VOLUME II

Health-Promoting Churches

Edited by Mwai Makoka

A handbook to accompany churches in establishing and running sustainable health promotion ministries

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World Council of Churches Publications

HEALTH-PROMOTING CHURCHES
Volume II: A handbook to accompany churches in establishing and running sustainable health promotion ministries
Editor: Mwai Makoka

WCC Publications is the book publishing programme of the World Council of Churches. Founded in 1948, the WCC promotes Christian unity in faith, witness and service for a just and peaceful world. A global fellowship, the WCC brings together more than 350 Protestant, Orthodox, Anglican and other churches representing more than 580 million Christians from more than 110 countries and works cooperatively with the Roman Catholic Church.

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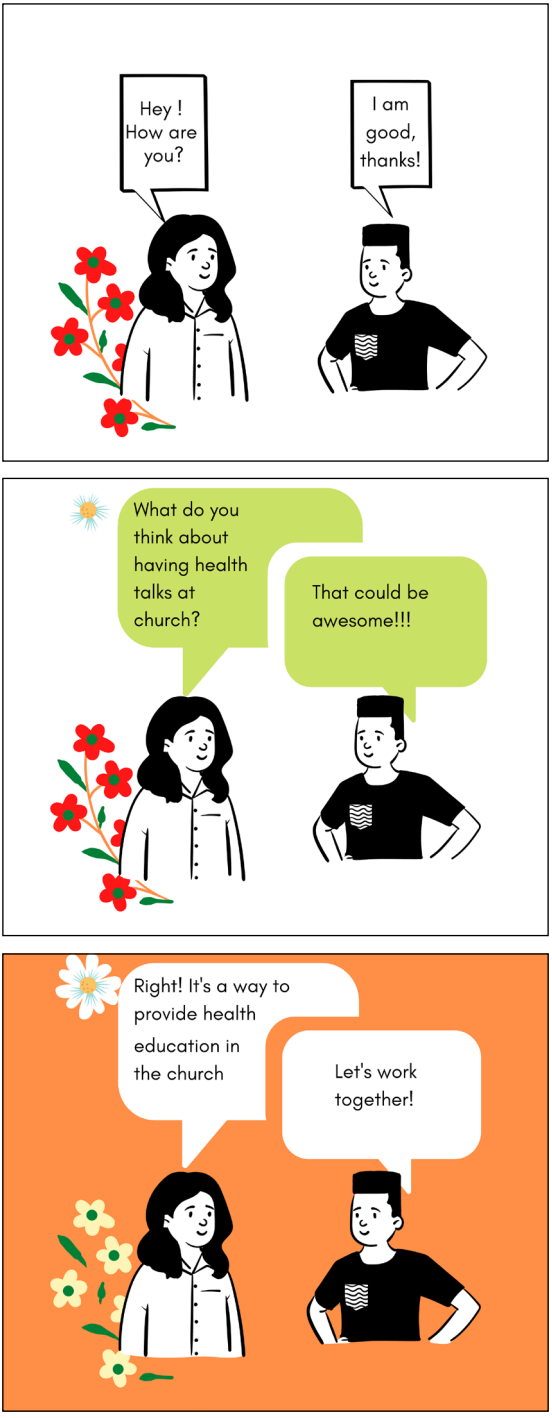
"Everywhere people are dying from diseases that are preventable. Christians can lead the way in providing models of a comprehensive approach that can remove the burden of preventable death. Thus, prevention becomes a tool for healing."

Healing and Wholeness: The Churches' Role in Health,
World Council of Churches (Geneva: WCC, 1990), 21.


Hey ! How are you?
I am good, thanks!
What do you think about having health talks at church?
That could be awesome!!!
Right! It's a way to provide health education in the church
Let's work together!

Contents

Foreword

Health and healing have always been important in the work of the World Council of Churches (WCC). A study undertaken across all regions of the world from 1979 to 1987 emphasized the important role of churches in the health landscape, not least of which is in health education. The WCC mission statement *Together towards Life*[1] reaffirms that as health and healing were central features of Christ's ministry and call to his followers, so they should be central to the mission of the church.

The WCC was heavily engaged in the Primary Health Care movement, including the 1978 Alma-Ata Declaration. Since 1980, the World Health Organization has used a healthy settings approach for health promotion, including healthy cities, healthy villages, and health-promoting schools. Unfortunately, places of worship have not been recognized and reached with this approach. The WCC's Health-Promoting Churches programme is thus an opportunity to strengthen existing efforts in churches in a coherent and evidence-based manner.

Both this handbook and *Health-Promoting Churches: Reflections on Health and Healing for Churches on Commemorative World Health Days* support the Ecumenical Global Health Strategy, a health expression of the WCC's Pilgrimage of Justice and Peace.

Rev. Prof. Dr Ioan Sauca
Acting general secretary
World Council of Churches
November 2020

1. Jooseop Keum, ed., *Together Towards Life: Mission and Evangelism in a Changing Landscape* (Geneva: WCC Publications, 2013).

Preface

The World Council of Churches (WCC) defines health as a dynamic state of wellbeing of the individual and society. It is a state of physical, mental, spiritual, economic, political, and social wellbeing. And it is a state of humans being in harmony with each other, with the material world, and with God.

In June 2018, the WCC central committee approved the Ecumenical Global Health Strategy, whose purpose is to support churches as healing communities. This handbook contributes to that goal by giving churches practical guidance on starting and running a congregation-based health ministry.

What does this handbook aim to achieve?

This handbook is expected to support local Christian congregations in starting a sustainable health ministry to ensure that:

- **The church is a place of health education.** Knowledge is power, and the church is a safe and effective space to provide critical health education from medical, social, and biblical perspectives. Health and medical conditions are often surrounded by myths and misinformation, which limits healing, a practical holistic response, and the possibility of addressing root causes of diseases. To address this situation, this handbook provides practical guidance for churches to design and explore creative ways of providing health education.

- **The church is a place of practical action.** Jesus sent out the disciples to preach, teach, and heal. Information and awareness may create intention, but intention does not always translate into action. This handbook will support churches in running a health ministry based on mutual loving care and accountability so that Christians can take concrete actions together toward healthy lifestyles as individuals, families, and communities. In this way the church will help people to bridge the gap between knowledge and action.
- **The church is a place for advocacy and care for creation.** The theology of health and healing calls the church to act beyond individual and family health concerns. We need to bring the healing ministry into the political, social, environmental, and economic arenas. The Holy Spirit empowers the church to prophetically denounce the root causes of suffering and to call for transformation of structures of injustice and destruction. This handbook provides a guide for churches to identify, analyze, and approach these policy, systems, and environmental issues.
- **The church is a place of empowerment for public witness.** Every Christian is called to be salt and light for the world. The church is a place where individual Christians are empowered to be that salt and light in their areas of influence. From the highest to the lowest office in the land, people make decisions based on their values and convictions. And Christians, in whatever personal or official capacity, are called to make decisions that promote life and testify to the lordship of Christ over all creation.

How is the handbook organized?

This handbook begins by providing a theological and public health basis of the Health-Promoting Churches (HPC) model. Next it provides a guide on organizing the HPC programme sustainably. Work

plans are then provided on seven intervention areas: diet, physical exercise, tobacco, alcohol, mental health, tuberculosis, COVID-19 and other health issues. A monitoring and evaluation framework and guidance on how to address other emerging health issues are also provided. Appendices that provide more detailed information are found at the end of the document for ease of reference.

What is the role of the church health committee?

The hub of the HPC is the church health committee (CHC), which leads the health ministry. It should represent the full diversity of the local church. The main criteria for membership in the committee are passion for health issues, willingness to work as a team, and ability to organize and motivate others. Church members who are trained health professionals are encouraged to participate in the committee without having to dominate it. Besides the CHC, all church members should be encouraged to participate and contribute with their gifts and abilities as much as possible.

Dr Isabel Apawo Phiri
Deputy general secretary for
Public Witness and Diakonia
World Council of Churches

Handbook Development Process and Acknowledgements

This manual is a culmination of efforts by many people along with consultations that started in 2017. On 10 May 2017, I received a surprise visit from a person I had never met before, Dr Pratap Jayavanth. Dr Jay, as we fondly call him, met up with his friend Dr Cherian Varghese, Coordinator for Noncommunicable Diseases at the World Health Organization (WHO), who referred him to the World Council of Churches (WCC). Until his retirement, Dr Jay was heading the WHO office in Tonga, an island nation that was struggling to control non-communicable diseases (NCDs).

Dr Jay had opined that churches could be mobilized and equipped to help fight NCDs. He worked with church, government, and political leadership to establish Tonga Church Promoting Health Partnership (CPHP) in 2009. The purpose of his august visit to the WCC was to see if the WCC could support an impact assessment of the programme in Tonga, to which I agreed. While Dr Varghese had already been a close friend of the WCC Health and Healing Programme providing invaluable support, Dr Jay has, since his visit, journeyed with us in the development of this manual.

With the support of many friends and partners, we identified other beautiful church-based health programmes in the United States, Jamaica, and South Africa. The following milestones in developing this handbook demonstrate wide contributions from different churches, councils of churches, Christian organizations, and government departments:

1. 11–15 September 2017: programme visit by Dr Jay to Tonga, conducted an assessment of the CPHP, held discussions with church leaders, Ministry of Health, and other government officials, and made recommendations
2. 17–20 October 2017: programme visit by Dr Mwai Makoka to Tonga, followed up on recommendations from Dr Jay's report; participated in programme activities; held discussions with church leaders and Ministry of Health officials
3. 5–8 February 2018: programme visit by Dr Mwai Makoka to the Village HeartBEAT programme in Charlotte, North Carolina, USA, in collaboration with Evedith Landrau, WCC central committee member; participated in programme activities; held discussions with Mecklenburg County public health officials, church leaders, and other programme partners
4. 10–16 February 2018: programme visit by Dr Mwai Makoka to Whole Person Ministry at Bethel Baptist Church, Kingston, hosted by Jamaica Council of Churches; held discussions with church leaders and Ministry of Health officials and participated in programme activities
5. 17–19 July 2018: consultative meeting in Charlotte, North Carolina, USA, hosted by Village HeartBEAT and the Mecklenburg County health department; participants came from the programmes in Tonga, Jamaica, and Charlotte as well as the WHO Collaborating Centre in Health Promotion; participated in programme activities; shared experiences and agreed to develop a handbook on health-promoting churches to reach a global audience
6. 18–23 August 2018: Dr Mwai Makoka programme visit to the Methodist Church in Southern Africa health programmes in Durban and Johannesburg, South Africa; made programme site visits and held discussions with church leaders

7. 8–15 November 2018: drafting workshop hosted by the Evangelical Lutheran Church in America, Chicago, Illinois; agreed on the style of the handbook, table of contents, and key issues
8. 3–5 December 2018: second consultation held in Charlotte, North Carolina, hosted by Village HeartBEAT and the Mecklenburg County health department; reviewed the draft outline and added more structure and content
9. 1–7 March 2019: second drafting workshop held in Johannesburg, South Africa, hosted by the Methodist Church in Southern Africa
10. 3 March 2019: focus group discussions with church members in the Central Methodist Church in Johannesburg, held by the drafting team
11. 7 April 2019: focus group discussion with church members in Wiegrabe Parish of the Evangelical Presbyterian Church in Accra, Ghana, held by Dr Jay in collaboration with Rev. Dr Cyril Fayose of the Christian Council of Ghana and Dr James Duah of the Christian Health Association of Ghana
12. 5 May 2019: focus group discussion with church members in the Balmer Memorial Methodist Church of Sierra Leone, Freetown, by Dr Mwai Makoka in collaboration with Florence Bull of the Christian Health Association Sierra Leone
13. August and September 2020: four online working sessions of the drafting team to review the final draft

The people who contributed to and participated in these processes are listed in **Appendix 11** and are gratefully acknowledged. All contributions and support are also well appreciated, not least of which are Cheryl Emmanuel, senior health manager of the Mecklenburg County Health Department, and Prof Susan Jackson, director of the WHO Collaboration Centre in Health Promotion at the University

of Toronto, Canada. Gibbie Harris, Mecklenburg County director of health; Rev Gary Harriot, former general secretary of the Jamaica Council of Churches; Rt Rev Zipho Siwa, Methodist Church in Southern Africa presiding bishop emeritus; Rt Rev Elizabeth Eaton, Evangelical Lutheran Church in America presiding bishop; and Rev Filifai'esea Lilo, former general secretary of the Tonga Church Leaders Forum are acknowledged for warmly hosting the aforementioned programme activities.

My WCC colleagues, including Dr Isabel Phiri, Rev Dr Nyambura Njoroge, and Dr Manoj Kurian provided guidance and support to the processes; former general secretary Rev. Dr Olav Fykse Tveit and acting general secretary Rev. Prof. Ioan Sauca provided critical guidance. Special thanks to Lyn van Rooyen for coordinating the publication processes and, not least, Lona Lupai for providing administrative and logistical support for all the travel and meetings.

Dr Mwai Makoka
WCC programme executive
for Health and Healing

Abbreviations and Definition of Terms

CHC	Church health committee
church(es)	Same as congregation(s)
congregation	Corporate fellowship of the people of God wherever it manifests itself in worship, witness, and service;[1] local church community, not necessarily denomination
HPC	Health-Promoting Churches programme
M&E	Monitoring and evaluation
NCD	Non-communicable diseases
NGO	Non-governmental organization
PSE	Policy, systems, and environment

1. *The Healing Church*, World Council Studies No. 3 (Geneva: WCC Publications, 1965), 30, 31.

CHAPTER 1

Introduction

This chapter provides a theological basis for the involvement of the church in health and healing.

Life is God's gift

The Lord our God revealed himself as a healer very early in the Bible narrative; this was later affirmed by Jesus Christ. The church through the ages has sought to follow in these footsteps, albeit with different degrees of understanding and various ways of expressing that healing ministry. The healing ministry pertains to the whole being of the church, which finds its root in the living Creator, the triune God, made flesh in Jesus Christ and received as the power of the Holy Spirit. God's gift to all people is life.

Health, healing, and wholeness

The way health and healing are defined, and sickness and illness are explained depends largely on conventions and culture—including values, structures, worldviews, ethics, and religion. It is therefore not easy to make a substantive definition of health that prevails across space and time. The World Health Organization (WHO) states that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" and provides further

defining descriptions of health.[1] In the 1980s, there were attempts to include "spiritual" in the WHO definition of health, but this was not approved by the World Health Assembly.

For its part, the World Council of Churches (WCC) proffered a definition of health as a dynamic state of wellbeing of the individual and society; of physical, mental, spiritual, economic, political, and social wellbeing; of being in harmony with each other, with the material world, and with God.[2] This definition underlines that health is not a static condition in which a clear boundary can be made between being healthy and being ill. Every person is constantly moving between different degrees of staying healthy and struggling with disease and illness.

Further ecumenical studies provided more functional or operational descriptions of health. Health is not primarily medical. Although the health industry is producing increasingly sophisticated and expensive technology, the fact remains that most of the world's health problems cannot be best addressed in this way.

Health is a justice issue: The number-one determinant of diseases in the world is poverty, which is the result of oppression, exploitation, marginalization, ethnic cleansing, and war. The prophets and Jesus cried out against the oppression and exploitation of the poor, both within and between nations, and urged just and fair distribution of resources.

Health is a peace issue: The current world climate of heightening militarism and struggle for supremacy, dozens of proxy wars, and perennial low-intensity conflicts in many countries, is preventing millions from experiencing health and wellbeing. Increased military expenditure

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1. World Health Organization. Constitution. **https://www.who.int/about/who-we-are/constitution**.

2. World Council of Churches, *Healing and Wholeness: The Churches' Role in Health.* The report of a study by the Christian Medical Commission (Geneva: WCC, 1990), 6.

is suffocating resources for holistic human development. 2019 world military expenditure exceeded $1.9 trillion.[3] The vision of "Health and wellbeing for all" cannot be achieved under these conditions.

Health is an integrity of creation issue: A significant proportion of illnesses in the world is directly or indirectly linked to environmental degradation, pollution of water and air, and global warming. Humanity has failed to balance industrial development with care for the earth. Greed, negligence, selfishness, and ignorance are taking the earth and all its inhabitants, the *oikoumene*, down the path of self-destruction. Diseases and disasters will get worse unless significant restoration is made to mother earth.

