'From Places of Despair to Spaces of Hope'

The Local Church and Health Promotion in Victoria

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DECLARATION

This is to certify that:

i. the thesis comprises only my original work towards the PhD

ii. the thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other institution

iii. due acknowledgment has been made in the text to all other materials used

iv. the thesis is less than 100, 000 words in length, exclusive of tables, maps, bibliographies and appendices

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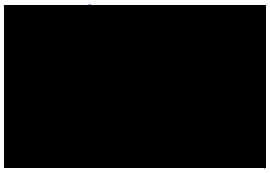

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ABSTRACT

Although the phenomenon of church-based health promotion has received academic and government attention in the US, the cultural, social and religious characteristics of this society differ to those of Australia, and consequently the literature describing this is not generalisable. Churches and church affiliated organisations have worked to address factors, now regarded as social determinants of health, throughout Australia's history, but there has been little research on the role of the church in health promotion in Australia. The aim of the study reported in this dissertation was to investigate the mission and practices of local churches in Victoria to determine whether these align with health promotion principles and approaches. In this dissertation, drawing on conceptual frameworks of health promotion, I explore how churches understand their mission and give expression to it through addressing the social determinants of health. I also consider how and why churches are involved in partnerships and collaborations for health, and the tensions, challenges and limitations to local churches undertaking health promotion activities. Theological discourses related to church mission, biblical interpretation and church expression have also informed my study.

The research was exploratory and used a qualitative research methodology consisting of three phases. Phase one entailed a document mapping exercise of the partnership networks and funding sources of local churches and church affiliated organisations, as well as conducting in-depth interviews with the directors of five church affiliated organisations and five ministers of local churches to identify key themes of church-based health promotion. In phase two, semi-structured telephone interviews were conducted with staff members from 25 local churches in rural and urban Victoria, representing six Christian denominations (Anglican, Baptist, Catholic, Churches of Christ, Uniting, and Salvation Army). Based on findings from these two phases, ten local churches representing five different health promotion approaches

were chosen as case studies for further exploration in phase three. This involved participant observation of church activities and programs, interviews with church staff, focus groups with volunteers, and document analysis.

The study findings, theological underpinnings and conceptual basis of this thesis were used to construct a typology of churches for health promotion action. Six variables associated with church involvement in health promotion were identified: church expression (traditional, new modern or emerging); the minister's understanding of health; church hierarchy; community engagement; partnerships; and church mission (evangelism-focussed versus Kingdom of God focussed). The typology reflects the characteristics of churches operating at different levels of health promotion action, and highlights the health promoting nature of various church activities and programs. Not all churches, however, had an ethos that supports the values of health promotion, nor the structures and systems to implement health promotion activities effectively. In this study, I make a unique contribution to public health by developing a typology to guide health promotion practitioners engaging with local churches, while acknowledging the challenges and barriers to church involvement in health promotion.

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RESEARCH OUTCOMES

JOURNAL ARTICLES

- Ayton, D., Carey, G., Keleher, H., Smith, B. (2012). Historical Overview of Church Involvement in Health and Wellbeing in Australia: Implications for Health Promotion Partnerships. *Australian Journal of Primary Health* 18(1): 4-10.
- Ayton, D., Carey, G., Joss, N., Keleher, H., Smith, B. (2012). Exploring the Partnership Networks of Churches and Church-Affiliated Organisations in Health Promotion. *Australian Journal of Primary Health* 18(2): 148-157.
- Carey, G., and Ayton, D. (2013). Partnerships between Not-for-Profit Organisations and Health Promotion: Exploring Critical Issues Through an Organisational Typology. *Third Sector Review* 19 (1): 27-49

CONFERENCE PRESENTATIONS

- Ayton D. The Local Church and Health Promotion in Victoria. Australian and New Zealand Third Sector Research Conference, Sydney, 15-16 November 2010
- Ayton, D. The Local Church and Health Promotion in Victoria. Public Health Association of Australia Conference, Brisbane, 26 – 28 September 2011
- Ayton, D. A Typology of Churches for Health Promotion Interventions. Population Health Congress, Adelaide, 10-12 September 2012
- Ayton, D., and Carey, G. The Partnership Networks of Church Affiliated Organisations and Local Churches in Victoria: An Exploration of Facilitators, Barriers and Issues of Sustainability. Australian and New Zealand Third Sector Research Conference, Tasmania, 21 - 23 of November, 2012

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ACRONYMS

ACOSS - Australian Council of Social Services

CALD - Culturally and Linguistically Diverse

CAO - Church Affiliated Organisation

CAOS - Community Agents of Sustainability

CBHP - Church Based Health Promotion

CSDH - Commission on Social Determinants of Health

FBO - Faith Based Organisation

LHD - Local Health Department

PBI - Public Benevolent Institution

PCP - Primary Care Partnership

RSL - Returned Service League

SDOH - Social Determinants of Health

UNOH - Urban Neighbours of Hope

VCOSS - Victorian Council of Social Services

VicHealth - The Victorian Health Promotion Foundation

WHO - World Health Organization

A note about citations:

A number of books referenced in this thesis were read electronically via kindle. Kindle provides location numbers (abbreviated to loc) instead of page numbers. When I have quoted from these texts, I have provided the loc number.

TABLE OF PSEUDONYMS

CHURCH NAME	CHURCH EXPRESSION	PRIMARY PARTICIPANT
Tinworth Anglican Church	Emerging	Mitchell
Murcutt Anglican Church	New Modern	Cohen
Luckington Anglican Church	Traditional	Paul
Peverell Anglican Church	New Modern	Henry
Meryton Anglican Church	New Modern	Nigel
Belton Baptist Church	New Modern	Anne
Oakham Mount Baptist Church	Emerging	Michael
Ashridge Baptist Church	Emerging	Andrew
Lincolnshire Baptist Church	New Modern	Harry
Sudbury Baptist Church	New Modern	Benjamin
Grantham Rise Baptist Church	Emerging	Luke
Aurorville Baptist Church	New Modern	Rachel
Edgcote Catholic Church	Traditional	Les
Downton Catholic Parish	Traditional	Charles
Ponden Catholic Church	Traditional	Peter
Haworth Catholic Church	Traditional	Mary
McManus Catholic Church	Traditional	Victor
Perrington Church of Christ	New Modern	Megan
Hangleton Church of Christ	New Modern	Richard
Fortescue Church of Christ	New Modern	James
Regum Church of Christ	Emerging	Ayesha
Sunderland Church of Christ	New Modern	Trevor
Benbow Church of Christ	Emerging	Pamela
Milltown Salvation Army	Emerging	Dale
Wilton Salvation Army	Emerging	Nathan
Burghley Salvation Army	Emerging	Robert
Derby Uniting Church	Emerging	Samuel
Minder Bend Uniting Church	Traditional	Cynthia
Marshland Uniting Church	New Modern	Walter
Longbourn Uniting Church	New Modern	Margaret

CHURCH AFFILIATED AGENCY/ORGANISATION NAME	DENOMINATION AFFILIATION	PRIMARY PARTICIPANT
LutherCare	Uniting	George
Beriah Mission (church affiliated agency)	Uniting	Melissa
KyrieCare	Uniting	Catherine
Ignatius Social Services	Catholic	Emily
EmpowerYouth (church affiliated agency)	Non-denominational	Mark

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IN THE BEGINNING: CIVIL SOCIETY, CHURCHES AND HEALTH PROMOTION

> The hungry man needs bread, and the homeless man needs a roof; the dispossessed need justice and the lonely need fellowship; the undisciplined need order and the slave needs freedom. To allow the hungry man to remain hungry would be blasphemy against God and one's neighbour (Bonhoeffer, 1995, p. 137)

The main building of my church looks like a warehouse. It is two stories high and the walls are made of glass panels to allow passers-by a glimpse at its inner workings. From the road on the ground floor, I can see a playground and kindergarten rooms, a cafe stretching almost the length of the main building, and meeting rooms which circle the perimeter. The upper floor is accessible by either a tiny lift or steep concrete stairs. The long foyer is decorated with posters advertising upcoming events, pictures from a recent youth group activity and flowers from the wedding on the weekend. I enter the large main auditorium through big blue doors, greeted by people on welcoming duty: "Welcome! Here is a newsletter." Clutching my newsletter, I enter the room where masses of padded seats make up a semicircle in front of the black modern stage. The right side wall is made of clear glass, stretching 25 metres in length, providing a view of the busy road below. There is a sound desk in the middle and audio technology room at the back. The cross in the middle of the stage is metallic and almost blends in with the design of the room: it is neither prominent nor confronting. On the left side of the auditorium, the glassed parents and babies room allows parents to listen to and view the service without their infants disrupting other members of the congregation.

I sit on one of the padded seats a few rows down from the sound desk. I flick through the newsletter as people arrive. Someone sits next to me and strikes up a conversation, "How has your week been?" It is already 6pm and the place is not full. However, we young Baptists are notorious for being late. A young man with tousled blond hair gets up on the stage and is joined by backup singers and musicians. "Welcome to church tonight! Let's worship our God!" he yells as they launch into an upbeat, contemporary worship song. The drums roll, the young singers wave their arms and the big screens on either side of the stage project the words for everyone to sing along. During this first song, the congregation numbers swell as people hurry inside: the place fills up rapidly. The seating seems to follow rules of life stratification - high school students sit in the middle, university students and young working people sit to the left, parents sit on the right. At the back of the middle section, there are two rows of elderly people, here to support the young people coming to church. They sit with their fingers in their ears to block out the loud music. They always have an encouraging word to say and are known as the best birthday card writers in the area.

After a number of songs and a few announcements, the preacher takes the stage. He is young, wearing jeans and casual shirt, with a hands-free microphone strapped to his head. He is holding his iPad in one hand. The sermon is filled with illustrations from popular culture, sport and stories about his kids. He finishes the message with three take-home points. The band and singers take to the stage to bring the service home.

♦ ♦ ♦ ♦

This thesis explains why the story above is part of health promotion and why it is important to understand the role of different local level organisations, including churches, in promoting health and wellbeing. I explore if and how church programs and activities, in a variety of denominations and locations in Victoria, align with health promotion values, principles, practices and frameworks. In particular, I examine the extent and types of health promoting activities in various church settings; the influence of church mission and theology; church partnerships with government and secular organisations; and the strengths and challenges of engaging with Christian churches in health promotion efforts. From my findings, I have developed a typology of churches based on key characteristics that support different levels of health promotion action. This typology will be useful in informing health promotion practice, in particular, in engagement with Christian churches in Victoria.

