in the relational model this is not encouraged. There are legitimate and illegitimate sources of influence according to Blackaby and Blackaby (2011). The legitimate forms are God's Hand, Integrity, Successful track record, Preparation, Humility, and Courage (Blackaby & Blackaby, 2011). The illegitimate forms include Position, Power, and Personality (Blackaby & Blackaby, 2011). I have come to accept that leadership is a spiritual discipline. It has much more to do with a change in the leader's character than it has to do with a change in his employees.

In adaptive/relational leadership there is a focus on human beings as whole persons made up of physical, mental, and spiritual capabilities. Many professions only focus on two of these capabilities. As mentioned in *Soul at Work,* many individuals are looking for places of work where they can exhibit their spiritual traditions to help them accomplish their task (Benefiel, 2005). In our society spirituality has been kept out of the workplace to the detriment of both employees and employers. Employees are looking for leadership that is characterized by compassion, service, respect, and wisdom (Benefiel, 2005). They want to know that they are making a difference in the world. I believe that the church is in a unique place to meet this kind of leadership style.

This leadership, in my view, is closest to the leadership of Jesus. According to *Spiritual Leadership*, Jesus' mission was to follow the Father's will (Blackaby & Blackaby, 2011, p. 46). Jesus made a great leader because he was a great follower of His Father's will. There is much that can be learned from this adaptive model and I believe that this shift is in complete alignment with the biblical leading style. In my opinion this principle of adaptive/relational leadership does not only act upon followers but the leaders as well. Many of the earlier theories focused on the traits of leaders assuming that they had all the answers. However, the adaptive/relational gives more freedom for the leader to learn and adapt just as his or her followers are doing the same. It seems that in this leadership style it takes longer to accomplish a mission.

However, as mentioned by Heifetz et al., one must be able to get on the balcony to see a clearer picture. This type of leadership seems to be that the main job of the leader is to help the people all move in the same, clear direction. True leading is not concerned with putting out the fires of minor challenges that arise day-to-day in an organization but

concerns itself with the direction of the company, the vision that is being set collectively, and the desire for the company to move in that direction together. I believe that the progress of leadership theory to its current focus on relationship theory is good, not just for employees or volunteers but also for employers. Second, I hold the view that the relational model helps to create a sense of dignity within the workplace and a high level of respect between employer and employee. I do agree that the relational model places a high priority on the leader's character. I believe that this is very important because a leader influences the views, actions, and state of mind of many individuals (Gardner, 1995). This can prove to be disastrous if the leader's character is demented.

Communication is a critical aspect of adaptive leadership. Gardner (1995) states that in order for leading to be truly effective one has to communicate the contours of how the person wants his or her organization to be throughout the life. There are two ways of doing this. He says that all organizations have two kinds of leaders: direct and indirect. This is exemplified by the contrasting lives of Churchill and Einstein. Churchill is seen as being a direct leader because of the stories that he communicated to audiences. However, Einstein is noted as an indirect leader because he developed ideas that were captured in theory and then communicated to audiences to make a difference. Gardner (1995) concludes that leaders achieve their success through the stories that they relate. In the arts those stories can be media or artistic expression such as dance or music. In the sciences, those stories can be symbols, mathematical equations, or an anatomical model. However, leaders in both disciplines must embody those stories. Thus, the adaptive leader, whether direct or indirect leader must embody the principles of the organization in the personal life and allow leadership to account for the whole being.

As mentioned by Blackaby and Blackaby (2011), there is an emphasis not so much on what the leader does but more on who the leader is as a person. In supporting this position, Benefiel (2005) affirms that the values and vision of the company have to be lived throughout the leader's life. However, there is vulnerability, especially in the trait theory of leadership that leaders use their charisma to influence others but in the relational model this is not encouraged. There are legitimate and illegitimate sources of influence.

Studies were conducted to ascertain what people valued most about their leaders. The results showed that people want leaders who are honest and that they can trust to follow, leaders who are skilled and have an experience with wins and can use this experience to awaken that same desire in others (Kouzes & Posner, 2003). Margaret Benefiel highlights the lives of various CEOs who take personally what they preach about to their employees. Those whose employees caught the vision of their job were able to catch a glimpse of that through their CEO. The only way to make a difference in the thought processes of others is that we have to be the change we want to see in the organization.

As mentioned by Benefiel (2005), many individuals are looking for places of work where they can exhibit their spiritual traditions to help them accomplish their task. In our society spirituality has been kept out of the workplace to the detriment of both employees and employers. Employees are looking for leadership that is characterized by compassion, service, respect, and wisdom (Benefiel, 2005). They want to know that they are making a difference in the world. I believe that the church is in a unique place to meet this kind of leadership style. Sider (2002) states that Christians have always recognized

that the world is broken, and it falls short of the glory God intended it to have at creation. But Sider asserts that Christ is making people whole individually and corporately as the church. It is God's Spirit that brings wholeness to others (p. 51).

The Church as Leader

Churches can be utilized as leaders in the transformation of their communities because of their commitment to spiritual, mental, and physical needs of their communities. They are highly valued for their instructions and teachings in living a quality life and their consistent presence in communities give them an edge. Studies conducted by experts show that church attendance highly influences volunteerism "through the formation of social networks and sense of community" (Becker & Dhingra, 2001, p. 317). It was also important to note that denomination and political persuasion did not greatly influence this, but education level and family status did increase the odds among churchgoers (Becker & Dhingra, 2001). Particularly in the African-American community, churches are a "trusted source for health education materials and programming" (Harmon, Chock, Brantley, Wirth, & Hebert, 2016, p. 1412). It was also noted from this study that churches because of their social networks and history as a trusted source have the opportunity to distribute information fairly quickly and "may be very reactive to public health crises and early adopters of public health messages" (p. 1420).

The local church along with its governance structure and upper organizational levels has the opportunity to develop relationships with communities over time and therefore, can become a leader in community transformation. In my research, I have

identified several churches that have utilized this model and plot their journey towards wholeness in their communities.

In a study conducted by Slade et al. (2018), the authors recruited African-American churches to participate in early cancer screening. The pastors of these churches served a key role because of the trust they helped to facilitate. The article mentioned potential barriers to recruitment was the "perceived unequal authority" (Slade et al., 2018, p. 6) between the leaders of African-American churches and predominately white university students seeking to do "research" or "study" (p. 7). Despite all the perceived challenges, there had been a level of trust already in place because the community-based organizations had a history of working with "faith-based organizations" (Slade et al., 2018, p. 8) and this had formed a good level of trust with the participants. And before the implementation phase, the community-based organizations had developed relationships with the advisory panel and church leaders. The engagement and recruitment of African American churches was above average, and it showed the power of collaboration amongst community-based organizations, the church, and other community partners to effect change in the community.

A study conducted among Caribbean Seventh-day Adventists in Barbados showed that the influence of the Seventh-day Adventist Church helped its members to experience lower rates of chronic illnesses such as hypertension, obesity, and diabetes (Brathwaite et al., 2003). Once individuals join the Adventist Church, they are "discouraged from consuming other meats, fish, eggs, hot spices, pepper, and caffeine-containing beverages, and are encouraged to adopt a vegetarian diet" (pp. 34, 35). This research "has suggested that participation in church and social activities has protective benefits and may reduce

mortality" (p. 39). The results from the study were also validated by researchers from Loma Linda University, which suggested that Seventh-day Adventists have a "lower mean body mass index, and a lower risk for both diabetes mellitus and hypertension" (p. 38).

In the AJPH, there was a study whose interventions included "teachings on health, physical activity class offerings, personal calls and motivational interviewing" all to get participants more physically active (VanderWeele, 2017, p. 1024). However, preliminary analyses of the study shows that the social support found in the class setting may prove to be more beneficial in increasing physical activity than interviewing (VanderWeele, 2017). This shows the benefits of the social networks in religious communities.

Nigeria "accounted for 37,000 of the world's 160,000 new cases of babies born with HIV in 2016" (Cohen, 2018, p. 1164). However, a partnership with U.S. National Institutes of Health and Centers for Disease Control and Prevention, has shown progress. Celebrations that celebrate the arrival of the baby have expanded to more than 115 churches (Cohen, 2018). These celebrations which also test for HIV and other diseases have seen an increase of 55% to 92% in pregnant women (Cohen, 2018). The key to its effectives is that the celebrations are held in churches which takes away the stigma of being tested for HIV in the hospital according Amaka Ogidi, coordinator of a local project (Cohen, 2018).

Tim Breene states that the 2014 Ebola crisis in West Africa was not stayed by the medical professionals alone but faith leaders played a critical role, which is well documented in the 2015 Report, "Keeping the Faith" by Christian Aid, CAFOD, Tearfund and Islamic Relief Worldwide. According to Magezi (2012), during recent years the work

of the church has been gaining popularity. In his article, he shows that the church's contribution to public health has not been celebration. He brings out that "out of 671 churches surveyed in Namibia, Uganda, and Sierra Leone, 53% have church-based HIV initiatives, but only 25% of these churches receive external funding" (p. 2). During the crisis, the faith leaders were not engaged at first even though they were highly trusted and respected in the nations of Liberia and Sierra Leone (Breene, 2017). The medical professionals used measures that "went against cultural values and religious practices, resulting in a widespread public denial of the disease and even hostility towards those who were seeking to contain it" (Breene, 2017, p. 13). However, when the faith leaders became involved

> they preached acceptance of Ebola workers and survivors and role modeled this acceptance in religious services. They also helped to drive out the stigma that was destroying community cohesion. Where Ebola-control practices were considered irreligious, it was the participation of religious leaders alone that enabled an acceptance of the necessary changes to curb the spread of the disease. (Breene, 2017, p. 3)

Magezi (2012) brings out an important fact in his research that "churches seem to be increasingly marginalized in shaping health policy despite church-care ministries forming the foundations of present day care as it is practiced (p. 1). It is very important for churches to be "repositioned for a practical contribution towards health-care ministries in a manner that effectively integrates the spiritual and practical dimensions (p. 1). This method proved successful in the HIV/AIDS crisis in Africa about twenty years ago (Breene, 2017). As a result, World Relief has begun to operate Church Empowerment Zone models. This model relies on the local church to serve the "most vulnerable" in its community by delivering World Relief's messages regarding health, family and social issues to its neighbors across denominational and tribal groups (Breene, 2017, p. 4). This

is the best way to create sustainable change "by building the capacities of church leaders and their congregation, and by enabling them to identify the unique needs and harmful beliefs in their communities" (p. 4). Levin (2013) states, "religious institutions and organizations . . . have a long history of engagement within the healthcare and public health sectors, dating back many centuries" (p. 368). The Office of the Surgeon General (OSG) has been called to reach out in partnerships with these faith-based organizations because of the potential to directly impact the health of communities and to improve health disparities (Levin, 2013). According to Levin, it is believed by the United States government that faith-based organizations offer one of the "strongest social networks" and many "receive information that can be of value to the health of their families and neighborhoods" (p. 369).

It has been shown that faith-based organizations improve health results (Levin, 2013). One study that was conducted, "Physical Health Screenings Among African-American Church and Community Members," showed the importance of churches conducting health fairs in helping their members to be educated about their health (Moore et al., 2016). It has been noted that "regular church attendance has been linked to a greater likelihood of reporting blood pressure screenings and increasing the likelihood of having a Pap test for uninsured women" (p. 1787). The study also revealed the pastor can help to promote health emphasis in a way that very few others can (p. 1787). "The African-American church has been recognized as a potential forum for promoting health behaviors" (p. 1796). Another study in the *Journal of Community Health*, stated three facts that resulted in higher recruitment were "the commitment of the church volunteer, whether the nurse was a member of the church, and pastoral involvement" (Ellis &

Morzinski, 2018, p. 926). “Religious communities often provide important resources that make partnerships effective including spaces to meet, regular gatherings with large numbers, a community with relationships of trust, and a shared spiritual and moral message” (VanderWeele, 2017, p.1024).

In another study entitled “Recruitment and participation of African-American men in church based health promotion workshops,” there were listed several recruitment strategies in addressing this population.

> They included: 1) overcoming fear and mistrust of sponsored research by having a recruitment letter written by a prominent African American man in the community (e.g., a former NBA player), 2) having the research team include persons whose racial, ethnic, and language backgrounds are similar to those of potential study participants, 3) providing follow-up calls for appointments and educational programs, 4) having church-based sessions that increased the sense of community partnership between study staff and local community members, 5) convening sessions at times that do not conflict with earning wages, and 6) addressing transportation barriers to participation. (Saunders et al., 2015, p. 1301)

There have been cases when the recruitment was low the pastor took a more leading role by making announcements during pastoral remarks, preaching on the topic, attending the workshop and participating in the study themselves (Saunders et al., 2015). In *Health Promotion Practice*, the authors indicated that “congregants expected their church to promote health and desire to learn about healthy living through the Bible and that these two beliefs are strongly associated with their willingness to attend health promotion events” (Odulana et al., 2015, p.130). These findings suggest that churches and community partners such as research institutions may be able to partner for the common goal of health promotion (Odulana et al., 2014).

There have been several studies that have looked at the methods that have been used to expose the church’s members to the need for screening in the area of diabetes

(Boltri et al., 2008; Davis-Smith et al., 2007; Frank & Grubbs, 2008), prostate cancer (Holt et al., 2009; Husaini et al., 2008), colorectal cancer (Campbell et al., 2004; Holt et al., 2011; 2012), blood pressure (Frank & Grubbs, 2008), and HIV testing (Berkley-Patton et al., 2010). It was concluded by the authors that more studies need to be conducted on how African-American churches "can assist in promoting and offering routine seeking health screenings, especially in considering churches' reach and influence with these populations (p. 1796). It is commonly accepted that churches have to be willing to find new and innovative ways to reach the most vulnerable among them (p. 1797). It is believed the more health screenings in religious community will proportionately increase the number of African-Americans receiving interventions. (Moore et al., 2016).

This was understood by the residents of Atlantic City, New Jersey. The city has crime rates that exceed the national averages, unemployment is almost double the national rate, and it is ranked 17th in health outcomes among 21 counties in New Jersey (Atkins & Hagerman, 2018). A grant was awarded to AtlantiCare Foundation whose goal is "to bring together the right people, build trust, and foster productive conversation that all lead to a stronger, healthier community" (Atkins & Hagerman, 2018, p. 2). As a result, they brought together a team which included the fields of healthcare, social services, community organizations, government officials, and business leaders. One of the challenges this team realized was that there was not enough communication sharing between the organizations who basically were helping with the same population. They realized their need for streamlining and sharing data is critical to their efforts. As churches reach out to their communities we should not seek to "reinvent the wheel" but

we should be open to partnerships that will provide resources to help us reach the most vulnerable among us (Atkins & Hagerman, 2018).

The Church and Strategic Planning

The idea of the church being intentional in its missionary focus is not foreign to the Scripture. Oyinloye (2014) states,

> After Jesus' baptism at the Jordan River, He was divinely anointed by the Holy Spirit, and led into the wilderness, where for 40 days, He fasted and prayed and was tempted. Then Jesus went up to Galilee and began His ministry (Luke 4:1-14). His itinerary took him to Nazareth where He grew up. On the Sabbath day, He was given the book of Isaiah to read (vv.16-17). Opening the book, He read Isa 61:1-2, as recorded in Luke 4:18,19. 'The Spirit of the Lord is upon Me, Because He has anointed me to preach the gospel to the poor; he has sent me to heal the brokenhearted, to proclaim liberty to the captives and recovery of sight to the blind, to set at liberty those who are oppressed; to proclaim the acceptable year of the Lord.' This was His declaration of purpose. This is the passage that summarizes the duties Messiah was to engage in and the reason for Jesus' coming. (pp. 36, 37)

Today, we as the body of Christ should be no different in our approach in reaching the souls of people. Mintzberg (1994) states "planning is decision making" (p. 9). Many times in our planning we think about the future or even try to control it but planning, as Koontz defines, (in Mintzberg) is "the conscious determination of courses of action designed to accomplish purposes" (p. 9).

In the garden of Gethsemane, Jesus did not try to control the future. His prayer was "O my Father, if this cup may not pass away from Me, except I drink it, Thy will be done" (Matt 26:42). He made a conscious decision to go to the Cross. It was a deliberate decision. As the churches engages in strategic planning one of the first rules to understand is that what we think about the future or our power to control the future is not within our grasp. We have the example of Jesus to make decisions that will help to

accomplish our purposes. Galatians 4:4 states "4 But when the fullness of the time was come, God sent forth his Son, made of a woman, made under the law."

Another view of planning according to Mintzberg is "integrated decision making" (p. 11).

> Planning as integrated decision making imposes a particularly stringent requirement, however: that the decisions in question be batched-be drawn together periodically into a single, tightly coupled process so that they can all be made (or at least approved) at a single pint in time. (p. 11)

Lastly, "planning is a formalized procedure to produce an articulated result, in the form of an integrated system of decisions" (p. 12). According to Mintzberg, the formalized procedures involves three things: "(a) to decompose, (b) to articulate, and especially (c) to rationalize the processes by which decisions are made and integrated in organizations" (p.13).

According to Malphurs, the church in North America is on the decline (Malphurs, 2013). Many blame the church for its lackluster focus on evangelism and seminaries for their outdated curriculum (Malphurs, 2013). Malphurs believes the answer to the decline is to start new areas of growth such as church planting, church growth, and church revitalization (Malphurs, 2013). "Since every church in time will wane and die, it is imperative that we start new churches, or the church as a whole will cease to exist" (Malphurs, p. 12). Before churches plateau and still are growing, the leaders must be asking God for what is next in order to avoid complacency (Malphurs, 2013). This is hard to do because churches within this context do not see the need for change. Many times leaders within this "second curve" get weary and lose momentum needed to effect change (Malphurs, 2013). A way to help foster a "second curve" in our church is to go back to its foundation. This involves discovering core values, developing a mission, vision, and

strategy (Malphurs, 2013). Church revitalization is another S-curve that can help to ward off decline. However, it is more difficult than church planting. Starting change in a growing church is not as likely to flourish (Malphurs, 2013).

> The answer to the problem of church decline is to start new S-curves. This necessitates a strategic planning process along with leaders or navigators who can effectively lead their church through the process. It is imperative that strategic planning be at the heart of starting new S-curves. (Malphurs, p. 15)

Malphurs states that whether it is church planting, growth, or revitalization, two pieces are necessary ingredients: a church that is ready for growth and a pastor who has learned the skill of leading a church through change (Malphurs, 2013). Strategic planning is a process that is a "soul-searching and potentially painful experience" (Malphurs, p. 18).

Strategic planning is important because it helps with the three identity questions of existence, who are we? Where are we going? How will we get there? (Malphurs, 2013). Studies have showed that churches that have done evaluation and long-range planning have seen an increase in church growth (Malphurs, 2013). Potential members and the congregation need to have an idea of the vision for the future. This creates an environment where each member believes that they are an important step of this process. They believe that their voice is being heard. Strategic planning is critical to the long-term survival of any church because ministry is constantly changing (Malphurs, 2013). Many times, the practices of the church are not in harmony with the values, mission, and vision of the church. Strategic planning effects how we build, and even what we build. It affects how we do business and questions why we even do business in a certain way.

> Strategic planning is the fourfold process that a point leader, such as a pastor, who works through regularly with a team of leaders to envision or reenvision and revitalize his church by developing a biblical mission and a compelling vision,

> discovering its core values, and crafting a strategy that implements a unique, authentic church model. (Malphurs, 2013, p. 28)

Strategic planning is a process that is ongoing and never finishes (Malphurs, 2013). The plan needs a strategic point leader who works closely with a team. This strategic point leader should not be the person who is responsible for the process being implemented (Malphurs, 2013). As a vision caster, the strategic point leader cannot occupy the role of implementation. If the pastor is the point leader, he or she needs to find an individual who can help support them in the implementation of the process. This brings out the fact about the importance of the strategic leadership team (SLT) as Malphurs calls it. The author mentions in the scripture there is the example of Moses and his father-in-law, Jethro. Jesus had the twelve disciples.