Health is a spiritual issue: The spiritual dimension is very important to health. The prayer by the Apostle John "that all may go well with you and that you may be in good health, just as it is well with your soul" (3 John 2) aptly captures the balance between good health and spiritual wellbeing. A study of 74,534 female nurses who were followed for 20 years showed that those who attend church services more often actually have a better chance of living longer.[4]

Health is a personal issue: A significant proportion of diseases are self-inflicted due to certain lifestyles and values. Similarly, healthy personal habits agree with the injunction to take care of our bodies as they are temples of the Holy Spirit.

Health is a community issue: Jesus always related health and healing to the life of the community. He questioned existing laws, cultural values, and practices that did not serve the interests of the poor and did not promote life and wellbeing. People cannot be healthy in isolation.

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3. SIPRI Yearbook 2020: Armaments, Disarmament and International Security. Summary. Stockholm International Peace Research Institute. 10–11.

4. S. Li, M.J. Stampfer, D.R. Williams, and T.J. VanderWeele, "Association of Religious Service Attendance with Mortality among Women," *JAMA Internal Medicine* 176: 6 (2016), 777–85. doi:10.1001/jamainternmed.2016.1615.

The quest for health requires the church to denounce policies, traditions, habits, cultures, systems, and structures that perpetrate injustices and militate against health and wholeness. Healthy communities make healthy people.

Health is a systemic issue: Even though we knew it all along, the COVID-19 pandemic has demonstrated beyond a shadow of doubt that health is closely linked to all other aspects of life and sectors of society in terms of its underlying determinants and effects. Health is no longer the territory of a chosen few professions. All professions and sectors must proactively and visibly do their part to promote the health and wellbeing of all.

Healing

Healing is a process: Healing is a "process towards health and wholeness. It embraces what God has achieved for human beings through the incarnation of Jesus Christ. God's gifts of healing are occasionally experienced instantly or rapidly but in most cases healing is a gradual process taking time to bring deep restoration to health at more than one level."[5] There are four spheres of healing: physical, mental, social, and spiritual. No disease is confined to only one of these spheres in its causes or effects, and so healing should be holistic.[6]

Healing, cure, and salvation: "God is the source of all healing. In the Old Testament, healing and salvation are interrelated and, in many instances mean the same thing: 'Heal me, O Lord, and I shall be healed; save me, and I shall be saved' (Jer. 17:14). The New

5. *A Time to Heal*. A report for the house of Bishops of the General Synod of the Church of England on the Healing Ministry (London: Church House Publishing, 2000).

6. *The Healing Church*, World Council of Churches Studies No. 3 (Geneva: WCC, 1965), 30.

Testament, however, does not equate being cured from an ailment with being saved. The New Testament also makes distinction between curing and healing. Some may be cured but not healed (Luke 17:15–19) while others are not cured but healed (2 Cor. 12:7–9). Cure denotes restoring lost health . . . Healing refers to the eschatological reality of abundant life that breaks in through the event of Jesus Christ, the wounded healer, who participates in all aspects of human suffering, dying, and living, and overcomes violation, suffering, and death by his resurrection. In this sense, healing and salvation point to the same eschatological reality."[7]

Healing practices: Many practices can aid in healing. They can, however, also be used for evil, intentionally or unintentionally. Intentional harm, for example, is when these are used to harm or exploit people. Unintentional harm, on the other hand, is inflicted when, for example, limited resources are used to provide sophisticated treatment for only a few, while others are denied basic healthcare.[8] The practices of healing include modern medical science and technology,[9] traditional

7. Jack Messenger, ed., *Mission in Context: Transformation, Reconciliation, Empowerment* (Geneva: Lutheran World Federation, 2004), 39–40. **https://www.lutheranworld.org/content/resource-mission-context-transformation-reconciliation-empowerment**.

8. *Healing and Wholeness,* 10, 11.

9. Modern science and technology are a reality. In light of the gospel, we note, however, that i) well-equipped hospitals are often only able to serve those who can afford to pay; and ii) specialization fragments healthcare and increases its cost beyond the reach of the poor. Health professionals struggle to find a balance between curative versus preventive/promotion services. The crux of the matter is how hospitals define their role in the community and what determines their priorities. Health promotion—through concrete and effective community action in setting priorities, making decisions, planning strategies, and implementing them to achieve health—should be a priority community engagement programme in every hospital. *Healing and Wholeness*, 10.

healing practices,[10] liturgical acts,[11] faith healing,[12] prevention,[13] and community building.[14]

Challenges and gaps in the global context of health

Information in this section is taken from the 2018 WHO Global Burden of Disease report.[15] There were 56.9 million deaths worldwide

10. These normally consist of two components: the medicinal and the ritual. The medicinal component includes preparations from medicinal plants, animals, and inorganic substances. The ritual component may involve divination, trance states, baths, offerings to spirits, or body incisions. Like Western medicine, traditional medicine can be abused, but this does not mean it cannot be used by God. *Healing and Wholeness*, 12, 13.

11. These include prayer, the laying on of hands, anointing the sick with oil, visiting the sick, etc. These practices, however, do not exempt us from the responsibility of using the resources of medical science or from political participation simply because we are praying for the sick. *Healing and Wholeness*, 13, 14.

12. Healing acts/prayers that demand that the sick person should discontinue medication or should not take medicines at all as a demonstration of faith are inconsistent with the holistic biblical understanding of health and healing.

13. "Congregations are urged to be involved in and promote primary health care [PHC] as a means of correcting the existing unjust distribution of health care resources. Through PHC the heavy dependence on professional and institutional health services can be lifted, allowing them to provide more expert care for the complicated illnesses for which they are trained and equipped." p. 33. "Everywhere people are dying from diseases that are preventable. Christians can lead the way in providing models of a comprehensive approach that can remove the burden of preventable death. Thus prevention becomes a tool for healing." p. 21 *Healing and Wholeness*.

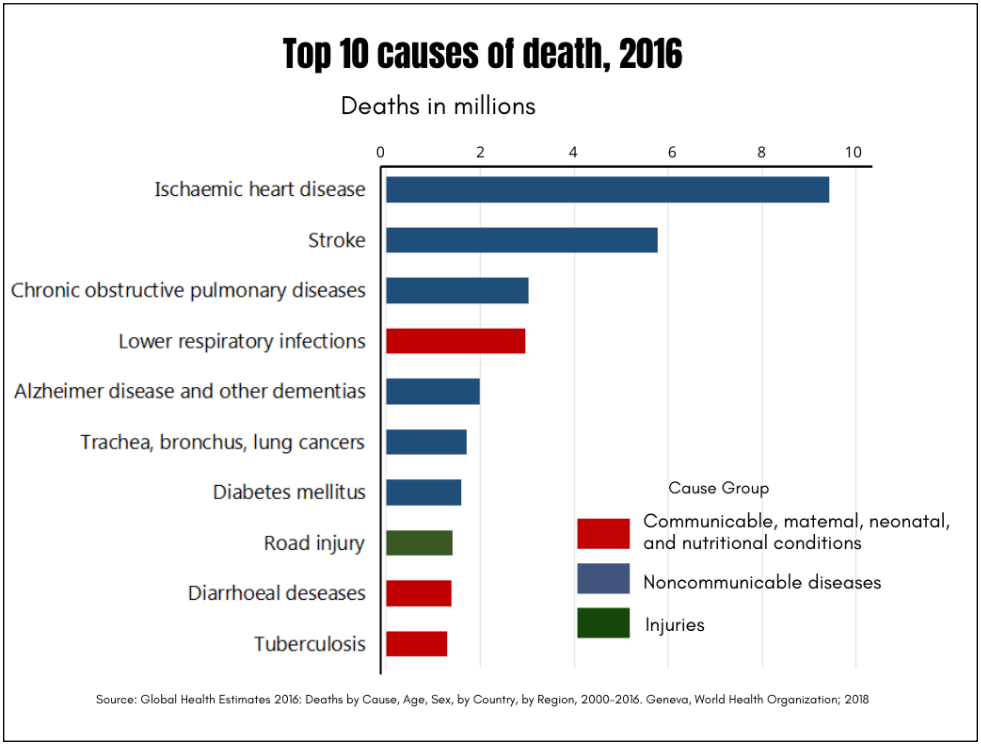
14. "The congregation is challenged to recognize, support and cooperate with healing partners such as family, health professionals, traditional and alternative healers, other agencies and communities, and other faith groups." *Healing and Wholeness*, 33.

15. This section has been taken from World Health Organization, "The top 10 causes of death" (24 May 2018). **https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death**.

in 2016, of which more than half (54%) were caused by the top ten diseases shown in the figure below. In particular, non-communicable diseases (NCDs) were responsible for 71% of the deaths.

When analyzed according to income, NCDs are more significant in terms of percentages in high-income countries. Nevertheless, NCDs caused death ranging from 37% in low-income countries up to 88% in high-income countries. In absolute numbers, however, 78% of all deaths due to NCDs were in low- and middle-income countries.

Non-communicable diseases include heart disease, stroke, cancer, diabetes, and chronic lung disease. They are collectively responsible for almost 70% of all deaths worldwide—most of which occur in low- and



middle-income countries. NCDs have increased globally primarily due to four major risk factors: tobacco use, physical inactivity, the harmful use of alcohol, and unhealthy diets.

Mental health disorders have increased by about 13% in the last decade. Around 20% of the world's children and adolescents have a mental health condition, with suicide being the second-leading cause of death among 15- to 29-year-olds. Even when mental problems do not cause death, they cause 20% of disabilities—more commonly among people living in conflict situations. It is estimated that two of the most common mental health conditions—depression and anxiety—cost the global economy US$1 trillion each year. Unfortunately, less than 2% of government health expenditures is directed to mental health.

The church as a healing community

In the midst of pain and suffering, the church is called to be a channel of peace and hope, healing and reconciliation. "Everywhere people are dying from diseases that are preventable. Christians can lead the way in providing models of a comprehensive approach that can remove the burden of preventable death. Thus, prevention becomes a tool for healing."[16]

A WCC consultation in 1964[17] affirmed that "the Christian ministry of healing belongs primarily to the congregation as a whole, and only in that context to those who are specially trained."[18] The local congregation is the primary agent for healing, and each individual member has a unique gift to contribute to this healing ministry. Besides the need and legitimacy of specialized Christian health institutions, the local

16. *Healing and Wholeness*, 21.

17. Two WCC consultations were held in 1964 and 1967 at the German Institute of Medical Mission (Difäem) in Tübingen, Germany. The theme for the 1964 consultation was "The Healing Church," while for 1967 it was "Health: Medico-theological Perspectives."

18. *The Healing Church*, 35.

Religious resources and their potential role in health and healing

Religious ideas may give the people conviction, legitimacy, and willpower to engage in personal and community transformation.

Religious practices and experiences may inspire people to care for each other and to be active participants and agents of change in their communities and beyond.

Religious organizations may serve as midwives of social movements by providing them with leadership and decision-making structures, financial resources, collective identity, and purpose.

congregation in itself—as the body of Christ—has a healing significance and relevance. The way people are received, welcomed, and treated have a deep impact on its healing function. When nurtured and maintained in a local congregation, a network of mutual support, listening, mutual care, and concrete action expresses the healing power of the church.

Health and healing may be hindered by beliefs, values, and ideas; practices; and policies. Governments and development actors more easily engage at the level of policies and practices; they are not well suited to engaging at the level of beliefs, values, and ideas, but this deeper level is most important for sustainable change.[19] Fortunately, churches have religious resources that enable them to engage at all three levels and so

19. Gweneth Berge, "Recognising the Role of Religion in Development Cooperation: Experiences and Examples from Norwegian Church Aid (NCA)," *Ecumenical Review* 68: 4 (2016), 423–432.

be agents of healing and sustainable change to the congregants and the surrounding communities (Text box page 9).[20]

As part of a creation that is groaning in pain and longing for its liberation, the Christian community is called to be a sign of hope, an expression of God's kingdom, a community of "wounded healers"—in need of help and capable of giving help, reciprocity of giving and receiving, of helping and being helped—who are mutually sharing in the pains of today's suffering and in the hope of our eventual healing and salvation.[21]

20. Berge, 2016.
21. *Healing and Wholeness*, 21.

CHAPTER 2

Purpose and Approach of the Health-Promoting Churches Model

This chapter provides a model for church health ministries to design effective health promotion programmes.

Purpose

The purpose of the World Council of Churches (WCC)'s Health-Promoting Churches programme (HPC) is to support churches as healing communities. Specifically, this handbook aims to accompany churches in establishing and running a successful healing ministry. The hub of the ministry is a church health committee (CHC) that should be well constituted, well equipped, and passionate about leading effective implementation of health initiatives in the congregation.

Developing process

In developing the HPC, we have avoided a top-down approach. Instead, we have studied existing congregation-based health promotion programmes in Tonga, Jamaica, North Carolina (USA), and South

Africa.[1] Through several programme visits and workshops,[2] we have analyzed these programmes and have drawn lessons and good practices from them. In particular, we identified critical components of the programmes and factors for success.

While developing this handbook, we considered that churches would prefer flexibility in selecting and prioritizing the health challenges to address, determining the interventions to make and designing the tools and resources to use. This would allow the programme to be well tailored to the local context. With such an approach, however, programme components and activities would be varied across different churches and countries to the extent that it would not be seen as a cohesive programme. It would be easily derailed by competing priority problems. Also, some churches may not have the in-house expertise to develop their own programmes organically from scratch.

We have therefore taken a hybrid approach, in that we have developed a standardized programme while providing a lot of room to adapt activities and their content to the local situation. (The advantages of a standardized approach is summarized on page 13.) We also provide, as appendices, tools to help churches to adapt the HPC to their local contexts.

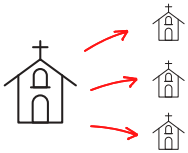
Witness and mission for health promotion

All of God's people are in need of help and capable of giving help, a reciprocity of giving and receiving, helping and being helped. Wholeness thus means that only together, the sick and the healthy, do we

1. The programmes in Tonga, Jamaica, and North Carolina (USA) have been described in Mwai Makoka, "Health Promoting Churches: A Case for Congregation-Based Health Promotion Programmes," *Contact*, Special Series No. 5 (October 2018). **https://www.oikoumene.org/en/what-we-do/health -and-healing/Contact2018Final.pdf**.

2. Details of the programme visits and workshops are provided on **pages xiii-xvi**.

ADVANTAGES OF STANDARDIZATION



Programme

... can be easily rolled out to other church branches, churches, countries, etc.

Resources and expertise

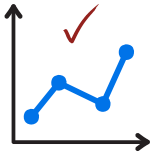
... can be quantified, pooled or shared, e.g., different churches in an area can do some activities together.

Tools and resources

... can be centrally developed and shared, e.g., training materials, activity reporting forms, or computer solutions, etc.

Progress

... can easily be tracked over time to determine programme success.



Global and ecumenical

... potential to cross geographical and denominational boundaries to build an ecumenical and global momentum of HPCs.

form a whole. The HPC galvanizes this healing ministry through four interventions: education, action, advocacy, and public witness. These are interrelated and reinforcing. Health education is a good starting point; it is expected that as the healing ministry grows, the participating church will be able to implement interventions of more advanced dimensions.

The church as a place of health education: Knowledge is power, and the church is a safe and effective space to provide critical health

Top left: a health education session in a church, Tonga; **Top right:** a church leader admiring his home fruit and vegetable garden, Tonga; **Bottom left:** church leaders raising community health concerns with their local parliament, NC, USA; **Bottom right:** solidarity in empowerment for health ministry.

education. Health education should be provided on causes of non-communicable diseases (NCDs) and how to prevent and control them. In addition, there should be education for critical consciousness, where social and historical analysis of the diseases is done with the aim of forming a holistic worldview which opens up the possibility of intervening from multiple angles, including addressing root causes of diseases.

The church should design and explore various creative ways of providing health education. A monthly ten-minute health talk during the main church service is an ideal way to reach the whole congregation and to give prominence to the healing ministry. Other methodologies include special interactive health education sessions where in-depth discussions can be held, with teaching aides; online modules; and information bulletins. Health talks should be provided by people who are qualified in health and health promotion—either church members or persons from the surrounding area. Affected individuals should also be empowered to teach others from their lived experiences. Health talks should be structured and well planned. Motivational talks made from the pulpit go a long way to inspire beliefs, values, and ideas that promote health.

The church as a place of practical action: Jesus sent out the disciples to preach, teach, and heal. Most churches today preach and teach but have abdicated healing to medical professionals. However, the churches we visited are doing various health-promotion activities, especially with regard to NCDs: cooking demonstrations, growing of fruits and vegetables, group physical exercises, biomedical screening, etc.