Health promotion has transitioned from a conceptualisation of behavioural and individual determinants to acknowledging the social determinants of health. In seeking to address these social determinants, health promotion efforts need to be directed at social factors such as housing, unemployment, and social support and connection - factors traditionally addressed outside of the health sector.

Health promotion is guided by the World Health Organization (WHO) charters and declarations from Ottawa[1] to the most recent conference in Nairobi.[2] These documents set out the values and principles which underpin the practice of health promotion while setting new agendas to be examined in health promotion efforts. Yet these documents fail to indicate how

[1] The Ottawa Charter for Health Promotion was developed by participants attending the First International Conference for Health Promotion held in Ottawa Canada in 1986. It sets out the guiding principles for health promotion action (WHO, 1986).

[2] The Nairobi Call to Action for Closing the Implementation Gap in Health Promotion was developed by participants of the 7th Global Conference on Health Promotion held in Nairobi, Kenya in 2009 (WHO, 2009).

to operationalise health promotion action in the community (Gregg & O'Hara, 2007). Over the past decades, academics and health promotion practitioners have developed frameworks and models to guide health promotion actions, taking into consideration context and need. Keleher and Murphy (2004, 2007b) developed a continuum of health promotion approaches, beginning with primary care and disease prevention drawing on biomedical science at an individual level (downstream factors), to a population focused socio-ecological approach addressing the determinants of health (upstream factors).

Downstream factors are the proximal determinants of health and include behaviours and individual lifestyle factors such as age, sex, genetic factors, smoking, alcohol consumption, diet and physical activity (Keleher, 2007a; Smith, Orleans, & Jenkins, 2004). Midstream factors are psychosocial factors such as social support, social isolation, self-esteem, and resilience, with actions in this area including strengthening of neighbourhoods and networks, early childhood programs, support for mothers, supportive physical environments which promote physical activity and food access programs (Keleher, 2007a). Upstream factors include material and social structural conditions and include poverty, social exclusion, racism and discrimination, housing and social environments (Keleher, 2007a; Ostlin, Eckermann, Shankar Mishra, Nkowane, & Wallstam, 2007; World Health Organization, 2003). Actions to tackle upstream factors include for example the development of healthy public policy and creating supportive environments through multi-sectoral partnerships (Jackson et al., 2007; World Health Organization, 2003).

Health is hindered or promoted via the complex interweaving of factors across the upstream to downstream continuum. Hence a multipronged process at these different levels and determinants is required for effective health promotion. Five health promotion approaches ranging from downstream to upstream actions can be identified in Table 1.1. These different approaches provide a conceptual framework for my doctoral study.

Table 1.1: Summary of Health Promotion Approaches (ADAPTED FROM KELEHER, 2007B, P. 26)

Approach	Theory	Aims	Methods	Level & Action Type
Primary care/ disease prevention	Biomedical diagnosis, medical treatment, prevention and management of conditions	Improve physiological risk factors (e.g. high blood pressure, early detection, immunisation) and personal behaviours	Takes advantage of a person's point of entry to health system through GP, nurse or allied health consultation screening advice	Individuals expert-led passive client
Health education & behaviour change	Behaviour change theories: reasoned action; health belief and stages of change	Reduce psychosocial and behavioural risk factors (e.g. smoking, poor nutrition, physical inactivity)	Health information one-to-one or group education sessions development of personal skills	Individuals or groups expert-led passive clients
Participatory health education	Participation empowerment	Empowerment of individuals e.g., education and facilitation of healthy choices, provision of social support and development of personal skills	Integrated methods health development one-to-one or group education sessions, social marketing, settings approaches	Individual or groups active clients facilitation
Community action	Community development and community engagement	Action on determinants of health sustainable social change strengthening community capacity empowerment	Intersectoral partnerships and collaborations, community capacity-building, building social capital, community control, policy and organisational change and promoting community advocacy strategies	Intersectoral partnerships and collaborations, community action. community leadership and organisational change
Socio-ecological health promotion	Framework for the social determinants of health, health and social development, primary health care, empowerment and community engagement	Addressing inequities via determinants of health (e.g. social, political, and environmental)	Primary health care, community engagement, creating supportive environments, advocacy strategies, organisational development to reorient health services and build healthy local policy	Active clients and communities, changes in communities and organisations

Health promotion is a process, an activity enabling people to take action. Health promotion therefore is not a practice done on or to people; health promotion values participation and partnership with people and communities (Nutbeam, 1998a). The underlying values of health promotion consequently include equity, respect for human rights, social justice, advocacy, community participation and partnership, multi-sectoral approaches, cooperation, accountability, and capacity building (Keleher, 2007b; World Health Organization, 1986, 1988, 1991, 1997, 2000, 2003, 2005; World Health Organization & Public Health Agency of Canada, 2008; World Health Organization, 2009). Health promotion strives to reduce inequities in health in the spirit of social justice to achieve health for all (The Commission on Social Determinants of Health (CSDH), 2007b). Health promotion therefore is effective when comprehensive approaches to health, with multiple strategies, are undertaken to address health determinants at all levels (World Health Organization, 1997).

THE SOCIAL DETERMINANTS OF HEALTH

In 2005, The Commission on the Social Determinants of Health (CSDH) was established by WHO to assess the evidence of how to promote and achieve health equity globally (Marmot et al., 2008). The key foundations of the work of the CSDH include commitments to health equity, human rights and empowerment. The basis for the social determinants of health (SDOH) is recognising the social and economic conditions which influence health disparities between and within countries (World Health Organization, 2003). The framework for action on the SDOH is conceptualised in three key components: (1) the socio-political context, (2) the structural determinants and socio-economic position, and (3) the intermediary determinants (CSDH, 2007b). I discuss each of these components below.

The socio-political context of the social determinants of health cannot be assessed at the individual level as it comprises the structural, cultural and functional aspects of the social

system which influences the social stratification of populations (CSDH, 2007b). This social stratification within countries can also be conceptualised as the social gradient of health (Marmot et al., 2008; Wilkinson & Marmot, 2003; World Health Organization, 2003). The social gradient of health is based on foundational work by Marmot and colleagues (1991), indicating that those positioned on the lower rungs of the social ladder (incorporating concepts such as employment level (management versus junior staff), socio-economic status and concepts of class) experience poorer health outcomes when compared to those at higher levels of the social ladder (Marmot et al., 1991; Siegrist & Marmot, 2004; World Health Organization, 2003). The socio-political context can be examined by assessing the patterns of governance of society, macroeconomic policy, public policy, cultural and societal values, and epidemiological patterns (CSDH, 2007b).

The structural determinants represent the components of an individuals' socioeconomic position. Key structural determinants and their proxy markers include income, education, occupation, social class, gender and race/ethnicity (CSDH, 2007b). In the CSDH framework, the structural determinants are identified as factors which create or perpetuate the social stratification in society and the factors which define an individual's socioeconomic position (CSDH, 2007b). The structural determinants influence the health opportunities of individuals and social groups, for example, women, migrants, refugees, dependent on their positioning within hierarchies of power, prestige and access to resources (CSDH, 2007b; Denton, Prus & Walters, 2004; Williams, 2003). Combined with the socio-political context, the structural determinants contribute to the social determinants of health inequities as these are the factors that shape social hierarchies, and are the root cause of inequities in health (CSDH, 2007b).

The structural determinants operate via the intermediary determinants which are factors at the individual level, including health-related behaviours and physiological factors. Intermediary determinants of health include material circumstances, psychosocial circumstances,

behavioural and/or biological factors and the health system itself (CSDH, 2007b). An individual's socioeconomic position affects the conditions in which he or she grows, learns, lives, works and ages, his or her vulnerability to ill-health, and the consequences of ill-health (CSDH, 2007a; Graham & Kelly, 2004).

ADDRESSING HEALTH INEQUALITIES AND INEQUITIES

Marmot and colleagues (2010) write in *Fair Society, Healthy Lives - The Marmot Review* that the empowerment of individuals and communities is vital to reduce health inequalities associated with the social determinants of health. Partnerships with civil society organisations in the planning and implementation of health promotion interventions defined as "purposeful action by a human agent to create change" (Matheson, Howden-Chapman, & Dew, 2005, p. 11), allow access to local communities and foster individual and collective empowerment and capacity building (Marmot et al., 2010). While social epidemiology has identified the social causes associated with health disparities, community psychology has highlighted successful implementation factors. In particular community capacity, human agency and the process of change have been identified as key drivers for strategic policies and interventions to reduce health inequalities (Matheson et al., 2005)

Community capacity and related concepts discussed in the health promotion literature (such as community participation, capacity building and development) describe the process by which community resources and characteristics are increased or improved for the benefit of life and health. Labonte (1990) conceptualised community empowerment as a five point continuum consisting of personal empowerment; the development of small mutual groups; development or strengthening of community organisations; development or strengthening of inter-organisational networks; and social and political action (Lavarack & Labonte, 2000; Lavarack & Wallerstein, 2001). This approach illustrates a bottom-up approach to health

promotion which adopts values and principles such as participation, empowerment, capacity building and responding to the needs of the community (Lavarack & Labonte, 2000)

The settings approach to health promotion and partnerships for health promotion are two approaches which build on the notion of community empowerment and capacity. The local church as a setting for health promotion interventions is widely used in the United States of America, best documented among the African American Methodist churches (see Chapter 2). Partnership with churches is also a significant component of international aid and development efforts (Marshall & Keough, 2004). These strategies are important in meeting the health needs of people in all country settings. I discuss settings and partnerships for health promotion below.