> Strategic planning is an envisioning process that results in the revitalization of plateaued and dying churches. Rather than start with the present and work forward incrementally toward a mission and vision, you start with a clearly articulated, compelling mission and vision and work backward to where you are. You envision the future and then ask, How will we get there? (Malphurs, 2013, p. 29)

The church's vision is what the church will look like in the next five to ten years of its life as it accomplishes the mission (Malphurs, 2013, p. 30).

> The strategy accomplishes the church's mission and vision and includes five key elements or steps: reaching out to the community, making mature disciples, building a ministry team (congregation, staff, and possibly a board), assessing the ministry's setting (location and facilities), and raising the necessary finances to carry out the mission and the vision (p. 30)

The strategic planning process according to Malphurs (2013, p. 30):

I. Development of the Mission

II. Development of the Vision

III. Discovery of the Core Values

IV. Design of the Strategy

a. Outreach into the Community

b. Making Disciples

c. Building the team

d. Assessing the Setting

e. Raising Finances

The strategic planning process helps a church to develop its unique ministry model (Malphurs, 2013). The author states that many churches look to other ministries to provide a blueprint for how their church is to be run. He terms this "trying to franchise someone else's model" especially when it involves another ministry in another part of the country. The author also points out that strategic planning is biblical. There are many examples in the Bible when Moses gave the ministry to his successor, Joshua (Malphurs, 2013). Then there was Nehemiah who helped revitalize Jerusalem through strategic planning (Malphurs, 2013). In the New Testament the author also brings out the strategic planning of the spread of the gospel through the Great Commission. The Holy Spirit was the strategic operator and selected cities that would make the greatest impact on the kingdom with Paul's missionary journeys. We always have to remember that it is in the heart of God to revitalize his church and as we undertake it, we become partners with God to work for his church.

Malphurs (2013) has developed 26 purposes of strategic planning for churches (pp. 33-36):

1. To discover the church's strengths, limitations, and weaknesses.
2. To build on a ministry's strengths and minimize its weaknesses.

3. To facilitate congregational communication and build the congregation's trust.
4. To understand and implement spiritually healthy, Christ-honoring change.
5. To get your people-leadership team and congregation on the same page.
6. To encourage and promote spiritual revival.
7. To discover and articulate your ministry core values.
8. To develop and communicate your God-given mission.
9. To develop and articulate an inspiring, compelling vision.
10. To understand and relate more effectively to the community.
11. To develop a disciple-making process for the entire church.
12. To assess, recruit, and develop a strong staff team.
13. To mobilize the congregation to serve and do the work of the ministry.
14. To make wise decisions about the facilities and their location.
15. To inventory and assess current giving.
16. To explore new streams of giving to increase current income.
17. To design a stewardship strategy to help people become good stewards of their finances.
18. To analyze and evaluate the church's budget, looking for ways to best handle congregational finances.
19. To raise additional funds and direct capital funding projects.
20. To know how to implement the entire strategic plan.
21. To regularly evaluate and improve the church's ministries.
22. To discover the ways God is blessing churches across America and abroad, and why.

23. To know and work with the latest technology (internet, website, and other).
24. To empower the governing board and pastor to lead with excellence.
25. To build a lay and staff leadership development process.
26. To develop a marketing strategy that will best position the church in the community to glorify God.

CHAPTER 4

DESCRIPTION OF THE INTERVENTION METHODOLOGY

The Church as a Leader in Health Transformation in the Community

I choose Tallahassee to do my project because the church believed that the message of health would receive more openness from an evangelistic approach; second, because the city prides itself as an ideal place for young families; and third, according to *Wikipedia* (2016), is considered the most degreed county in Florida. Prior to making the decision to focus on health, the church had no strategy to reach their local community. This chapter describes the processes used in developing the intervention to meet the felt needs of the community.

Reaching and Testing Consensus

The process of moving together for a collective vision included an interchange of ideas with the church. In 2012 one of my first duties after being installed as pastor was to take the church members through a "congregational timeline." To see where we came from as a community and where we wanted to go was an eye-opening experience for the members. During the timeline we also had formal talks with the elders. Our strategy was to move away from having sporadic events with different focuses to having an intentional focus on an area over time, and to solidify the church's future mission and passion. As the members began focusing they realized that the church had a strong interest and desire for a health ministry as well as other community service ventures. The Fellowship Seventh-

day Adventist Church drew up a timeline showing its history from 1994 to 2013 (see Appendix A).

Our second area of focus during this timeline was on the three biblical principles of the intervention known as the theological reflection. I examined Galatians 4:4-5; Acts 20:17-21, and Numbers 21:4-9. Galatians 4:4-5 (KJV) says, 4But when the fullness of the time was come, God sent forth his Son, made of a woman, made under the law, 5To redeem them that were under the law, that we might receive the adoption of sons." We saw individuals whom we wanted to reach as heirs having been adopted into the family of God. We felt that it was our commission to take this message to those around us and include them as part of the great family of God.

Our next text, Acts 20:17-21 (NIV), states that

> From Miletus, Paul sent to Ephesus for the elders of the church. When they arrived, he said to them: "You know how I lived the whole time I was with you, from the first day I came into the province of Asia." (Acts 20:17-21). I served the Lord with great humility and with tears and in the midst of severe testing by the plots of my Jewish opponents. You know that I have not hesitated to preach anything that would be helpful to you but have taught you publicly and from house to house. I have declared to both Jews and Greeks that they must turn to God in repentance and have faith in our Lord Jesus."

Presence was very important to Paul's ministry. He says in the text that he also lived with them. This text also mentioned specifically the presence of Paul with the church.

Galatians 4:4-5 was my focus when I was installed at the church. Our position as sons and daughters of God compelled us towards the mission of telling the world about the hope we have through Jesus and this in turn impacts our communities. This, along with Acts 20:17-21 which focused on the presence of Paul, was to guide our future mission projects.

In 2013, to test our new resolve and strategic commitment we conducted an evangelistic effort with a focus on the family. This focus consisted of a four-week Bible teaching conference in October, followed by community baby dedication, 100-praying-men anointing service of all the men in the community, individual and group family counseling in homes, and individual Bible studies given in the community. The church also extended its reach into the community with restarting the Adventurer/Pathfinder club and basketball ministry; by reopening the local Adventist primary school and becoming a constituent thereby increasing its community footprint. All of these initiatives resulted in the church being more spiritually present in the community we served. The church also voted in 2013 to start a daycare in the newly purchased and remodeled fellowship hall as there was no childcare in the immediate community. We hosted a Vacation Bible School every summer which brought 40-50 children from the immediate neighborhood. These steps during 2013-2014 were very essential in extending the next phase of the focus: community-based health evangelism.

During this consolidation phase we also explored other areas of ministry. The strategy was to build from having sporadic events with different focuses to having an intentional focus on an area over time. These steps from 2013-2014 were very essential because a strong interest in family ministries needed to be explored before extending to the area of health ministry. As we also looked at Numbers 21:4-9, we began to turn our focus specifically towards the church as a leader in health transformation. We believed that our church was a tool that could be used for not only the salvation of souls but for the improvement of the overall health of the community. We sought to find principles of health that were biblically based and scientifically proven to work towards the health of

communities. We reached and tested consensus. Health outreach was the new ministry.

Selecting a Health Team

After consensus on ministry direction the next action was to select a health evangelism team. The church board selected and voted in the team. It consisted of a voluntary group of nine people to operate alongside me in this project. The team included lay members from the personal ministries, health ministries, board of elders, and healthcare professionals, along with the pastor. Our aim was to implement the church's new vision. To fulfill this the team reported to the church board, which agreed that preventative health ministry was more effective than a treatment-based health ministry for the community. The team thus led the church in stressing the importance of prevention rather than cure, in formulating and coordinating all the plans of the project, and in keeping a focus on the data and effectiveness of the project. Last, the team assisted the pastor in organizing all health events, along with proctoring the survey, screening tools and planning programs in the health evangelism series. Furthermore, it mobilized and formed subgroups, including college students as well as professors.

Recruiting Participants

Subjects for the project called CREATION Health were recruited on a completely voluntary basis with no pressure or coercion. They were informed that CREATION Health is a faith-based wellness plan complete with lifestyle seminars for those who want to live healthier and happier lives. This information was placed on a postcard that was given out to the community. On the postcard, information was also given that would allow subjects to track their progress. Instructions were also repeated at the beginning of the seminar. Other means of advertising the seminars were posters, bulletin inserts, and

personal invitations. We informed all recruits about filling out pre-tests and post-tests. However, if any subject chose not to participate in the surveys and screening tools, they were still able to go through the seminar free of charge. There was a donation of $15 from subjects who wanted to have a book of bonus health assessments and health information for their personal use. For those who did not have money for a donation, some assessment items were photocopied and distributed to them to complete.

Consent Form

The informed consent form was distributed at the beginning of the seminar and used for both the pre- and post-tests. Completion was voluntary. Even though participants signed the form, they were also advised that if they were unable to continue in the program they could drop out anytime.

Voluntary Participation

Participation in the seminar was voluntary and subjects were free to join or leave at will without any penalty or loss of benefits, if any. I mentioned to the subjects prior to the pre-test that participation was voluntary.

Target Population and Site

The target population were residents of the zip code where the church was located. The project site was the Fellowship Church, which included the total campus: sanctuary, parking lot, fellowship hall, and garden area.

The Intervention

The intervention we used was the CREATION Health Model. According to the Creation Health website:

> CREATION Health is a faith-based wellness plan complete with lifestyle seminars and a special training program for those who want to live healthier and happier lives and share this unique whole person health philosophy. By consistently practicing the eight principles of CREATION Health–Choice, Rest, Environment, Activity, Trust, Interpersonal Relationships, Outlook, and Nutrition–we fulfill God's original plan for our lives, which is to live and be happy. (www.creationhealth.com)

We had a CREATION Health VBS that focused on teaching the church's children as well as children from the community on health principles and stewardship of the body prior to the main CREATION Health Seminar.

Then, we started our CREATION Health Seminar and Fit, Fabulous, and Free! program. The CREATION Health Seminar was conducted in conjunction for eight weeks, once per week on Saturdays. It followed a seminar format for an hour and then formed into a small group session afterwards during the divine worship hour of the church. Fit, Fabulous, and Free! was a two-month program that included a twice-a-week free exercise class with a personal trainer for adults and fitness class for children; and a once-a-week Sunday cooking class and development of a community garden.

During the last two weeks of the CREATION Health series we overlapped it with a revival entitled Ignite. It featured an international motivational speaker known as "the blind evangelist" who spoke for two weeks nightly and shared how the Gospel has allowed him to live life to the fullest despite physical challenges. At the conclusion of the revival, we had a CREATION health expo highlighting all the healthy foods, testimonies, medical personnel, and vendors for our CREATION Health series. The health expo was a one-day event. The attendance was voluntary, and it lasted for four hours on that day.

Data Collection/Tracking and Monitoring

During the eight-week CREATION Health Seminar, there were screening tools along with a pre- and post-survey which was given out. At the end of the CREATION Health Seminar we proctored the same survey to assess the effectiveness of our intervention through the eight-week CREATION health seminar. The survey and screening tools were directly related to the areas of need in our local zip code. The data was gathered by one of my members who is a professor at a local university. The data on our neighborhood was composed of public records from local health departments and community agencies. It also included health services utilized by the agencies and scoring that determined which services were needed most in our neighborhood. The areas of need that were identified were mental health, pneumonia (infections), and colon health. The survey on Global Health focused on general health as well as touching on mental health issues. A pre- and post-test was done on this survey. On the pneumonia (infections) form, the subject was asked to fill out three sections on this form: influenza vaccination, pneumococcal vaccination (PCV13, PPSV23), and Haemophilus influenza type b (Hib) vaccination. The subject's name was not used, but a number was assigned to each individual. The date of birth was not recorded; however, it was asked by the healthcare professional during the interview process.

I worked with local members of my church who were nurses to help proctor this screening tool which took the form of an interview. This interview was of vast importance because the number one health concern in our zip code was pneumonia. This form was given more as a safety precaution to individuals in the area who were susceptible to contracting it by virtue of their location. Thus, we used healthcare

professionals to recommend vaccinations. No vaccinations were given as part of this project. The interview entailed just reading the vaccination screening to the subjects. The interview on vaccinations was at the beginning of the seminar and was proctored in three private rooms in the church. These were designated private areas and the only persons in the room were medical personnel and the subject. The screening tool on colon health included a screening tool along with information on colon health. The two screening tools–vaccination and colon health, along with the global health survey–took about 10-15 minutes to complete as a whole. Other information gathered from the subjects were height and weight. Each subject was given a specific number and designation of M/F for gender as well as a place to put in their zip code. The subjects were also given a copy of their number to reference for the post-survey.

The development of the CREATION Health Seminar content was part of the study. All subjects were offered two screening tools, and one survey at the beginning of the seminar and at the end to measure the effectiveness of the seminar as an intervention. We did not use a video or audio recording of the subjects. The survey that was conducted at the beginning and the end of the eight-week CREATION health seminar was administered by the investigator, research team, and qualified medical personnel in the church lobby. The interview on vaccinations at the beginning of the seminar was proctored in three private rooms in the church. These were designated private areas and the only persons in the room were medical personnel and the subject.

Assessments of individual weight and mental health did not involve subject identifying information. Each subject was given a number and a letter designation to determine gender. This was done to avoid duplication and in order to track progress in

relation to the survey. They were used to identify interview information. The survey and screening tools were filled out by the subject without any assistance needed from a healthcare professional. One survey was used at the beginning and the end of the seminar, to track progress and the effectiveness of the intervention in relation to our local community's health needs.

Advertisement

Information that advertised the event was put on a postcard which was given out to the community. On the postcard, information was given which would enable subjects to track their health progress during those eight weeks. And it was mentioned that further details would be given at the beginning of the seminar. There was also a general announcement through posters, bulletin inserts, and personal invitations to the eight-week seminar that included the same message. All 42 attendees were asked to voluntarily fill out pre-tests and post-tests. There was a donation of $15 for subjects who wanted to have a book of bonus health assessments and health information for their personal use; however, for those who were not able to contribute, assessments were made available but did not include bonus assessments and extra health information.

Risk

The project had a minimal risk because we did not track subjects individually. We measured the change in level of knowledge of subjects and the change in overall health in the community.

Securing of Data

The main project did not involve subject identifying information. Each subject was given a number and a letter designation to determine gender. This was done to avoid

duplication and in order to track their progress in relation to the survey. They were also used to identify interview information. All data was kept confidential in locked cabinets at the investigator's office. The documents will be kept there for the length of time suggested by the Andrews University IRB.

Summary

The project used a team approach; helped the church formulate a vision for their community; and brought a more strategic approach to ministry. The use of the team approach followed the example of Jesus where he had twelve disciples. As a church we thus developed our own approach through use of the CREATION health intervention along with Fit, Fabulous, and Free!, and the Ignite Revival which helped to create an open door of opportunity to our community.

CHAPTER 5

NARRATIVE OF THE IMPLEMENTATION

Timeline of Fellowship

I was installed as the pastor of the Fellowship Seventh-day Adventist Church in October, 2012. Upon coming to my new district, I spent the first several months doing an in-depth analysis through formal talks with the congregation on their interests in the community as well as through a congregational timeline of my church in Tallahassee, Florida.

We conducted a timeline of our church to trace its history in order to determine its strengths and weaknesses. In terms of weaknesses, two were listed. One was that our church claimed to be a community-oriented church, but history showed something completely different. We had not reached out to our local community as much as we thought. Strengths were ministry driven. The most active ministries of the church at that time included youth and young adult ministries, health ministry, children's ministry, and women's ministry. These ministries mostly included one leader that worked with a committee of individuals. The youth and young adult ministries built bonds of friendships through rap sessions and other social events. This was important because we had 10-15 students from the nearby colleges who attended our church, and many were actual members. The health ministry partnered with other community agencies in their history at random times but not consistently nor strategically to provide health fairs and screenings, seminars, and cooking classes. The children's ministry main feature was the annual

summer Vacation Bible School and community fun day which was attended by children of the church and the community. It was noted by the membership that several of the children who attended years ago came back to volunteer their services as leaders and team members. Women's ministry was focused on empowering the women of the church to be more involved in the work of the church as well as reaching out to non-Adventist women. A popular event was the annual spring tea extravaganza, a social outreach event which attracted around 40 individuals.

The community where the church is located includes low to middle income housing, mothers in a crisis housing complex, and college student housing complexes. According to the latest census, the race composition is 57.6% Caucasian and 35.2% African-American or Black American. The predominant population between 2012 and 2016 was at 46,660. The largest proportion of people was 20 to 24 years old at 44.9% and the second largest group was 15 to 19 years old at 19.5%. The age group of 60 to 84 years old made up the total of 4.6%. The neighborhood consisted of working class families and students. There were also young families with children through high school age and young adults with no children. The community tends to be transient. There are a lot of renters and broken homes. The majority work blue collar jobs and their education level is high school but not college level. The demographics of the membership are totally opposite. Church members are educated with higher incomes. Some of them are business owners and others are gainfully employed. The building the church worships in is well known as a "community marker," but the members are not as well-known and integrated within the community. Twelve members at that time lived in the zip code area and others

voiced their opinion that the community was not interested in attending our church unless there was something being distributed.

Through informal talks with members and formal talks with the leadership of the church we began to construct areas of interest for future mission that had the potential to ignite the church's passion for ministry in the community. From prior discussion with the former pastor, I understood from the beginning of my ministry that the church had a strong interest in health ministry as well as other community service ventures. At the time seven church members served in the healthcare field. When it came to the ministry of the church, health ministry was one of the strongest as we looked at our overall trends. We also gathered from the "congregational timeline" that the church had a life cycle of about five years. It seemed that there was quite a turn-around in membership as well as leadership. This was because of the college students who graduated every four to five years.

Due to the transient nature of the area, it was realized by the congregation that the local population needed to be reached who would not leave after a number of years. There was a need to attract new, young families who lived in the area. The investment of leadership to the college students proved to be successful. So, we began to transition the church to focus on the needs of families in our community through an evangelistic focus. The focus began with a family life evangelistic series held in October, 2013. This event had a week of prayer centered on praying for the family. It also boasted of a four-week evangelistic series centered on the family. During this event, we also held nightly children's program in our fellowship hall. Throughout the series there were events focused solely on the family such as a community-wide baby dedication for all neighbors,

100-praying-men anointing service of all the men in the community, individual and group family counseling in the homes, as well as individual Bible studies given in the homes of our community.

Fellowship's Family Focus

In the month following the series, the church began to expand this focus on the family. The family department with cooperation from the pastor's office began "family on the altar." It was a ministry catered to praying and highlighting a family of the month. The family would be interviewed in front of the congregation and then prayed for during the service with a laying on of hands by the elders as well as systematically praying for them during that particular month. It was a way for the church's social connections between families to be strengthened. The church also restarted the Adventurer/Pathfinder ministry to help provide a ministry to the children of the church and the community. The members also voted to became a constituent, financially supporting member of the local Adventist school which helped to reopen the school after several years of being shut down. This began to offer families in our area and children in the community a Seventh-day Adventist Christian education. The church also voted to start a daycare in the newly purchased and remodeled fellowship hall. As a result, we are in an intense mortgage liquidation campaign prior to moving forward with daycare plans. In addition, the church continued to host the annual Vacation Bible School which brings around 40-50 children from the community. These steps were essential in extending to the next phase of focus in community-based health evangelism.