In terms of behavioural sciences, often people don't engage in healthy behaviours even though they know the benefits. Information and awareness may create intention, but intention does not always translate into action. The church is a powerful community to help bridge the gap between knowledge and action. Mutual loving care and accountability help Christian communities to take concrete actions toward healthy lifestyles at the individual, family, and community level.

The church as a place for care of creation (advocacy): The theology of health and healing calls the church to act beyond individual and family health concerns and to bring the healing ministry into the political, social, environmental, and economic arenas. The Holy Spirit empowers the church to offer a prophetic denunciation of the root causes of suffering and to call for transformation of structures of injustice and destruction.[3]

The church engages in advocacy at different levels commensurate with its level of engagement. For example, a congregation can easily engage with issues in its local community, while the national headquarters of a church is better positioned to collate issues from its lower structures and engage at the national level. The churches can strengthen their voice by acting together ecumenically with one voice on health issues at the local, provincial, national, regional, or global level. Advocacy activities may include meeting with elected officials, public service providers, or private sector actors; publishing policy briefs; etc.

The church as a place of empowerment for public witness: Every Christian is called to be salt and light for the world. The health ministry should be a place where individual Christians are empowered to be that salt and light in their areas of influence. From the highest office of the land to the lowest, people make decisions based on their values and convictions; Christians in whatever personal or official capacity are called to make decisions that promote life and testify to the lordship of Christ over all creation.

The healing ministry of Jesus was marked by his siding with the weak, the poor, and the suffering; his unwillingness to accept delay in alleviating their suffering; and his challenging of laws, traditions, and systems that perpetrated injustice and inequality. He calls us by his word and strengthens us by his Spirit to thus follow him.

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3. Jooseop Keum, ed., *Together towards Life: Mission and Evangelism in a Changing Landscape* (Geneva: WCC Publications, 2013), 19.

Structure of this handbook

Subsequent chapters of this handbook are generally divided into four sections: rationale, steps to follow, resources, and standards of success. Appendices are placed at the end of the handbook.

Rationale: This provides the key justification for the section.

Steps to follow: This outlines critical steps to be undertaken so that the topic concerned is successfully addressed. In some cases, these are to be undertaken step by step, one after the other. In other cases, two or more steps may be carried out at the same time, or they may be scheduled differently. Some steps are to be completed in the short term and others in the long term. The CHC should ensure that the programme doesn't get stuck at one or two steps.

Resources: This lists resources that support the chapter. These include resources that are provided as appendices, tools that are available on the HPC website, and resources that are available elsewhere. Only pertinent resources have been listed. WCC publications that have been listed are available for free download from the Health and Healing Programme section on the WCC website.

Standards of success: These are proposed indicators to measure successful understanding or implementation of the issues covered in the chapter. These have been kept to a minimum and contain a mix of measures for process and for impact. It should be borne in mind that these measures won't be achieved all at once, but even when the CHC has moved on to subsequent chapters, it must follow up to ensure that the standards are eventually achieved.

Appendices: The appendices have tools and reference materials that provide details without disturbing the flow of the handbook.

SCOPE OF OPERATION			
	CHURCH	**CHURCH and COMMUNITY**	**CHURCH, COMMUNITY, and BEYOND**
Overall	• Has supportive pastor, motivated church health committee (CHC), and champion • The church has a standing budget line for the health promotion ministry • Small congregation • HPC package: Basic/Beginner • Implements a range of activities that are basic and entirely reliant on internal resources and reach • HPC activities are implemented in one group only	• Has supportive pastor, motivated CHC, and champions • The church has a standing budget line for the health promotion ministry • Mid-size congregation • HPC package: Intermediate/Growing • Establishes health policies for the church • Begins to influence public policy and practice at community level • Forms coalitions with other churches and partnerships with other community organizations for health promotion • HPC activities may be implemented in more than one setting, e.g., women's guild, youth group, choir, with one overall coordinator	• Has supportive pastor, motivated CHC, and champions • The church has a standing budget line for the health promotion ministry • Large congregation • HPC package: Advanced/Mentor • Establishes health policies for the church at various levels • Influences public policy and practice up to national level • Forms coalitions with other churches and partnerships with various organizations for health promotion • Able to mentor other churches in starting their own HPCs • Acts as a hub for some HPC activities for several churches in the area • Implements HPC activities in more than one setting, e.g., women's guild, youth group, choir, with one overall coordinator
Health education	• Conducts formal health education (HE) sessions for church members based on their health needs assessment • Develops 6-monthly work plans with topics and facilitators, and adjusts according to formal review processes (feedback, monitoring and evaluation [M&E]) • Integrates HE in sermons, liturgy, bulletins, reports, etc. • Relies on in-house experts or external experts on an ad hoc basis	• Conducts formal HE sessions for church members based on their health needs assessment • Develops 6-monthly work plans with topics and facilitators, and adjusts according to formal M&E processes • Integrates HE in sermons, liturgy, bulletins, reports, etc. • Relies on in-house experts or external experts on a regular schedule	• Conducts formal HE sessions for church members, community, and beyond • Participates in planning for HE activities beyond the church and community • Integrates HE in sermons, liturgy, bulletins, reports, and other church structures/programmes (publications, mass media, etc.) • Relies substantially on in-house experts and has a memorandum of understanding with external experts and government health authorities • Develops annual work plans with topics and facilitators based on formal M&E processes

Practical actions	• Offers health promotion activities for church members • Conducts activities that are simple to organize and manage	• Offers health promotion activities for church members and community • Conducts activities that are more demanding in terms of resources, planning, and execution, e.g., competitions, marathons • The activities may be held jointly with other HPCs in the area (same or different denomination)	• Offers health promotion activities for church members and community • Conducts activities that are complex in terms of resources, planning, and execution, e.g., competitions, marathons • Leads in organizing activities jointly with other HPCs in the area (same or different denomination) • Works with local clinics or hospital to host clinical services like screening for tuberculosis (TB) or diabetes, collection of specimens, dispensing of medicines, CPR training, smoking cessation, community TB-care services, etc.
Advocacy	• Conducts advocacy on issues internal to the church • Uses its own data	• Advocates for policy, systems, and environment (PSE) changes first in the local church and then in higher church structures and the community (e.g., legislative ward, constituency, district with local mayor, councils, etc.) • Uses its own data plus data from other HPCs in the area, reports from local health authorities, etc., for evidence-based advocacy	• Advocates for PSE changes at all levels of the church structure/hierarchy • Advocates for PSE changes at state, provincial, national, and global levels by engaging with health, political, civil society, and development leadership at any level • Uses its own data plus data from other HPCs in the area, from other levels of the church, reports from local, national, or global health authorities, etc., for evidence-based advocacy
Public witness	• Empowers Christians to be salt and light within their areas of influence	• Empower Christians to be salt and light within their areas of influence	• Empowers Christians to be salt and light within their areas of influence
Monitoring and evaluation	• Collects data to track programme implementation • Conducts annual evaluations to assess programme impact • Uses its data for evidence-based decisions, including adjustment of programme activities, advocacy, and resource mobilization • Shares evaluation reports with congregation, higher church structures, and other stakeholders	• Collects data to track programme implementation • Conducts annual evaluations to assess programme impact • Uses its data for evidence-based decisions, including adjustment of programme activities, advocacy, and resource mobilization • Shares evaluation reports with congregation, other church structures, and other stakeholders • Evaluation reports reflect changes made because of individual and programmatic data collected and analyzed	• Uses international standards for monitoring and evaluating health promotion programmes and outcomes • Communicates relevant evaluation findings through local, regional, national, and international media and outlets

Scope of Operation for participating churches

It is expected that all participating churches will implement interventions in each category described above: health education, practical actions, advocacy, and public witness. However, it is not expected that each church will do everything in each category. Some churches may start with a bang, while others may start with basic activities and then move on to more advanced ones as they grow. Others may be limited because of the small size of their membership or their geographical location.

This handbook provides the scope of operation at three levels: basic/beginner, intermediate/growing, and advanced/mentor. A smaller or more remote church may decide to implement the basic package, while a larger church may decide to implement the basic package to start with and then move to the intermediate level as the health ministry grows.

The previous table provides a more elaborate description to allow churches to select their scope of operations as they start the HPC. They will also return to see the areas in which their ministries should grow.

CHAPTER 3

Getting Started

This chapter assumes that your church is starting at ground zero. It provides steps for creating awareness and building support through sufficient conversation among all roles and parties in a church congregation.

Rationale

How does a church start and establish a health and wellness ministry? The churches we have studied embarked on their health and wellness ministries in different ways and organized them at different levels of church hierarchy. For instance, in Jamaica this ministry was established at the Bethel Baptist Church; it was anchored there for many years, until other churches started adopting it much later. In Tonga it was anchored at the National Forum of Religious Leaders, thereby reaching almost all churches from the outset. In the United States, the Village HeartBEAT programme is a partnership between the Department of Health and the churches in Charlotte, North Carolina. In South Africa, it is anchored at the headquarters of the Methodist Church of Southern Africa, with a full-time responsible officer. There are obviously many other possible variations.

Steps to follow

Church leadership: The local church leadership must commit to understanding that the church's ministry must embrace the whole

Benefits of documenting HPC activities

- Ensures that the programme does not deviate from agreed terms
- Ensures continuity and smooth transition when some key people leave or join the church/leadership
- Allows leadership to see if some section of the church is not participating in HPC activities and to correct the situation
- Enables the church to track progress of the programme—that is, how well programme activities are being implemented—and institute corrective measures where necessary (monitoring)
- Enables the church to evaluate programme success over the years and see if the intended objectives are being achieved
- Helps in communication and visibility of the programme. Documentation allows the church to communicate in concrete terms, such as "80% of our people have controlled their blood pressure" and not vaguely, such as "we are doing a great job"
- Helps partners to develop trust in the programme, which can attract resources for programme expansion: for example, a church that is running a successful HPC may be asked to mentor other churches; it may even be asked or contracted by the government to extend the programme to the whole community
- Allows for witness sharing through publications, etc.

person, with health and healing as an integral part. It must also identify people with talent and passion for a health ministry and provide them with spiritual, moral, and logistical support.

Theological grounding: The Health-Promoting Churches programme (HPC) is informed and underpinned by a strong theological grounding. This, however, must be reflected upon and internalized by each participating church. Church members must understand why they are engaging in HPC and how this is a worthwhile expression of their faith. This is an ongoing process, but it will ensure that HPC ties in with all church activities and teachings.

Champions: Besides formal leadership (such as committees), individuals with a particular interest, passion, or influence in the community should be identified and empowered to promote HPC. Of course, the local pastor should be the first champion!

Involve everyone: The congregation is the primary beneficiary and the primary implementer of the HPC. The healing ministry belongs to the whole congregation, and not only to persons trained in the health profession. Church members who are medically trained, such as doctors, nurses, and dentists, must make their expertise available to the full extent possible, but they must guard against personalizing or medicalizing the HPC (or pushing others away). The whole church must be adequately and meaningfully engaged at each and every step. The programme must not be personalized by a few individuals or sections of people.

Documentation: This is a critical factor for success. Unfortunately, many churches are not in the habit of writing things down. Programmes with weak documentation were weak, with inconsistent implementation and unclear methods of measuring success. For the HPC, the church must start documenting all procedures, processes, outcomes, challenges, etc. This will ensure sustainability and overall success of the programme (Text box page 22).

Resources

1. World Council of Churches, *Healing and Wholeness: The Churches' Role in Health.* The report of a study by the Christian Medical Commission (Geneva: WCC, 1990).
2. Mwai Makoka, "Health Promoting Churches: A Case for Congregation-Based Health Promotion Programmes," *Contact*, Special Series No. 5 (October 2018). **https://www.oikoumene.org/en/what-we-do/health-and-healing/Contact2018Final.pdf**
3. *The Healing Mission of the Church*. Preparatory Paper No. 11, 60 (Geneva: WCC, 2005). Unpublished.
4. Village HeartBEAT: **www.villagehb.org**

Standards of success

1. A sensitization talk on the HPC is given during mass/church service; all church members are invited to participate in activities and programme leadership
2. Church leadership/minister incorporates health and wellness themes and messages in liturgy and sermons

CHAPTER 4

Thinking Long Term

This chapter helps the church to start a health ministry that is sustainable.

Rationale

The church has systems and structures that have allowed it to exist over the years, overcome challenges and obstacles, and prevail over changing times. In order for the Health-Promoting Churches programme (HPC) to be sustainable, it must be an integral part of the life and witness of the church at all levels. It must be included in the systems and structures of the church and not be treated as a project. This will ensure continuity and sustainability: even when some people/leaders come and go, the church will continue to thrive in the quest for health and healing for all.

How each church recognizes the mandate of the healing ministry depends on its tradition and structure. In general, however, the minister is responsible for encouragement, education, and spiritual and pastoral advice for the healing ministry. The healing ministry thus receives visible recognition and support in the church as a whole instead of being delegated to just one corner of the church.[1]

1. *The Healing Mission of the Church*. Preparatory Paper No. 11, 60 (Geneva: WCC, 2005). Unpublished.

Steps to follow

Church health committee: A church health committee (CHC) should be put in place to champion establishment of the HPC and take the lead in implementing the activities. The committee must comprise a good mix of gender, age, skills, ethnicity, etc. The main role of the committee is to plan and implement the HPC and to report to the church leadership and the entire congregation on the progress of programme implementation. A more detailed description of the committee is provided in **Appendix 1**.

Orientation of the church health committee: The CHC should be oriented on all aspects of the HPC. A reliable health professional who is committed to health prevention may be called upon to facilitate the orientation session. The facilitator, however, should not divert the committee away from the HPC framework. New committee members should also be oriented, and a refresher can be done annually or biennially, even as part of a planning or evaluation retreat. Key components of the orientation are outlined in **Appendix 2**.

Planning: The CHC should develop general short-, medium-, and long-term goals highlighting where they want their HPC to be in six months, one to two years, and two to five years.

Budget allocation: Most health-promotion activities can be implemented with the church's own financial, material, and technical resources. Churches are advised to start where they are and with what they have. The story of Moses can be an encouragement here, where God asked him to use what he had in his hand, a shepherd's staff, and not what he did not have. The Zarephath widow also used all she had to serve God; only later did she receive an abundance of supplies. The HPC is not meant to impose a financial burden on churches but to stimulate and accompany them to use their stewardship and creativity to identify and address their own health problems to the extent possible.

Organogram and agenda: The place of the HPC should be secured by introducing the CHC as a standing committee on the church's organogram, at all levels. Equally, health should be a standing agenda item at the general assembly and other gatherings where reports are received from various church committees.

Mainstreaming in pastoral formation: Ultimately, the denomination should include health and healing in its curriculum at seminary and all other places where its ministers are trained. This will ensure that qualifying pastors/ministers are well equipped for whole-person ministry, which includes health and healing.

Resources

1. Roles and responsibilities of the CHC: **Appendix 1**

Standards of success

1. The CHC is appointed and oriented
2. Short-, medium-, and long-term plans are developed
3. The HPC has a standing annual budget allocation from the church
4. Health is included in the church's organogram or structure
5. A health report is presented and discussed at church general assemblies
6. The HPC is mainstreamed in the curriculum for training pastors and ministers

CHAPTER 5

Understanding the Situation

This chapter helps the church to understand its health and wellness needs and its capacity for effective health ministry.

Rationale

The Bible has many records of leaders conducting a situational analysis before launching a project. Nehemiah assessed the extent of damage to the walls of Jerusalem as well as the resources that were available to his team. It is interesting that he included the goodwill he had with the king as an asset or resource. No person or community has everything, and no person or community has nothing. Expertise, goodwill, relationships, and indigenous knowledge are important intangible assets that should creatively be put to use.

Before the church asks for support from church headquarters, ecumenical partners, government, or other partners, it must demonstrate that it is already applying all its resources to identify and solve its problems. It is important that additional resources should come to strengthen and augment local commitments.

An assessment is required so that plans and actions of the Health-Promoting Churches programme (HPC) are grounded in evidence. This also harnesses all resources of a worshipping community toward a healthy church. A good assessment will allow the church to know exactly where it is and what it has.

Steps to follow

Community-level information gathering: Gather existing data or statistics regarding non-communicable diseases (NCDs) and risk factors in your area (national, regional, and local, if available). This information may be gathered from local public health authorities, national reports, country-specific reports from the World Health Organization (WHO), local media reports, etc.

Personal-level information gathering: Where possible, an anonymous survey should be administered to church members on common health problems, risk factors, and access to health services.