THE SETTINGS APPROACH

The settings approach in health promotion, identified in the Jakarta Declaration[3] as offering practical opportunities for health promotion practice includes as possible settings: cities, islands, municipalities, local communities, markets, schools, the workplace, and health care facilities (World Health Organization, 1997). These settings are where people congregate, spend time, interact and are exposed to barriers and enablers to health (Naidoo & Wills, 2000). The importance of the settings approach is typified in the Ottawa Charter which states that "health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (World Health Organization, 1986, p. 3). The involvement of the non-health sectors in the settings approach for health promotion sees a concern for health

[3] The Jakarta Declaration on Leading Health Promotion into the 21st Century outlines health promotion strategies discussed at the 4th International Conference on Health Promotion held in Jakarta, Indonesia in 1997 (WHO, 1997).

built into organisational systems, and ensures that the activities and practices of the sector consider and take health into account (Naidoo & Wills, 2003).

Creating supportive environments through a settings approach in health promotion challenges those inside and outside of the health field to work in partnership to contribute to the health and wellbeing of individuals and communities (Kickbusch, 2003; World Health Organization, 1991). The settings strategy requires an analysis of the setting, considering "who is there; how they think or operate; implicit social norms; hierarchies of power; accountability mechanisms; local moral, political, and organizational culture; physical and psychosocial environment; broader socio-political and economic context" (Poland, Krupa, & McCall, 2009, p. 506).

HEALTH PROMOTION PARTNERSHIPS

The WHO Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005) describes the kind of institutions and structures necessary to meet the commitments to health and to implement the strategies identified for health promotion practice:

> Partnerships, alliances, networks and collaborations provide exciting and rewarding ways of bringing people and organizations together around common goals and joint actions to improve the health of populations (World Health Organization, 2005, p. 6)

A partnership is a voluntary agreement between parties to work together towards shared or compatible objectives which do not jeopardise the principles of either (Keleher, 2007c). To enter into a partnership involves sharing responsibility, resources, risks, decision making, trust and cooperation in the pursuit of the agreed objectives (Keleher, 2007c). The WHO Health Promotion Glossary defines an alliance for health promotion as a partnership between two or more parties in the pursuit of agreed goals in health promotion (Nutbeam, 1998b). To achieve an alliance, discussion between the parties is essential to define goals, ground rules,

joint action areas and the partnership agreement (Nutbeam, 1998b). In essence, an alliance gives rise to a partnership, and the two terms are used interchangeably in the literature.

The Victorian Health Promotion Foundation (VicHealth) developed a partnership continuum incorporating four dimensions: networking, coordinating, cooperating and collaborating (VicHealth, 2001). Networking is seen as the first level in partnerships and is an arrangement of sharing information (Joss & Keleher, 2011; VicHealth, 2001). Coordination builds on networking, in that while there is the exchange of information between parties, activities are altered for a common purpose and there is communication between parties to ensure that the activities of one does not compromise those of the other (Joss & Keleher, 2011; VicHealth, 2001). Cooperation builds on the previous two levels, but also incorporates a greater level of trust, investment of time, and the sharing territory (VicHealth, 2001). The organisational processes and agreements at each of these levels, become more complicated to achieve the desired objectives (VicHealth, 2001).

Collaboration is the highest level on the partnership continuum, and is defined as involving all the characteristics of networking, coordination and cooperation, while also seeking to build the capacity of another party for mutual benefit and for a common purpose (VicHealth, 2001). Carnwall and Carson (2003, p.8) view partnership and collaboration as distinct with partnership being about "who we are" which relates to identity, while collaboration is about "what we do" and is associated with practice (see also Joss and Keleher, 2011).

Another key concept in the health promotion literature, particularly in relation to settings based health promotion and partnerships as a strategy, is the intersectoral or multisectoral approach to health promotion. In the Jakarta Declaration, "settings for health" are described as the infrastructural base required for health promotion, which require the development of

intersectoral collaborations to meet health challenges (World Health Organization, 1997). WHO defines intersectoral collaboration as:

> A recognised relationship between part or parts of different sectors of society which have been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone (Nutbeam, 1998b, p. 15).

The different sectors of society have been identified as the public sector, civil society and the private sector (Nutbeam, 1998b). Health promotion sees an intersectoral approach as vital for the "achievement of greater equity in health" (Nutbeam, 1998b, p. 15), which is one of the underlying values of health promotion. Intersectoralism requires two or more sectors to join their work through collaboration, cooperation, coordination and networking (Keleher, MacDougall, & Murphy, 2007).

Marmot, in his recent review on health inequalities in the United Kingdom, touted partnerships with civil society organisations as vital in the implementation of interventions to redress health inequities (Marmot et al., 2010). The not-for-profit sector, the third sector and civil society terms used synonymously to refer to voluntary and community organisations that sit outside government and the sphere of private business. These comprise of (but are not limited to) welfare organisations, sporting clubs, community groups, advocacy networks and religious bodies (Lyons, 2001). The Christian church is part of civil society. All civil society organisations emphasise social objectives with a commitment to social change, citizen responsibility, advocacy and community development (Crampton, Dowell & Woodward, 2006; Lyons, 2001). These organisations have a history of working in and with communities. The work of Christian welfare organisations in welfare, advocacy and health, referred to in

this thesis as church affiliated organisations, is widely acknowledged in Australia. However, the activities undertaken by local churches in the community that may be oriented to health have received little attention in Australia.

Churches have been investigated as a potential civil society partner for health promotion due to their work with and in communities (Marmot, 2010; Sutherland, 1995; Trinitapoli, Ellison & Boardman 2009). In Australia, the Christian church has contributed to the welfare of persons in need since colonisation, with church denominations and local churches founding the main welfare organisations that have operated in Australia (for example UnitingCare, Anglicare, Mission Australia, The Brotherhood of St Laurence and The St Vincent's de Paul Society) (Ayton, Carey, Keleher, & Smith, 2012; Cleary, 2002; Dickey, 1980; Swain, 2005; Thame, 1974). Christian welfare organisations were established to provide housing, deliver employment services, coordinate emergency relief programs and community meals, supply clothing and material necessities, and conduct social support groups for vulnerable and disadvantaged individuals and families (Ayton et al., 2012; Cleary, 2002; Smyth, 2003). As illustrated by the introductory quote from Dietrich Bonhoeffer, a German Lutheran pastor and theologian, seeing to the needs of neighbours is core teaching in the Christian faith. While this work may not be viewed as health promotion, working in the framework of the social determinants of health has brought these key areas into the health promotion sphere.

CHRISTIANITY IN AUSTRALIA

Australian Census data indicate that Christianity is the largest religion in Australia with 61% of people identifying as Christian (Australian Bureau of Statistics (ABS). 2012). The characteristics of the church in Australia can be further investigated through the National Church Life Survey. The National Church Life survey was developed by ANGLICARE (Diocese of Sydney), the Uniting Church in Australia NSW Board of Mission and the

Australian Catholic Bishops Conference. The survey, conducted four times to date: 1991, 1996, 2001 and 2006, has investigated church characteristics including congregation members, church leaders and church activities. The 2001 survey, which involved over 435,000 church attendees from more than 7000 congregations across Australia, found that of the denomination of weekly church attendees, half are Catholic (50.2%), followed by Anglican (12%), Uniting Church (8%), Baptist (7%) and Assemblies of God (7%) (Bellamy & Castle, 2004). Although the Catholic Church accounts for the largest proportion of church attendees, this number is declining, as are the numbers among mainstream Anglican and Protestant denominations, such as Lutheran, Presbyterian and Uniting (Bellamy & Castle, 2004). While there have been increases in membership and strong growth in many of the smaller Protestant and Presbyterian denominations, these increases have not been sufficient to counter the large decreases in Catholic attendance, resulting in an overall decrease in church attendance from 9.9% of the Australian population in 1996 to 8.8% of the population in 2001 (Bellamy & Castle, 2004).

The age group, gender and socio-economic status of church populations varies depending on location and denomination and may provide opportunities to access populations that are not otherwise reached through other channels such as work-place based health promotion strategies. Church attendees, when compared to non-church attendees, are more likely to be women and retirees (Maddox, 1999).

CHURCH AFFILIATED ORGANISATIONS

As mentioned earlier, the majority of large welfare organisations in Australia stemmed from Christian groups, with the first welfare organisation established following colonisation being founded by an Anglican church (Lyons, 1993-1994). However by the late 18th century, all churches already established had taken up the role of social welfare provision and pastoral

care in different ways. This provides the foundations for contemporary church engagement in health promotion. Of these, one of the most visible has been the Australian Catholic Church which has provided professional social services for over 150 years, predominantly through the St Vincent's de Paul Society (McMahon, 2001). In 1886, Reverend Charles Strong, founder of an institution called the 'Australian Church,'[4] established the Australian Church Social Improvement Society which served the 'indigent' (i.e. poor) people of Collingwood and Richmond in Melbourne. Strong and his wife set up Melbourne's first crèche in Collingwood, and this was recognised as fostering wellbeing through advancements in health and hygiene (Hyslop, 1980). Strong also advocated for reforms such as free kindergartens, juvenile courts, and the maternity stipend (Hyslop, 1980). This is just one example of the work of an early church affiliated organisation in Australia. Church affiliated organisations have since played substantial roles in welfare provision and are an integral part of civil society.

These organisations are described variously as not-for-profit organisations (Lyons, 1993-1994), welfare organisations, religious social service organisations, or faith based organisations; the latter is the common term used in the US literature (DeHaven, Hunter and Wilder et al, 2004). Smith and Sosin use the term "faith-related agencies", based on the following definition by Chaves (1994 as quoted by Smith & Sosin, 2001, p. 652):

> Faith-related agencies may be defined as social service organizations that have any of the following: a formal funding or administrative arrangement with a religious authority or authorities; a historical tie of this kind; a specific commitment to act within the dictates of a particular established faith; or a commitment to work together

[4] The Australian Church was disbanded in 1957.

> that stems from a common religion. These agencies have some link to religion at the institutional level, either directly or because some individuals act on the basis of their relation to a religious institution, not simply on the basis of their personal belief system.

Bretherton (2010) believes the use of the word "faith" in "faith-based organisations" or "faith communities" is problematic. He argues that firstly it suggests a "Christianisation" of other religious groups as it is a common term in Christian discourse. Secondly it promotes a homogenisation of disparate and distinct groups, for example Sikhs are aligned with Muslims and finally the term "faith" resonates with private and personal practices as opposed to public and institutional organisations (Bretherton, 2010).