Community Health Evangelism

After the development, growth, and sustainability of family-focused ministries which took about two and half years, we began to switch our focus to the area of community-based health evangelism. The community health evangelism team was a voluntary group of nine persons and was voted by our church board to operate alongside me, the principal investigator in the project. They were my research assistants and assisted me in organizing all the health events along with proctoring the surveys. The community health evangelism team included lay members from the personal ministries, health ministries, board of elders, and healthcare professionals in the church. The team also worked with me to clarify the church's vision.

I was introduced to the concept of community health evangelism through ministries that would offer health services in a community that desperately needed it such as health seminars, cooking classes, and exercise classes. These ministries use this opportunity of "disinterested benevolence" to form relationships with the people in the community and connect them through relationships to local churches in the area. The idea is to use health as a "right arm" to the gospel. White (1946) says, "Doors that have been closed to him who merely preaches the gospel will be opened to the intelligent medical missionary. God reaches hearts through the relief of physical suffering" (p. 513.3). And again, "I can see in the Lord's providence that the medical missionary work is to be a great entering wedge, whereby the diseased soul may be reached" (White, 1946, p. 513.4).

> Medical missionary work is the pioneer work of the gospel, the door through which the truth for this time is to find entrance to many homes. . .. A demonstration of the

> principles of health reform will do much toward removing prejudice against our evangelical work. The Great Physician, the originator of medical missionary work, will bless all who thus seek to impart the truth for this time. (White, 1946, p. 513.5)
>
> Do medical missionary work. Thus you will gain access to the hearts of the people. The way will be prepared for more decided proclamation of the truth. You will find that relieving their physical suffering gives an opportunity to minister to their spiritual needs. (White, 1946, p. 514.1)

As we began to brainstorm, I shared with them a video from *Your Best Pathways to Health* ministry. In 2015, this organization offered $10 million dollars of free medical services and supplies to San Antonio's uninsured and under-insured families. It was a three day event and was held before the church's main business meeting. The *Rivard Report* (2015) states that organizer, Dr. Lela Lewis said "the reason we are doing the clinic is because, instead of just coming to town and having a meeting we wanted to come to town and give back to the citizens in the city." The organizer stated that they were equipped to treat more than 6,000 people but expected more than 7,000 or 8,000 people to show up.

I wanted to share with them the vision of possibly scaling down a version of this ministry and then to test its effectiveness in terms of evangelism. The team saw the clip but wrestled with the probability of such a ministry. In addition, many within the team did not agree with all the principles of conventional treatment and believed that its focus should be upon preventative health which would be more effective than focusing on treatment.

One of the first things we did was to evaluate how to reach the community. We knew as a church that it was impossible to reach the entire town of Tallahassee with a message of health. So, it was decided to target individuals in our local zip code.

Non-Adventist families were the primary group that the church planned to focus on in the local zip code, 32304. We then began to plan our strategy for reaching our target zip code. It involved a series of events before the intervention and after it so that we could build the potential of recruiting more residents from our target zip code. Our total project lasted from July 15-November 14, 2015. I have included a figure of the actual time layout that we followed during the event (see Figure 1). Notice that many of our events overlapped with others which was intentional to keep up the momentum.

The project first began with our annual Vacation Bible School also known as VBS. Afterwards we began the Fit, Fabulous, and Free! exercise program which ran prior to and simultaneously with our CREATION Health seminar on Saturdays. Also during the Creation Health Seminar and the Ignite revival we held CREATION Health for kids (children's church). We overlapped the last two weeks of the CREATION Health seminar with the Ignite Revival Series and Health Fair.

In order to start the series with the annual VBS, we consulted with the health ministry leader to see if we could partner with the department to offer the CREATION Health VBS program. The excerpt taken from their website describes its purpose:

> CREATION Health is a faith-based wellness plan complete with lifestyle seminars and a special training program for those who want to live healthier and happier lives and share this unique whole person health philosophy. By consistently practicing the eight principles of CREATION Health–Choice, Rest, Environment, Activity, Trust, Interpersonal Relationships, Outlook, and Nutrition–we fulfill God's original plan for our lives, which is to live and be happy. (www.creationhealth.com)

We decided to utilize the Creation Health VBS. However, before beginning the program we launched the annual Sunday Fun Day registration. During this event, we customarily have bounce houses, food, arts and crafts, games, and registration. This time we decided to add a more community service element. We partnered with two local

barbers to provide free haircuts for children in the community as well as hosting a clothing give-a-way. The members of the church canvassed the neighborhoods surrounding the community to get the word out. This was a great way we felt to break through with the parents to have the children of the community learn about holistic health. The VBS lasted one week and at its conclusion we continued with our customary "Back to School" giveaway for all kids who attended. There was so much material for the CREATION Health VBS that we continued offering them to the children in our community throughout the remainder of the project.

Fit, Fabulous, and Free!

The health evangelism team continued to brainstorm and, prior to offering the CREATION Health seminars for the adults, wanted a follow up from CREATION Health VBS that could be a bridge-building event to the CREATION Health seminars, which also included small groups on Sabbaths in place of the divine worship. The team came up with a three-part program entitled Fit, Fabulous, and Free! This program included: (a) exercise classes with a personal trainer twice a week (Sunday and Thursday) for adults and an aerobics/gymnastics class for children, (b) a weekly cooking class held on Sunday, and (c) a community garden class held on Sundays. Fit, Fabulous, and Free! was held exclusively on the church property, except for the Thursday exercise class, which was held at a local university's track to increase participation from the community. The other exercise classes were held outside in the church parking lot to draw visitors from the community to the event. Music was played over a public audio system that made our presence known in the community. Several individuals from the community came to be part of our local exercise class and cooking classes. As we worked in the community

garden, children who attended were able to help plant seeds which was a good way for them to get involved. We also had several members as well as local guests from the community present healthy recipes that helped encourage people to have healthier meals.

We advertised the exercise classes by creating a social media page on Facebook, and by using group texts which were also used for the CREATION Health seminars. We ordered workout t-shirts that displayed Fit, Fabulous, and Free! and CREATION Health and participants wore them during the events. This all helped to create a sense of community for those who attended these events. We also used the events as a platform to advertise and to spring into our CREATION Health seminar.

CREATION Health Seminar

The CREATION Health Seminar is an eight-week seminar that expounds on all the major principles for the CREATION health acronym–Choice, Rest, Environment, Activity, Trust, Interpersonal relationships, Outlook, and Nutrition. No one had any previous knowledge of or experience with running the program. Therefore, I went to a CREATION Health Seminar to get training and instruction regarding how to conduct the program.

I was able to contact others who had done the program and learn from their mistakes and obtain advice. I also completed the online instruction that certified me as a CREATION health instructor. Then, I purchased all the materials that would be needed to conduct the seminar and train the team. It took about two-three hours after church on several Sabbaths going over the material until the team felt that they were ready.

The CREATION Health materials have been used by churches, schools, as well as governmental agencies. The Advent Health hospital system uses the tool as wellness

guide for their employees and offers them incentives for participating in the program. A clinical trial was conducted with a start date of August 27, 2018 and a completion date for June 30, 2019 for a CREATION Health Assessment Tool for college students. The plan is to assess Adventist university students' health and wellbeing, and advance approaches to mediate and increase their wellbeing. However, these results were not available for the time this research was done.

Then the team wrestled with the time when these events should be discussed. It was first suggested that we offer them on Wednesday nights in place of prayer meeting, but more discussion ensued. The size of our church, which has an average of 45 individuals in attendance on Sabbath, presented the opportunity of being flexible. The team decided to do the seminar as well as small groups on Sabbath in place of the divine service. We asked eight members from the health evangelism team to pick a topic to present on Sabbath. They were asked to be in pairs and conduct the small groups at the end of each session.

The time chosen for the event was from 11 a.m. to 1 p.m. on Sabbath. The first hour was for the presentation and the second hour for the small groups. A theme song was chosen to sing at the end of each service. Sabbath School in the morning would still be in session for the adults and children prior to the seminar. During the eight-week seminar, the children went to the fellowship hall for their program.

We wanted to test the effectiveness of CREATION health as an intervention in relation to our local community's health needs which included pneumonia (infection), colon health, and mental health. It was hard to monitor infection so we gave a screening tool that would be proctored by healthcare personnel to test the risk for infection. We

used healthcare professionals to recommend vaccinations. The interview on vaccinations took place at the beginning of the seminar and was proctored in two private rooms in the church. The subject was only asked questions from three sections on this form:
(a) influenza vaccination, (b) pneumococcal vaccination (PCV13, PPSV23), and
(c) Haemophilus influenza type b (Hib) vaccination.

The interview was of vast importance because the number one health concern in our zip code is pneumonia. This form is given more as a safety precaution to individuals in the area who may be susceptible to contracting it by virtue of their location.

It was too complicated to monitor the health of the subjects' colons, so we administered a screening tool which included an informational packet and short quiz to test one's general knowledge of proper colon health. As it relates to mental health, a survey was given to measure the current status of overall physical health and its relation to mental health.

Each individual who participated in the study was offered an informed consent form which had to be signed and dated at the beginning of the seminar. A copy of the consent form was provided to the subjects. We asked all participants to fill out the voluntary pre- and post-survey. If a participant was not willing to participate they were not forced or coerced. All subjects were offered two screening tools and one survey given at the beginning and the same survey at the end of the eight-week CREATION Health seminar and were administered by me, the research team, and qualified medical personnel. The interviews on vaccinations were proctored by qualified medical personnel and the subject. Each subject was given several identifying markers for their file: a specific number, a designation of M/F for gender, as well as a place to put in their zip

code. Other information gathered from the subjects was height and weight. Each participant was also given a copy of their number to reference it for the post-survey.

If any person chose not to participate in the surveys and interview they were still allowed to go through the seminar free of charge. There was a donation of $15 for subjects who wanted to purchase the *CREATION Health Seminar* book with bonus health assessments and health information for their personal use.

The event was advertised at local health stores, social media, and during Fit, Fabulous, and Free! The church also used general announcement through posters, bulletin inserts, and personal invitations to the eight-week seminar. At the end of the eight-week period the leaders were interested to see if the participants had improved in their overall health as compared to when they first started all the health and fitness events. At the end of the CREATION Health seminar, we proctored the same surveys to assess the effectiveness of our intervention through the eight-week CREATION Health seminar tool.

During the CREATION Health seminar, we wanted to add a relational tool that would begin to address the spiritual needs of those attending. This was considered prior to the events that started and it was planned to have Bible workers come six weeks before to attend the Ignite evangelistic series to begin building relationships from those attending. Prior to the Bible workers coming we had collected interests from previous evangelistic series at our church as well as current interests from family members. The church had been meeting for prayer and fasting every Sabbath after church during the summer of 2015 before contacting interests. We asked for and received the support of members who visited individuals, signed them up for Bible study, and found others who

were interested. Many of the names had outdated contact information but we were able to contact some and follow up with Bible study. The two Bible workers conducted bridge building to our next event, which was the Ignite evangelistic series. Throughout those six weeks, the Bible workers developed relationships with the community as well as motivated and trained the church. This was all to prepare individuals who would be ready to be spiritually engaged with the upcoming evangelistic series, Ignite.

Ignite Revival

The Ignite revival was follow up on interest generated by the CREATION Health seminar. It was a motivational series that talked about aspects of emotional healing. It was led by an evangelist who shared his personal experiences of being brought up broken. He gave hope and healing to individuals who were suffering spiritually and emotionally. In Swenson's (2004) book he states that

> Margin is the space between our load and our limits. It is the amount allowed beyond that which is needed. It is something held in reserve for contingencies or unanticipated situations. Margin is the gap between rest and exhaustion, the space between breathing freely and suffocating. (Swenson, 2004, p. 69)

Many times, we live our lives without margin and without these boundaries we find ourselves emotionally exhausted and overloaded. However, there are many offenses which happened to us prior to learning the skills on how to adapt to them. There are many stressors in our society that overload our emotions, from fracturing families to extended families; "from individualism to narcissism;" "add child abuse, sexual abuse, and wife abuse to pornography" (Swenson, 2004, p. 85). We have to guard against or provide margin so that these stressors do not steal away our emotional well-being.

The evangelist talked about how his disability from birth did not allow him to live his life without margin. He provided a sense of purpose for himself through God that

helped him not limit his usefulness to humanity despite his disability. The evangelist despite being legally blind received his doctorate, wrote several books, and was an international evangelist traveling to share the good news. This event inspired many to come out nightly and hear what the Bible had to say about emotional healing. The series lasted for two weeks and was held every night except for Thursdays. It was advertised on the radio, Facebook, and flyers. At the end of the Ignite evangelistic series we celebrated individuals' achievements in reaching their health goals as well as spiritual commitments made to Christ. On the last Sabbath of the evangelistic series a beautiful lunch was prepared by the church members. There was an all-raw salad bar that boasted many different fruits and vegetables skillfully prepared. There were special desserts made and 30 baptisms were celebrated from August 2015 to June 2016.

Health Expo

The last event that had been planned was a health fair. Churches have used health fairs as a way to build relationship with their community. The health fair usually consists of vendors and participants both of whom are from within the community. It is a time when the Adventist church can present its perspective on health. The Adventists believe in following nature's law to help with the healing process. Hansen (1923) expounds on the Seventh-day Adventist health platform:

> The control of appetites and passions–self-control instead of self-indulgence–involves all the habits of life; all should be conformed to right principles by conscientious conviction. This means a self-mastery that is possible only through grace. The use of wholesome and nourishing foods, containing the necessary food elements in proper proportion, calls for a reasonable amount of knowledge of foods and nutrition. . . . Abstinence from the use of alcohol and tobacco is generally accepted as essential to healthful living. The same may be said of tea and coffee, for these too are classed as harmful. Abstinence from flesh meats, rich and highly seasoned foods, irritating spices and condiments, are further steps in health progress to him who would be truly temperate. The limited use of sugar and pastry foods is no

> less important as a health measure. . . . The proper clothing of the body as relates to warmth, protection, simplicity, and modesty, avoiding constrictions and improperly adjusted weights, is a part of the consistent health program. This means abstinence from the use of poisonous drugs, above all, from the patent medicine habit; and an intelligent application of the principles of rational treatment, as represented in the proper use of water, air, food, electricity, massage, and other natural physiological stimuli and therapeutics. Strict cleanliness of person and premises belongs to the commonest hygiene and sanitary observations of the day, and even more so to the practice of Christian healthful living. Proper and sufficient hours of sleep and relaxation are among the commonly recognized health requirements of popular health propaganda. The Bible long ago enjoined these as important and essential to efficient service. Proper and sufficient ventilation of churches, schools, dwelling-houses, and especially sleeping-rooms, is one of the first principles of healthful living. (p. 6)

Thus, in the health fair we sought to shed light on local businesses and health practitioners who offered services that were in sync with our health platform as Adventists. During the expo, we had a licensed psychologist who provided crisis counseling, a doctor on call to provide medical advice, a nurse practitioner conducting blood pressure checks, a local business owner who offered her health products and free taste tests, and our Bible workers who were ready to assist with spiritual advice and/or prayer. Different ministries had booths set up with information to give away and the Pathfinder/Adventurer Club had a booth to get children to join the club. The health fair was held in the lobby of our church for about five hours one day with 40 persons in attendance. The project officially ended November 14, 2015. The experience of implementing this project took a lot of planning and work (See Implementation Timeline in Figure 1). The church was able to learn through the process about strategic planning and goal setting.

July – November, 2015	Church planning time for outreach
Aug. 15 – Nov. 15, 2015	Fit, Fabulous & Free!
Sept. 26 – Nov. 14, 2015	CREATION Health seminar and children's church
Oct. 2 – Nov. 14, 2015	Bible worker arrival and training
Oct. 31 – Nov. 14, 2015	Ignite evangelistic meeting
November 1	Health Expo

Figure 1. Implementation timeline for the Fellowship Seventh-day Adventist Church in 2015.

CHAPTER 6

PROJECT RESULTS

The aim of the project was to change the health profile of the targeted population and to bring in new non-Adventist families into our church from within our zip code through a multicomponent initiative. This chapter highlights the process accomplishments during the implementation phase and also the impact or outcome of the initiative on the participants.

Evaluation of Implementation Processes

This evaluation addresses the question of how faithful we were in executing the project as planned. We were faithful in selecting the sites as planned. There were three sites: the church property, local health and fitness track, and individuals' homes for Bible study. It covered five months. Our health evangelism team coordinated and assisted in the planning and execution of all phases of the project. They were very intentional, creative, and engaged throughout the project. I was very satisfied with their performance.

The church itself was very engaged during the implementation. It was involved in advertising the project, in recruiting participants, and in registering and welcoming them. We learned lessons of cooperation, collaboration, interpersonal relationships, persistence, and focus through the experience, and are now interested in tweaking the project adding valuable ideas that were learned to better serve the community and give itself a purpose that can be pursued throughout the years. The church was willing to take a chance and

change the way they viewed mission in order to reach out. As long as the church remains with this attitude towards mission and evangelism, I believe that it has enough creativity and ideas to keep it thriving for the future.

Some things that we should have done better included participant's identifying information. We wanted to avoid having individual names listed because of privacy so we gave all the participants a three-digit number; however, many of the individuals did not remember their three-digit number. We were able to find matches by comparing the other data given such as zip code and gender. It was also suggested that blood pressure and age should have been a health indicator. We would then have been able to analyze these with other biometric screenings.

As we began to implement the strategy, we noticed an increase in the involvement of non-Adventist families from both our local zip code and outside of it participating at our local church activities. We also noticed an increase of our membership during this time as well; between the months of August and December we witnessed an increase of eighteen new members. At the end of the implementation phase, we noticed a significant growth of non-Adventist families involved in the network of our church from within and outside of our zip code. They joined our youth groups, attended church social events, and attended invitations to members' homes for fellowship.

After the project the community health evangelism team met August 20, 2016, to assess how we had performed. It was stated that we needed to have a better record system to track individuals (how many days during the study did people attend). It was stated we should have had better marketing of the programs we were offering. A suggestion was given to take the program on the road to a local community where we could adopt the

community and combine the health and personal ministries as an evangelism tool with the belief that it would bring some permanence to the results. It was also stated that health has its limitations, and that the church should follow a similar model with another area of interest, such as family ministry. There was input from the health evangelism team that we should have integrated components of CREATION Health to the NEW START program, making several adjustments to meet specific needs for the community.

The PowerPoint material for the CREATION Health seminar was effective; however, when the presenters added their personal stories and experience based on the topic it added to the relatability of the presenter and the topic. The emotional health emphasis was a powerful influence. The Health Study was useful in bringing in new members and settling new ones in the church. However, there were several concerns: a concern of the seminar structure differing from normal worship (the seminars and small group sessions were held during the divine worship time); the cooking class recipe book was not completed; and the church garden was a failed attempt. Also, the t-shirts purchased were an expense that remained with the church; we overestimated their use in the project.

Impact on Participants

The data showed that a total of 42 subjects participated in the project. Twenty subjects completed both the pre- and post-survey. Out of the 20 subjects, 17 participated in the vaccination screenings, and 19 participated in the colon health screening. However, 22 subjects were not completed, which means that they never completed the second part of the survey. The subjects that were not completed with invalid identifying information could not remember their assigned number and/or did not attend the final seminar;

therefore, their data was invalid due to there not being any way of knowing how many sessions each completed. They may have completed all those sessions except for the last but we do not have any way of measuring this.

Out of the 22 uncompleted subjects, 18 participated in the vaccination screening as well as an equal number in the colon health screening.

We had a 48% completion rate as it related to the surveys. Of these we had 45% males (9) and 55% females (11). The completion rate is determined by those participants who filled out the forms at the beginning and end of the seminar; however, there was no system in place to determine who had been there the whole eight weeks. There was also no system in place to account for address changes within the eight-week period. They may have started with one zip code but may have changed to another during the eight-week period. Our target zip code was 32304 and we had six qualifying subjects from this zip-code; however, they were all invalid. Needless to say, we had a hard time reaching and maintaining subjects in our target zip code. The rate for those subjects who participated in the health screenings were 85% for the vaccination and 95% for the colon health screening among those who completed the pre- and post-survey. The rate for those subjects who participated in the vaccinations and colon health screenings were 82%.