Engagement of members: The church health committee (CHC) should use the information gathered so far to stimulate discussion and engage the whole church community. A SWOT analysis (strengths, weaknesses, opportunities, and threats) is a simple but effective tool to structure a group discussion and to get the most out of it. A guide to a SWOT analysis is provided in **Appendix 3**. SWOT assesses both the internal and external environments. If necessary and where possible, an extensive analysis of the environment outside the church can be done using PESTEL (**p**olitical, **e**conomic, **s**ocial, **t**echnological, **e**nvironmental, and **l**egal); see **Appendix 4**.

Asset mapping: This involves documenting the assets and resources that exist in the church along with those that are outside the church but within its reach. It should include both tangible and intangible resources, such as physical structures, equipment, programmes, meetings, networks, relationships, human resources, and expertise.

Mini-STEPS survey: STEPS is a WHO tool used to collect data and measure NCD risk factors. It covers three different levels or steps of risk factor assessment: Step 1 (questionnaire), Step 2 (physical measurements), and Step 3 (biochemical measurements). This generic tool is adapted by each country. We have tailored the baseline assessment tool to the HPC in the form of a mini-STEPS survey; see **Appendix 5**.

Baseline report: Compile a report of the church's NCD situation, incorporating collective and individual data as well as qualitative and quantitative data. The report should also include the resources that are available.

Scope of operation: Based on this assessment, the CHC must decide on the scope of operation at which it will start its HPC. As the church grows in its health ministry, it will move to more advanced levels. It may start doing more complex activities, be able to mentor other churches, or serve as a hub for advanced HPC activities in the area.

Resources

1. Guide to a SWOT analysis: **Appendix 3**
2. Guide to a PESTEL analysis: **Appendix 4**
3. Mini-STEPS survey: **Appendix 5**
4. Mental health assessment for the church community: **Appendix 7**

Standards of success

1. Church members are involved
2. A mini-STEPS survey and asset mapping are done
3. A baseline report is compiled

CHAPTER 6

Working with Others

This chapter helps the church to give and receive support for mutually growing the health ministry.

Rationale

Health is multidimensional, as it touches on almost all levels of life: personal, domestic, community, national, and global. A holistic approach to health demands that we intervene in more than one area simultaneously and not be simplistic or narrowly focused. Holistic health promotion therefore requires stakeholders to collaborate to leverage each other's strengths and to address weaknesses.

Churches have many strengths, such as strong links and trust with communities and the ability to reach hard-to-reach and marginalized people. However, churches have major weaknesses in other areas, such as funding and documentation. Churches should therefore forge strategic partnerships that will add value to their health ministries.

The early disciples of Jesus wrongly assumed that the ministry belonged only to them and that they had to work in isolation. One day they saw a person who was not part of their team driving out demons, and they complained to Jesus. To their surprise, Jesus told them, "Do not stop him . . . for whoever is not against us is for us" (Mark 9:38–39).

Partnerships and collaboration allow the church to obtain additional technical, material, and financial resources that would otherwise

be lacking. More importantly, they provide an avenue whereby others may also contribute to the ministry and thereby experience the joy and blessings of serving the Lord.

Steps to follow

List stakeholders: A stakeholder is a party that has an interest in and influence on the Health-Promoting Churches programme (HPC) and can either affect or be affected by it, either positively or negatively. A party can be a person (in a personal or official capacity) or a group of people, like a choir, a company, or an organization. Refer to **chapter 5** and generate a list of internal and external stakeholders.

Stakeholder mapping: Evaluate each stakeholder according to their influence and interest in the programme. *Influence* or power refers to the ability to advance or frustrate your programme, while *interest* is the willingness or appetite to use that influence. Create a 2x2 table containing four boxes: *Influence low/high* on one axis and *Interest low/high* on the other. See the sample stakeholder map in **Appendix 6**.

Establish boundaries: Establish clear boundaries regarding from whom support may be solicited or accepted. In general, health programmes do not accept any donations from industries that produce, manufacture, or deal in products that are well known to be harmful to health, such as tobacco, alcoholic beverages, ultra-processed foods, breast milk substitutes, and firearms. Equally, support should not be accepted from those involved in human rights abuses, child labour, environmental degradation, tax evasion, etc.

Communication: Establish communication with priority stakeholders, according to the stakeholder mapping, to explore areas of collaboration.

Collaboration: There are various degrees of collaboration. At first, the church health committee (CHC) may partner with others on an ad

hoc basis—that is, only when there is a need or opportunity. However, some partnerships may grow, in which case a memorandum of understanding may be developed to formalize the partnership. Here are some examples of partnerships:

- clinics or hospitals (public or private) whose staff can provide health talks or carry out health screening
- health worker training schools, with senior students helping with programme activities
- media to support the publicity of programme activities
- private sector companies or groups that can provide in-cash or in-kind support (e.g., materials like blood pressure monitors, glucose test kits)
- academic or research institutions that can help with data management, monitoring, and evaluation
- health NGOs that can share knowledge and expertise
- local or national health authorities that can provide overall political support, make recommendations to potential donors, and possibly offer technical or financial support.

Update: Review the stakeholder map and update it annually, as some partners' interest in and influence on the programme may change over time. Some of these changes may be a result of deliberate engagement by the CHC and church leadership.

Resources

1. Sample stakeholder map: **Appendix 6**
2. List of organizations working on health in your area, region, or country

Standards of success

1. Stakeholder mapping is done
2. A number of stakeholders are actively collaborating with you
3. You have a number of memoranda of understanding with other partners

CHAPTER 7

Eating Well

This chapter helps the church to develop work plans to promote healthy eating.

Rationale

Jesus affirmed the Old Testament teaching that man shall not live by bread alone, but by God's word. But he also demonstrated that food has an important place in our lives and discipleship through his teachings and miracles. He taught us to ask for "our daily bread" when we pray, to give thanks for the food, to eat mindfully, and to share with others.

Food is sacred. On the road to Emmaus (Luke 24:28–31), the disciples were enlightened as Jesus explained the spiritual meaning of his crucifixion and resurrection. But it is only when they invited Jesus (the stranger) to stay and when he broke the bread that they recognized it was their Lord. Jesus still reveals himself to us when we share our food with others. Other scripture passages also reveal the deep spiritual significance of food.

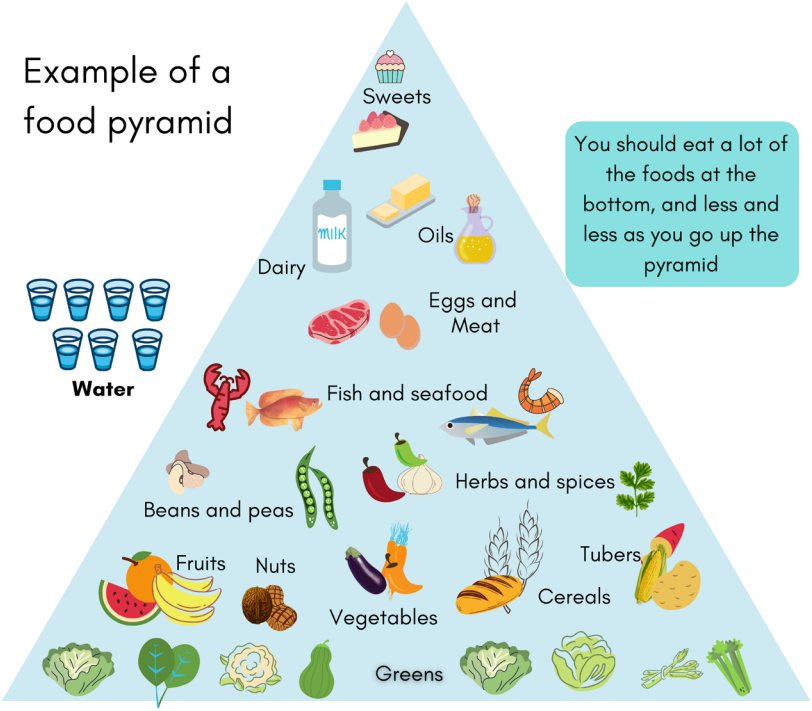
Food is the first medicine. Many diseases can be avoided or cured when we eat the right foods in the right quantities—a balanced diet. Poor nutrition (malnutrition) increases susceptibility to diseases, impairs physical and mental development, and reduces productivity. There is

now a double burden of malnutrition whereby undernutrition coexists with obesity and diet-related non-communicable diseases within individuals, households, and populations.

Steps to follow

Planning: The church health committee should now review the situational analysis and prepare a work plan according to their chosen scope of operation. The work plan should allow the participants to adapt global or national issues to the local context and support local solutions.

Education: Areas for education on healthy eating should include food groups; balanced diet; food pyramid; food labels; nutritional values; Recommended Dietary Allowances, especially for sugar and salt;



food production (land, agricultural practices); import and export; access; affordability; availability; storage; quality; taxation; etc. In addition, special dietary requirements for people with diabetes or hypertension should be covered. Information, education, and communication materials can also be developed and used.

Action: Here are some examples of practical actions that churches can do: offer cooking demonstrations, develop healthy recipes, host friendly competitions, set up farmers' markets, serve healthy foods at all church functions, develop a food pyramid, and create a garden for fruits and vegetables (on the church grounds or at home).

Advocacy: Create advocacy on policy, systems, and environmental bottlenecks affecting the food chain—production, access, affordability, storage, quality, taxation, marketing, fortification, unhealthy foods in schools, sugar and salt content, fizzy drinks, fast foods, etc.

Public witness: Any church member who has influence in any of the advocacy areas and takes action on it.

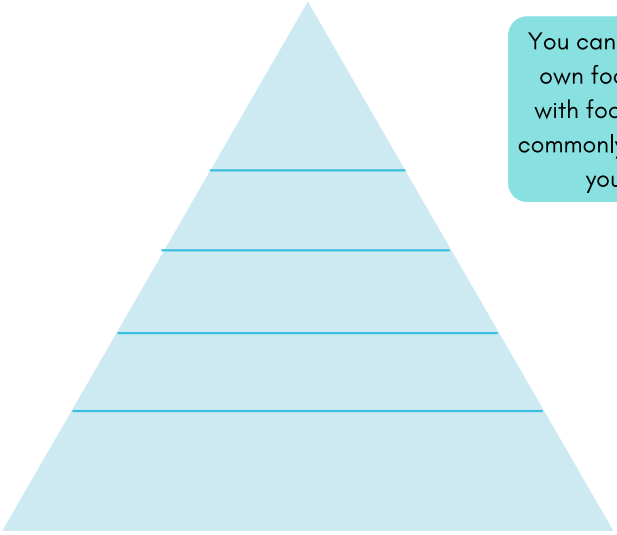
Resources

1. World Council of Churches. Ten Commandments of Food. https://www.oikoumene.org/en/resources/documents/wcc-programmes/diakonia/eaa/ten-commandments-of-food
2. For background information on the development and use of the food pyramid read The Healthy Eating Pyramid. https://www.hsph.harvard.edu/nutritionsource/healthy-eating-pyramid

Standards of success

1. Health talks are offered (disaggregated by participants, resource personnel, topics)
2. A local food pyramid is developed
3. Policy, systems, and environment issues are identified
4. Testimonies or reports on advocacy and/or public witness are shared

My food pyramid



You can create your own food pyramid with foods that are commonly available in your area

CHAPTER 8

Living Actively

This chapter helps the church to develop work plans to promote active lifestyles.

Rationale

There are many biblical and health reasons for exercising. In many places, the Bible uses the imagery of physical exercises, marathons, and other strenuous activities to illustrate spiritual disciplines such as endurance, discipline, hard work, self-control, and holiness (Heb. 12:1; 1 Cor. 9:24–27). The Bible affirms that physical exercise is valuable (1 Tim. 4:8), even though its value is limited compared to godliness. Physical exercise loses its value when it leads to a vain obsession with physical appearance and fails to connect to spiritual realities or confer spiritual benefit.

Active lifestyles, and physical exercise in particular, help us to take care of our bodies and thus honour God, help us with self-discipline (and ward off excesses of gluttony), and help us to fight the vice of laziness. Our imperfect bodies will be resurrected one day, but in the meantime, as good stewards, we endeavour to keep them healthy and ready for anything that God calls us to do. In the toughest moments of an exercise workout, we step beyond what's comfortable to what's necessary; we transcend from effort to grace and declare with Paul, "I can do all things through Christ who strengthens me" (Phil. 4:13).

Regular and adequate physical activities improve the health of the heart, lungs, muscles, bones, and joints; reduce the risk of non-communicable diseases and depression; and promote energy balance and weight control. Leading an active lifestyle requires personal and collective efforts as well as effective and culturally acceptable interventions.

Steps to follow

Planning: The church health committee should now review the situational analysis and prepare a work plan according to their chosen scope of operation. The work plan should allow participants to adapt global or national issues to the local context and create local solutions.

	Key issues for health education	Examples of practical actions	Examples of advocacy issues	Examples of public witness
Veins	• How blood flows in veins; thrombosis and embolism	• Taking a walk hourly from a sedentary position	• Promote occupational health	Within your area of influence, what can you do to promote any of these? e.g., • schoolteachers can promote healthy snacks • university professors can conduct research on physical activities • entrepreneurs can promote healthy foods • media people can introduce programmes on health • various groups can sponsor friendly competitions • politicians can introduce appropriate legislation • groups can create social media tools and messages
Muscles, bones, and joints	• Factors affecting muscle and bone strength, e.g., age, hormones, micronutrients	• Moderate exercises, e.g., cycling, running, aerobics, games, walking, stretching exercises • Strengthening major muscle groups, e.g., squats, pushups • Intensity depends on age group • Walking trails around church premises	• Provide facilities to promote regular exercise • Provide safe, walkable roads • Design buildings to promote (and not discourage) physical exercises, e.g., staircases not hidden away, car park at the back • Availability of screening services for heart and lung conditions • Removal of taxes on equipment and materials that promote active lifestyles	
Heart and lungs	• Heart health • Lung health	• Vigorous exercises, e.g., cycling, swimming, running, rope skipping, aerobics, dancing • Monitoring blood pressure		
Energy balance and weight control	• Daily energy requirements; energy storage • Energy expenditure per activity			
Body building	• Not part of the Health-Promoting Churches programme			

Key issues for health education and examples of practical actions and issues for advocacy and public witness are provided in the table on the previous page. In addition, special requirements for people with limited physical abilities due to age, disability, or illness should be covered.

The intensity, in terms of total number of minutes per week for each activity type, depends on age and physical ability. Those with limited ability should do as much as they can. For example, "chairobics" allows those with limited mobility to do adequate physical exercises while seated on a chair. The example of the 1 km Walking Challenge shows how a programme can be adapted to individual ability.

Resources

1. WHO Global action plan on physical activity 2018–2030: More active people for a healthier world. https://www.who.int/ncds/prevention/physical-activity/global-action-plan-2018-2030/en
2. National Health Service. Physical activity guidelines for children, young people, adults, and older adults. https://www.nhs.uk/live-well/exercise/?tabname=how-much-exercise

Standards of success

1. Physical exercise instructors are identified and trained
2. Regular group exercise routine is established (disaggregated by participants' age, sex/gender, and type of exercise)
3. Policy, systems, and environment issues are identified
4. Reports and personal testimonies of improved physical fitness are given

CHAPTER 9

Avoiding Alcohol Abuse

This chapter helps the church to develop work plans that help members avoid alcohol abuse.

Rationale

Alcohol is an intoxicant that affects several structures and processes in the central nervous system, increases the risk of intentional and unintentional injuries, and has adverse social consequences. Alcohol also has considerable toxic effects on the digestive and cardiovascular systems. Ethanol, the simplest chemical form of alcohol, is now classified as a cancer-causing substance. Alcohol consumption contributes to three million deaths each year globally, and to disabilities and poor health for millions of people. Any alcohol use is associated with some short-term and long-term health risks, and so it is very difficult to define universally applicable population-based thresholds for low-risk drinking. Alcohol is contained in different beverages, such as wine, beer, whiskey, and rum, that are brewed in different ways in different parts of the world, on industrial or local scale.

Alcohol use is recorded in both testaments of the Bible—for treatment (of common ailments like wounds, stomach ulcers, and indigestion), as a mental suppressant given to people receiving capital punishment, and as a beverage for celebrations and merrymaking.

Wine is used in holy communion to symbolize the sacrificial blood of Jesus Christ and the everlasting joy of the kingdom of God.

The Bible, however, also admonishes on the folly and pain of abusing alcohol. Churches therefore should help to address the medical, social, and economic harms of alcohol abuse among church members and in society. Support should be directed to both individuals and families affected by the alcohol abuse.