I have chosen to refer to these organisations as church affiliated organisations as they are either associated with or have roots in the Christian faith. These organisations were established by a church congregation or denominational group and for the most part they maintain links with these local churches. In the multicultural context of Australia, I have used this term to distinguish these organisations from those associated with other religious groups.

Faith based organisations in the US differ in size, social organisation, culture, resources, links to church congregations, denominational influences, authority and advocacy efforts (Smith & Sosin, 2001). A similar pattern of diversity can be seen in the Australian context. In my study, I have chosen six Christian denominations which represent diverse mission and practices of Christianity in Australia. Below I outline the organisational structures of the denominations and the relationships between the local church congregations and their church affiliated organisations.

The Anglican Church

The leadership of local Anglican churches (also termed parishes) is undertaken by the Parish Council (also referred to as the Vestry). The priest (rector or vicar) of the parish is usually the chairperson of the parish council with the other representatives elected from members of the parish. The parish council is responsible for local decision making regarding parish budgets, buildings maintenance, pastoral care, church programs and activities (ministries and outreach), and overseas work. Nationally, the parishes are organised into 23 dioceses which are grouped into five provinces or regions. Each diocese is led by a diocesan bishop who is responsible for chairing a synod (meeting) with clergy and laity (non-clergy members) representation. The bishop ordains and licences ministers, doctrine and worship. Every three years a General Synod is held with representatives from all 23 dioceses. These representatives include three groups: the 23 diocesan bishops; the clergy; and the laity (elected representatives of the dioceses). There are three types of Anglican organisations in Australia: 1) organisations established and managed by the General Synod such as the Anglican Board of Missions and the National Home Mission Fund, 2) Theological Colleges and 3) other welfare-based Anglican organisations including Anglicare, Brotherhood of St Laurence and the Bush Church Aid Society. These organisations are independent and not accountable to the General Synod, however representatives of these organisations are found within most dioceses in Australia (Anglican Church of Australia., 2012).

Anglicare and the Brotherhood of St Laurence are prominent church affiliated organisations. Anglicare provides a variety of community services including for example residential and community aged care, foster care, family violence programs, employment services, alcohol and drug programs, assistance for refugees and migrants and social research and advocacy (Anglicare, 2013). The Brotherhood of St Laurence is a Melbourne based organisation. The vision of the organisation is to see an Australia free of poverty with services focused on

people at risk at four transitional life stages: children and families, young people, adults seeking work and training opportunities and older people experiencing challenges associated with retirement and ageing (Brotherhood of St Laurence, 2011).

The Baptist Church

The national body of the Baptist Church of Australia is Australian Baptist Ministries. Each of the State and Territory Unions and local churches work together to develop and support the work of the Baptist Church in Australia. This work is governed by the National Council, consisting of representatives from each State and Territory Union and associated ministries and governed by the National Director. Baptist organisations overseen by the Australian Baptist Ministries include affiliated organisations such as Baptist Care Australia, which operate under their own boards, directors and staff, and delegated organisations that are supported by task forces and report to the National Council (Australian Baptist Ministries., 2009).

The Australian Baptist Ministries and the State and Territory Unions are responsible for key policy, organisational and administrative functions. The Unions provide encouragement, accountability and administrative support for the local Baptist churches. However, the local Baptist congregations are autonomous and responsible for setting the vision, budget, programs, activities and decision-making processes for the local church (Australian Baptist Ministries., 2009). The pastor of a Baptist church is appointed to lead the congregation in worship, administer the sacraments, and oversee the work of the church which is discerned and decided on by congregation members in church meetings (Baptist Union of Victoria., 2012).

Baptcare is the church affiliated organisation of the Baptist Church in Victoria and is a member organisation of Baptist Care Australia. Baptcare is involved in providing aged care

services and facilities, family services and disability support groups. Individuals from the Baptist churches can volunteer in these services. Additionally Baptcare coordinates community projects such as affordable housing, supported accommodation for asylum seekers, and nursing care to people experiencing homelessness. Local Baptist churches are supported by Baptcare in community engagement efforts, which include the provision of information, resources and consultation services for local churches to undertake community development work and social enterprise planning, provision of funding through community engagement grants, leadership on issues of social justice and advocacy through seminars, conferences and networking, and ongoing support through formal congregation partnerships (Baptcare, 2012).

The Catholic Church

The Catholic Church of Australia comprises of 33 dioceses, 28 representing defined territory areas, four representing Catholics belonging to the Chaldean, Maronite, Melkite and Ukrainian rites, and one diocese for those serving in the Australian Defence Forces. Each diocese is governed by a bishop who is responsible for the legislative, executive and judicial powers of the churches, including oversight of church teaching, worship and activities. The dioceses comprise of parishes led by a parish priest who is appointed by and accountable to the diocese bishop. The bishops of the dioceses meet at least annually as the Australian Catholic Bishops Conference, defined as "a permanent institution," is the assembly of the bishops of a country or a particular territory, exercising together certain pastoral offices for Christ's faithful of their territory. By forms and means of the apostolate suited to the circumstances of the time and place, it is to promote, in accordance with the law, that greater good which the Church offers to humankind (Catholic Church in Australia, 2012).

The Australian Catholic Bishops Conference has established a number of agencies including the Australian Catholic Migrant and Refugee Office, Caritas Australia, and the Disability Projects Office, and has formal relationships with organisations such as Catholic Health Australia, Catholic Mission and Young Christian Workers. The Australian Catholic Bishops Conference cooperates with organisations such as the Prison Chaplains National Network and the United Nations Economic and Social Council (Catholic Church in Australia., 2012).

The key Catholic church affiliated organisations, in particular, Jesuit Social Services and the St Vincent's de Paul Society, are not associated with the Catholic dioceses of Australia and are independent, autonomous organisations. However individuals from Catholic churches may volunteer in the activities of the organisations. In particular, St Vincent's de Paul draws on a number of volunteers, both from within the Catholic Church and wider community to run its services (McMahon, 2001).

Churches of Christ

Unlike the Catholic and Anglican denominations discussed above, the welfare and community mission and engagement activities of the Churches of Christ originate and are operationalised by the local churches either through 'CareWorks' projects or through the establishment of separate agencies. The Australian Churches of Christ denomination is governed by the Council of Churches of Christ in Australia which comprises of the State Conferences. The term 'conference' is used in reference to the "conferencing together and joining together" (Boutros & Reid, 2012) of local churches and indicates congregational interdependence. Local churches work closely with their State Conferences, but decisions regarding the work of the church are made at the local church level. Diversity in the practice of church is encouraged.

As with the Baptist Union, the State Conferences provide guidance and support for local churches including church health assessments, risk management procedures and policies, staff professional development and mentoring. Additionally the conference provides partnership opportunities for local churches with Community Care, the not-for-profit, public benevolence arm of Churches of Christ, for community mission and engagement programs (Churches of Christ Victoria Tasmania, 2012).

Local church projects and programs that meet the eligibility criteria of a public benevolent activity can partner with Community Care in a CareWorks project and therefore are able to utilise the public benevolent institute (PBI) status of Community Care. Through CareWorks, Community Care aims to create local, diverse and caring communities:

> CareWorks seeks to serve local communities by working in partnership with churches to develop, utilise resources and operate community-based welfare projects, for the direct relief of poverty, suffering, distress, misfortune, disability or helplessness in the community. CareWorks is committed to faith in action, based on the faith community [local church or Christian Group] intentionally being involved in their geographical community, inclusive of all regardless of the recipients or participants' religious beliefs. CareWorks is committed to assisting churches for effective ministry to the poor and marginalised providing direct relief but also facilitating empowerment and community development in the process (Churches of Christ Community Care, 2012, para 1 and 2).

The Salvation Army

The Salvation Army in Australia is divided into two Territories - Eastern Territory and the Southern Territory. Each Territory has a Territory Commander who reports to the International Headquarters. The Territories oversee the Divisions, which are similar to the

dioceses of the Anglican and Catholic denominations. Each Division is governed by a commander and comprises of corps (pronounced "core"), which are the local churches, and community service centres. Within the corps, the congregation members are termed soldiers; the ordained minister is termed an officer and can progress up the ranks to be a captain (The Salvation Army, 2012). The Captains report to the territory commissioners, and therefore any plans for new initiatives need to be officially proposed to and signed off by the commissioner.

Through community service centres, the Salvation Army coordinates and manages a number of welfare and social services including crisis accommodation, youth support, recovery services, emergency services, employment services, chaplaincies, rural and outback support, court and prison services, defence force services, a family tracing service, either face-to-face or telephone counselling (financial, professional and personal), aged care services and pastoral care visits, suicide prevention and bereavement support and English speaking classes (The Salvation Army Australia, 2012).

The Salvation Army in Victoria has a number of models for engaging in congregation work and community work. In some instances, a corp is separate from the community services arm, whereas in other circumstances, the corp and the community service centre are one and the same. The alternate situation is where the corp is separate, yet individuals from the corp volunteer or coordinate a community services program.

The Uniting Church

The Uniting Church is a denomination specific to Australia and is the union of three denominations: the Congregational Union of Australia, the Methodist Church of Australasia and the Presybyterian Church of Australia. The Assembly is the national council and governing body with responsibilities for the worship, doctrine, government, discipline and

national policies of the Uniting Church. The Assembly oversees justice and advocacy ministries (UnitingJustice, UnitingWorld, UnitingCare and Frontier Services) as well as other ministries and teaching services (Multicultural and Cross Cultural Ministries, Uniting Aboriginal and Islander Christian Congress). There are six synods in Australia for different States and Territories, responsible for supporting and resourcing the local churches in such areas as community engagement, mission planning and church practice. These synods report to the National Assembly. Presbyteries are a council of ministers and deacons of regional Uniting churches. The main responsibilities of the presbyteries include the settlement of ministers, establishment, merging and disbanding of congregations, mission strategy, and support of congregational life (Uniting Church in Australia, 2012).

UnitingCare is the largest non-government provider of community services in Australia, consisting of institutions, agencies and parish missions. UnitingCare consists of agencies such as Hotham Mission and Wesley Mission, which exist separate to a local church or presbytery. These agencies, however, receive support and volunteers from a number of local church congregations, including congregations of other denominations (UnitingCare Australia, 2009).