As listed in Figure 2, the total or aggregate weight before the program was 3,298.7 pounds for an average of 165 pounds per person. Whereas, the total weight after the program was 3,249.9 pounds or 162 pounds per person. The average weight loss per person was 3 lbs. (See Figure 3). There was a total loss of 48.8 pounds. This result exceeded expectations. According to *Eating for a Healthy Colon* by Rush University (2012), “the American Cancer Society (ACS) reports that the links between diet, weight,

exercise and colorectal cancer risk are some of the strongest for any type of cancer." The loss of extra pounds and exercise we thus believed was a positive intervention for colorectal cancer.

Conclusion

As discussed earlier, Levin (2013) states, "religious institutions and organizations . . . have a long history of engagement within the healthcare and public health sectors, dating back many centuries" (p. 368). Faith-based organizations because of the potential to directly impact the health of communities and to improve health disparities, have received a call to help from the Office of the U.S. Surgeon General (Levin, 2013). According to Levin, it is believed by the United States government that faith-based organizations offer one of the "strongest social networks" and many "receive information that can be of value to the health of their families and neighborhoods" (p. 369). It has been shown that faith-based organizations improve health results (Levin, 2013). This has been proven true in the African-American community where the church plays an essential role in the congregations' health.

Seventh-day Adventists place an emphasis on holistic health. White (2002) states:

> The health reform is one branch of the great work which is to fit a people for the coming of the Lord. It is as closely connected with the third angel's message as the hand is with the body. The law of Ten Commandments has been lightly regarded by man; yet the Lord will not come to punish the transgressors of that law without first sending them a message of warning. Men and women cannot violate natural law by indulging depraved appetites and lustful passions, without violating the law of God. Therefore He has permitted the light of health reform to shine upon us, that we may realize the sinfulness of breaking the laws which He has established in our very being. (p. 20)

Fellowship attempted to share this vital information of health reform to our local community. The data shows that individuals made some changes in their lifestyle even though they may fail. Sometimes we hope that the principles they were taught will never

leave the impress of their mind. The relationships formed with individuals from the community showed that the statement by White (1942) is correct:

> Christ's method alone will give true success in reaching the people. The Saviour mingled with men as one who desired their good. He showed His sympathy for them, ministered to their needs, and won their confidence. Then He bade them, 'Follow Me.' (p.142)

The process of developing relationships with the community afforded Fellowship the opportunity to make a difference in its life. We hope that the model used can serve as a platform for other churches attempting to make a difference in their communities.

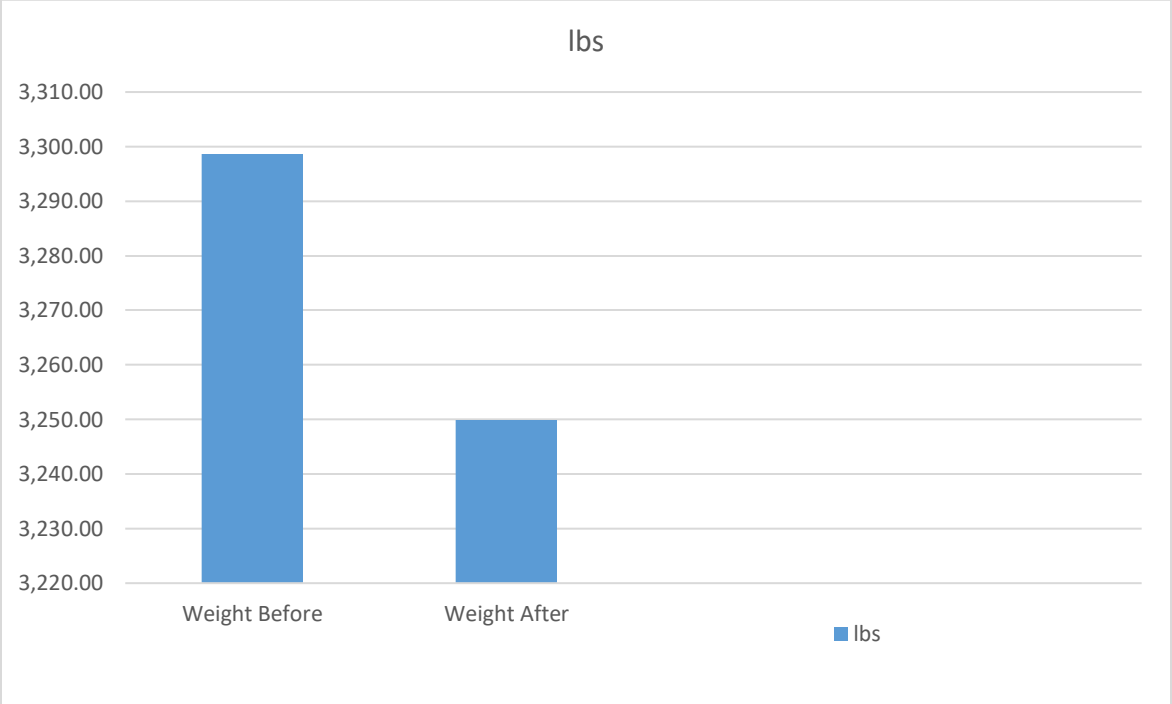


Figure 2. Comparison weight for participants before and after program.

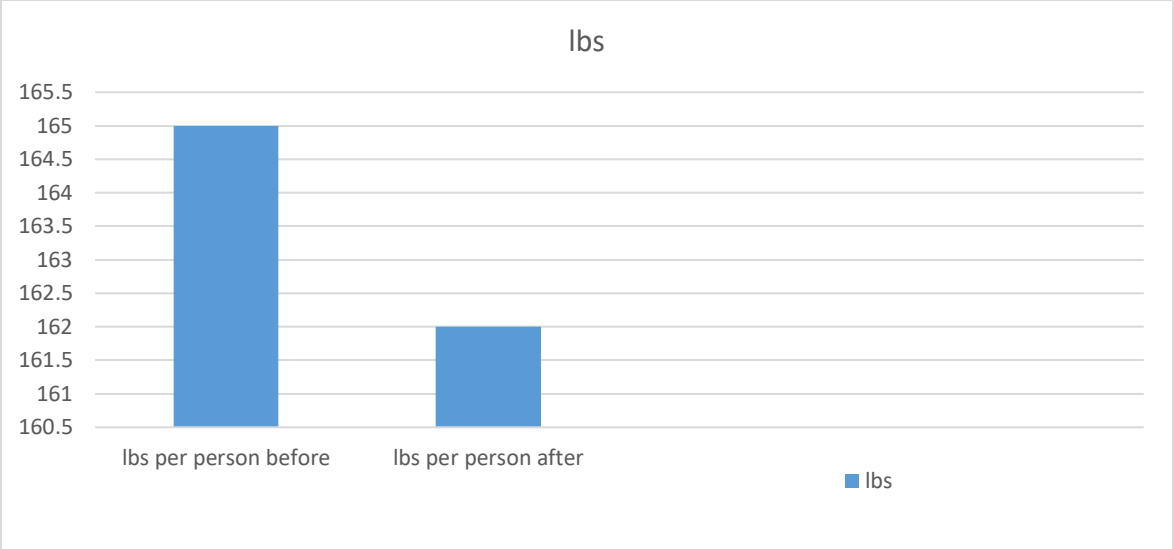


Figure 3. Pounds lost per person.

On the Global Health study, there were several questions asked and the results were noted (See Figures 4-13).

1. *In general, how would you measure your health?* The results showed only a minimal change towards better health of those asked prior to and after the study.

2. *In general, how would you measure your quality of life?* The results showed no change between those asked prior to and after the study.

3. *In general, how would you rate your physical health?* The results showed a minimal change towards better physical health of those asked prior to and after the study.

4. *In general, how would you rate your mental health, including your mood and your ability to think?* The results showed a moderate change towards increase in better mental health of those asked prior to and after the study.

5. *In general, how would you rate your satisfaction with your social activities and relationships?* The results showed a moderate increase towards the direction of greater satisfaction among those participants asked prior to and after the study.

6. *In general, please rate how well you carry out your usual social activities and roles.* The results showed a moderate increase towards the direction of greater satisfaction among those participants asked prior to and after the study.

7. *To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?* The results showed an equitable increase and decrease in the ability to carry out every day physical activities among those participants asked prior to and after the study.

8. *How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?* The results showed an increase in the direction towards more feelings of anxiousness, depression, and irritability among those participants asked prior to and after the study.

9. *How would rate your fatigue on average?* The results showed a moderate increase in fatigue as well as a reduction in fatigue. This may be attributed to the exercise program that may have caused fatigue in some while reducing fatigue in others. This study failed to identify which participants who completed the questionnaire may have actually participated in the exercise program.

10. *How would you rate your pain on average?* The results showed a significant decrease in pain among those participants asked prior to and after the study. There was a minimal increase in pain, but this study did not qualify the type of pain. The exercise

program may have caused soreness by the subjects and may have contributed to more pain through soreness.

In the Global Health study, we noticed that there were several areas associated with the greatest increase of improvement. Subjects who participated saw a positive increase in their mood and ability to think, a positive increase in their physical activities such as walking, climbing stairs, carrying groceries, or moving a chair, and a decrease in pain. The highest change was noted in how well an individual can carry out their usual social activities and roles.