Effects of alcohol

Steps to follow

Planning: The church health committee should now review the situational analysis and prepare a work plan according to their chosen scope of operation. The work plan should allow participants to adapt global or national issues to the local context and strengthen local solutions.

Education: Health talks should include medical, social, and economic impacts of alcohol; local sources of alcohol (imported or local brews); alcohol content in different brews/beverages; and local laws and policies regulating the production, sale, and consumption of alcohol.

Action: Examples of practical actions that churches can do are counselling, support groups such as Alcoholics Anonymous, and pastoral accompaniment.[1]

Advocacy: Advocacy on policy, systems, and legal issues that promote alcohol consumption and abuse: local brewing, importation, advertising, sponsorships, age restrictions, etc.

Public witness: Any church member who has influence in any of the advocacy areas and takes action on it.

Resources

1. WHO Global Status Report on Alcohol and Health 2018. https://www.who.int/publications/i/item/9789241565639

1. Accompaniment means walking together with someone or with others in solidarity, so their journey becomes our journey also—like the two disciples and Jesus on the road to Emmaus.

Standards of success

1. PSE issues are identified
2. Practical actions are being undertaken in the church
3. Reports and personal testimonies are being shared

CHAPTER 10

Saying "No" to Tobacco

This chapter helps the church to develop work plans to help church members eliminate tobacco consumption.

Rationale

Tobacco and smoking are not mentioned in the Bible. It is estimated that there are over one billion smokers in the world, and that over six trillion cigarettes are smoked annually, besides other methods of consuming tobacco like using snuff, chewing, and dipping.

There are no known benefits of tobacco consumption. On the contrary, tobacco contains hundreds of toxic chemicals which cause addiction and deadly diseases, especially cancers. Over six million people die every year as a result of using tobacco, and almost one million more die from second-hand smoke. Tobacco also poses social, economic, and environmental hazards by displacing food crops on good arable land, making excessive use of chemical fertilizers, driving deforestation, polluting water supplies, using child labour, diverting household financial income, etc. About $730 billion of the $770 billion global tobacco industry in 2017 belonged to only five companies, while farmers and factory workers at the bottom of the supply chain are left in poverty.

Governments rely on the use of authority to control tobacco use by, for example, imposing higher taxes and restricting packaging and

advertising. Churches, however, have different tools. Our bodies are temples of the Holy Spirit and we are called to take good care of them. We are also called to be responsible stewards of the world—the natural environment as well as its socio-economic systems.

Steps to follow

Planning: The church health committee should now review the situational analysis with regard to tobacco and prepare a work plan according to their chosen scope of operation. The work plan should allow participants to adapt global or national issues to the local context and strengthen local solutions.

Education: Health talks should include medical, social, and economic impacts of tobacco; sources of tobacco (imported, manufactured, or local); second-hand smoke; different ways of consuming tobacco (e.g., smoking, sniffing, chewing); local laws and policies regulating the cultivation, processing, sale, and consumption of tobacco; and economic drivers of tobacco.

Action: Examples of practical actions that churches can do are pastoral accompaniment, cessation/quitting counselling, support groups, and a smoking-cessation hotline.

Advocacy: Advocacy on policy, systems, and legal issues that promote tobacco production and consumption, such as land tenure practices; local production; importation; advertising; sponsorships; age restrictions; incentives and support to farmers to transition from tobacco to alternative crops; and legislation and by-laws on smoke-free zones.

Public witness: Any church member who has influence in any of the advocacy areas should be encouraged to take action on it.

Resources

1. Mwai Makoka, "World No Tobacco Day," in *Health-Promoting Churches: Reflections on Health and Healing for Churches on Commemorative World Health Days* (Geneva: WCC Publications, 2020), 27–30. **https://www.oikoumene.org/sites/default/files/2020-10/English-Health-PromotingChurches.pdf**

Standards of success

1. Practical actions are undertaken in the church
2. Personal testimonies of church members quitting tobacco use are shared
3. Policy, systems, and environment advocacy activities are done

CHAPTER 11

Keeping Mentally Fit

Rationale

Mental health is a vital aspect of a person's wellbeing throughout their life: it is the ability to be self-aware, manage one's emotions, and cope with problems. Unlike other diseases, mental disorders do not show the usual symptoms of disease—such as pain, swelling, or fever—but mainly manifest as abnormalities in thoughts, emotions, behaviour, and disturbed relationships with others. Mental disorders affect one in ten people at any given time, and 25% of people globally suffer from mental disorders in their lifetime. Common mental health problems include the following:

- Depression, where affected people show persistent sadness and loss of interest in normal daily activities, affects over 300 million people
- Suicide, which claims about one million people annually, mainly among the youth, is associated with depression, alcohol abuse, and various socio-economic problems
- Dementia, which mostly occurs as people grow old, includes diseases that affect memory, cognitive abilities, and behaviour significantly enough to interfere with the ability of the affected people to maintain normal daily lives

Global mental health context

Before COVID-19 emerged, statistics on mental health conditions (including neurological and substance use disorders, suicide risk and associated psychosocial and intellectual disabilities) were already stark.

- The global economy loses more than US$ 1 trillion per year due to depression and anxiety.
- Depression affects 264 million people in the world.
- Around half of all mental health conditions start by age 14, and suicide is the second leading cause of death in young people aged 15–29.
- More than 1 in 5 people living in settings affected by conflict have a mental health conditions.
- People with severe mental health conditions die 10–20 years earlier than the general population.
- Fewer than half of countries report having their mental health policies aligned with human rights conventions.
- In low-and middle-income countries, between 76% and 85% of people with mental health conditions receive no treatment for their condition, despite the evidence that effective interventions can be delivered in any resource context.
- Globally there is less than 1 mental health professional for every 10,000 people.
- Human rights violations against people with severe mental health conditions are widespread in all countries of the world.

Source: United Nations Policy Brief: COVID-19 and the need for action on mental health, 13 May 2020, p5

- Mood disorders, which are serious changes in mood that disrupt life activities, include depressive, manic, and bipolar disorders
- Neurological disorders, including epilepsy, chronic headaches, Parkinson's disease, complications of stroke, and other diseases.

While overt mental illnesses are easily recognizable, most mental disorders are more subtle and are therefore largely misunderstood and overshadowed by stigma, misconceptions, prejudice, and superstition. The good news is that most mental disorders are preventable and treatable, or otherwise manageable to promote quality of life of the affected persons and their families.

Churches have a great role to play in promoting mental health—first among church members and then in the community. Indeed, research shows that religious faith is associated with greater hope, increased sense of meaning in life, higher self-esteem, optimism and life satisfaction, lower rates of suicide, lower rates of drug and alcohol abuse, and reduced delinquency.[1] Churches are called upon to shine the light of the gospel of hope and peace on the darkness of shame, fear, misunderstanding, stigma, criminalization, and superstition that surround mental illnesses. Churches must make deliberate efforts to embrace a gospel that heals and not one that hurts people.

Steps to follow

Planning: The church health committee (CHC) should conduct a baseline community mental health assessment. **Appendix 7** proposes a simple tool that assesses church members' perception of mental health challenges, causes of mental health issues, and services that may be

1. S. Dein, "Against the Stream: Religion and Mental Health—The Case for the Inclusion of Religion and Spirituality into Psychiatric Care," *BJPsych Bulletin* 42: 3 (2018), 127–29. doi:10.1192/bjb.2017.13.

available. The CHC should integrate mental health issues in the plan of activities for the Health-Promoting Churches programme (HPC).

Education: The goal of this education is to help the church to have mental health literacy, which means basic knowledge and appropriate beliefs to help in the prevention, recognition, and management of mental disorders. The HPC should do the following:

1. Know how to maintain and promote good mental health
2. Have a basic understanding of mental disorders and their treatments
3. Eliminate the stigma around mental illness
4. Have attitudes that promote effective help-seeking for mental health challenges among their congregations
5. Have key attributes of mental health literacy.

The CHC should draw on mental health professionals in the congregation or surrounding community to lead the planned health talks. In addition, the CHC should tap into the power of testimonies of church members who have experiences with mental health and are willing to share their experiences to promote understanding. Above all, the attitude and perception of pastors and church leaders on mental health will determine the success of these efforts.

Action: The beauty of mental health is that many activities that help in other aspects of life also promote mental health: for instance, regular physical exercise, eating a balanced diet, having a regular sleep pattern, and abstaining from drug and alcohol use. The CHC should therefore realize that the other areas in the HPC also contribute to mental health.

Other possible actions are establishing a team of mental health responders and training them in mental health first aid, counselling, and

support to affected persons and their families and friends. "The patient with an emotional problem is often lonely and isolated, desperately needing to feel a sense of community with others. The congregation has within its very structure the ability to heal his or her isolation."[2]

Advocacy: The church can lend its voice to campaigns to uphold the human rights and dignity of people with mental health challenges: e.g., enact laws that decriminalize suicide attempts; increase budget allocation and access to equitable and quality mental illness prevention, treatment, and care services; and promote training, recruitment, and retention of mental health professionals. Inappropriate handling of mental health crises, especially by the police, should be challenged.

Public witness: Any church member who has had issues with mental disorders and is willing to openly share their story should be encouraged to do so to the whole congregation, youth groups, and men's and women's groups. This helps demystify and subsequently reduce stigma toward those living with mental disorders. It provides a new narrative for the church to embrace everyone in their brokenness, whether they are suffering physically, mentally, or spiritually.

Resources

1. Mwai Makoka, "World Mental Health Day", in *Health-Promoting Churches: Reflections on Health and Healing for Churches on Commemorative World Health Days* (Geneva: WCC Publications, 2020), 38–41. **https://www.oikoumene.org/sites/default/files/2020-10/English-Health-PromotingChurches.pdf**

2. J. Knight. "Introduction," in H.J. Clinebell Jr, *Mental Health Through Christian Community* (Nashville: Abingdon, 1972). **https://www.religion-online.org/book/the-mental-health-ministry-of-the-local-church**.

2. Ecumenical International Youth Day 2020 Toolkit: Young People and Mental Health (Geneva: WCC Publications, 2020). **https://www.oikoumene.org/en/resources/documents/wcc-programmes/youth/iyd-2020-toolkit**
3. Ecumenical International Youth Day commemoration webinar, 12 August 2020. Accessed November 30, 2020. **https://youtu.be/_oBp8ToiGh0**
4. World Health Organization. Mental Health Action Plan 2013–2020 (Geneva: WHO, 2013).
5. Mental Health First Response. **https://www.mhfirstresponse.org**
6. H. J. Clinebell, Jr, *The Mental Health Ministry of the Local Church*. Religion Online. **https://www.religion-online.org/book/the-mental-health-ministry-of-the-local-church**

Standards of success

1. Mental health talks are presented
2. Mental health first responders and a counselling team are established, trained, and active
3. Policy, systems, and environment (PSE) issues are identified and prioritized
4. Advocacy is done on PSE
5. Knowledge of local issues on mental health is pursued

CHAPTER 12

Defeating Tuberculosis

Rationale

Tuberculosis (TB) is among the top ten causes of death worldwide. It can affect all parts of the body, especially the lungs. About one-third of the world's population has latent TB, which means they have been infected with TB bacteria but are not (yet) ill with the disease and cannot transmit it. When a person develops active TB, the symptoms (such as coughing up blood or sputum, fever, night sweats, or weight loss) may be mild for many months. This can lead to delays in seeking care and results in prolonged transmission of the disease to others within the household, neighbourhood, and workplace.

Major risk factors for developing TB are HIV infection, diabetes, malnutrition, alcohol consumption, and tobacco smoking. While malnutrition increases the risk for TB, TB also causes malnutrition. In addition, certain populations have increased vulnerability to TB: e.g., people in crowded living conditions (such as prisons, nursing homes, refugee camps, and slums), homeless people, miners, and those exposed to silica, and healthcare workers caring for patients with TB. Also at high risk are people with weak immune systems, such as those with severe kidney disease, cancer, and organ transplants; children; pregnant women; and the elderly—this is because latent TB can become active.

Overall, poverty is the major underlying factor for TB. An integrated approach is therefore necessary to control the burden of TB and the related causative and risk factors.

TB is curable, but the success of treatment depends on early identification and correct treatment. On the other hand, it is imperative that health services, including national TB programmes, safeguard the continuity of TB services while responding to COVID-19. Stigma and discrimination are major hindrances to effective TB control. Churches are well placed to implement viable community-based activities to enhance early identification and effective treatment of TB, as well as to help to address the various socio-economic risk factors.

Globally, three million TB cases are "missed" out of an estimated ten million new TB cases each year. The Health-Promoting Churches Programme (HPC) could be a cost-effective tool to strengthen TB strategies for active case finding through contact tracing, referral of presumptive TB patients to the nearest health facilities for diagnosis, supporting treatment adherence to prevent drug resistance, and offering community-based care to improve accessibility to TB services. Good nutrition, physical exercise, and abstinence from alcohol and tobacco will contribute to preventing and controlling TB. Similarly, health education, practical action, advocacy, and public witness are effective community-based interventions that can be used not only to prevent TB but also to reduce stigma and discrimination.

Steps to follow

Planning: The church health committee (CHC) should obtain national TB data from the National TB Programme (NTP) and review it to understand the key issues around TB. A situation analysis would provide an update on TB-related issues in their respective area or community and the key challenges and barriers to TB services. Once the

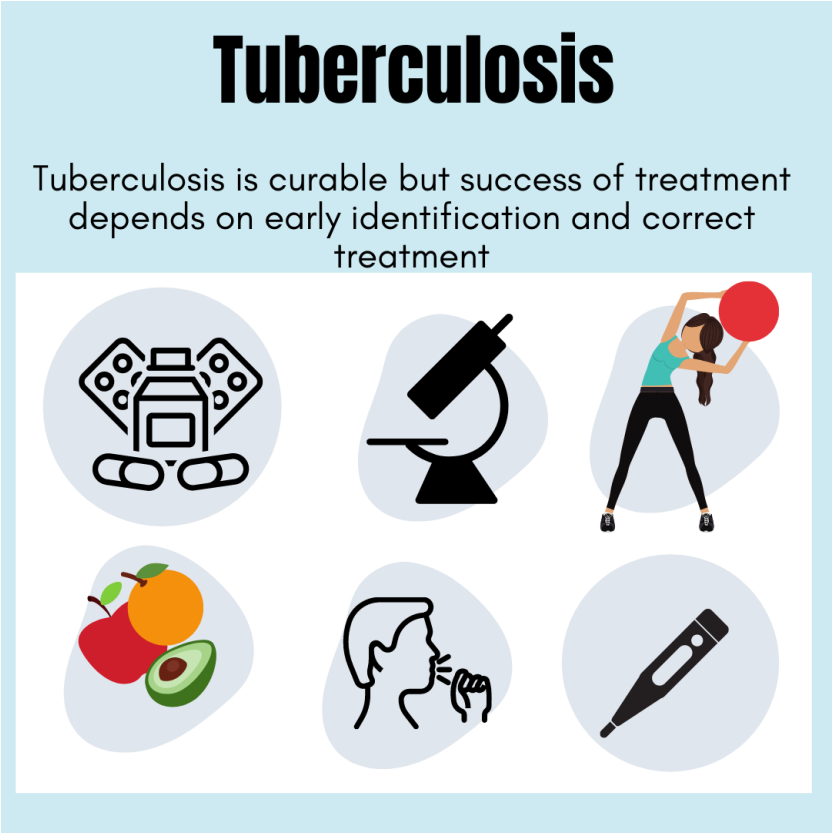
decision has been taken to include TB in the HPC, the CHC should determine the areas for intervention, depending on the identified needs and capacity of the church. Examples of areas of interventions are promoting early diagnosis through contact tracing and the collection and transportation of sputum to the nearest diagnostic centre; treatment adherence support for patients with TB through home-based and community TB care; and assistance in recording and reporting to enhance data quality and reliability.

Education: The following issues should be taught: what causes TB; how TB is transmitted, diagnosed, and treated; types of TB; contact tracing; factors that increase risk for TB; issues of stigma and discrimination; drug resistance; treatment literacy and adherence; etc.

Action: Actions on TB should be taken in consultation with the local health authorities. Examples of practical actions are doing contact tracing in the church and community; referring presumptive cases to health facilities; conducting or facilitating the collection and transport of sputum samples; offering support for treatment adherence; setting up treatment collection points; and establishing socio-economic programmes to support individuals and families affected by TB.