I have described the organisational structures of the six denominations included in this study to highlight the diversity in practice and hierarchy of the denominations. As I discuss later in this thesis, the denominational structures and hierarchy influences if and how local church congregations engage in activities considered health promoting. As indicated above, all of the denominations have major church affiliated organisations that provide social and other care to the community. The primary focus of this thesis, however, is what is occurring at the local church level. The above summary of denominations provides an indication of the structural organisation of the denomination and how local churches are positioned and relate to church affiliated organisations. The findings and discussions that I present in this thesis relate to the

work of local churches unless otherwise specified. Below I present a summary of each of my chapters.

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THESIS STRUCTURE

In this thesis, I explore the role of local churches in health promotion in Victoria. The research findings in conjunction with health promotion frameworks and theory have informed the development of a typology of Christian churches by health promotion approach. This typology is presented in the final chapter of this thesis with the complexities of each variable discussed in the preceding results chapters.

In chapter one I provided an introduction to the significance, scope and setting of the research topic with an overview of health promotion concepts and frameworks. In chapter two I review and critique the relevant literature for church based health promotion. In chapter three I present the theological underpinnings that have informed the analysis of my findings. In chapter four I state the research questions and describe the research methods employed in this study. In chapters five to ten I present findings concerning the dimensions of health promoting work of local churches from downstream approaches to upstream actions. In chapter eleven I discuss the challenges and limitations of engaging with local churches in health promotion efforts. Chapter twelve is the discussion chapter in which I reflect on the findings of this study and present a typology of Christian churches by health promotion action. I discuss each component of the typology, emphasising how the typology may facilitate engagement with local churches for health promotion action. In this final chapter I acknowledge the limitations of this research study, recommend future research directions, and highlight the unique contribution of this study.

I begin each of the results chapters with a vignette or reflection from my field work or an extensive quote from a participant. I have done this to provide context and colour to the findings of the chapter and as a method of introducing the reader to what may be unfamiliar territory. As I discuss throughout the chapters, the heterogeneity of churches is not often recognised or known and therefore these chapters seek to highlight this diversity.

In this chapter, I have introduced the concepts and frameworks associated with civil society, health promotion, the social determinants of health, and partnerships for health promotion. I also provided a brief introduction to the potential for church based health promotion (CBHP), and an overview of Christianity and the church in Australia. In the following chapter, I review the CBHP literature, and discuss the different models of CBHP, including parish nursing.

Chapter 2

LITERATURE REVIEW

The Christian church has a long history of serving the poor and marginalised in Australia through welfare activities and the establishment of hospitals, schools and orphanages (Ayton et al., 2012; Badger, 1971; Camilleri & Winkworth, 2005; Cleary, 2002; Horsburgh, 1988; Swain, 2005; Thame, 1974). In addition, churches have played a role in health promotion, disease prevention and tertiary care in all societies (Luker, 2003; Marmot, 2010; Marshall & Keough, 2004; National Center for Cultural Competence, 2001). As my research is based in Australia and engages with contemporary discourses of health promotion, I will focus on previous research from industrialised countries which is more relevant to my study.

In 1974, over a decade before the Ottawa Charter for Health Promotion, Galli (1974) described the role of church groups in health promotion to address health issues associated with poverty and the agricultural and farming crisis of the Transkei people in South Africa. The Transkei region is overpopulated and underdeveloped with the population experiencing issues of poor nutrition and infectious diseases (Galli, 1974; Merrett, 1984). In a manner consistent with values and principles of health promotion, the Transkei Council of Churches embarked on a mission to address the issues facing their community. The Council conducted needs assessments and on this basis established programs to empower women and provided health education and agricultural training as well as participating in capacity building, multi-sectoral partnerships, community participation, and community development efforts (see Galli 1974 for more details). Galli (1974), however, made no reference to the impact the apartheid regime had on the socio-political environment and consequently the health and wellbeing of the Transkei people. This is illustrated in how the churches and community leaders in the study identified the pressing needs of the community:

> Foremost among them were (1) the need to make people aware of their problems, and to motivate them to improve the quality of their lives; and (2) the need for education relevant to their major problems, especially health, nutrition and agricultures, these three vital facets being seen so interrelated as to be completely inseparable (Galli, 1974, p.71)

The health and social problems affecting the Transkei population were articulated as individual behavioural problems with some environmental determinants such as agricultural conditions. The broader social determinants of health, such as unemployment, poor living and working conditions, limited access to health services, low levels of education and racial segregation, perpetuated by the apartheid regime were not acknowledged (Pillay, 2001; Nightingale, Hannibal, Geiger, Hartmann, Lawrence & Spurlock, 1990; Thomas, 1990; Mooney & McIntyre, 2008). Nevertheless, the Transkei Council of Churches initiative is an early example of a health promotion project where local churches worked in partnership with other sectors to address health issues.

Churches for the most part share values with health promotion such as social justice, equity, empowerment and a desire to contribute to community wellbeing, and hence, churches are a "force which can be channelled towards specific and integrated community action for health improvement" (Galli, 1974, p.71). In this chapter, I review literature which describes how churches have been engaged in health promotion activities to date. Studies on CBHP are predominantly from the United States, and hence I discuss throughout this chapter how CBHP is influenced by the religious, political and cultural context of the US. In the literature, different models for CBHP programs have been described. These models consider the extent of religious or spiritual content in the health promotion program/intervention, the perspective and conceptualisation of health and whether the program is, in Campbell and colleagues

terminology, 'emic' or 'etic'[5] to the church setting (Campbell et al., 2007; DeHaven, Hunter, Wilder, Walton, & Berry, 2004).

I begin this chapter by providing an overview of the models of CBHP. This is followed by an analysis of how the CBHP literature describes behavioural interventions and not strategies or actions that address the social determinants of health. I conclude this chapter by discussing the concept of "being church" and how it is important to understand the mission and practices of local churches and thereby consider how churches may be enaged in health promotion.

MODELS OF CBHP

Parish Nursing

Churches have participated in the delivery of health care in various forms for centuries. Indeed, when examining the history of nursing there are many examples of religious orders and congregations involved in providing nursing care to, particularly poor communities (Brudenell, 2003). The concept of parish nursing received renewed attention in the 1980s by Lutheran minister and hospital chaplain, Granger Westberg and was formalised as a model of nursing care in 1984 (Brudenell, 2003; Schweitzer et al., 2002). Westberg believed that churches needed to recognise the relationship between body, mind and spirit and that "nursing has the gifted ability to provide this care; nursing combines scientific medical knowledge, educational pursuits, emotional and spiritual growth, and life experiences and in doing so answers the call of God to be all one can be" (Lane, 2000, p. 117). Since 1998, the practice of parish nursing has been recognised with the American Nurses Association as a

[5] 'Emic' refers to health programs established from within the church (for example a health ministry) versus 'etic' programs which are initiated from outside the church (for example from a health service or university) (Campbell et al., 2007)

nursing speciality area (Anderson, 2004). The association identifies seven role responsibilities of the parish nurse: the integration of faith and health, health education, personal health counselling, referrals, volunteer training, support group development and coordination, and health advocacy (Brudenell, 2003).

Parish nursing has been adopted predominantly in the US and Canada, where nursing care focusing on health promotion and disease prevention is practised in the context of a faith community (Brudenell, 2003). The parish nurse is a registered professional nurse, with his or her practice established under the health ministry of a church or faith-based organisation (Anderson, 2004). The practice of parish nursing involves the physical, emotional and social needs of members of the faith community incorporating spiritual needs as a core area (Schweitzer, Norberg, & Larson, 2002).

Anderson (2004) identified three models of parish nursing. The first is the health services parish nurse program in which the hospital and church collaborate, with the nurse employed through the hospital and supervised by a committee consisting of both a physician and a chaplain (Anderson, 2004). The second model is the volunteer model, where church leaders partner with a hospital, with the nurse receiving information and support from hospital staff and the church being responsible for supervision (Anderson, 2004). In the majority of cases, the nurse is a member of the church; however if a suitable volunteer cannot be found, the hospital assists the church to select a nurse (Anderson, 2004). The final model is the nurse parishioner model, in which an informal approach is taken and nurses from the congregation either volunteer in the role of parish nurse or conduct health promotion activities (e.g., leading an exercise class or educating members about healthy eating) (Anderson, 2004). These nurses do not have support from a hospital and rely on each other and the church for supervision (Anderson, 2004).

It has been reported that nurses and church clients[6] both benefit from participating in parish nursing programs (Chase-Ziolek & Gruca, 2000; Chase-Ziolek & Iris, 2002; Wallace, Tuck, Boland, & Witucki, 2002). In studies examining this model, the nurses valued the long term relationships built with clients and the relaxed working environment of the church when compared to a hospital (Chase-Ziolek & Iris, 2002). While nurses faced challenges such as balancing responsibilities and time commitments, they felt satisfied in being able to empower clients to utilise the health care system effectively and appropriately (Chase-Ziolek & Iris, 2002). The clients described how the parish nurse had improved their access to care, and how they found the church setting more comfortable and peaceful than other health settings (Chase-Ziolek & Gruca, 2000; Wallace et al., 2002).

Bokinskie and Kloster (2008), in a three year study with over 400 parish nurses, explored the facilitators and barriers associated with successful parish nursing ministries. Factors associated with successful parish nursing programs were clergy support, followed by congregational support and involvement, personal faith beliefs of the nurse and spiritual development, an active health council in the church, and support from volunteers (Bokinskie & Kloster, 2008). Common barriers were time and scheduling constraints, lack of financial support, lack of congregational support and involvement, inactive or no health council in the church, no volunteer support, and lack of clergy support (Bokinskie & Kloster, 2008).

King and Tessaro (2009) surveyed 75 parish nurses from Western Pennsylvania and Maryland in the US with the aim of investigating the health promotion activities of parish nurses. The study found that parish nurses operated predominantly within a health promotion context with minimal direct care (administering or managing treatment regimes). Health

[6] Church client is reference to church members or church attendees who access parish nursing services

promotion activities included blood pressure screening, counselling in relation to physical health and spiritual health, and the provision of health education on exercise, nutrition, weight control and stress reduction (King & Tessaro, 2009). These activities align with downstream health promotion practices with a focus on the health and wellbeing of individuals.