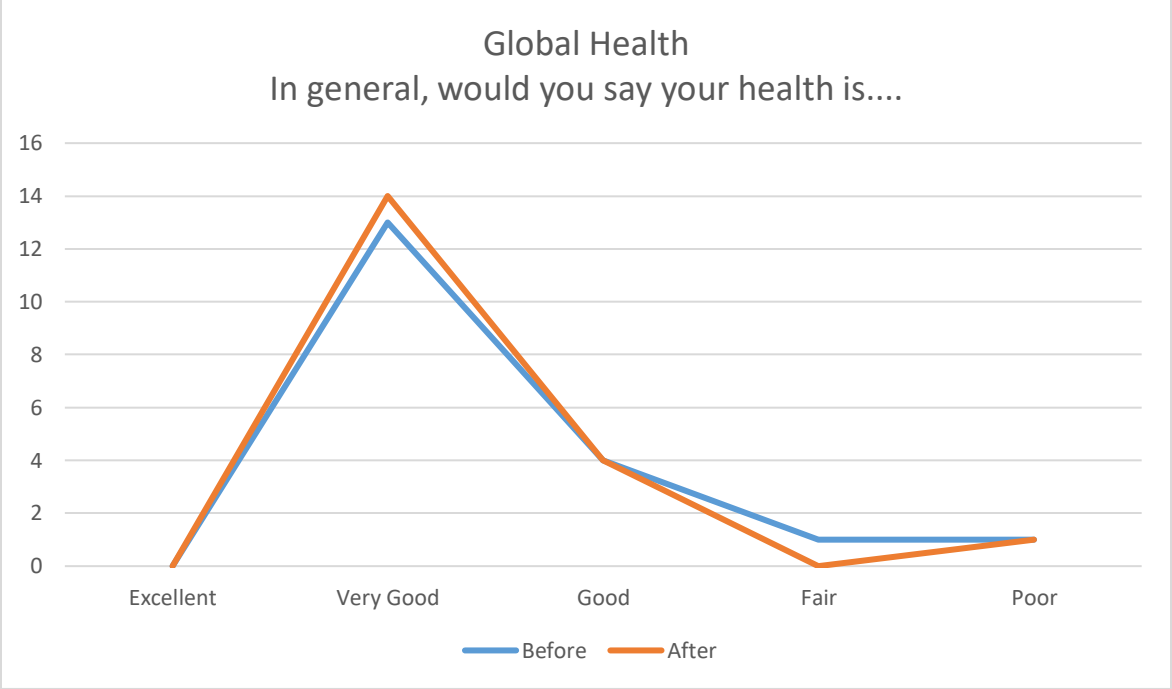


Figure 4. Global health Survey Question #1

Figure 5. Global Health Survey Question #2

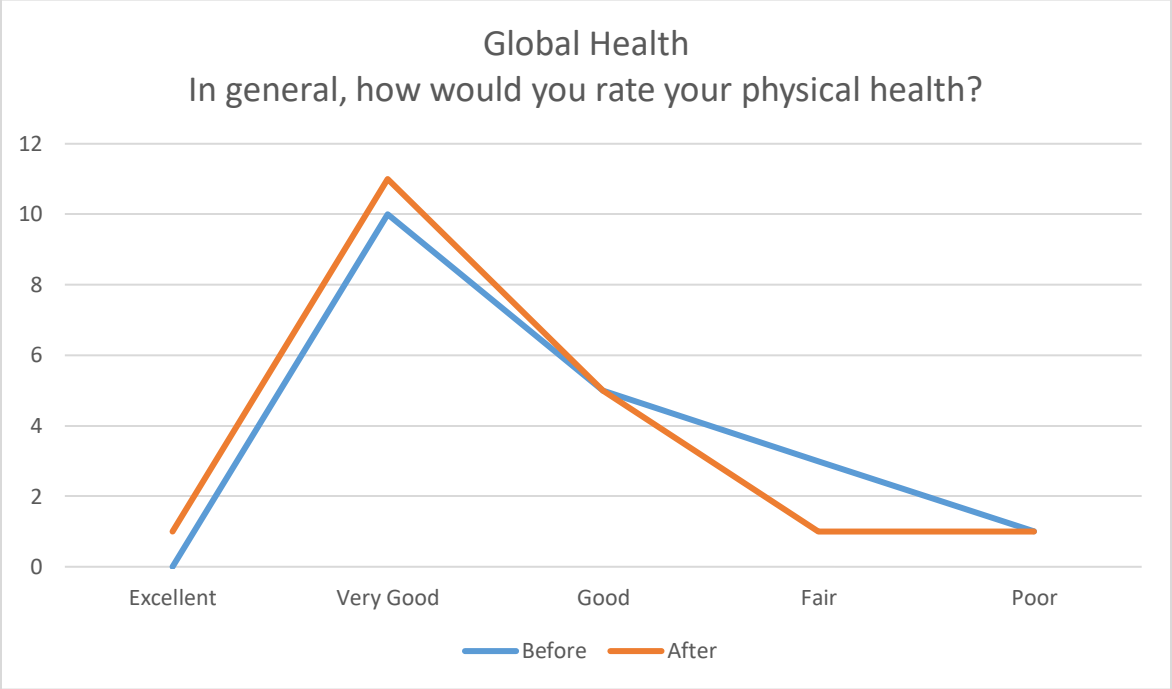


Figure 6. Global Health Survey Question #3

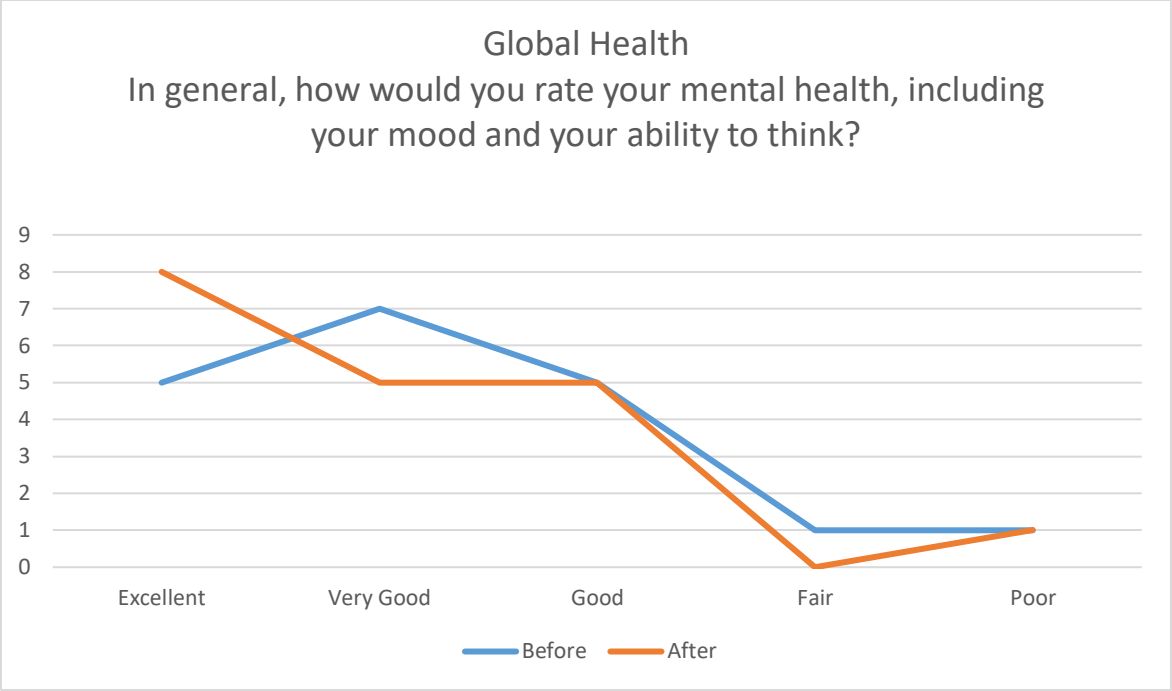


Figure 7. Global Health Survey Question #4

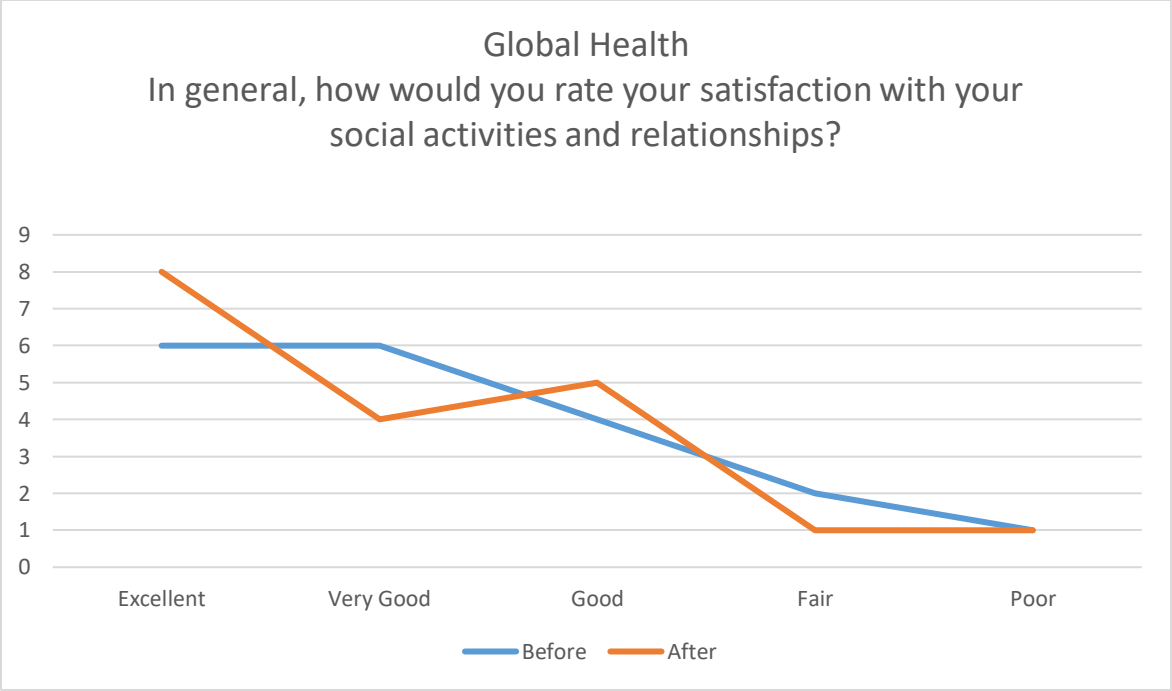


Figure 8. Global Health Survey Question #5

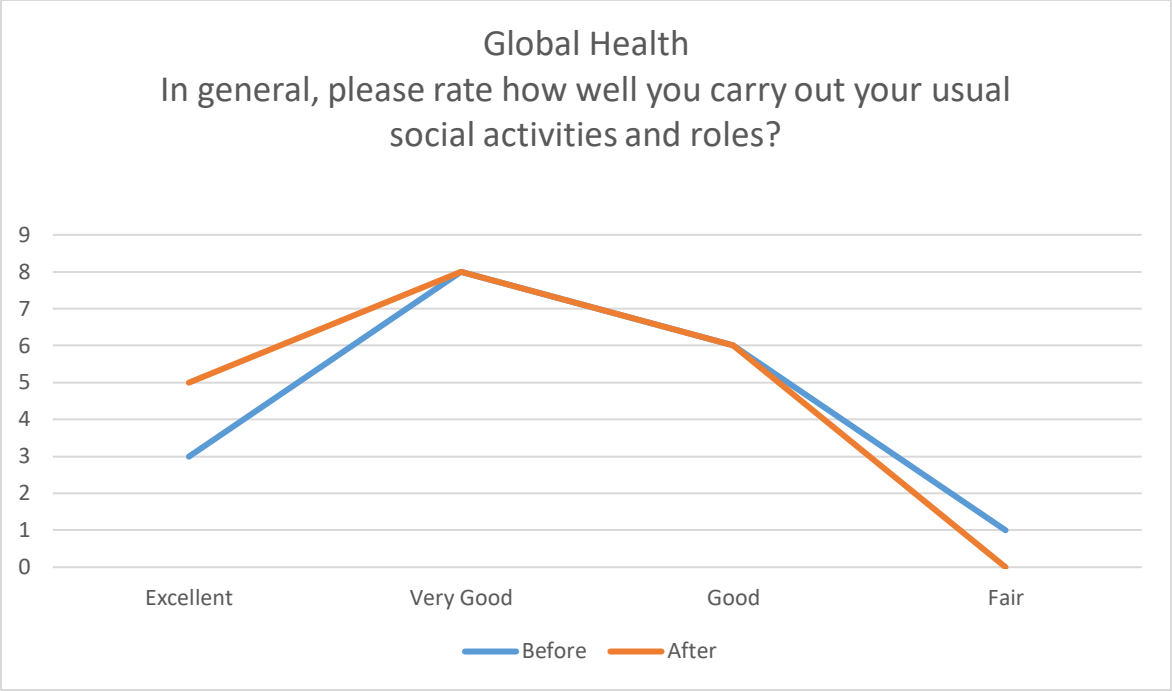


Figure 9. Global Health Survey Question #6

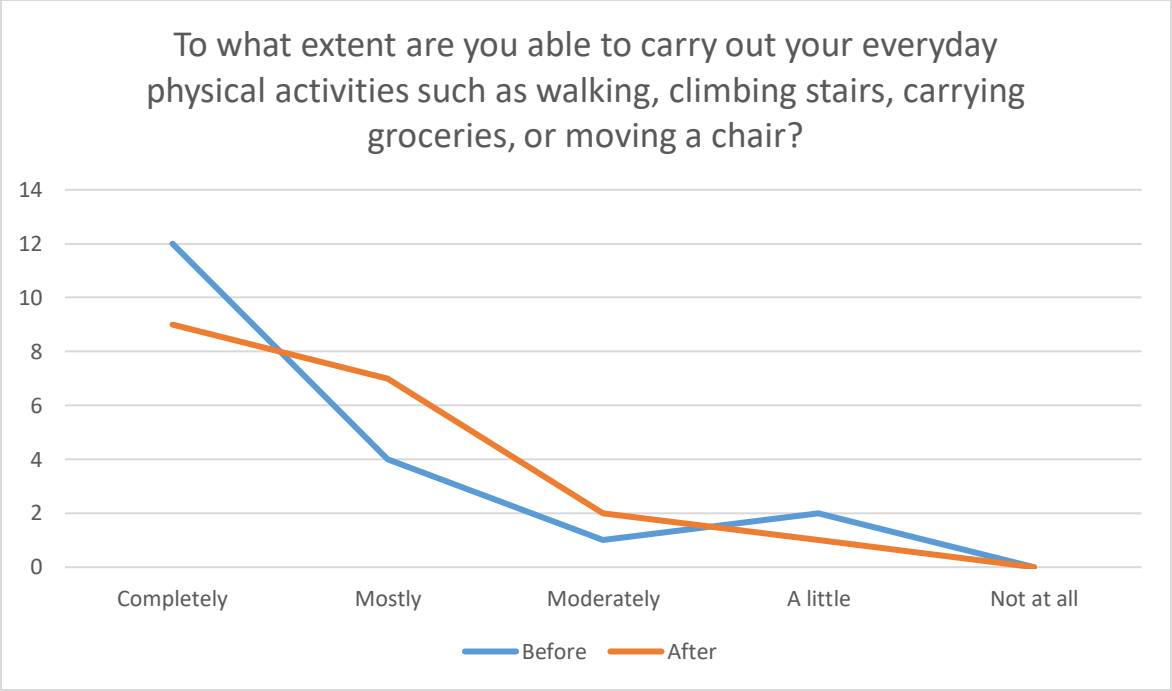
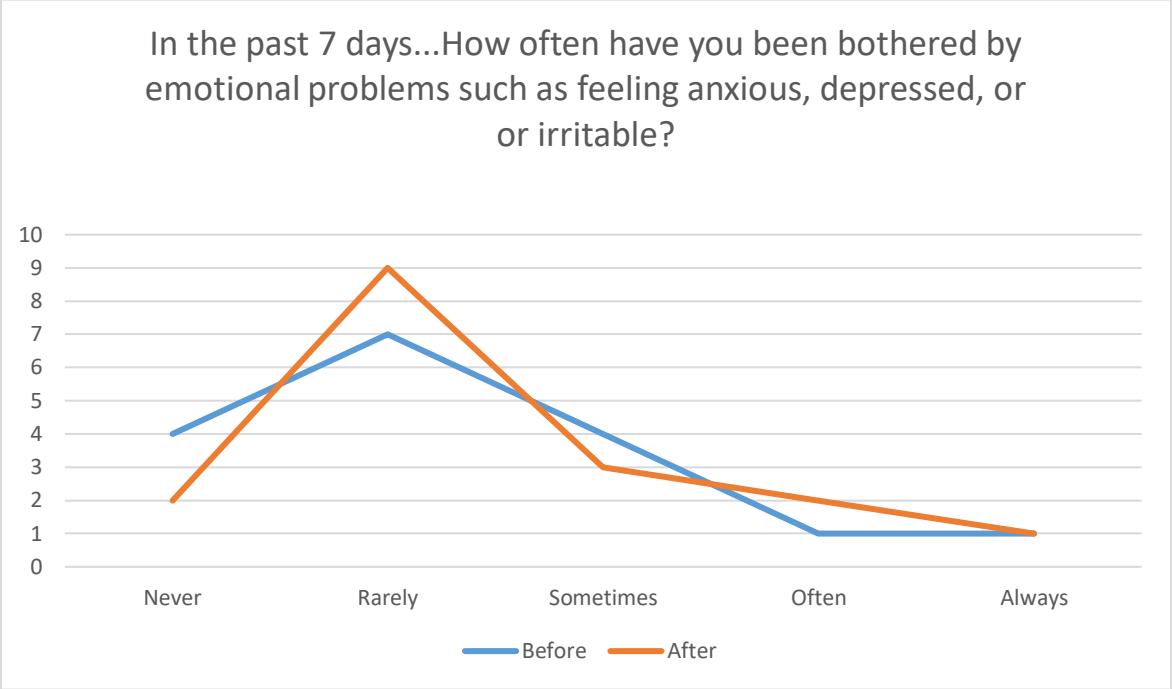


Figure 10. Global Health Survey Question #7



Figiure 11. Global Health Survey Question #8

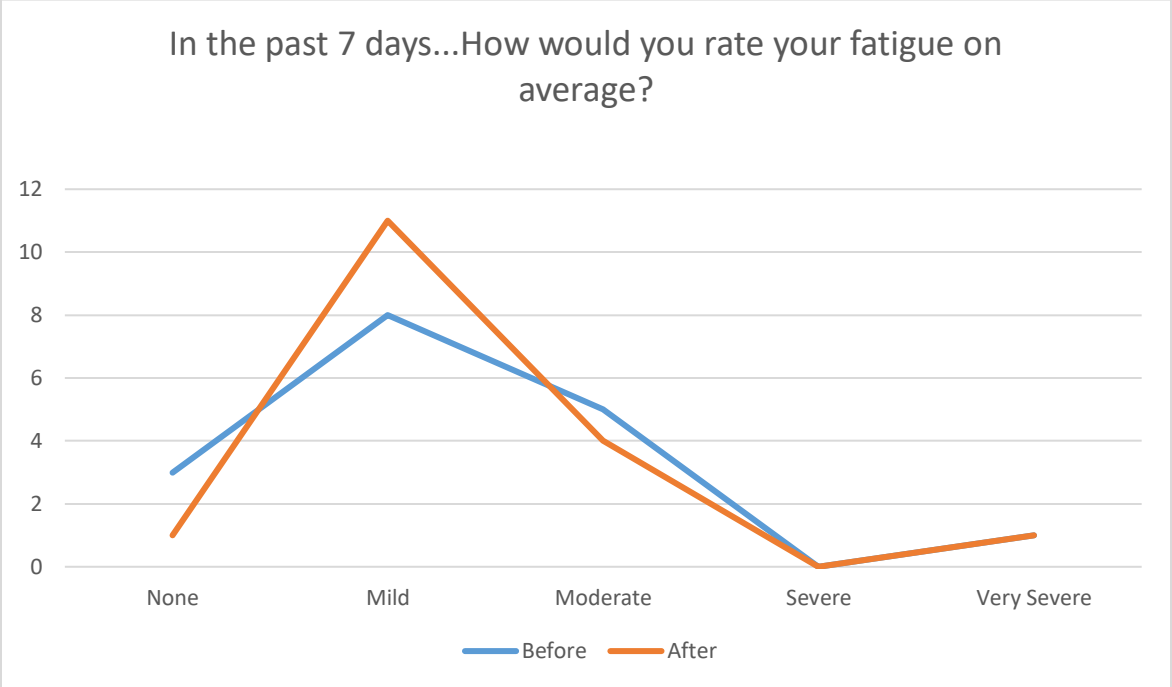


Figure 12. Global Health Survey Question #9

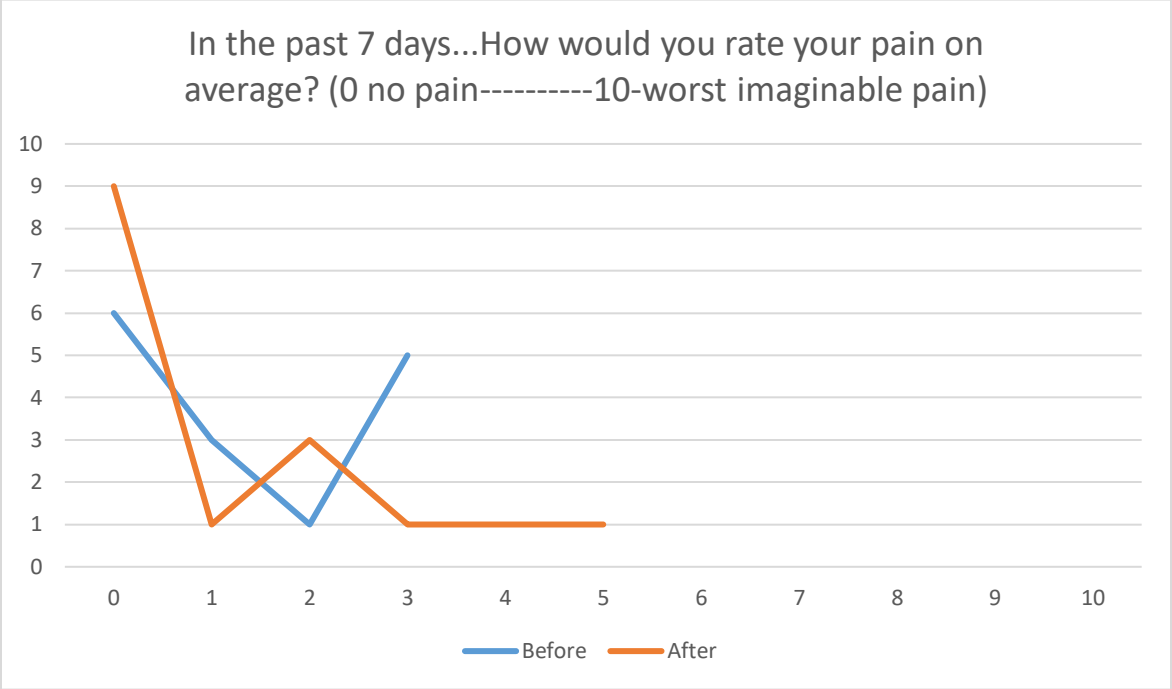
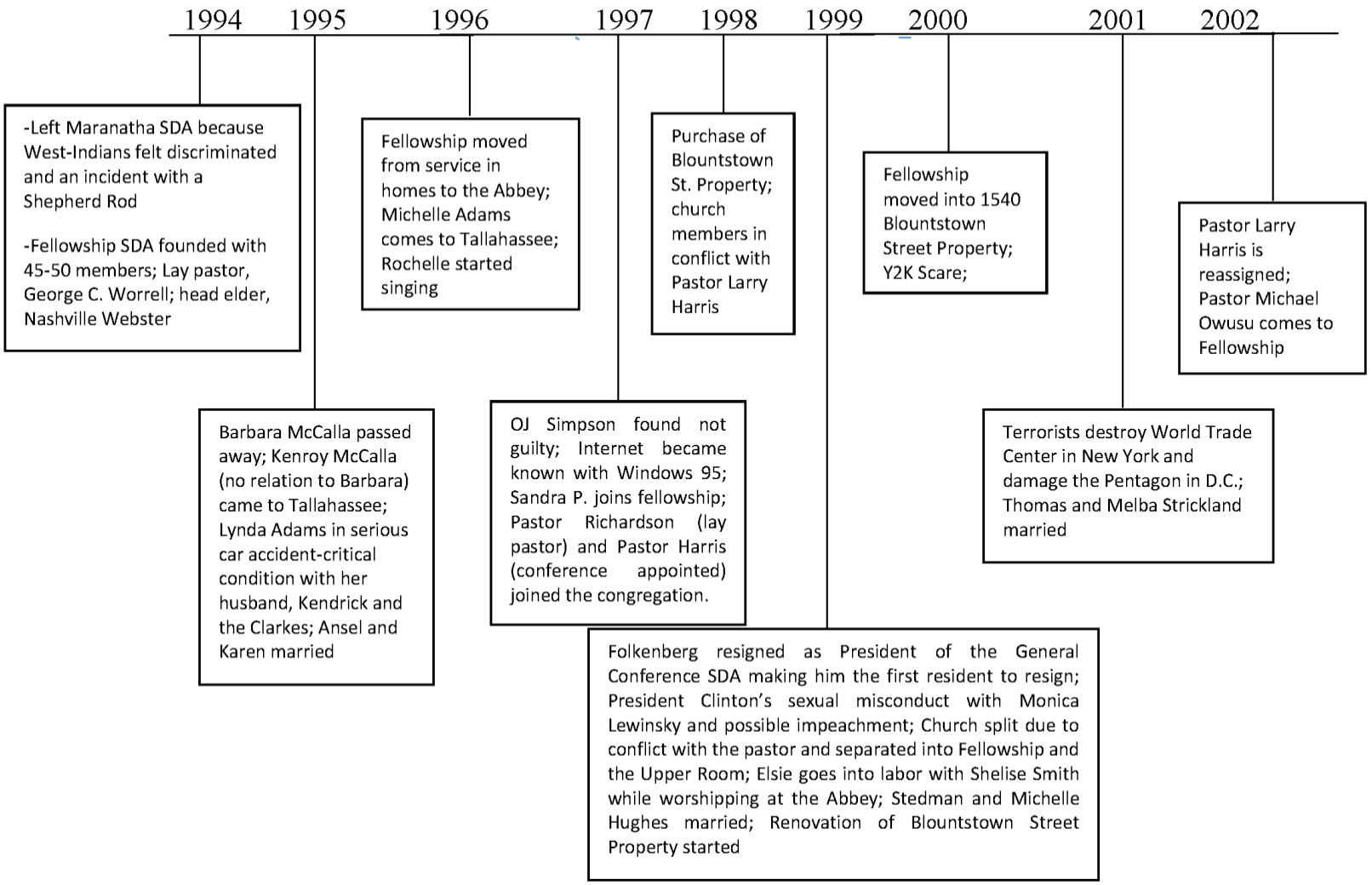


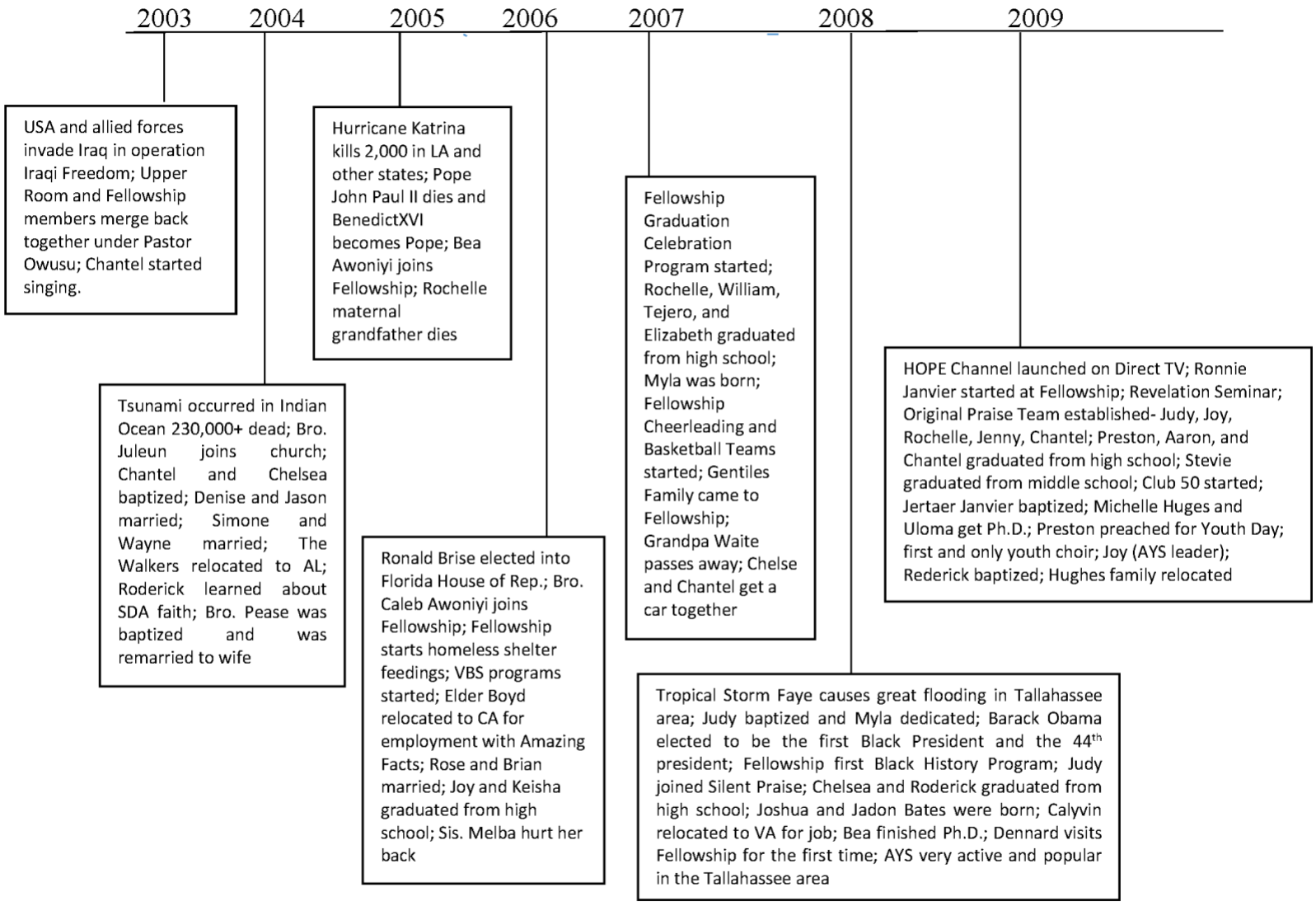
Figure 13. Global Health Survey Question #10