Advocacy: The CHC could use advocacy to sensitize policy makers and stakeholders to address the socio-economic factors that are aggravating the TB situation, including barriers faced by patients and families battling TB. In some countries, governments along with development partners have established health equity funds and/or health insurance coverage to reduce the financial burden of TB on individuals and families. The CHC can support these initiatives. Participation in World TB Day is another way to highlight challenges and successes with TB.

Public witness: The CHC can provide a platform for people cured of TB to publicly proclaim their experience; this would help remove the fears, stigma, and discrimination attached to TB. Church members should also be empowered to join the fight against TB through all other means available to them.



Resources

1. Mwai Makoka, "World Tuberculosis Day," in *Health-Promoting Churches: Reflections on Health and Healing for Churches on Commemorative World Health Days* (Geneva: WCC Publications, 2020), 13–15. **https://www.oikoumene.org/sites/default/files/2020-10/English-Health-PromotingChurches.pdf**
2. World Health Organization, "Tuberculosis (TB): TB comorbidities and risk factors." **https://www.who.int/tb/areas-of-work/treatment/risk-factors/en**

3. Treatment Action Group, "Know Your Rights: Tuberculosis Prevention, Diagnosis, and Treatment Guide" (August 2019), 1–6. **https://www.treatmentactiongroup.org/publication/know-your-rights-tuberculosis-prevention-diagnosis-and-treatment-guide/**

Standards of success

1. A situation analysis on TB is conducted
2. TB interventions are incorporated into the HPC
3. People are reached through community awareness campaigns
4. Referral of suspected TB cases to hospitals for diagnosis and treatment

CHAPTER 13

Monitoring and Evaluation

This chapter helps the church to create, improve, and sustain the church as an effective healing community through evidence-based activities and decision making.

Rationale

Monitoring refers to an organized process of checking and overseeing that activities are undertaken as planned so that the expected results will be achieved. **Evaluation**, on the other hand, is a process of ascertaining that the results have been achieved or are being achieved. Most programme results can only be evident after several months or years, so in the meantime, we rely on monitoring data to check that we are doing the right things in the right way. We use **indicators** (See text box on p. 62) to systematically measure the activities and results.

If the intended results are a destination, then programme activities are the journey and indicators are signposts. Signposts tell us whether we are going in the right direction, at the right speed, etc., and also whether we have arrived at the intended destination. The importance of monitoring and evaluation is highlighted under "Documentation" in chapter 3.

Characteristics of a good indicator

Valid: accurate measure of a behaviour, practice, or task that is the expected output or outcome of the intervention

Reliable: consistently measurable over time in the same way by different observers

Precise: operationally defined in clear terms

Measurable: quantifiable using available tools and methods

Timely: provides a measurement at time intervals that are relevant and appropriate in terms of programme goals and activities

Relevant: linked to the programme or to achieving the programme objectives

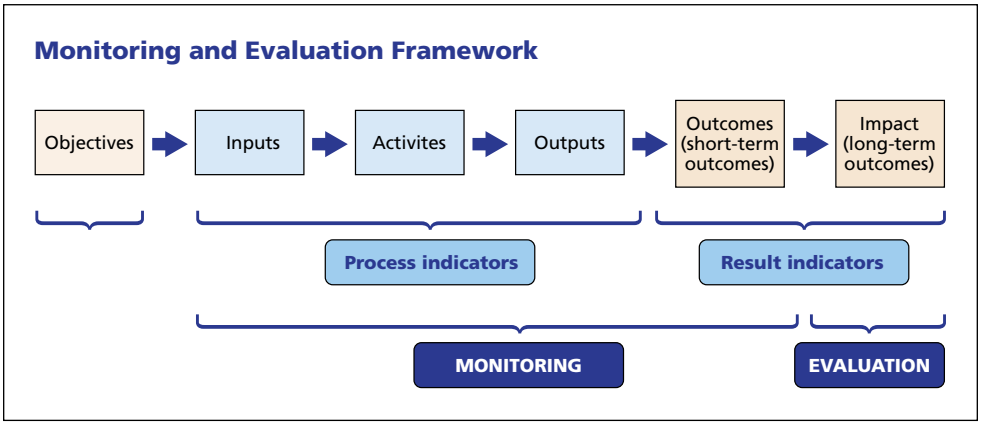
Steps to follow

Selection: Select a set of indicators to track: these should be a mixture of process indicators (input and output indicators) and result indicators (outcome and impact indicators) that fit the criteria outlined in Text box above and the further descriptions in **Appendix 8**.

Definition: Design and agree on an indicator register that details the indicators to be captured, their definitions, who collects, when to collect, and where to record them (**Appendix 9**). Key indicators have been proposed under "Standards of Success" in each chapter.

Schedule: Agree on a schedule for when the church health committee should receive and review quarterly and annual reports, and provide feedback.

Data collection: Design forms to use for data collection and reporting: activity reporting forms to be used for each activity, monthly reporting form, etc. An example of a monthly reporting form is provided in **Appendix 10**.



Resources

1. Description of indicators: **Appendix 8**
2. Sample indicator register: **Appendix 9**
3. Sample monthly reporting form: **Appendix 10**

Standards of success

1. Indicator register is in place
2. Monthly, quarterly, and annual reports are prepared
3. Health-Promoting Churches programme reports are presented and discussed at church governance meetings or assemblies
4. Monitoring data is being used for decision making

CHAPTER 14

COVID-19 and Other Health Issues

Rationale

The Health-Promoting Churches programme (HPC) in general and this handbook in particular do not provide ready answers to all health challenges, nor do they speak to all health issues. As explained in the foreword and in **chapter 2**, this handbook's aim is to illustrate a vision of a dynamic church-based health ministry and provide tools and accompaniment toward that reality. It is expected that as the church becomes more experienced in implementing the interventions proposed in this handbook, it will venture out and begin to address additional and equally important health issues.

However, care must be taken on two fronts:

- First, the church health committee (CHC) must not rush to take on additional health issues too quickly before the programme is well established. This may lead to a disastrous failure, which will make people lose trust in and enthusiasm for the health ministry. The CHC must patiently nurture the programme until it grows before expanding its scope.
- Second, the CHC must maintain a delicate balance between adhering to the tools and procedures proposed in this book and

adopting homegrown solutions. The CHC must exercise some flexibility in reflecting to local contexts the methodologies and tools in this handbook, as indeed it is not meant to be a straitjacket for them to simply fit into. However, as discussed on page 13, a complete departure from the proposed tools and methodologies will make it impossible for different implementing churches to speak the same language.

Any health issue can be addressed with the same approach, from situational analysis to designing interventions (education, practical actions, advocacy, and public witness), developing monitoring and evaluation tools, creating work plans, etc.

Ecumenical Global Health COVID-19 Response Framework (reproduced)

An example of a health issue to which the HPC can contribute in a significant way is COVID-19. A recent resource developed by the WCC and which can be useful is the Ecumenical Global Health COVID-19 Response Framework.[1] The framework identifies core challenges and response strategies for a global ecumenical response to the COVID-19 pandemic, and also recommends specific actions. This tool provides practical, simple guidelines for action through which faith communities can have an impact for their members and beyond in these challenging times. The text is copied here

> The Church emulates the ministry of Jesus by promoting health and healing, finding strength in weakness, modeling servant

1. The drafting team comprised Prof Sujith Chandy, Doug Fountain, Rev. Judith Johnson-Grant, and Dr Mwai Makoka. Download from **https://www.oikoumene.org/resources/publications/ecumenical-global-health-covid-19-response-framework**.

leadership, and witnessing to the power and love of the kingdom of God. Churches—places for physical, social, emotional, and spiritual care—connect people with health workers and faith leaders.

The COVID-19 pandemic has taken so many lives and disrupted the lives of many more. The effects are not only felt in health and healthcare, but also in the capacity of families and communities to survive and thrive amidst mounting economic uncertainty. COVID-19 has furthermore, created new grounds for stigma. This complicates efforts to restore health and human dignity, especially for those being discriminated against. This pandemic highlights the need for the church's prophetic voice and action and its unparalleled potential to demonstrate love and compassion.

Against this background, church, and healthcare leaders from many countries, convened by the World Council of Churches, deliberated, and developed this framework to encapsulate their engagement with the pandemic.

CHALLENGES DUE TO COVID-19 PANDEMIC

Problem	Summary and Local Manifestations	Effect and Impact	Populations Affected	Strategies to Address Issue	Vision
Information "Infodemic"	• Overload of information and misinformation • Information is repeated by social media • Churches and other authorities lack accurate information • Conspiracy theories and misleading interpretation of theology that have an appeal in these desperate times	• Constant messaging overwhelms people, so they may miss information that is vital and relevant • Fake information distracts people from truths • People are reluctant to follow health measures and to take personal responsibility • People take inappropriate medicines and do not get immunized	• Community populations • Leaders of religious and civil society organizations • Populations who are aged, unable to read, see, or hear	• Identify 2–3 highly trusted resource centers that have accurate information • Ensure that accurate information and clear messages are translated, printed, shared, and broadcast in low literacy settings	• People have access to relevant, accurate information
Livelihoods threatened for daily wage laborers and others on the economic margins	• Disruptions to local economies, supply chains, and the food supply, restricting individuals' ability to earn money and procure necessary goods and services • Disruptions to social services, especially those that can't be moved online, e.g., school feeding, vocational skills training	• Hunger, as people cannot access food • Potential for mass demonstration, riots, or displacement • Ill health and inability to access or afford healthcare	• People who lack regular income • People who live hand to mouth • People being laid-off • General population due to reduced government revenue	• Facilitate small-scale economic activity, e.g., production of personal protective equipment and other pandemic supplies • Develop guides and initiatives to help microenterprises and microfinance via the church	• Communities are resilient, independent, and have resources to adequately manage the health of their populations
Shortages in skills and supplies at faith-based health care facilities	• Faith-based facilities handling COVID cases without adequate skills and supplies • Insufficient infection prevention, WASH, supplies, medicines • Poor real-time information hampering planning	• Shortages in supplies • Increased risk and low morale among health workers and staff • Increased anxiety and trauma among healthcare workers	• Populations served by faith-based facilities • Healthcare workers	• Strengthen health sector leadership and advocacy • Assess WASH priorities, especially in facilities that handle COVID patients • Equip health workers to care for others and for themselves	• Faith-based healthcare providers gain visibility as vital to local health systems
Churches not fully engaged	• General population experiencing anxiety and trauma related to COVID, fostering stigma • Pastors and lay leaders not fully engaged in promoting healthy behaviors and struggling with ministering to their congregations.	• Fear and stigma, interfering with healthy behaviors • Confusion about how to care for those affected • Insufficient action to promote health, hygiene, and care-seeking behavior	• Congregations • Leaders of faith-based institutions • Healthcare workers	• Support church leaders to offer mental health, home-based care and other support • Promote ecumenical and interfaith discussions on prevention and care	• Churches and church-based health workers act together within regions to assess and respond to health needs.

INTERVENTION STRATEGIES FOR DIFFERENT STAKEHOLDERS

Problem	Strategies	Local and National Media	National Church Health Networks	Local and National Church Leaders	Country-Level Policy Makers	Global Policy Makers and Donors
Information "Infodemic"	• Identify 2–3 highly trusted resource centers that have accurate information	• Share WHO, CDC info with media houses • Create and share social media messages	• Disseminate links and messages in networks • Flag problem messages and sources to national regulators	• Develop, share, and utilize approved information sources • Share experiences, shaping norms via social media	• National government communications regulators to limit spread of fake news	• Seek WHO guidelines on mass communication • Accredit independent information sources and training programmes
	• Ensure that accurate information and clear messages are translated, printed, shared, and broadcast in low literacy settings	• Produce 3–5-minute messages to share in local languages, using non-verbal cartoons	• Generate and use accurate information • Distribute information to health centers	• Ask leaders to discuss and share correct information • Utilize churches and church structures to disseminate credible information	• Support printing and distribution networks	• Seek global support for low-literacy translations, materials, and productions
Livelihoods threatened for daily wage laborers and others on the economic margins	• Facilitate small-scale economic activity, such as production of personal protective equipment and other pandemic supplies	• Share stories of microenterprises	• Procure and distribute local products	• Invite economic development units to participate	• Support training and sharing of best practices • Offer innovation awards	• Capitalize microenterprise plans
	• Develop guides to help microenterprises and microfinance via the church	• Share stories on faith-based microenterprise and microfinance	• Generate and disseminate stories through networks	• Promote innovation and entrepreneurship • Establish support committees in churches • Promote scaling of successful strategies	• Facilitate and support schemes for microfinancing and microenterprise	• Create cost-share and public-private partnerships
Shortages in skills and supplies at faith-based health facilities	• Strengthen health sector leadership and advocacy	• Highlight role of faith-based healthcare services in case studies of access, quality, and cost effectiveness	• Demonstrate leadership with government and partners • Facilitate pooled procurement • Provide training in advocacy	• Position church health facilities as partners with the public health system	• Plan for needs of the entire health system • Support faith-based providers for training, resources • Engage faith-based organizations in working groups	• Support case studies and learning
	• Assess IPC and WASH requirements, especially in facilities that manage COVID patients	• Share data on needs	• Document and share needs	• Mobilize resources for specific needs	• Plan for the capacity and needs of the entire health system	• Build awareness with case studies
	• Equip health workers to care for others and for themselves	• Support health workers and share encouraging messages	• Train health workers • Celebrate workers	• Ensure chaplaincies exist • Encourage chaplains to serve health workers	• Ensure that health workers have equitable access to information and support	• Support training and self-care initiatives
Churches not fully engaged	• Support church leaders to offer mental health, home-based care, and other support	• Share stories of effective ministry	• Provide technical inputs and support to churches	• Support health education • Integrate health and healing modules in theological seminaries • Introduce psychological first aid training	• Promote and support non-profit healthcare initiatives	• Donors support faith-based organizations
	• Promote ecumenical and interfaith actions on holistic health	• Hold and participate in talk shows	• Work towards developing and implementing a global training module on Christian perspectives on health and healing		• Facilitate and support discussions with FBOs on COVID experiences	• Fund country-level initiatives

There are two positioning statements as part of this framework:

- Firstly, the pandemic requires short- to intermediate-term responses in the next 18 months to protect and preserve lives and livelihoods
- Secondly, the urgent needs create a context for accelerating progress towards longer-term goals for resilience, human sustenance, and development.

Summary of the Response Framework

Our vision is that churches will embrace a holistic approach to health through mechanisms that provide:

- People with relevant, accurate information
- Communities with resources to promote resilience and independence in managing their health
- Church-based healthcare providers with possibilities to assess and respond to health needs in integrated ways
- More visibility to the vital role of church-based health care providers in their local health systems.

With that vision, these tables identify core challenges and response strategies. They recommend specific actions to advocates, practitioners, researchers, and other key stakeholders. These recommendations need to be adapted to local and regional contexts.

"We are called to live Christ's love, showing the world His face. We love because He first loved us. Lived love shows the true face

of Christianity. . . . Our faith becomes alive in action that lives out Christ's love. Therefore, working together for a better world builds God's kingdom of justice, peace and joy in many ways."[2]

2. *Serving a Wounded World in Interreligious Solidarity: A Christian Call to Reflection and Action During COVID-19 and Beyond.* Pontifical Council for Interreligious Dialogue and the World Council of Churches. 2020. Page 17. **https://www.oikoumene.org/resources/publications/serving-a-wounded-world-in-interreligious-solidarity**

Appendices

Appendix 1: Roles and Responsibilities of the church health committee

The church health committee (CHC) is the hub of the Health-Promoting Churches programme (HPC) and is tasked with leading the whole HPC. It should comprise five to ten people representing the full diversity of the church based on gender, ethnicity, age, socio-economic status, skills, etc.

Composition: A well-represented committee with no more than ten individuals with a mixture of skills, abilities, ages, and genders.

Key attributes: Committee members should have skills and abilities to drive, champion, organize, and plan activities. They should be good team players, able to motivate and mobilize fellow Christians, passionate about health issues, and able to accommodate the various gifts (professional and nonprofessional) in the church. The CHC should include a chairperson and a coordinator.

Chairperson: The CHC is led by a chairperson who should be a respected church leader who is able to bring health issues to the agenda of the church. The church may either assign an existing leader (e.g., church elder, member of church council) to serve as chairperson or appoint someone new.

Coordinator: The coordinator provides more hands-on leadership, making sure that various HPC activities and stakeholders are pulling

ROLES AND RESPONSIBILITIES OF THE CHURCH HEALTH COMMITTEE

The Church Health Committee

1. Leads the whole HPC programme. It should represent the full diversity of the church in terms of gender, ethnicity, age, socio-economic status, skills, disability, etc.