Faith Based and Faith Placed Initiatives

Literature examining the settings approach to CBHP in the US is extensive. A number of different models have been described taking into account factors such as whether the intervention program was initiated by the church congregation or a secular organisation and the extent practices such as prayer and sermon content is utilised. DeHaven and colleagues (2004) describe three models in their review of health programs in faith based organisations as described in the literature between 1990 to 2000: faith based, faith placed and collaborative (Campbell et al., 2007; DeHaven et al., 2004). The faith based model is used to describe programs that are 'emic' (i.e. programs that already exist in the church/religious organisation or are part of an existing health ministry), whereas faith-placed is used to describe programs or interventions which are 'etic' (i.e. programs initiated from organisations or agencies outside of the church) (Campbell et al., 2007; DeHaven et al., 2004). The third concept discussed in the literature is 'collaboration,' with this term used to describe programs or interventions if they are a combination of faith-based and faith-placed action through partnerships between church/religious organisations and other agencies (ibid). The review found that the majority of faith based CBHP programs described in the literature were concerned with adult African American populations and were directed at members of the congregation (60.4%) or the surrounding community (24.5%). Most programs (50.9%) were focused on primary prevention in the form of health education for general health maintenance, cardiovascular disease and cancer (DeHaven et al., 2004).

To better understand the types of CBHP programs being implemented, Lasater and colleagues (1995) developed a model of CBHP based on cardiovascular disease prevention projects. The model consists of four levels with categorisation based on the extent of church involvement and integration of spiritual themes into the intervention. Level I consisted of programs which used churches only as venues (Lasater, Becker, Hill, & Gans, 1995). This level aligns with the principles of faith placed programs described above. Level II programs were delivered at the church location, generally after a typical church activity such as a church service. Programs delivered by church members led to a level III categorisation. Level IV programs integrated religious content into the program, for example the inclusion of scripture and linking of religion and health. Levels III and IV are also examples of faith based programs.

Steinman and Bambakidis (2008) report on the prevalence of faith based and collaborative CBHP in a study of church based health collaborations. Data from the National Congregations Study of 1236 congregations indicated that the majority of churches in the study (57%) had "participated in or supported social services, community development, or neighbourhood organising projects of any sort within the past 12 months" (Steinman & Bambakidis, 2008, p.257). Of these churches, 11% collaborated with a secular agency in health related programs such as care for the sick, support for survivors of rape or domestic violence, physical activity initiatives and substance abuse programs (Steinman & Bambakidis, 2008).

Bopp and Fallon (2012) analysed faith based CBHP activities drawing on a survey of 844 church leaders from the US. The analysis of health and wellness activities in these churches comprised of activities being categorised into either educational programs or action-oriented activities (Bopp & Fallon, 2012). Educational programs utilised pamphlets, leaflets and bulletin notices on health topics and made available to congregation members libraries of

health and wellness books and videos, and health-related church classes (Bopp & Fallon, 2012). Action oriented activities for health included individual and group counselling for health, disease screenings, sports teams, educational classes, and practical health classes such as cooking classes (Bopp & Fallon, 2012).

There is a substantial literature reporting the inclusion of scripture readings, Bible based teaching and prayer in church based weight loss programs as a means to motivate and support people to eat well and be active (see Baruth et al., 2010; Baruth, Wilcox, & Condrasky, 2011; Baruth, Wilcox, Laken, Bopp, & Saunders, 2008; Bopp, Lattimore, et al., 2007; Bopp, Wilcox, et al., 2007; Cowart et al., 2010; Duru, Sarkisian, Leng, & Mangione; Fitzgibbon et al., 2005; Ivester et al.; J. A. Peterson & Cheng, 2011; Resnicow et al., 2002; Whitt-Glover, Hogan, Lang, & Heil, 2008; Wilcox, Laken, Anderson, et al., 2007; Wilcox, Laken, Bopp, et al., 2007; Wilcox et al., 2010; Williamson & Kautz, 2009; Yanek, Becker, Moy, Gittelsohn, & Koffman, 2001). The CBHP projects which had little to no spiritual component to the intervention (Izquierdo-Porrera, Powell, Reiner, & Fontaine, 2002; Peterson, Yates, & Hertzog, 2008) relied on the social support environment provided through the church community. These interventions did not differ markedly from other community-based interventions and the use of the church as a setting was associated with reaching the target population and utilising resources and facilities. However, researchers examining the spiritual component in the adoption of healthy eating and physical activity reported that the addition of the faith component increased the uptake of healthy behaviour (Cowart et al., 2010; Fitzgibbon et al., 2005; Yanek et al., 2001). Incorporating Bible verses into the health education by highlighting, for example, the body as the temple of God, was considered to be a motivator for behaviour change. Prayer for assistance in being healthy and fellowship with other church members was also identified as supporting healthy behaviours (Cowart et al., 2010).

The programs described as faith based or faith placed CBHP are primarily disease prevention activities, targeting the environment of the church as an avenue for change and providing health education and skills to individuals within a church community for behaviour change.

Church as a Setting for Health Promotion

It is common in the literature describing CBHP in the US for the church to be identified as a setting for health promotion. As described in Chapter 1, the rationales for the settings approach to health promotion was articulated in the Ottawa Charter for Health Promotion (World Health Organization, 1986): "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (p.3). The Jakarta Declaration (World Health Organization, 1997) highlighted settings as offering practical opportunities for health promotion practice. The settings approach adopts a socio-ecological model of health and aims to "integrate a commitment to health within the cultures, structures, processes and routine life of organizational and other settings" (Dooris, 2004, p. 52).

However, in the setting strategy, there is no 'one size fits all' model. As advocated by Poland and colleagues (2009), the settings strategy requires an analysis of the setting considering "who is there; how they think or operate; implicit social norms; hierarchies of power; accountability mechanisms; local moral, political, and organizational culture; physical and psychosocial environment; broader socio-political and economic context" (Poland et al., 2009, p. 506). For CBHP, the roles of the church member, minister and health promotion worker need to be considered.

Sutherland and colleagues (1995) conducted a role analysis on two case studies of church health programs. In these programs, the role of the church member included: initiating programs, serving on management committees, providing individual leadership, advocacy, service provision (after appropriate training), serving as role models, and assisting with the

institutionalisation of initiatives within church governance structures and processes (Sutherland, Hale, & Harris, 1995). The role of the minister, as church leader and spiritual director, is vital as the minister will often be the person who determines the church's involvement in health promotion. The minister plays the roles of: church liaison, bridging the gap between the church members and community health promotion efforts, provider, in being able to offer the church facilities for health promotion activities, and, social change agent, policy maker and program developer (Sutherland et al., 1995). The role of the health promotion worker therefore is to empower the church setting to adopt policies and organisational strategies that promote health and to assume the role of consultant. This will include conducting community needs assessments, training, providing technical program design, marketing, and conducting evaluations (Sutherland et al., 1995).

Peterson and colleagues (2002) provided an overview of the key elements that are entailed in health promotion in the church setting. The seven key elements include partnerships, positive health values, the availability of services, access to church facilities, community-focused interventions, health behaviour change, and supportive social relationships (Peterson, Atwood, & Yates, 2002). Health education and behaviour change initiatives were the most common interventions applied in church settings. Identifying elements such as the availability of services and access to church facilities has led to health services and universities using churches as a setting for health promotion. As Peterson (2002) and Campbell (2007) have identified, church resources such as kitchens and meeting rooms provide spaces for health promotion programs, and regular church services and meetings facilitate engagement with population groups, including hard-to-reach groups such as youth, the elderly and minority populations.

Church as a Health Promotion Partner

Church involvement in health promotion is described as a settings approach to interventions and programs. However, viewing CBHP as purely settings-based does not capture all health promotion efforts of the church. Some churches strive to be outward focused in their work, and accordingly initiate and participate in activities, programs and advocacy outside of the church sphere to address health inequalities. Partnerships with these churches for health promotion is more appropriate than adopting a purely settings approach.

Zahner and Corrado (2004) analysed the prevalence, characteristics and effectiveness of partnerships between local health departments (LHD) and faith-based organisations (FBO) in Wisconsin, US. Their findings suggested that partnerships between the LHD and FBO were predominantly formed to address difficult social issues which have traditionally been areas of concern for FBO (homelessness, child abuse, food insecurity) or issues requiring broad-based community partnerships (e.g., community assessment, education and prevention efforts for tobacco control) (Zahner & Corrado, 2004). These partnerships are different to the settings-based partnerships dominating the literature, which tend to focus on chronic disease and primary prevention problems (Zahner & Corrado, 2004). The churches are not viewed by health agencies as merely an avenue to capture at-risk populations; rather, their mission and work is harnessed to address key social determinants of health and causes of health inequities.

Garland and colleagues (2008) identified the church as a valuable partner in the provision of volunteers for social work services in some of the southern states of America. The study of

35 churches found that almost 50% of congregants volunteered in formalised[7] human services programs outside the realms of the church. This high level of volunteerism in community services is promoted in the church and is seen as an outward demonstration of faith (Garland et al., 2008). Garland and colleagues (2008) reported that social workers expressed concerns that Christians may use community volunteering as a means to proselytise and evangelise. However 87% of volunteers in their study reported actions as being more important than words in communicating their faith, and 77% felt that working for social change was a way to share their faith. The authors do acknowledge the importance of discussing the inappropriateness of evangelising when engaging as a volunteer in formalised social services (Garland et al., 2008) as this may lead to the exclusion of individuals who do not share the Christian faith or are from different denominations.

BEHAVIOURAL VERSUS SOCIAL DETERMINANTS OF HEALTH FOCUS

Large health inequities exist between the African American population and the White American population (Campbell et al., 2007; Steinman & Bambakidis, 2008). Despite having a lower prevalence of cardiovascular disease when compared to non-Hispanic whites, African Americans are more likely to die from the disease than any other racial or ethnic group, and cardiovascular disease accounts for one-third of all deaths. This increased vulnerability can be explained by genetic predisposition, but also by a lack of information regarding health, hesitancy in seeking primary prevention care, limited access to health services, and a lack of funds to be able to pay for health services (see Mayberry, Mili & Ofili, 2000; Clark, 1999; Safeer, Cooke & Keenan, 2006; Dressler, Bindon & Neggers, 1998). Giger and colleagues (2008) similarly note that African American vulnerability to disease is influenced by a

[7] Formalised services refers to professionalised services, as opposed to informal lay run services (Whittaker, 1986).

combination of genetic, psychosocial and cultural factors, and argue that the church can address health issues in a culturally relevant way which is likely to increase the success of a program.