APPENDIX A

FELLOWSHIP SEVENTH-DAY ADVENTIST CHURCH

TIMELINE


1994
1995
1996
1997
1998
1999
2000
2001
2002
-Left Maranatha SDA because West-Indians felt discriminated and an incident with a Shepherd Rod
-Fellowship SDA founded with 45-50 members; Lay pastor, George C. Worrell; head elder, Nashville Webster
Barbara McCalla passed away; Kenroy McCalla (no relation to Barbara) came to Tallahassee; Lynda Adams in serious car accident-critical condition with her husband, Kendrick and the Clarkes; Ansel and Karen married
Fellowship moved from service in homes to the Abbey; Michelle Adams comes to Tallahassee; Rochelle started singing
OJ Simpson found not guilty; Internet became known with Windows 95; Sandra P. joins fellowship; Pastor Richardson (lay pastor) and Pastor Harris (conference appointed) joined the congregation.
Purchase of Blountstown St. Property; church members in conflict with Pastor Larry Harris
Folkenberg resigned as President of the General Conference SDA making him the first resident to resign; President Clinton's sexual misconduct with Monica Lewinsky and possible impeachment; Church split due to conflict with the pastor and separated into Fellowship and the Upper Room; Elsie goes into labor with Shelise Smith while worshipping at the Abbey; Stedman and Michelle Hughes married; Renovation of Blountstown Street Property started
Fellowship moved into 1540 Blountstown Street Property; Y2K Scare;
Terrorists destroy World Trade Center in New York and damage the Pentagon in D.C.; Thomas and Melba Strickland married
Pastor Larry Harris is reassigned; Pastor Michael Owusu comes to Fellowship


2003
2004
2005
2006
2007
2008
2009
USA and allied forces invade Iraq in operation Iraqi Freedom; Upper Room and Fellowship members merge back together under Pastor Owusu; Chantel started singing.
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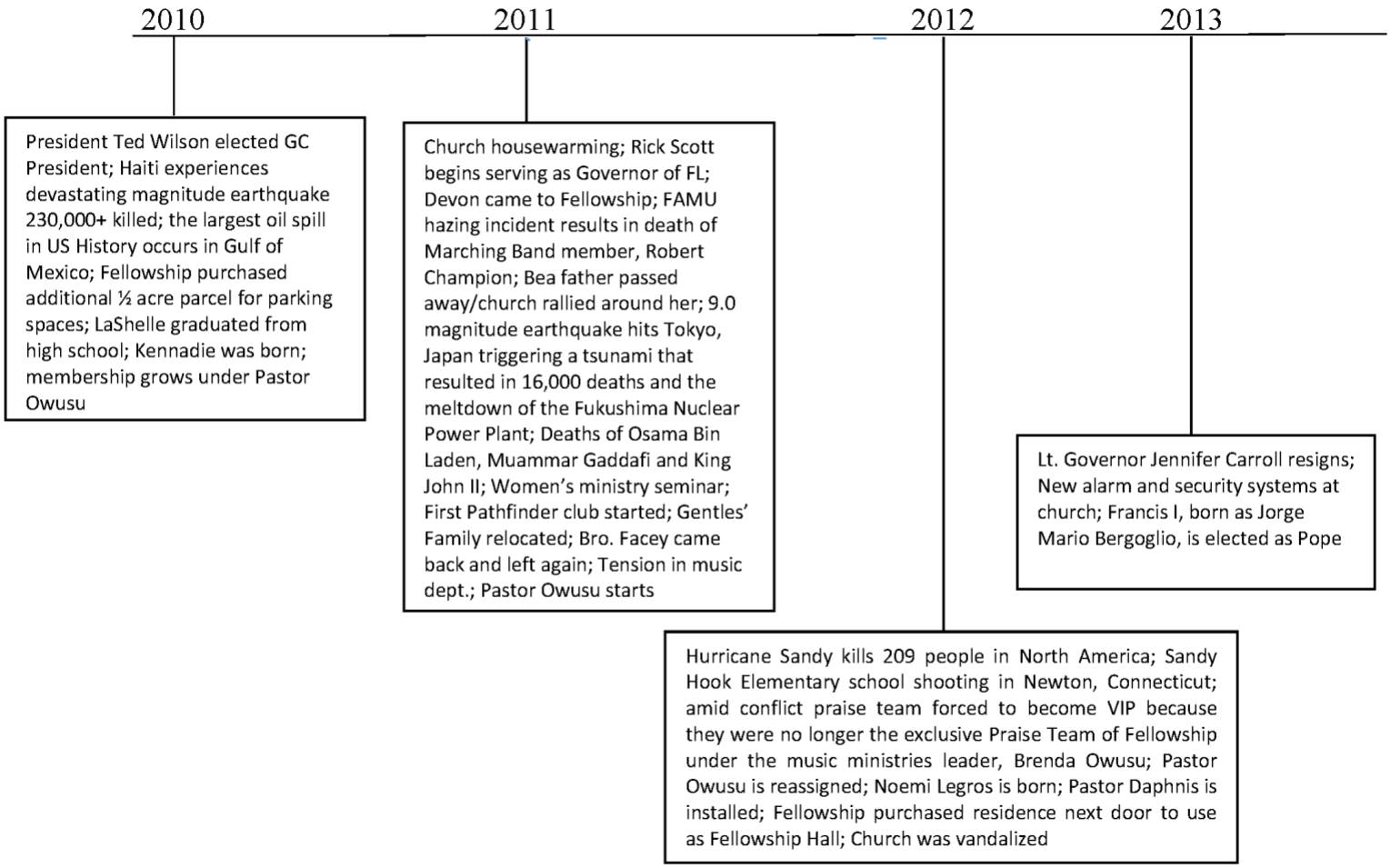
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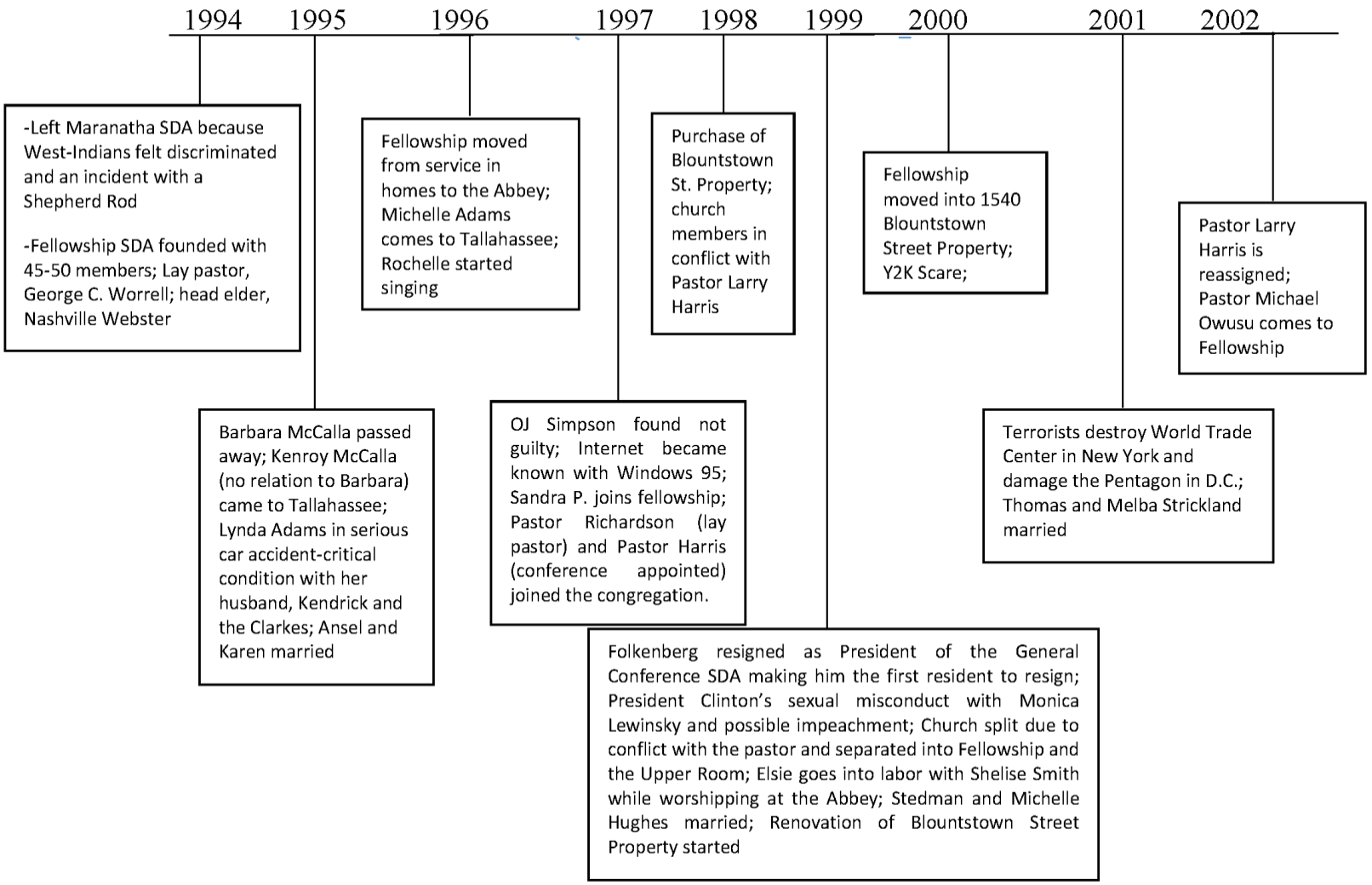
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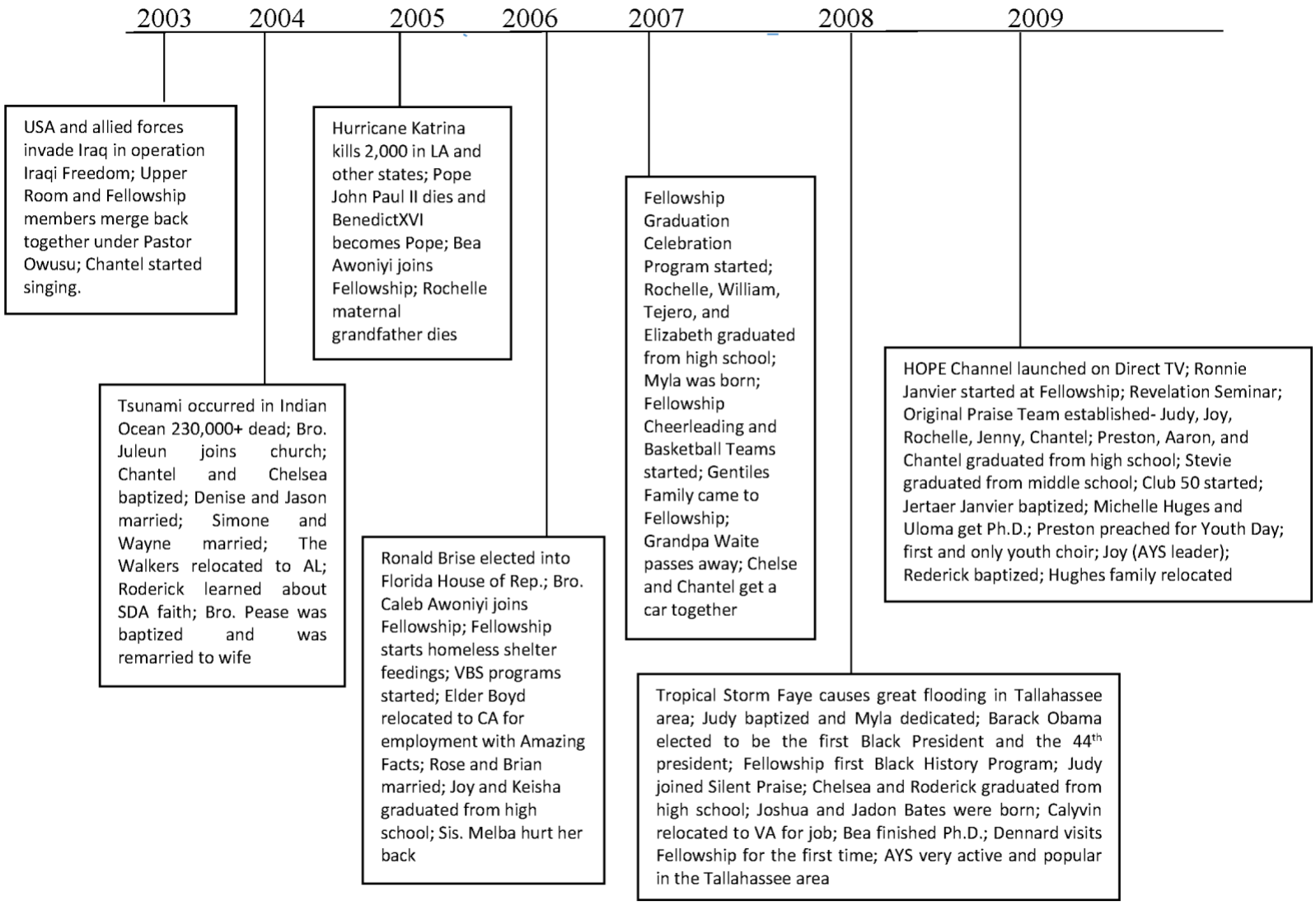
-Left Maranatha SDA because West-Indians felt discriminated and an incident with a Shepherd Rod
-Fellowship SDA founded with 45-50 members; Lay pastor, George C. Worrell; head elder, Nashville Webster
Barbara McCalla passed away; Kenroy McCalla (no relation to Barbara) came to Tallahassee; Lynda Adams in serious car accident-critical condition with her husband, Kendrick and the Clarkes; Ansel and Karen married
Fellowship moved from service in homes to the Abbey; Michelle Adams comes to Tallahassee; Rochelle started singing
OJ Simpson found not guilty; Internet became known with Windows 95; Sandra P. joins fellowship; Pastor Richardson (lay pastor) and Pastor Harris (conference appointed) joined the congregation.
Purchase of Blountstown St. Property; church members in conflict with Pastor Larry Harris
Folkenberg resigned as President of the General Conference SDA making him the first resident to resign; President Clinton's sexual misconduct with Monica Lewinsky and possible impeachment; Church split due to conflict with the pastor and separated into Fellowship and the Upper Room; Elsie goes into labor with Shelise Smith while worshipping at the Abbey; Stedman and Michelle Hughes married; Renovation of Blountstown Street Property started
Fellowship moved into 1540 Blountstown Street Property; Y2K Scare;
Terrorists destroy World Trade Center in New York and damage the Pentagon in D.C.; Thomas and Melba Strickland married
Pastor Larry Harris is reassigned; Pastor Michael Owusu comes to Fellowship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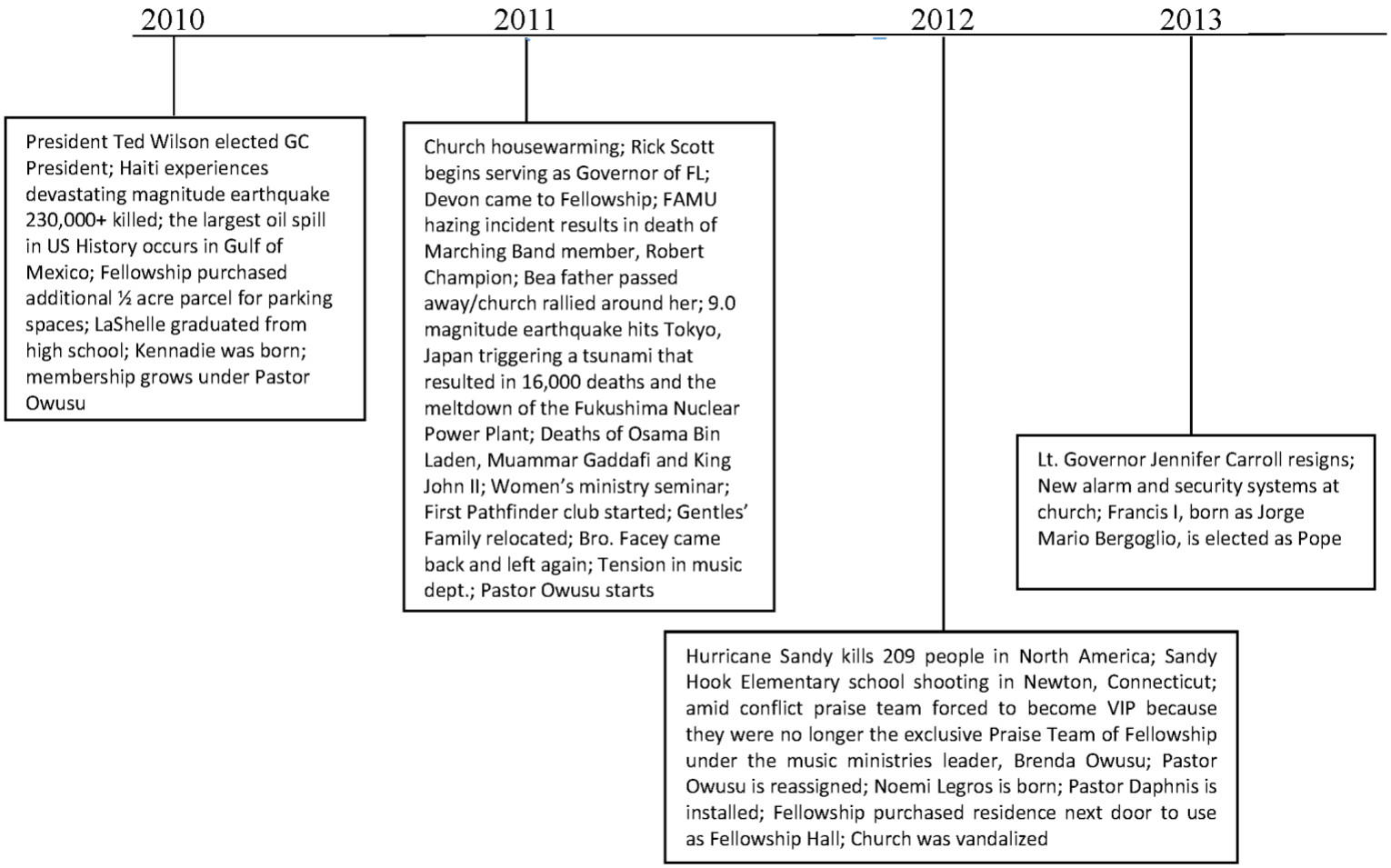
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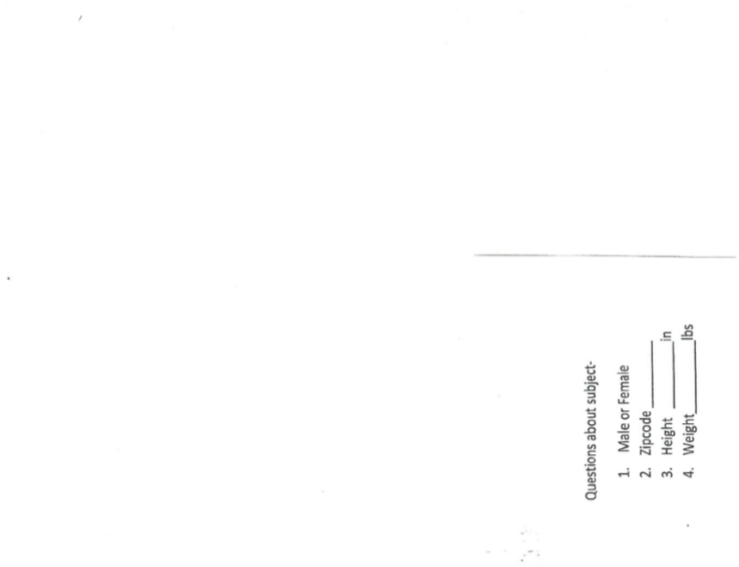
APPENDIX B

QUESTIONS ABOUT SUBJECT



Questions about subject-

1. Male or Female
2. Zipcode _____
3. Height _____in
4. Weight_____lbs

APPENDIX C

PATIENT-REPORTED OUTCOME MEASUREMENT INFORMATION SYSTEM (PROMIS) GLOBAL HEALTH

Global Health

Please respond to each item by marking one box per row.