2. Passionate about health issues, team players; able to plan and organise activities, motivate and mobilise fellow Christians; accommodate the various gifts in the church, and build partnerships.

3.

Is a Church leader that is able to champion and bring health issue to the agenda of the church.

4.

Provides more hands-on leadership, if some or all programme activities shall be carried out at a sub-unit level, e.g., youth group, women's guild, etc., then each group may have its own coordinator. Young people should be encouraged and mentored to take up such roles.

5. The Church Health Committee leads in programme documentation, monitoring, reporting and evaluation.

in the same direction. In case of a large church where some or all of the programme activities shall be carried out at a sub-unit level (e.g., youth group, women's guild), each group may have its own coordinator, who should then be a member of the CHC. Young people should especially be encouraged and mentored to take up such roles.

Key roles and responsibilities of the church health committee:

1. Conduct the initial health situational analysis of the church (see **chapter 5**)
2. Be oriented in all aspects of the HPC through the tools and resources that accompany this handbook
3. Develop an annual activity work plan and budget
4. Lobby the church leadership to demonstrate its commitment by making an annual budget allocation to the HPC
5. Mobilize additional resources: financial, technical, etc.
6. Establish and maintain relations with external partners, such as government/public health authorities, private sector, NGOs, patient associations, etc. (see **chapter 6**)
7. Understand programme activities and adapt them to the local context (also using tools provided)
8. Document all programme activities, including compiling reports (using provided tools)
9. Provide regular (once or twice a year) reports to church leadership and the whole congregation on the progress of programme implementation, receive feedback, and adjust implementation strategies accordingly

10. Ensure that the programme is evaluated regularly (every one to two years) to ensure that it is reaching the intended goals. The church may establish mutually beneficial relationships with academic institutions (e.g., schools of nursing, medicine, or public health) whereby the school conducts external/independent programme evaluations and the HPC provides an opportunity for learning and academic advancement.

Reporting lines:

Reporting lines depend on the complexity of the denominational governance structures, of which the implementing church is a part. In general, however, the following minimum standard should be followed:

- Monthly report prepared at the church level
- Quarterly report submitted to higher administrative structures, if applicable, e.g., diocesan/synod/connexional health coordinator
- Annual report submitted to the governance structure, e.g., general assembly.

Note: It is good practice to compile the report when it is due, even if it may not yet be submitted or discussed. For instance, if the general assembly takes place once every two years, the annual report should still be prepared annually to ensure that the CHC prepares it while its experiences are still fresh, instead of preparing a report for the past two years.

Appendix 2: Key issues for the orientation of the CHC

The orientation of the CHC should include the following areas:

1. Purpose of the HPC programme: how and why it is relevant to their church
2. Roles and responsibilities of the CHC
3. Overview of the handbook and key issues in each chapter
4. Overview of the national and local health systems
5. Selection of the chairperson and coordinator(s)
6. Documentation, monitoring, reporting, and evaluation

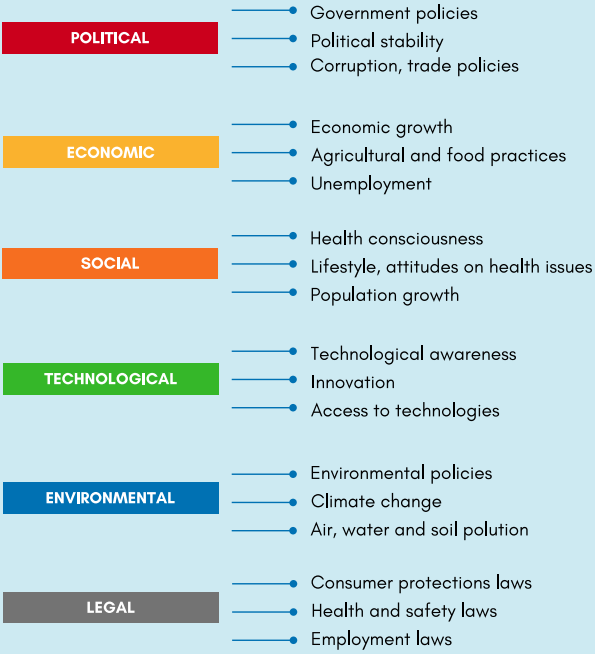
Appendix 3: SWOT analysis

Internal to the church: systems, structures, practices, members	**Strengths** – issues that promote or may be used to promote a health ministry, e.g.: • Physical resources: property and infrastructure (space and equipment to hold health talks, physical exercise classes, etc.) • Financial • Teachings • Practices, gatherings, rituals • Skills available among members (human resources) • Other institutions owned by or affiliated with the church, e.g., schools, hospitals • . . .	**Weaknesses** – issues that may hinder a health ministry or that need to be addressed or overcome for the health ministry to be successful, e.g.: • Teachings and practices that do not promote health • Habits or practices that weaken member engagement, e.g., minimal participation in church activities • Poor access to health services, e.g., medical schemes, health facilities too far away • . . .
External to the church	**Opportunities** – issues outside the church system that may benefit the health ministry, e.g.: • Presence of a strong non-communicable diseases (NCD) programme in the country • Presence of a national action plan on NCDs • Professional and/or patient associations devoted to NCDs, e.g., diabetes associations • Internet penetration/access to smartphones that can facilitate programme implementation • . . .	**Threats** – issues outside the church that may hinder the health ministry and need to be avoided or wisely navigated, e.g.: • Traditional/cultural practices that sustain risks, e.g., dietary habits • Other NCD risk factors are prominent, e.g., air pollution • Limited political space for churches to carry out activities • . . .

Appendix 4: PESTEL

Example of issues to consider to analyse the HPC's external operating environment

A PESTEL analysis is a thorough analysis of the environment in which the programme will be operating, and includes analysis of Political, Economic, Social, Technological, Environmental and Legal. PESTEL differs from SWOT in that SWOT deals with both internal (SW) and external (OT) issues, while PESTEL deals entirely with external factors. It is thus an expansion of the OT.



Appendix 5: Baseline assessment

Mini-STEPS for the Health Promoting Churches

Introduction

This is the generic STEPS Instrument developed by WHO and is used all over the world. It has been simplified by removing several questions so that it is applicable to the HPC. The codes have been maintained so that the results can be compared to the national surveys. The survey can be used at the start of the programme to provide baseline information and then annually to assess impact of the programme.

Survey Information

Location and Date	Response	Code
Cluster/Centre/Village name **(Name of the Church / congregation)**		I2
Interviewer ID **(Name of the Church Health Coordinator)**	⌊_⌊_⌊_	I3
Date of completion of the survey	⌊_⌊_ ⌊_⌊_ ⌊_⌊_⌊_⌊_ dd mm year	I4

Consent, Interview Language and Name	Response	Code
Consent has been read and obtained	Yes 1 No 2 **If No, End**	I5
Interview Language *[Insert Language]*		I6
Family Surname (optional)		I8
First Name (optional)		I9
Additional Information that may be helpful		
Contact phone number where possible		I10

Guide to the columns The table below is a brief guide to each of the columns in the Instrument.

Column	Description	Country Tailoring
Question	Each question is to be read to the participants	
Response	This column lists the available response options which the interviewer will be circling or filling in the text boxes.	
Code	The column is designed to match data from the instrument into the data entry tool, data analysis syntax, data book, and fact sheet.	**This should never be changed or removed. The code is used as a general identifier for the data entry and analysis.**

Step 1 Demographic Information

CORE: Demographic Information		
Question	**Response**	**Code**
Sex (*Record Male / Female as observed)*	Male 1 Female 2	C1
What is your date of birth? *Don't Know 77 77 7777*	⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋⌊_⌋⌊_⌋ dd mm year	C2
How old are you?	Years ⌊_⌋⌊_⌋	C3
In total, how many years have you spent at school and in full-time study (excluding pre-school)?	Years ⌊_⌋⌊_⌋	C4

EXPANDED: Demographic Information		
Which of the following best describes your **main work** status over the past 12 months?	Government employee 1 Non-government 2 Self-employed 3 Non-paid 4 Student 5 Homemaker 6 Retired 7 Unemployed (able to 8 Unemployed (unable 9 Refused 88	C8
How many people older than 18 years, including yourself, live in your household?	Number of people ⌊_⌋⌊_⌋	C9

Step 1 Behavioural Measurements

CORE: Tobacco Use		
Now I am going to ask you some questions about tobacco use.		
Question	**Response**	**Code**
Do you **currently** smoke any **tobacco** products, such as cigarettes, cigars or pipes?	Yes 1 No 2 *If No, go to T12*	T1
Do you currently smoke tobacco products **daily**?	Yes 1 No 2 Don't know 77	T2
During the past 12 months, have you tried to **stop smoking**?	Yes 1 No 2	T6

EXPANDED: Tobacco Use		
Question	**Response**	**Code**
Do you currently use any smokeless tobacco products such as [snuff, chewing tobacco, betel]?	Yes 1 No 2	T12
During the past 30 days, did someone smoke **in your home**?	Yes 1 No 2	T17

CORE: Alcohol Consumption		
The next questions ask about the consumption of alcohol.		
Question	**Response**	**Code**
Have you consumed any alcohol within the **past 12 months**?	Yes 1 No 2	A2

CORE: Alcohol Consumption, continued		
The next questions refer to consumption of homebrewed alcohol, alcohol brought over the border/from another country, any alcohol not intended for drinking or other untaxed alcohol. Please only think about these types of alcohol when answering the next questions.		
Question	**Response**	**Code**
During the **past 7 days**, did you consume any **homebrewed** alcohol; any alcohol **brought over the border/from another country**, any alcohol **not intended for drinking** or other **untaxed** alcohol? *[AMEND ACCORDING TO LOCAL CONTEXT]* *(USE SHOWCARD)*	Yes 1 No 2	A11

CORE: Diet		
The next questions ask about the fruits and vegetables that you usually eat. I have a nutrition card here that shows you some examples of local fruits and vegetables. Each picture represents the size of a serving. As you answer these questions please think of a typical week in the last year.		
Question	**Response**	**Code**
In a typical week, on how many days do you **eat fruit**?	Number of days ⌊_⌋⌊_⌋ *If Zero days, go to D3* Don't Know 77	D1
How many **servings** of fruit do you eat on **one** of those days?	Number of servings ⌊_⌋⌊_⌋ Don't Know 77	D2
In a typical week, on how many days do you **eat vegetables**?	Number of days ⌊_⌋⌊_⌋ *If Zero days, go to D5* Don't Know 77	D3
How many **servings** of vegetables do you eat on one of those days?	Number of servings ⌊_⌋⌊_⌋ Don't know 77	D4

Dietary salt		
With the next questions, we would like to learn more about salt in your diet. Dietary salt includes ordinary table salt, unrefined salt such as sea salt, iodized salt, salty stock cubes and powders, and salty sauces such as soy sauce or fish sauce (see showcard). The following questions are on adding salt to the food right before you eat it, on how food is prepared in your home, on eating processed foods that are high in salt such as *[insert country specific examples]*, and questions on controlling your salt intake. Please answer the questions even if you consider yourself to eat a diet low in salt.		
How often do you **add salt or a salty sauce such as soy sauce** to your food right before you eat it or as you are eating it? *(Select only one)*	Always 1 Often 2 Sometimes 3 Rarely 4 Never 5 Don't know 77	D5
How often is **salt, salty seasoning or a salty sauce added** in cooking or preparing foods in your household?	Always 1 Often 2 Sometimes 3 Rarely 4 Never 5 Don't know 77	D6
How often do you eat **processed food high in salt**? By processed food high in salt, I mean foods that have been altered from their natural state, such as packaged salty snacks, canned salty food including pickles and preserves, salty food prepared at a fast food restaurant, cheese, bacon and processed meat *[add country specific examples].*	Always 1 Often 2 Sometimes 3 Rarely 4 Never 5 Don't know 77 Too much 2 Just the right amount 3 Too little 4	D7

EXPANDED: Diet		
Question	**Response**	**Code**
How important to you is **lowering the salt** in your diet?	Very important 1 Somewhat important 2 Not at all important 3 Don't know 77	D9
Do you think that too much salt or salty sauce in your diet could cause a **health problem**?	Yes 1 No 2 Don't know 77	D10
Do you do any of the following on a regular basis to **control your salt intake**?		
Limit consumption of processed foods	Yes 1 No 2	D11a
Look at the salt or sodium content on food labels	Yes 1 No 2	D11b
Buy low salt/sodium alternatives	Yes 1 No 2	D11c
Use spices other than salt when cooking	Yes 1 No 2	D11d
Avoid eating foods prepared outside of a home	Yes 1 No 2	D11e
Do other things specifically to control your salt intake	Yes 1 *If Yes, go to* No 2	D11f
Other (please specify)	⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌋	D11other

CORE: Physical Activity		
Next I am going to ask you about the time you spend doing different types of physical activity in a typical week. Please answer these questions even if you do not consider yourself to be a physically active person. Think first about the time you spend doing work. Think of work as the things that you have to do such as paid or unpaid work, study/training, household chores, harvesting food/crops, fishing or hunting for food, seeking employment. *[Insert other examples if needed].* In answering the following questions 'vigorous-intensity activities' are activities that require hard physical effort and cause large increases in breathing or heart rate, 'moderate-intensity activities' are activities that require moderate physical effort and cause small increases in breathing or heart rate.		
Question	**Response**	**Code**
Work		
Does your work involve vigorous-intensity activity that causes large increases in breathing or heart rate like *[carrying or lifting heavy loads, digging or construction work]* for at least 10 minutes continuously?	Yes 1 No 2 *If No, go to P 4*	P1
In a typical week, on how many days do you do vigorous-intensity activities as part of your work?	Number of days ⌊_⌋	P2
How much time do you spend doing vigorous-intensity activities at work on a typical day?	Hours : minutes ⌊_⌋⌊_⌋ : ⌊_⌋⌊_⌋ hrs mins	P3 (a-b)
Does your work involve moderate-intensity activity, that causes small increases in breathing or heart rate such as brisk walking *[or carrying light loads]* for at least 10 minutes continuously?	Yes 1 No 2 *If No, go to P 7*	P4
In a typical week, on how many days do you do moderate-intensity activities as part of your work?	Number of days ⌊_⌋	P5
How much time do you spend doing moderate-intensity activities at work on a typical day?	Hours : minutes ⌊_⌋⌊_⌋ : ⌊_⌋⌊_⌋ hrs mins	P6 (a-b)
Travel to and from places		
The next questions exclude the physical activities at work that you have already mentioned. Now I would like to ask you about the usual way you travel to and from places. For example to work, for shopping, to market, to place of worship. *[Insert other examples if needed]*		
Do you walk or use a bicycle *(pedal cycle)* for at least 10 minutes continuously to get to and from places?	Yes 1 No 2 *If No, go to P 10*	P7
In a typical week, on how many days do you walk or bicycle for at least 10 minutes continuously to get to and from places?	Number of days ⌊_⌋	P8
How much time do you spend walking or bicycling for travel on a typical day?	Hours : minutes ⌊_⌋⌊_⌋ : ⌊_⌋⌊_⌋ hrs mins	P9 (a-b)

Recreational activities		
The next questions exclude the work and transport activities that you have already mentioned. Now I would like to ask you about sports, fitness and recreational activities (leisure), *[Insert relevant terms].*		
Do you do any vigorous-intensity sports, fitness or recreational *(leisure)* activities that cause large increases in breathing or heart rate like *[running or football]* for at least 10 minutes continuously?	Yes 1 No 2 *If No, go to P 13*	P10
In a typical week, on how many days do you do vigorous-intensity sports, fitness or recreational *(leisure)* activities?	Number of days ⌊_⌋	P11
How much time do you spend doing vigorous-intensity sports, fitness or recreational activities on a typical day?	Hours : minutes ⌊_⌋⌊_⌋ : ⌊_⌋⌊_⌋ hrs mins	P12 (a-b)
Do you do any moderate-intensity sports, fitness or recreational *(leisure)* activities that cause a small increase in breathing or heart rate such as brisk walking, *[cycling, swimming, volleyball]* for at least 10 minutes	Yes 1 No 2 *If No, go to P16*	P13
In a typical week, on how many days do you do moderate-intensity sports, fitness or recreational *(leisure)* activities?	Number of days ⌊_⌋	P14
How much time do you spend doing moderate-intensity sports, fitness or recreational *(leisure)* activities on a typical day?	Hours : minutes ⌊_⌋⌊_⌋ : ⌊_⌋⌊_⌋ hrs mins	P15 (a-b)