In response to these health disparities, a number of CBHP initiatives in African Americans churches have been implemented. There have been church based health promotion initiatives (settings based interventions as described above) to promote physical activity (White, Drechsel, & Johnson, 2006; Wilcox, Laken, Anderson, et al., 2007; Wilcox, Laken, Bopp, et al., 2007), improve nutrition (Izquierdo-Porrera et al., 2002; Resnicow et al., 2002), encourage and facilitate weight loss (Fitzgibbon et al., 2005), educate participants about diabetes and cardiovascular disease (Yanek et al., 2001), conduct disease screening (Darnell, Chang, & Calhoun, 2006; Davis et al., 1994; Holschneider et al., 1999), provide addiction interventions (Stahler, Kirby, & Kerwin, 2007), and promote mental wellbeing (Bay, Beckman, Trippi, Gunderman, & Terry, 2008).

Overwhelmingly, these CBHP programs take an individualised behaviour change approach. For example, the Health-e-AME physical activity and nutrition intervention in South Carolina focused on health education and information and the provision of church based opportunities for exercise, with the onus on the individual to participate and engage in the program. Health-e-AME is an example of a collaborative model of CBHP, as the program is conducted in partnership with the 7th Episcopal District of the African Methodist Episcopal (AME) Church and the Medical University of South Carolina and the University of South Carolina. The aim of the Health-e-AME project was to increase the physical activity in African American adult congregants from 524 congregations.

The design of the intervention was embedded in the trans-theoretical (stages of change) model (Wilcox, Laken, Anderson, et al., 2007). The trans-theoretical model of behaviour

change defines behaviour change as a progression through stages: pre-contemplation (individual is not planning to take action in the near future); contemplation (individual is planning to take action in the next six months); preparation (individual intends to take action in the immediate future); action (individual has changed behaviour in the previous six months); and maintenance (individual is maintaining behaviour change and hopes to prevent relapse) (Prochaska, 2008). The randomised delayed intervention consisted of three action oriented programs: praise aerobics, chair exercises, and walking programs. Praise aerobics consisted of aerobic exercises set to popular gospel music and targeting different levels of intensity (Wilcox, Laken, Anderson, et al., 2007). Chair exercises, also set to popular gospel music, were tailored to adults with medical conditions or physical limitations. Walking contests and programs were incorporated into the project, as this was the preferred form of exercise for many participants (Wilcox, Laken, Anderson, et al., 2007).

The investigators of the Health-E-AME project also implemented the FAN (Faith, Activity and Nutrition) intervention a few years later. They posit that FAN differed from Health-e-AME in that it undertook a socio-ecological approach to health promotion. The FAN Program involved training the church cooks to prepare healthy meals. Pastors supported the program through participation in activities, sermons on healthy eating and exercise, and changing church policies to incorporate, for example, healthy foods being served at church events. The appointment of a church health director or health ministry was another component of the intervention (Wilcox et al., 2010). Examples of strategies implemented by churches included physical activity programs at the church (group walks, aerobics class); physical activity exercises before or during church services; growing fruit, vegetables and herb gardens; weight loss contests; healthy food fairs; menu plans; physical activity breaks for meetings lasting more than one hour; and physical activity and nutrition messages included on church message boards and bulletins (Wilcox et al., 2010). Unlike the Healthy-e-

AME project, FAN used a socio-ecological model to focus on church environmental factors and church policy as opposed to individual behaviours. Participants in the evaluation listed church bulletins, sermons and print materials as having the biggest influence on increasing fruit and vegetable consumption (Baruth et al., 2011).

The FAN study and the Health-e-AME study were conducted by some of the same investigators and both these interventions adopted a settings based approach to health promotion. However the interventions described above did not engage with some of the wider determinants of health such as poverty, food insecurity, unemployment or insecure housing, which have been reported to impact on the health and wellbeing of individuals and communities, particularly the African American population in the US. For example, in 2008, 39.8 million Americans were living in poverty, with the poverty rate for African Americans being 24.7% compared to 8.6% for non-Hispanic White Americans (DeNavas-Walt, Proctor, Smith, & U.S. Census Bureau., 2009). In the same period, the rate of uninsured African Americans was double the rate for non-Hispanic Whites at 19.1% and 10.8% respectively (DeNavas-Walt, Proctor, Smith, & U.S. Census Bureau., 2009). African Americans are less likely to achieve the same levels of educational attainment and face higher rates of unemployment when compared to White Americans and Asian Americans (Kao & Thompson, 2003; Williams, 2006). Race discrimination and issues of segregation experienced by African Americans are also linked to disparities in physical and mental health (Mays, Cochran & Barnes, 2007; Williams, 2006; Fainstein, 1993). These determinants are the root causes of health disparities experienced by African Americans, yet are not being addressed by CBHP interventions.

"BEING CHURCH"

The concept of "being church" is part of the Christian discourse (Gibbs & Bolger, 2005). It is a phrase that seeks to capture the mission and practice of local churches in society. Churches have beliefs, practices, values and morals that may be in conflict with messages from secular health promotion or public health agencies (Chatters, 2000; Chatters, Levin, & Ellison, 1998). Therefore it is important to understand and consider the cultural and spiritual context of the church in relation to health promotion interventions and initiatives (Campbell et al., 2007a). Campbell and colleagues (2007) have identified some of the tensions and barriers of engaging the church in setting based health promotion in the US. These include concerns by local churches and church leaders about the separation of church and state which can lead to a lack of participation if a program is funded by government and requires strict auditing and reporting (Campbell et al., 2007). Also, many churches have an agenda of evangelism and proselytising, and while the church may be genuinely interested in working in promoting the health and wellbeing of its congregation and wider community, its members may also see the health promoting program or activity as a means to preach the gospel (Campbell et al., 2007); in other words, health promotion may be a vehicle for religious goals (Campbell et al., 2007). The church has values which may also compete with health promotion and public health practice such as discussions about sexual health and sexually transmitted diseases. These issues indicate that further exploration of the church as a setting and partner is required to unpack the barriers and limitations as well as opportunities for health promotion practice.

Currently the research exploring CBHP concentrates on the implementation and evaluation of health promotion interventions in local churches. As discussed above, these interventions can be faith based, faith placed or collaborative. However, such a focus is narrow, in that it does not consider if churches are health promoting in the practice of "being church".

Nile Harper (1999), in his book *Urban Churches, Vital Signs - Beyond Charity Towards Justice*, describes the activities of urban churches in the US. The book is written for a Christian audience, with Harper writing about churches, through "being church", were "creating meaningful worship, doing a good job of Christian education, and engaging the challenges of housing, health, employment, education and family life. The churches selected illustrate creative ministries of redevelopment, social justice, and engagement with the tough challenges of urban life in city centres" (Harper, 1999, pp. xiv-xv). Harper profiles 13 churches of varying size and from different denominations to present a continuum of church practice from charity to justice, highlighting the shift from individualised, reactive, short-term actions to deeds that consider inequities, community development principles, policy, proactive long-term strategies and empowerment (Harper, 1999).

A key driver of health promotion partnerships is the recognition that sectors beyond the health sector can be levers of influences for the social determinants of health. The current literature base for CBHP is dominated by a settings approach to health promotion through disease prevention interventions, as described above, yet does not explore how churches, through "being church," work in and with communities, and how these practices align with the social determinants of health and health promotion principles and values. My study seeks to address this gap in documenting and analysing the activities and programs of churches, to assess how these may be health promoting. However, it is pertinent to understand the "why" of church based health promotion practice, and hence I provide a theological and theoretical discussion of church mission in the following chapter.

Chapter 3

THEOLOGICAL UNDERPINNINGS

> A church without mission or a mission without the church are both contradictions. Such things do exist, but only as pseudostructures (Braaten, 1977, p. 55)

The mission of a church reflects how it understands its role, values and practice. However, there is wide diversity in how churches articulate their mission and practice. A distinction is often made between the ecclesiola ("true church" or little church) which is situated under the umbrella of the ecclesia, the large and nominal church (Bosch, 1991a). In my thesis, to avoid unnecessary jargon, I refer to the ecclesiola as the local church and refer to the ecclesia as the overarching denominational institution of church. For example, the ecclesia of the Catholic Church is the Church in the Vatican City governed by the Pope, who provides guidance for the ecclesiola. The ecclesiola are the individual congregations spread throughout the world. The ecclesiola, not the official church, tends to be viewed as the true bearer of mission (Bosch, 1991a). The institutional structures of the church and the apex of the church (the ecclesia) is not germane to this study, as the focus is on the work and role of local churches (ecclesiola) in health promotion.

In this chapter I discuss three different expressions of local churches and how these are represented in church mission. These concepts are core to analysing the how and why of church involvement in health promotion. The three expressions[8] of church that are described are categorised as *traditional*, *new modern* and *emerging*. Fenella Cannell, an anthropologist

[8] I have adopted the term 'expression of church' to describe different types of churches based on practices, beliefs and mission. This term is used in the Christian discourse.

who has written broadly about Christianity and social theory, writes of the incongruous assumption that "Christianity is an 'obvious' or 'known' phenomenon that does not require fresh and constantly renewed examination" (Cannell, 2006, loc 46). As churches are the main manifestation of Christianity, there is a similar risk in regard to understanding local churches. The church is, however, far from static; in theological discussions, there have been clear shifts in how church mission, doctrine, practice and values have been conceptualised. This is evident in the different expressions of church that I describe here.

The Christian church is not homogenous, but as Cannell cautions, needs to be understood as taking widely varied forms, reflected in a panoply of beliefs and actions:

> [We need] to allow anthropology to stop ruling out of court seemingly heterodox Christianities – Christianities which fail to supply such apparent essentials as a radical separation between body and spirit, between this life and the life to come, or between spirituality and kinship. We might instead come to see these not just as local 'resistance', or as peripheral parts of 'real Christianity', but as alternative Christianities deeply rooted in the highly unstable syntheses which Christian orthodoxies themselves represent (Cannell, 2005, p. 352).