		Excellent	Very good	Good	Fair	Poor
Global01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global02	In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global04	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global09	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.).....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Completely	**Mostly**	**Moderately**	**A little**	**Not at all**
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
Global 10	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

		None	Mild	Moderate	Severe	Very severe
Global 08	How would you rate your fatigue on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Global 07	How would you rate your pain on average?.....	☐ 0 No pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst imaginable pain

APPENDIX D

COLON HEALTH SCREENING

Colon Health Screening

Your age:

1. Are you 50 years or older? Circle one. Yes No

Health conditions:

Circle all the choices that apply to you in the following statements:

1. You or a close relative have had colorectal polyps or colorectal cancer.
2. You have inflammatory bowel disease.
3. You have a genetic syndrome such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colorectal cancer.

Diet/Lifestyle

The American Cancer Society (ACS) reports that the links between diet, weight, exercise, and colorectal cancer risk are some of the strongest for any type of cancer. In fact, an estimated 50 to 75 percent of colorectal cancer can be prevented through lifestyle changes like health eating, according to the Colon Cancer Foundation*

Circle all the choices that apply.

1. What is an example of whole grains?

   A. Oatmeal B. White Bread C. Whole-wheat flour D. Brown rice

2. What is a good source of calcium?

   A. Milk B. Spinach C. Collard Greens D. Kale

3. What is a good source of fiber?

   A. Pears B. Raspberries C. Cheese D. Oranges

*Taken from Eating for a Healthy Colon by Rush University

EATING FOR A HEALTHY COLON

A healthy diet can help protect against colon disorders

Just as diet can have a positive or negative impact on heart, brain and bone health, your colon's overall health can be affected by what you eat.

The colon is a crucial part of the digestive system, and many different conditions can cause it to work improperly. Some of these include inflammatory bowel diseases, such as ulcerative colitis and Crohn's disease; diverticular disease; irritable bowel syndrome; and colorectal cancer.

Treatment for these conditions includes diet and lifestyle modifications, medications and/or surgery.

Colorectal cancer is one of the most serious colon diseases. It's the third most common cancer and the third deadliest cancer in the U.S. Risk factors for colon cancer include age (risk increases over age 50); race (blacks have the highest rates of colorectal cancer in the U.S.); family history; previous polyps; inflammatory bowel disease; smoking; and heavy alcohol use.

"There is also a strong correlation between obesity and having a higher risk of getting cancer in the colon," says Joshua Melson, MD, MPH, a gastroenterologist who specializes in colorectal cancer at Rush University Medical Center.

A weighty connection

According to the National Cancer Institute, the association between obesity and increased colon cancer risk may be due to multiple factors, including increased levels of insulin in the blood, a condition that may occur more often in obese individuals. Increases in insulin and associated conditions such as insulin resistance may promote the development of certain tumors, including those in the colon.

The American Cancer Society (ACS) reports that the links between diet, weight, exercise and colorectal cancer risk are some of the strongest for any type of cancer. In fact, an estimated 50 to 75 percent of colorectal cancer can be prevented through lifestyle changes like healthy eating, according to the Colon Cancer Foundation.

"Fewer than 10 percent of colon cancers are hereditary, which means a lot of it is lifestyle," says Heather Rasmussen, PhD, a registered dietitian at Rush. "Therefore, good nutrition is an important aspect of good colon health."

Diet dos and don'ts

Diets high in vegetables, fruits and whole grains and low in red and processed meats have been associated with a decreased risk of colon cancer, according to the ACS. To help promote good colon health, follow some of these diet recommendations:

- **Limit red meat consumption and steer clear of processed meats.** According to the ACS, the risk of colon cancer increases by 15 to 20 percent if you consume 100 grams of red meat (the equivalent of a small hamburger) or 50 grams (equivalent of one hot dog) of processed meats, like sausage, bacon or hotdogs, per day. "You can still have a little bit of red meat — about two four-ounce servings of red meat per week," says Rasmussen. "However, it is best to limit processed meats to a special treat now and then because they have other components, such as preservatives, that may cause cancer."
- **Hold the sugar.** Studies have found that people with ulcerative colitis and Crohn's disease often have diets high in sugar and low in fiber. While sugar has not been directly associated with the progression of colon cancer, foods high in sugar are often high in calories and can lead to weight gain and obesity.

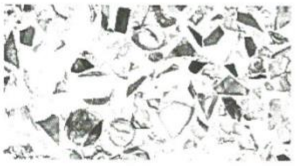
- **Up your fiber intake.** Eating a high-fiber diet is good for overall intestinal and colon health. "On average, Americans eat about 13 grams of fiber a day, but we're supposed to have 25 to 35 grams," says Rasmussen. The best way to add fiber into your diet is through fiber-rich fruits and vegetables, such as raspberries, pears, apples, bananas, oranges, cooked artichoke, peas, broccoli and corn. Whole grains and legumes are also good sources of fiber. Fiber aids colon health by helping to keep you regular and prevent constipation. This may then lower your risk of developing hemorrhoids and small pouches in your colon that can lead to diverticular disease.
- **Drink your milk.** Recent studies have found that calcium and vitamin D may be associated with a decreased risk of colorectal cancer. However, the ACS does not recommend increasing your calcium intake above the recommended amounts because there is a potential increased risk of prostate cancer associated with high calcium intake, exceeding 2,000 milligrams a day. Instead, make sure you're getting the recommended amount of calcium in your diet: depending on age, that is 1,000 milligrams to 1,300 milligrams a day (three to four eight-ounce glasses of low-fat or fat-free milk). Other dietary sources of calcium include leafy greens, such as spinach, kale and collard greens.
- **Choose grains wisely.** Whole grains are foods that contain all their essential parts and naturally occurring nutrients. The Dietary Guidelines for Americans recommend that all adults eat at least half of their daily grains as whole grains, about three to five servings. Some readily available whole grains include barley, quinoa, whole wheat flour, wild and brown rice and oatmeal. These foods contain more colon-friendly vitamins, minerals, fiber, essential fatty acids, antioxidants and phytochemicals (natural compounds in plants that have a beneficial effect on the body) than their refined grain counterparts, such as white flour and white rice.

Make screening a priority

While eating right can help keep your colon happy, the most powerful way to prevent colon cancer is through screening. A colonoscopy is a structural examination of the colon that allows physicians to both screen for and prevent colorectal cancer.

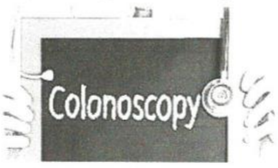
"Colonoscopy reduces the risk of developing colon cancer because we can find precancerous polyps during the test and remove them," says Melson. "This test is unique to most screening tests because we can actually look for precancerous growths and remove them during the procedure, which ultimately reduces a person's risk of developing colon cancer."

If detected early, up to 95 percent of colorectal cancers are curable, according to the Colon Cancer Foundation. "Colon cancer is a largely treatable condition," says Melson. "For colorectal cancer, we have a test, it is not complicated and it is extremely effective in preventing it and catching it early."



Don't Ignore Color Changes

When the color of your tongue, pee, poop or snot changes, it may be time to see your primary care physician.

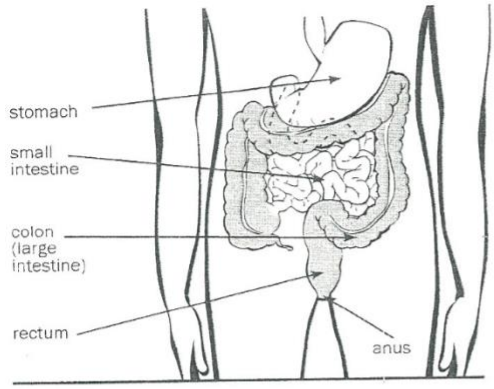


Colorectal Cancer Screening

If you're not up to speed on colorectal cancer, its risk factors and the importance of screening, grab a bowl of high-fiber cereal and take a few moments to read up on the second leading cause of cancer deaths in the United States.

Colorectal Cancer Screening

Basic Fact Sheet



Colon and Rectum

What Is Colorectal Cancer?

Colorectal cancer is cancer that occurs in the colon or rectum. Sometimes it is called colon cancer. The colon is the large intestine or large bowel. The rectum is the passageway that connects the colon to the anus.

It's the Second Leading Cancer Killer

Colorectal cancer is the second leading cancer killer in the United States, but it doesn't have to be. If everyone aged 50 years or older had regular screening tests, at least 60% of deaths from this cancer could be avoided. So if you are 50 or older, start getting screened now.

Who Gets Colorectal Cancer?

- Both men and women can get it.
- It is most often found in people 50 or older.
- The risk increases with age.

Are You at High Risk?

Your risk for colorectal cancer may be higher than average if:

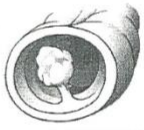
- You or a close relative have had colorectal polyps or colorectal cancer.
- You have inflammatory bowel disease.
- You have a genetic syndrome such as familial adenomatous polyposis (FAP) or hereditary nonpolyposis colorectal cancer.

People at high risk for colorectal cancer may need earlier or more frequent tests than other people. Talk to your doctor about when to begin screening and how often you should be tested.

Screening Saves Lives

If you're 50 or older, getting a colorectal cancer screening test could save your life. Here's how:

- Colorectal cancer usually starts from polyps in the colon or rectum. A polyp is a growth that shouldn't be there.
- Over time, some polyps can turn into cancer.



Colon Polyp

- Screening tests can find polyps, so they can be removed *before* they turn into cancer.
- Screening tests also can find colorectal cancer early. When it is found early, the chance of being cured is good.

Colorectal Cancer Can Start With No Symptoms

Precancerous polyps and early-stage colorectal cancer don't always cause symptoms, especially at first. This means that someone could have polyps or colorectal cancer and not know it. That is why having a screening test is so important.

Screen for Life
National Colorectal Cancer Action Campaign

1-800-CDC-INFO (1-800-232-4636)
www.cdc.gov/screenforlife

your name_____ date of birth ____/____/____ today's date ____/____/____
month day year month day year

☑ Do I Need Any Vaccinations Today?

This questionnaire will help you and your healthcare provider determine if you need any vaccinations today. Please check the boxes that apply to you.

Influenza vaccination

☐ I haven't had my annual influenza vaccination yet this season – so I need it now.

Pneumococcal vaccination (PCV13, PPSV23)

☐ I am 65 or older. I have never received a pneumococcal shot, I have received just 1 pneumococcal shot in the past, or I don't remember receiving any pneumococcal shots.

☐ I am 65 or older and received 1 or 2 doses of pneumococcal vaccine when I was younger than 65. It has either been 5 years or more since my last shot or I don't remember how long it has been.

☐ I am younger than 65. I have not been vaccinated against pneumococcal disease, and I am in one of the following risk groups:

- ☐ I smoke cigarettes.
- ☐ I have heart, lung (including asthma), liver, kidney, or sickle cell disease; diabetes; or alcoholism.
- ☐ I have a weakened immune system due to cancer, Hodgkin's disease, leukemia, lymphoma, multiple myeloma, kidney failure, HIV/AIDS; or I am receiving radiation therapy; or I am on medication that suppresses my immune system.
- ☐ I had an organ or bone marrow transplant.
- ☐ I had my spleen removed, had or will have a cochlear implant, or have leaking spinal fluid.
- ☐ I live in a nursing home or other long-term care facility, and I have never had a pneumococcal shot.

Tetanus-, diphtheria-, and pertussis (whooping cough)-containing vaccination (e.g., DTP, DTaP, Tdap, or Td)

☐ I either never received a dose of Tdap vaccine or I don't remember if I have.

☐ I have not yet received at least 3 tetanus- and diphtheria- containing shots.

☐ I have received at least 3 tetanus- and diphtheria-containing shots in my lifetime, but I believe it's been 10 years or more since I received my last shot.

☐ I am in my late second or third trimester of my pregnancy and haven't had a dose of Tdap vaccine during this pregnancy.

Measles, mumps, rubella (MMR) vaccination

☐ I was born in 1957 or later and either never received an MMR shot or I don't remember receiving a shot.

☐ I am a woman thinking about a future pregnancy and do not know if I'm immune to rubella.

☐ I am a healthcare worker, and I have no laboratory evidence of immunity to measles, mumps, or rubella. I received 1 dose of MMR vaccine, but I don't remember receiving 2 doses.

☐ I was born in 1957 or later. I received only 1 MMR shot, and I am in one of the following groups:

- ☐ I am entering college or a post-high school educational institution.
- ☐ I am planning to travel internationally.

continued on page 2 ►

immunization action coalition
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Saint Paul, Minnesota - 651-647-9009 - www.immunize.org - www.vaccineinformation.org

www.immunize.org/catg.d/p4036.pdf - Item #P4036 (3/15)

Human papillomavirus (HPV) vaccination

☐ I am a woman 26 or younger and haven't completed a 3-dose series of HPV shots.

☐ I am a man 21 or younger and haven't completed a 3-dose series of HPV shots.

☐ I am a man 22 through 26 years. I haven't completed a 3-dose series of HPV shots, and I am in one of the following groups:

- I want to be protected from HPV.
- I have a weakened immune system as a result of infection (including HIV), disease, or medications.
- I have sex with men.

☐ I am older than 26 and although I started the HPV series when I was younger, I never completed it.

Hepatitis A vaccination

☐ I want to be vaccinated to avoid getting hepatitis A and spreading it to others.

☐ I was vaccinated with hepatitis A vaccine in the past. I either never received the second shot or don't remember if I received it.

☐ I might have been exposed to the hepatitis A virus in the past 2 weeks.

☐ I am in one of the following risk groups, and I haven't completed the 2-dose series of hepatitis A shots:

- I travel or plan to travel in countries where hepatitis A is common.[1, 2]
- I have (or will have) contact with an adopted child within the first 60 days of the child's arrival from a country where hepatitis A is common.[2]
- I am a man who has sex with men.
- I use street drugs.
- I have chronic liver disease.
- I have a clotting factor disorder.
- I work with HAV-infected primates or with HAV in a research laboratory setting.

Hepatitis B vaccination

☐ I want to be vaccinated to avoid getting hepatitis B and spreading it to others.

☐ I am 18 or younger and haven't completed the series of hepatitis B shots.

☐ I was vaccinated with hepatitis B vaccine in the past. I either never completed the full series or don't remember if I completed the series.

☐ I am in one of the following risk groups. I either haven't completed the 3-dose series of hepatitis B shots or don't remember if I completed the series:

- I am sexually active and am not in a long-term, mutually monogamous relationship.
- I am a man who has sex with men.
- I am an immigrant, or my parents are immigrants, from an area of the world where hepatitis B is common, so I need testing and may need vaccination.[3, 4]
- I live with or am a sex partner of a person with hepatitis B.
- I have been diagnosed with a sexually transmitted disease.
- I have been diagnosed with HIV.
- I inject street drugs.
- I have chronic liver disease.
- I am or will be on kidney dialysis.
- I have diabetes and I am younger than 60 years and/or receiving assisted glucose monitoring.
- I am a healthcare or public safety worker who is exposed to blood or other body fluids.
- I provide direct services to people with developmental disabilities.
- I travel or plan to travel outside the U.S.[1, 3]

continued on next page ►

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www.immunize.org/catg.d/p4036.pdf • Item #P4036 (3/15)

Chickenpox (varicella) vaccination

- ☐ I was born in 1980 or later. I neither had chickenpox nor received the vaccine, or I don't remember if I had the disease or received the vaccine.
- ☐ I was born before 1980. I am either a healthcare worker or foreign born, and I am not sure if I've had chickenpox or not.
- ☐ I received one dose of varicella vaccine in the past but never got a second shot.

Meningococcal vaccination

- ☐ I am 18 or younger and haven't received a meningococcal shot.
- ☐ I am 21 or younger. I haven't had a meningococcal shot since my 16th birthday, and I am (or will be) in college, living in a residence hall.
- ☐ I am traveling to an area of the world where meningococcal disease is common.[1]
- ☐ I have sickle cell disease, or my spleen isn't working or has been removed, or I have a persistent complement component deficiency.
- ☐ I am a microbiologist routinely exposed to isolates of *Neisseria meningitidis*.
- ☐ I was vaccinated 5 or more years ago and continue to be at risk for meningococcal disease because I am in one of the risk groups listed above. Note: this does not apply to students whose only risk factor is attending college.

Shingles (zoster) vaccination

- ☐ I am 60 or older and haven't had a shingles shot.

Haemophilus influenzae type b (Hib) vaccination

- ☐ My spleen has been removed, or I am scheduled for an elective splenectomy.
- ☐ I am a recipient of a stem cell transplant.

Note: Adults who travel may need additional vaccinations, such as polio or others. Talk to your healthcare provider.

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footnotes

1. Call your local travel clinic to find out if additional vaccines are recommended.
2. Countries where hepatitis A is common include all countries other than the U.S., Western Europe, Canada, Japan, Australia, and New Zealand.
3. Areas with high rates of hepatitis B include Africa, China, Korea, Southeast Asia including Indonesia and the Philippines, South and Western Pacific Islands, interior Amazon Basin, certain parts of the Caribbean (i.e., Haiti and the Dominican Republic), and the Middle East except Israel. Areas with moderate rates include South Central and Southwest Asia, Israel, Japan, Eastern and Southern Europe, Russia, and most of Central and South America.
4. Most adults from moderate- or high-risk areas of the world do not know their hepatitis B status. All patients from these areas need hepatitis B blood tests to determine if they have been previously infected. The first hepatitis B shot can be given during the same visit as the blood tests but only after the blood is drawn.

immunization action coalition
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota - 651-647-9009 - www.immunize.org - www.vaccineinformation.org

www.immunize.org/catg.d/p4036.pdf - Item #P4036 (3/15)

REFERENCE LIST

Adams, J., Bailey, D., Anderson, R., & Galanos, A. (2013, March). Adaptive leadership: A novel approach for family decision making. *Journal of Palliative Medicine, 16*(3), 326-329. doi:10.1089/jpm.2011.0406

Ambrose, S. A., Bridges, M. W., DiPietro, M., Lovett, M. C., & Noraman, M. K. (2010). *How learning works*. San Francisco, CA: Jossey-Bass.

