

# Health Promotion and African-American Baptist Churches in North Carolina

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The General Baptist State Convention of North Carolina (GBSC) has actively sponsored disease prevention and health promotion services since 1978. The Faith and Health Initiative, sponsored by Kate B. Reynolds Charitable Trust, is the most recent of several area-based health promotion efforts. While the focus of GBSC health initiatives vary, including maternal and child health, smoking cessation, nutrition education, enhancement of parenting skills, and reduction in incidence and control of diabetes, faith-driven values and strategies motivate and direct the development, implementation, and ongoing work of each project.

Project efforts utilize the historic role of the African-American church as initiator, enabler, and sponsor of activities to improve life at the community level. Programs are initiated by discussing specific health concerns with pastors and selected lay leaders and asking them if programs focused on these concerns seem right for their congregations. Potential benefits to participants are considered as well as the role the church will be asked to play in implementation. A long tradition of lay leader participation in setting congregation priorities benefits program implementation. Each church has a structural authority to select priorities independently of central governance structures. A key component of these programs is the selection and training of volunteers who will be responsible for recruiting participants, coordinating church and community resources, facilitating participation, and providing specialized training when appropriate.

The Faith and Health Initiative, a primary and secondary prevention program, was designed to significantly change risk behaviors through encouraging nutritionally sound dietary practices, increasing physical activity and exercise, and utilizing the intersection between faith and health to strengthen and increase project viability and sustainability. Four GBSC Associations (regional subunits of the statewide Convention) serving rural underserved counties in the northeastern part of the state served as the targeted intervention points. Although the geographic area may be characterized as socioeconomically challenged, it is rich in human, cultural, and spiritual resources.

To build on this strong infrastructure, center leadership first enhanced the relationship between the Associations' pastoral faith leaders (called moderators) while seeking a shared vision as the springboard for the project. These leaders were instrumental in assisting the project in identifying 4 project facilitators (1 for each association) to coordinate the project at the regional level.

Facilitators were diverse in demographic background (eg, education, age, sex, and occupation). However, the common denominator was their active involvement with their associations and the way in which they were respected by other parishioners and the community in general.

From the beginning of the project, the faith leaders of the participating associations were engaged. Recognizing the critical role pastors play in supporting project efforts and in translating health teachings in relation to theological understandings, the project continued to actively include pastors in project planning and updates through quarterly meetings of participating churches' pastors. These meetings provided an opportunity to expose pastors to the project curriculum and selected activities, allowing them to better assist in the diffusion of information to parishioners. Also key to parishioner involvement and support, were the lay volunteers and natural helpers recruited for the respect they receive, the guidance they are sought for, and the helping role they play in the lives of fellow parishioners and others in their network.

An essential component of the Faith and Health Initiative and other GBSC projects is the development of partnerships with local human service agencies. These partnerships are critical in the continued support and sustainability of these locally owned projects. The Faith and Health Initiative enjoyed partnerships with both public and private entities. These working relationships not only maximized the resources available to the project and community, but also resulted in some of the relationships between resource staff and project leaders surviving past the formal project funding period.

Positive project outcomes were evident at both the individual and organizational level. Individuals experienced increased knowledge and behavioral modification (eg, increased fruit and vegetable consumption and increased physical activity) and became advocates within their social networks for health promotion policy and environmental changes. At an organizational level, churches and associations made system-level policy and environmental changes including establishment of health committees as ongoing organizational components, changing to healthier menu selections at congregational meal functions, and establishing walking trails on church grounds. The groundwork laid by the Faith and Health Initiative continues to provide fertile soil for addressing health disparities in these communities.

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