EXPANDED: Physical Activity		
Sedentary behaviour		
The following question is about sitting or reclining at work, at home, getting to and from places, or with friends including time spent sitting at a desk, sitting with friends, traveling in car, bus, train, reading, playing cards or watching television, but do not include time spent sleeping.		
How much time do you usually spend sitting or reclining on a typical day?	Hours : minutes ⌊_⌋⌊_⌋ : ⌊_⌋⌊_⌋ hrs mins	P16 (a-b)

CORE: History of Raised Blood Pressure		
Question	**Response**	**Code**
Have you ever had your blood pressure measured by a doctor or other health worker?	Yes 1 No 2 *If No, go to H6*	H1
Have you ever been told by a doctor or other health worker that you have raised blood pressure or hypertension?	Yes 1 No 2 *If No, go to H6*	H2a
Were you first told in the past 12 months?	Yes 1 No 2	H2b
In the past two weeks, have you taken any drugs (medication) for raised blood pressure prescribed by a doctor or other health worker?	Yes 1 No 2	H3

CORE: History of Diabetes		
Have you ever had your blood sugar measured by a doctor or other health worker?	Yes 1 No 2 *If No, go to H12*	H6
Have you ever been told by a doctor or other health worker that you have raised blood sugar or diabetes?	Yes 1 No 2 *If No, go to H12*	H7a
Were you first told in the past 12 months?	Yes 1 No 2	H7b
In the past two weeks, have you taken any drugs (medication) for diabetes prescribed by a doctor or other health worker?	Yes 1 No 2	H8
Are you currently taking insulin for diabetes prescribed by a doctor or other health worker?	Yes 1 No 2	H9

CORE: History of Raised Total Cholesterol		
Question	**Response**	**Code**
Have you ever had your cholesterol (fat levels in your blood) measured by a doctor or other health worker?	Yes 1 No 2 *If No, go to H17*	H12
Have you ever been told by a doctor or other health worker that you have raised cholesterol?	Yes 1 No 2 *If No, go to H17*	H13a
Were you first told in the past 12 months?	Yes 1 No 2	H13b
In the past two weeks, have you taken any oral treatment (medication) for raised total cholesterol prescribed by a doctor or other health worker?	Yes 1 No 2	H14

CORE: History of Cardiovascular Diseases		
Have you ever had a heart attack or chest pain from heart disease (angina) or a stroke (cerebrovascular accident or incident)?	Yes 1 No 2	H17
Are you currently taking aspirin regularly to prevent or treat heart disease?	Yes 1 No 2	H18

CORE (for women only): Cervical Cancer Screening		
The next question asks about cervical cancer prevention. Screening tests for cervical cancer prevention can be done in different ways, including Visual Inspection with Acetic Acid/vinegar (VIA), pap smear and Human Papillomavirus (HPV) test. VIA is an inspection of the surface of the uterine cervix after acetic acid (or vinegar) has been applied to it. For both pap smear and HPV test, a doctor or nurse uses a swab to wipe from inside your vagina, take a sample and send it to a laboratory. It is even possible that you were given the swab yourself and asked to swab the inside of your vagina. The laboratory checks for abnormal cell changes if a pap smear is done, and for the HP virus if an HPV test is done.		
Have you ever had a screening test for cervical cancer, using any of these methods described above?	Yes 1 No 2 Don't know 77	CX1

Step 2 Physical Measurements

CORE: Blood Pressure		
Question	**Response**	**Code**
Interviewer ID	⌊_⌊_⌊_⌋	M1
Device ID for blood pressure	⌊_⌊_⌋	M2
Cuff size used	Small 1 Medium 2 Large 3	M3
Reading 1	Systolic (mmHg) ⌊_⌊_⌊_⌋	M4a
	Diastolic (mmHg) ⌊_⌊_⌊_⌋	M4b
Reading 2	Systolic (mmHg) ⌊_⌊_⌊_⌋	M5a
	Diastolic (mmHg) ⌊_⌊_⌊_⌋	M5b
Reading 3	Systolic (mmHg) ⌊_⌊_⌊_⌋	M6a
	Diastolic (mmHg) ⌊_⌊_⌊_⌋	M6b
During the past two weeks, have you been treated for raised blood pressure with drugs (medication) prescribed by a doctor or other health worker?	Yes 1 No 2	M7
CORE: Height and Weight		
For women: Are you pregnant?	Yes 1 *If Yes, go to M 16* No 2	M8
Interviewer ID	⌊_⌊_⌊_⌋	M9
Device IDs for height and weight	Height ⌊_⌊_⌋ Weight ⌊_⌊_⌋	M10a M10b
Height	in Centimetres (cm) ⌊_⌊_⌊_⌋.⌊_⌋	M11
Weight *If too large for scale 666.6*	in Kilograms (kg) ⌊_⌊_⌊_⌋.⌊_⌋	M12
CORE: Waist		
Device ID for waist	⌊_⌊_⌋	M13
Waist circumference	in Centimetres (cm) ⌊_⌊_⌊_⌋.⌊_⌋	M14

Step 3 Biochemical Measurements

CORE: Blood Glucose		
Question	**Response**	**Code**
During the past 12 hours have you had anything to eat or drink, other than water?	Yes 1 No 2	B1
Technician ID	⌊_⌋⌊_⌋⌊_⌋	B2
Device ID	⌊_⌋⌊_⌋	B3
Time of day blood specimen taken (24 hour clock)	Hours : minutes ⌊_⌋⌊_⌋ : ⌊_⌋⌊_⌋ (hrs mins)	B4
Fasting blood glucose *[Choose accordingly: MMOL/L or MG/DL]*	mmol/l ⌊_⌋⌊_⌋ . ⌊_⌋ or mg/dl ⌊_⌋⌊_⌋⌊_⌋ . ⌊_⌋	B5
Today, have you taken insulin or other drugs (medication) that have been prescribed by a doctor or other health worker for raised blood glucose?	Yes 1 No 2	B6
CORE: Blood Lipids		
Device ID	⌊_⌋⌊_⌋	B7
Total cholesterol *[Choose accordingly: MMOL/L or MG/DL]*	mmol/l ⌊_⌋⌊_⌋ . ⌊_⌋⌊_⌋ mg/dl ⌊_⌋⌊_⌋⌊_⌋ . ⌊_⌋	B8
During the past two weeks, have you been treated for raised cholesterol with drugs (medication) prescribed by a doctor or other health worker?	Yes 1 No 2	B9
CORE: Urinary sodium and creatinine		
Had you been fasting prior to the urine collection?	Yes 1 No 2	B10
Technician ID	⌊_⌋⌊_⌋⌊_⌋	B11
Device ID	⌊_⌋⌊_⌋	B12
Time of day urine sample taken (24 hour clock)	Hours : minutes ⌊_⌋⌊_⌋ : ⌊_⌋⌊_⌋ (hrs mins)	B13
Urinary sodium	mmol/l ⌊_⌋⌊_⌋⌊_⌋	B14
Urinary creatinine	mmol/l ⌊_⌋⌊_⌋ . ⌊_⌋⌊_⌋	B15

EXPANDED: Triglycerides and HDL Cholesterol		
Question	**Response**	**Code**
Triglycerides *[Choose accordingly: MMOL/L or MG/DL]*	mmol/l ⌊_⌋⌊_⌋ . ⌊_⌋⌊_⌋ or mg/dl ⌊_⌋⌊_⌋⌊_⌋ . ⌊_⌋	B16
HDL Cholesterol *[Choose accordingly: MMOL/L or MG/DL]*	mmol/l ⌊_⌋ . ⌊_⌋⌊_⌋ or mg/dl ⌊_⌋⌊_⌋⌊_⌋ . ⌊_⌋	B17

Appendix 6: Sample Stakeholder Map

A stakeholder map is an analysis of everything that has influence on and interest in the Health-Promoting Churches programme, whether positive or negative. Categorizing influence and interest as either LOW or HIGH puts all stakeholders into four groups. A more detailed approach can use LOW, MEDIUM, and HIGH, which gives nine groups. There are generic strategies that are recommended for each group, as below.

Appendix 7: Mental health assessment for the church community

1. Without necessarily using medical terms, what do you think are the common mental health problems in different age groups in your area?

	Males	Females
Children		
Adolescents		
Youths		
Adults		
The elderly		

2. What do church members believe to be causes of these mental health problems?
3. What does the general community believe to be causes of these mental health problems?
4. Which mental health services are available in your church, in other churches in your area, in the general community, and in your country?

	In our church	In other churches in our area	In the general community	In our country
Awareness and preventive services				
Emergency services				
Treatment services				
Care and support services				
Training				

Appendix 8: Description of Indicators

Indicators

- Indicators are signs of progress—they are used to determine whether the programme or intervention is on its way to achieving its objectives and goal.
- An indicator is a specific, observable, and measurable characteristic that can be used to show the progress a programme is making toward achieving a specific outcome.
- The indicator should be focused, clear, and specific. The change measured by the indicator should represent progress that the programme hopes to make.
- An indicator should be defined in precise, unambiguous terms that describe clearly and exactly what is being measured. Where practical, the indicator should give a relatively good idea of the data required and the population among whom the indicator is measured.
- Indicators do not specify a particular level of achievement: the words "improved," "increased," or "decreased" do not belong in an indicator.

Characteristics of good indicators

See **page 62**.

Process versus result indicators

- **Process indicators** are used to monitor programme processes that are expected to produce desired results; they include input indicators and output indicators.
  - **Input indicators** track the resources and processes that are invested to enable programme activities to take place, e.g., sensitization meeting, materials
  - **Output indicators** illustrate the change related directly to the activities undertaken within the programme, e.g., "percentage of adult church members participating regularly in physical exercise"
  - Outputs may become inputs into a later stage of programme implementation: e.g., establishment of a church health committee may be an output of early consultations, and thereafter it serves as an input into subsequent programme activities
- **Results indicators** are used to evaluate whether the activity has produced the intended results.
  - **Outcome indicators** relate to change that is demonstrated as a result of the programme interventions in the short to medium term, e.g., "number of people referred for non-communicable diseases (NCD) services" (short term), "knowledge of how to prevent diseases" (medium term), "following healthy eating habits" (medium term)
  - **Impact indicators** measure the long-term effect of programme interventions, e.g., "prevalence of NCD risk factors"

How many indicators are enough?

- Have at least one or two indicators per result (ideally from different sources)
- Have at least one indicator for every core activity (e.g., health education sessions on eating well, physical exercise classes)
- Have no more than eight to ten indicators in total per programme area (i.e., for each of healthy eating, living actively, etc.)
- Use a mix of data collection strategies and sources (i.e., self-reporting, direct observation, biomedical measurement, etc.).

Appendix 9: Sample Indicator register

Prog. area	#	Indicator	Definition	Who to collect	When to collect	Where to record	Standard of success
Thinking long term	1		i)				
	2		ii)				
	3		iii)				
Eating well	4	Health education conducted	iv) Health education session conducted during a dedicated time, or v) Health messages conveyed through the sermon	Health coordinator, organizer of the session	Soon after the activity	Activity reporting form	
	5						
	6						
	7						
	8						
	9						
Living actively	10						
	11						
	12						
	13						
	14						
	15						
	16						

Appendix 10: Sample Monthly Reporting Form

HEALTH PROMOTING CHURCHES– MONTHLY/QUARTERLY REPORT FORM

CHURCH/CONGREGATION: _____ REPORT PERIOD MONTH YEAR

1. BLOOD PRESSURE	Participation				Results			
	Age group	M	F	Total		M	F	Total
	< 10				120 – 129/			
Conducted by:	10 – 19				80 – 85			
-	20 – 39				130 – 139/			
-	40 – 59				85 – 89			
	> 60				> 139 / 89			
	Totals				Totals			

2. WEIGHT & HEIGHT	Participation				Results			
	Age group	M	F	Total	BMI	M	F	Total
	< 10				< 25			
Conducted by:	10 – 19				25 – 29			
-	20 – 39				30 – 35			
-	40 – 59				35 – 40			
	> 60				> 40			
	Totals				Totals			

3. AEROBICS	Age group	M	F	Total
Led by:	< 10			
-	10 – 19			
-	20 – 39			
	40 – 59			
	> 60			
	Totals			

4. RUNNING & SPORTS	Age group	M	F	Total
	< 10			
	10 – 19			
	20 – 39			
	40 – 59			
	> 60			
	Totals			

5. TOOLS AND EQUIPMENT			
Weighing scales		Pedometers	
Measuring tapes		Sports equipment	
BP machines			

6. VEGETABLES		
	No. of groups	
	H/holds in groups	a
	Individual h/holds	b
	Total h/holds	a + b

7. PEDOMETERS	M	F	Total
Age group			
20 – 39			
40 – 59			
> 60			
Totals			

8. HEALTH EDUCATION & SUPPORT		
Health talk integrated in sermon		a
Health talk during church service		b
Talk in special session, e.g., evening		c
Totals		a+b+c
Talks done by:	Church leaders	
	H. Coordinator	
	MOH staff	
Support group meetings held:	Alcohol	
	Tobacco	
	Diet	
	Treatment adherence	

Compiled by: _____ day/mon/year

Review by: _____ day/mon/year

Reviewed by: _____ day/mon/year

Appendix 11: Participants to WCC Health-Promoting Churches consultations

1. Pastor Cornelius Atkinson
2. Dr Chiwoza Bandawe*
3. Bishop George E. Battle, Jr
4. Everett Blackmon
5. Dr Diane Bowles
6. Rev. Jordan Boyd
7. Chaplain Harry Burns
8. Rev. Gregory Busby
9. Manwell Bynum
10. Dr Helen Caldwell
11. Dr Lori Carter-Edwards
12. Denise Cathey
13. Dr David Cook
14. Jamar Davis
15. Gwendolyn Devins
16. Dr Barbara Edwards*
17. Thereasea Clark Elder
18. Bishop Wade Ferguson, III
19. Marques Fitch
20. Rev. Dr Sandra Gripper
21. Qiana Hansberry
22. Rev. Gary Harriott
23. Gibbie Harris
24. Albin Hillert
25. Gazzell Howard
26. Prof. Suzanne Jackson

27. Dr Pratap Jayavanth*
28. Rev. Judith Johnson-Grant
29. Dr Renier Koegelenberg*
30. Pastor Evedith Landrau
31. Commissioner Vilma Leake
32. Rev. Filifai'esea Lilo
33. Jodene Louw*
34. 'Eva Mafi
35. Bongani Makhaya
36. Dr Mwai Makoka*
37. Rev. Clifford Matthews
38. Dr Nomonde Mqhayi Mbambo*
39. Janet McConnel
40. Pearl Moroasui
41. Megan Neubauer
42. Anjeline Okola
43. Frank Parker*
44. Vennie Patterson
45. Sarah Phepeng
46. Jeanette Price
47. Pastor Donna Reed*
48. Cheryl Silver-Emanuel
49. Rev. Dr Sheldon Shippman
50. Mitchell Smith
51. Royland Smith
52. Pastor Gerome Stinson
53. Dr James Thomas
54. James Walker

55. Father Maurico West
56. Dr Melicia Whitt-Glover
57. Rev. Dr Ricky Woods
58. Dr Benita Yaw-Alfred
59. Joe Young

* members of the drafting team

"WHO fully supports WCC in this endeavour of promoting health and preventing disease through churches around the world."

Dr Tedros Adhanom Ghebreyesus
Director-General, World Health Organization

"This valuable handbook bears witness to a holistic comprehension of healing and health, providing a forceful tool for churches to join together in order to offer an effective common healing ministry to the world."

Ecumenical Patriarch Bartholomew

"I strongly support this excellent, innovative and highly practical resource that provides a roadmap to enable churches to become effective and transformative healing and health-giving communities, in the realities of the 21st century."

Professor John Wyatt, President, Christian Medical Fellowship, UK; Emeritus Professor of Neonatal Paediatrics, University College London

"Health was central to our Lord's ministry, and the Church's healing ministry comes like balm for our deep wounds. Read it, and be healed by the journey that Dr Makoka asks us to take."

Most Rev. Dr Thabo Makgoba, Archbishop of Cape Town

Mwai Makoka is Programme Executive for Health and Healing at the World Council of Churches. He received medical training from the University of Malawi and post-doctoral training in medical and public health microbiology from the University of North Carolina at Chapel Hill, USA. Besides clinical work, he has worked in academia and in health programmes both in the public sector and in ecumenical circles.

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