Ammerman, N. T., Carroll, J. W., Dudley, C. S., & McKinney, W. (Eds.). (1998). *Studying congregations: A new handbook*. Nashville, TN: Abingdon.

Association of Religion Data Archives. (2010). County membership report [Data file]. Retrieved from http://www.thearda.com/rcms2010/rcms2010.asp?U=12073&T=county&Y=2010&S=Name

Atkins, B., & Hagerman, D. (2018, February 20). Creating a shared vision to help restore Atlantic City [Web log post]. Retrieved from https://www.rwjf.org/en/blog/2018/02/creating-a-shared-vision-to-help-restore-atlantic-city.html

Bai, X., & Morris, M. (2014). Leadership and virtue ethics. *Public Integrity*, *16*(2*)*, 173-186. doi:10.2753/PIN1099-9922160205

Bartunek, J. M. (2003). *Organizational and educational change*. Mahwah, NJ: Lawrence Erlbaum.

Becker, P., & Dhringa, P. (2001). Religious involvement and volunteering: Implications for civil society. *Sociology of Religion, 62*(3), 315-335. Retrieved from https://static1.squarespace.com/static/5658afe2e4b0f33a7ad1a4d4/t/566637a025981d7249091091/1449539488886/3712353.pdf

Bell, S. (Ed.). (2014). *Servants and friends*. Berrien Springs, MI: Andrews University.

Benefiel, M. (2005). *Soul at work*. New York, NY: Seabury Books.

Bennis, W., & Nanus, B. (1997). *Leaders: Strategies for taking charge*. New York, NY: Harper Business.

Blackaby, H. T., & Blackaby, R. (2011). *Spiritual leadership: Moving people on to God's agenda*. Nashville, TN: B&H.

Blanchard, K., Carlos, J. P., & Randolph, A. (2001). *Empowerment takes more than a minute*. (2nd ed.). San Francisco, CA: Berrett-Koehler.

Bolton, R. (1979). *People skills*. New York, NY: Simon & Schuster.

Brantley, P., Jackson, D., & Cauley, M. (2015). *Becoming a mission-driven church*. Nampa, ID: Pacific Press.

Brathwaite, N., Fraser, H. S., Modeste, N., Broome, H., & King, R. (2003). Obesity, diabetes, hypertension, and vegetarian status among Seventh-day Adventists in Barbados: Preliminary results. *Ethnicity & Disease, 13*(1), 34-39.

Breene, T. (2017, March 3). Transforming lives and communities through the local church. Retrieved from http://www.worldrelief.org/blog/transforming-lives-and-*communities-through-the-local-church*

Bruce, F. F. (1982). *The epistle to the Galatians: A commentary on the Greek text.* Grand Rapids, MI: W.B. Eerdmans.

Burns, J. M. (1978). *Leadership*. New York, NY: Harper & Row.

Carter, S. (1996). *Integrity.* New York, NY: Harper Collins.

Centers for Disease Control and Prevention. (2014). *Colorectal cancer basic fact sheet*. Retrieved from www.cdc.gov/screenforlife

Clinton, J. R. (1988). *The making of a leader: Recognizing the lessons and stages of leadership development*. Colorado Springs, CO: NavPress.

Cohen, J. (2018). The mother of all challenges. *Science, 360*(6394), 1164-1169. doi: 10.1126/science.360.6394.1164

Cole, R. D. (2000). *Numbers* (Vol. 3B, p. 349). Nashville, TN: Broadman & Holman.

Conger, J. A., Spreitzer, G. M., & Lawler, E. E. I. (Eds.). (1999). *The leader's change handbook: An essential guide to setting direction and taking action*. San Francisco, CA: Jossey-Bass.

Cosgrove, C., & Hatfield, D. (1994). *Church conflict: The hidden system behind the fights*. Nashville, TN: Abingdon Press.

Davidson, R. M. (1992). A song for the sanctuary: Celebrating its goodness, its truth, its beauty. *Adventist Review,* July 2, 8-11. Available at http://www.andrews.edu/~davidson/ Publications/Sanctuary/song_for_the_sanctuary.pdf

Dick, D. R., & Miller, B. (2011). *Equipped for every good work*: *Building a gifts-based church.* Nashville, TN: Discipleship Resources.

Drath, W. (2001). *The deep blue sea*. San Francisco, CA: Jossey-Bass.

Duarte, D. L., & Snyder, N. T. (1999). *Mastering Virtual Teams*. San Francisco, CA: Jossey Bass.

Ellis, J. L., & Morzinski, J. A. (2018). Reaching and supporting at-risk community based seniors: Results of a multi-church partnership. *Journal of Community Health, 43,* 920-928. doi: 10.1007/s10900-018-0506-0

Farley, E. (2001). *Theologia: The fragmentation and unity of theological education*. Eugene, OR: Wipf & Stock.

Ferguson, E. (1993). *Backgrounds of early Christianity* (2nd ed.). Grand Rapids, MI: Eerdmans.

Florida Department of Health. (2017). *Leon County health improvement plan*. Retrieved from http://www.flhealthcharts.com/charts/documents/Leon_CHIP.pdf.

Friedman, E. (2007). *A failure of nerve: Leadership in the age of the quick fix*. New York, NY: Seabury.

Fryling, R. (2010). *The leadership ellipse: Shaping how we lead by who we are*. Downers Grove, IL: IVP Books.

Gardner, H., & Laskin, E. (1995). *Leading minds: An anatomy of leadership*. New York, NY: Basic Books.

Gill, R. (2006). *Theory and practice of leadership*. London, UK: Sage.

Gladwell, M. (2000). *The tipping point: How little things can make a big difference*. Boston, MA: Little, Brown and Company.

Gladwell, M. (2008). *Outliers: The story of success* (1st ed.). New York, NY: Little, Brown, and Company.

Goleman, D. (2005). *Emotional intelligence*. New York, NY: Bantam Dell.

Greenleaf, R. (1977). *Servant leadership*. Mahwah, NJ: Paulist Press.

Guder, D. L., & Barrett, L. (1998). *Missional church: A vision for the sending of the church in North America*. Grand Rapids, MI: W.B. Eerdmans.

Guinness, O. (2003). *The call: Finding and fulfilling the central purpose of your life*. Nashville, TN: Thomas Nelson.

Hagberg, J. (1984). *Real power*. Minneapolis, MN: Winston Press.

Hansen, L. A. (1923). The scope of healthful living. *The Advent and Sabbath Review Herald, 100*(20), 6-7.

Harmon, B. E., Chock, M., Brantley, E., Wirth, M. D., & Hebert, J. R. (2016). Disease messaging in churches: Implications for health in African-American communities. *Journal of Religion and Health, 55*, 1411-1425. doi:10.1007/s10943-015-0109-3

Harrison, L. M. (2011). Transformational leadership, integrity, and power. *New Directions For Student Services, 135(Fall)*, 45-52.

Harvard Business Review. (2010). *On managing yourself*. Boston, MA: Harvard Business Review.

Harvard Business Review's 10 must reads on change. (2011). Boston, MA: Harvard Business Review Press.

Harvard Business Review's 10 must reads on leadership. (2011). Boston, MA: Harvard Business Review Press.

Harvard Business Review's 10 must reads on managing people. (2010). Boston, MA: Harvard Business Review Press.

Harvard Business Review's 10 must reads on managing yourself. (2010). Boston, MA: Harvard Business Review Press.

Harvard Business Review's 10 must reads on strategy. (2011). Boston, MA: Harvard Business Review Press.

Heifetz, R. A. (1994). *Leadership without easy answers*. Cambridge, MA: Harvard University Press.

Heifetz, R., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership*. Boston, MA: Cambridge Leadership Associates.

Heifetz, R., & Linsky, M. (2002). *Leadership on the line*. Boston, MA: Harvard Business School.

Hirsch, A. (2006). *The forgotten ways: Reactivating the missional church*. Grand Rapids, MI: Brazos Press.

Kidder, J. (2011). *The big four: Secrets to a thriving church family*. Hagerstown, MD: Review and Herald.

Kruger, D. J., Lewis, Y., & Schlemmer, E. (2010). Mapping a message for faith leaders: Encouraging community health promotion with local health data. *Health Promotion Practice, 11(*6*)*, 837-844. doi: 10.1177/1524839908328995

Kohl, M. W. (2012). Every Christian institution needs a strategic plan. *International Congregational Journal*, *11*(2), p. 19-39.

Kouzes, J. M., & Posner, B. Z. (2003). *The leadership challenge*. San Francisco, CA: Jossey-Bass.

La Beach-Pollard, P. (2012). *Raise a leader–God's way: "train up a child"–yeah, but how?* Hagerstown, MD: Review and Herald.

Leadership-Central.com. (2013). *Leadership theories*. Retrieved from www.leadership-central.com/leadership-theories.html

Levin, J. (2013). Engaging the faith community for public health advocacy: An agenda for the surgeon general. *Journal of Religion and Health, 52,* 368-385. doi: 10.1007/s10943-013-9699-9

Magezi, V. (2012). From periphery to the centre: Towards repostioning churches for meaningful contribution to public health care. *HTS Teologiese Studies/Theological Studies, 68*(2), 1-8. doi:10.4102/hts.v68i2.1312

Malphurs, A. (2013). *Advanced strategic planning.* Grand Rapids, MI: Baker Books.

Markel, H. (2011). John Harvey Kellogg and the pursuit of wellness. *Journal of the American Medical Association, 305(*17*),* 1814-1815.

Merriam-Webster. (2018). Retrieved from www.merriam-webster.com.

Meyerson, D. (2003). *Tempered radicals: How everyday leaders inspire change at work.* Boston, MA: Harvard Business School.

Miller, T. (2011). Integrity in transactional leadership. *New Directions for Student Services, 135(Fall),* 35-44. doi:10.1002ss.402

Mintzberg, A. (1994). *The rise and fall of strategic planning.* New York, NY: Free Press.

Moore, E. W., Berkley-Patton, J., Berman, M., Burleson, C., & Judah, A. (2016). Physical health screenings among African-American church and community members. *Journal of Religion and Health, 55,* 1786-1799. doi: 10.1007/s10943-016-0264-1

Moxley, R. S. (2000). *Leadership and spirit.* San Francisco, CA: Jossey-Bass.

Munck, B., Kegan, R., Lahe, L. L., Meyerson, D. E., Sull, D., Hudson, K. M., & Levyet, P. F. (2002). *Harvard business review on culture and change*. New York, NY: Harvard Business Press.

Northouse, P. (2016). *Leadership* (7th ed.). Thousand Oaks, CA: Sage.

Odulana, A. A., Kim, M. M., Isler, M. R., Green, M. A., Taylor, Y. J., Howard, D. L., Godley, P. A., & Corbie-Smith, G. (2014). Examining characteristics of congregation members willing to attend health promotion in African American churches. *Health Promotion Practice, 15(*1*),* 125-133. doi:10.1177/1524839913480799

Oyinloye, E. A. (2014). *Health and social ministries: A holistic approach to ministering in contemporary society.* [Doctoral dissertation]. Retrieved from Digital Commons. https://digitalcommons.andrews.edu/dmin/264

Oxford Living Dictionaries. (2019). New York, NY: Oxford Univesity Press. Retrieved from htts://ww.en.oxforddictionaries.com

Parks, S. (2005). *Leadership can be taught: A bold approach for a complex world* (1st ed.). Boston, MA: Harvard Business School.

Pearce, C. L., & Conger, J. A. (Eds.). (2003). *Shared leadership: Reframing the hows and whys of leadership*. Thousand Oaks, CA: Sage.

Pollard, L. N. (Ed.). (2000). *Embracing diversity*. Hagerstown, MD: Review and Herald.

Pollard, L. (2014). Paul: Principles for leadership and contextualization. In S. Bell (Ed.), *Servants and friends* (p. 310). Berrien Springs, MI: Andrews University.

Polhill, J. B. (1992). *Acts: An exegetical and theological exposition of Holy Scripture*. Nashville, TN: Broadman and Holman.

PROMIS Health Organization and PROMIS Cooperative Group. (2012). *Global health*. Washington, DC: U.S. Dept. of Health and Human Services.

Raney, A. (2014, September). Agility in adversity: Integrating mindfulness and principles of adaptive leadership in the administration of a community mental health center. *Clinical Social Work Journal 42*(3), 312-320.

Riddle, M. B., & Starbuck, C. C. (2008,). Galatians. *In* J. P. Lange, P. Schaff, & O. Schmoller, *Commentary on the Holy Scriptures* (p. 96). LOGOS Software.

Rodin, R. S. (2010). *The steward leader: Transforming people, organizations and communities.* Downers Grove, IL: IVP Academic.

Rost, J. C. (1993). *Leadership for the twenty-first century*. Westport, CT: Praeger.

Rush University Medical Center. (2012). *Eating for a healthy colon*. Chicago, IL: Rush University. Retrieved from https://www.rush.edu/health-wellness/discover-health/eating-healthy-colon

Sahlin, M. (2004). *Understanding your community.* Lincoln, NE: Center for Creative Ministry.

Saunders, D. R., Holt, C. L., Le, D., Slade, J. L., Muwwakkil, B., Savoy, A., Williams, R., Whitehead, T. L., Wang, M. Q., & Naslund, M. J. (2015). Recruitment and participation of African American men in church-based health promotion workshops. *Journal of Community Health, 40,* 1300-1310. doi: 10.1007/s10900-015-0054-9

Scazzero, P. (2003). *The emotionally healthy church*. Grand Rapids, MI: Zondervan.

Schwarz, C. (1996). *Natural church development*. St. Charles, IL: Church Smart Resources.

Scott, S. (2004). *Fierce conversations: Achieving success at work and life, one conversation at a time*. New York, NY: Berkley Books.

Seamands, D. (1991). *Healing for damaged emotions*. Colorado Springs, CO:Victor.

Senge, P.M. (1990). *The fifth discipline*. New York, NY: Doubleday.

Shahhosseini, M., Daud Silong, A., & Arif Ismaill, I. (2013). Relationship between transactional, transformational leadership styles, emotional intelligence and job performance. *Researchers World: Journal of Arts, Science & Commerce*, *6*(1), p. 15-22.

Sharpe, J., Jr., & Creviston, T. (2013, Jan/Feb). Adaptive leadership: The way ahead for sustainment leaders. *Army Sustainment 45*(1), 5-9.

Sider, R. J., Olson, P. N., & Unruh, H. R. (2002). *Churches that make a difference*. Grand Rapids, MI: Baker Books.

Slade, J. L., Holt, C. L., Bowie, J., Scheirer, M., Toussaint, E., Saunders, D., & Sanots, S. L. (2018). Recruitment of African American churches to participate in cancer early detection interventions: A commuity perspective. *Journal of Religion and Health, 57*(2), 751-761. doi: 10.1007/s10943-018-0586-2

Smith, F. (1998). *The book of learning and forgetting*. New York, NY: Teachers College Press.

Spence, H. D. M., & Exell, J. S. (Eds.). (1910). Introductory essay on the authenticity and authorship of the book of Numbers. *Numbers*. New York, NY: Funk & Wagnalls.

Stanley, P. D., & Clinton, J. R. (1992). *Connecting: Finding mentors you need to be successful in life.* Colorado Springs, CO: NavPress.

Surowiecki, J. (2005). *The wisdom of crowds: Why the many are smarter than the few and how collective wisdom shapes, business, economies, societies, and nations.* New York, NY: Anchor Books.

Swenson, R. (2004). *Margin: Restoring emotional, physical, financial, and time reserves to overloaded lives*. Colorado Springs, CO: Nav Press.

Tutsch, C. (2008). *Ellen White on leadership.* Nampa, ID: Pacific Press.

VanderWeele, T. J. (2017). Physical activity and physical and mental well-being in church settings. *American Journal of Public Health, 107(*7*),* 1023-1024. doi:10.2105/AJPH.2017.303843

Vinson, J. (2015). For three days, Alamodome will host free medical care. *Rivard Report*. Retrieved from https://therivardreport.com/for-three-days-alamodome-offers-free-medical-care/.

Vroom, V. H. (1964). *Work and motivation*. New York, NY: John Wiley & Sons.

Wilkes, C. G. (1998). *Jesus on leadership*. Wheaton, IL: Tyndale House.

Wheately, M. J. (2006). *Leadership and the new science: Discovering order in a chaotic world* (3rd ed.). San Francisco, CA: Berrett-Koehler.

White, E. G. (1942). *The ministry of healing*. Boise, ID: Pacific Press.

White, E. G. (2000). *Steps to Christ*. Nampa, ID: Pacific Press.

White, E. G. (2001). *Counsels on diet and foods*. Hagerstown, MD: Review and Herald.

White, E.G. (2002). *Counsels on health*. Hagerstown, MD: Pacific Press.

White, E. G. (2010). *Christian leadership*. Silver Spring, MD: Ellen G. White Estate.

White, E.G. (1946). *Evangelism*. Washington, DC: Review and Herald.

White, E. G. (2012). *The great controversy.* Nampa, ID: Pacific Press.

Wikipedia. (2019). Imprinting (psychology). Retrieved from https://en.wikipedia.org/wiki/Imprinting(psychology)

Wikipedia. (2016). Tallahassee. Retrieved from https://en.wikipedia.org/wiki/Tallahassee, Florida

Williams, R. M., Glanz, K., Kegler, M.C., & Davis, E., Jr. (2012). A study of rural church health promotion environments: Leaders' and members' perspectives. *Journal of Religion Health, 51*, 148-160.

Williams, R. M., Tagai, E. K., Santos, S. L. Z., Slade, J. L., Carter, R. L., & Holt, C. L. (2018). The role of leadership support in a church-based cancer education implementation study. *Journal of Religion Health, 57*, 146-156.

Wingood, G. M., Lambert, D., Renfro, T., Ali, M., & DiClemente, R. J. (2019). A multilevel intervention with African American churches to enhance of point-of-care HIV and diabetes testing, 2014-2018. *American Journal of Public Health, 109(*S2*)*, S141-S144. doi:10.2105/AJPH.2019.304990

Whitworth, L., Kimsey-House, K., Kimsey-House, H., & Sandahl, P. (2007). *Co-active coaching: New skills for coaching people toward success in work and life* (2nd ed.). Mountain View, CA: Davies-Black.

Yukl, G. A. (1981). *Leadership in organizations*. Upper Saddle River, NJ: Prentice Hall.

VITA

Name: Ricardo A. Daphnis

Background: I was born and raised in Miami, FL on September 11, 1980. I have two older brothers and was raised in the Seventh-day Adventist Church by loving parents. I was baptized into the body of Christ and became a Seventh-day Adventist at a young age of 7 (1987). I am a product of Adventist Christian education and have attended Seventh-day Adventist schools in the 3rd grade then from the 6th grade through University.

Family: I was married on July 23, 2006 to Marsha Daphnis who is from Staten Island, NY. We have three children, Olivia Ariel Daphnis (born in 2009), Jeremiah "J.J." Daphnis (born in 2011), and Elizabeth Ariana Daphnis (born in 2017).

Education:

2003-2006	MDiv from Andrews Theological Seminary.
1998-2003	BA in Theology, Oakwood Adventist University AS in Nutrition

Ordained:

2012	Ordained by and currently hold ministerial credentials from Southeastern Conference of Seventh-day Adventists.

Experience:

2016-Present	Lead Pastor of the Ephesus Seventh-day Adventist Church (Jacksonville, FL)
2012-2016	Lead Pastor of the Fellowship Seventh-day Adventist Church (Tallahassee, FL) and Ephesus Seventh-day Adventist Church (Bainbridge, GA)
2007-2012	Lead Pastor of the Zion Hill Seventh-day Adventist Church (Hawthorne, FL) and Bethany Seventh-day Adventist Church (Palatka, FL)
2006-2007	Assistant Pastor of the Ephesus SDA Church (West Palm Beach, FL)