The term 'the Church' is used as an overarching generality and comes with a host of assumptions, which fail to recognise the heterogeneity of Christianity and local churches. While some tenets, such as belief in the virgin birth, death and resurrection of Jesus Christ, may hold true across different groups, the expression of church may vary. Cannell and colleagues (2006) challenge "both the notion that Christianity is a merely arbitrary category, and the notion that it is a completely homogenous phenomenon" (loc 119). They describe and examine Christian practices in developing countries such as Seventh-Day Adventists in Madagascar and Catholicism in South India and Bolivia, as well as a charismatic Christian

group in the US and in doing so, demonstrate the vast differences in how these populations feel about what it means to be Christian, and different perspectives on conversion, orthodoxy, rituals, customs, values, and the concept of heaven. Professor Gary Bouma (2012), an Anglican minister and sociologist of religion, discusses the phenomenon of multiple modernities of Christianity which exists between denominations and within denominations and even within congregations. These variations are shaped by the educational, employment and economic status of congregation members, as well as the increasing ethnic diversity of congregations (Bouma, in press). The ethnic composition of a congregation brings into the church aspects of other localities, and hence may change the values, systems and practices of an individual church (Cannell, 2005, 2006).

In the section below, I examine the nature of diversity of churches within Australia which begins with a consideration of the concept of church mission. Following this section, I provide an overview of the traditional church - highlighting the physical presence of the church in the community as well as its church practice and mission. I then discuss the new modern church - a church expression which has embraced the culture of the technology age of society and is reflected in, but not limited to, the phenomenon of mega churches. The final church expression category that I have identified is that of the emerging church, which has been influenced by post-modernism and has risen from the re-examination of theology and church practice.

CHURCH MISSION

> Our missiology (our sense of purpose in the world) must then go on to inform the nature and functions, as well as the forms, of the church...It is absolutely vital that we get the order right. It is Christ who determines our purpose and mission in the world,

> and then it is our mission that must drive our search for modes of being-in-the-world (Alan Hirsch, as quoted by Hill, 2012, loc 30).

The term 'mission' was used to describe missionaries in relation to the organisations that sent them, the work that they did, and the geographic area that they were sent to. The non-Christian world was viewed as the 'mission field' (Bosch, 1991d). Being a missionary was considered a profession; it required extensive study in theology and often in the native language of the 'mission field', as well as garnering support from local churches to fund the mission (Priest, Wilson, & Johnson, 2010). The message was one of salvation. The aim was to convince non-believers to turn to God and to repent so that eternity was spent in heaven. However, the work of many missionaries also involved establishing schools and hospitals, aiming to benefit the communities in which they came to preach (Cannell et al., 2006; Chen, 1996; Abraham, 1996). Geoffrey Blainey (2011) writes of the missionaries sent from Europe:

> Most Christian workers in overseas lands - but far from all - showed their spirit in the lives they lived. Most showed compassion; most maintained their faith in the face of personal and natural disasters; most tried to speak the truth as they knew it. They tried to be patient more often than impatient. They usually tried to forgive their enemies. Of course there were countless exceptions (p. 332).

Society is no longer in the 'age of Christendom' (Bosch, 1991d; Frost & Hirsch, 2003b; Hill, 2012) and therefore Christianity and missionary practice for the most part has changed. Moltman writes that "mission comprehends the whole of the church - its nature, its gospel proclamation, its spread of the Kingdom and its charitable and liberating ministries" (Hill, 2012, p. 168). Across many segments of the church, the term missionary has evolved to describe all Christians and not just those who have undertaken the professional missionary journey (Priest et al., 2010). This has occurred with the recognition that all life domains are

mission fields, and hence the workplace, schools, family and community of all Christians is a mission field in which the gospel can be spread (Hill, 2012).

Where previously the aim was to Christianise nations and spread the church, recent perspectives of the Kingdom of God have led to mission being interpreted as spreading the Kingdom - in essence, being part of redeeming the world and transforming it to good. In contemporary Christian discourse, the term mission has been replaced with words such as partnership, accompaniment and capacity building. It is now rare that a missionary from a developed country is sent in isolation with the ethos of doing something in and for a culturally distinct setting. Instead the aim is to partner with local churches in this setting to build their capacity to work in their local community (Gibson, 2009; Priest et al., 2010). Such partnerships are often established when a congregation member or minister has a connection with a church overseas, for example, a congregation member who has immigrated from Uganda and still has connections with a local church in Uganda (Gibson, 2009).

In the ensuing discussion of traditional, new modern and emerging churches, I examine the concept of the Kingdom of God, being understood in the individual Salvationist paradigm of 'heaven as a place one goes when they die' as opposed to the community oriented concept of ‘bringing heaven to earth.’ The different interpretations of the Kingdom of God, due to different approaches to biblical scholarship, has implications for how churches understand their mission. As the church has diverged from being traditional to emerging, it has battled the challenge of remaining relevant and the disenchantment with church by people in modern societies. These challenges have also shaped church mission and practice. The categories of traditional, new modern and emerging simplify complex practices and beliefs. These categories form a component of the typology which is discussed in the final chapter of this thesis. I present a critical analysis of the use of the typology including benefits and limitations in this final chapter. In brief I highlight that these categories are not fixed and churches may

represent more than one category due to influences of church staff and volunteers, cultural and social context, funding and partnership. Below I provide a conceptual basis to understand the mission paradigms of the three categories and to allow for further exploration throughout my thesis.

THE TRADITIONAL CHURCH

The traditional church is the archetype church for most people in Western societies (Lyons, 2012). In his book, *The Next Christians*, evangelist Gabe Lyons observes a pattern of architecture of traditional churches while travelling by train from London to Paris. He notes that the architecture and position of the church in the community provides insight into the social position of the church in pre-modern times:

> In each community I saw a town center surrounded by trees and an occasional cottage. And at the heart of every town I could see a church steeple appear among the treetops and above the storefronts. It was consistent with what I knew of ancient urban architecture, that the steeple was designed to be the tallest structure in the city, representing the sacred belief that the church should be the closest point between heaven and earth, God and humanity ... Miles apart, those communities now seemed lined up almost side by side, as if to make a collective statement for my observation: The church used to occupy the center of culture in the West (Lyons, 2012, p. 9).

Thomas Luckmann (1979), in his essay on the structural conditions of religious consciousness, discusses the historicity of human social structures. These social structures are the result of "purposive as well as blind, individual and collective human action" and are "ossifications, as it were, of the human mind" (Luckman, 1979, p. 34). In the pre modern age, churches and cathedrals were architecturally grand, rising up in towers and turrets against the sky. These are the traditional churches of today, and they reflect the social dominance of

Christianity, the authority of the Church, and the goal of exemplifying the glory of God with the extensive resources and toil invested to create such structures. As Lyons notes, these churches ruled the skyline.

The pre-modern era gave rise to what I term the traditional church. In this era, the world was seen as God-given, with God sovereign over all (Howe, 1994). The church embodied the influence of God and was seen as the city of God and the Kingdom of God. Rupp (1995) writes that despite this, the traditional church in Europe was a key public space used by all strata of society for a variety of activities, including the selling of goods and products, political discussions and a place for families to gather. The church in pre-modern times was an early version of welfare provision with orphanages, hospitals, hostels and hospices (Blainey, 2011; Cannell, 2006; Chen, 1996; Abraham, 1996). The Catholic Church was also the largest landowner in Europe, with a vast array of urban and rural properties, and the font of educational institutions such as universities, schools and libraries (Blainey, 2011; Callahan & Higgs, 1979; Cairns, 1996); it was a vital and powerful institution in society. The church used its power and influence to act as the protector and propagator of culture, and in doing so was the dominant influence over public affairs (Bosch, 1991b).

The mission of the traditional church is based on literal readings of the Bible and aims to bring people into the church, as the church is seen as the mediator between God and His people. Traditional church mission is completely church centred, with the belief that the church is the Kingdom of God on earth; hence being present in the church is equated to being in the Kingdom (Bosch, 1991c). Traditional churches conduct formal services with symbols such as a prominent cross, stained glass windows and orthodox practices. In contemporary society and as well as when Bosch (1991) was writing, the population attending these services are for the most part older, with the priest dressed formally and the congregation members usually well-dressed to mark their respect for the occasion.. The liturgy is a central

and vital part of the traditional church and the gospel is 'proclaimed' through doxology and liturgy (Bosch, 1991d). As I will argue, these factors shape the role that traditional churches adopt in communities, including the nature of their engagement in health promotion activities.

THE NEW MODERN CHURCH

Beck (1992) highlights that the process of modernization involves "not just structural change, but a changing relationship between social structures and social agents" (Beck, 1992, p. 2). Pollack (2008) notes that in pre-modern societies, the church was an institutionalised form of religion, while in modern societies (post Enlightenment), the relationship between church and religiosity decreased. Religion could be practised outside the church, for example, in disciplines such as psychoanalysis and in leisure activities such as sport and travel. With this shift to the margins, the geographical location of the church in society also moved. No longer the central anchoring point for suburbs and communities, church buildings moved with urban sprawl. In contemporary Australia, traditional churches still exist but are complemented by new modern churches which are far less visible in terms of their physical characteristics, but in fact attract large numbers of people. New modern churches are positioned in shopping strips between other conveniences cafes and restaurants, dry cleaners and laundries, convenience stores and $2 shops (Lyons, 2012).

While some believe that the rise of modernism has led to the secularisation of society, many others criticise this stance and posit instead that the dominant impact of modernism was that it gave rise to the age of the individual (Pollack, 2008). Politics and culture are for the most part, less explicitly influenced by Christian discourses and "Judeo Christian values no longer held sway in the public square" (Lyons, 2012, p. 16). Instead of accepting the authority of the church, people in modern societies became more critical of established doctrines,

disenchanted with the world[9], seeking rationalisation and reason, and being willing to challenge the power and dominance of societal institutions (Gane, 2002b; Giddens, 2006).

In light of the heightened period of empiricism and reason[10], church leaders attempted to establish the rational basis for belief and defend the authority of the bible as a historical document, endorsing its internal consistency and the fact that the birth, death and resurrection of Christ was the fulfilment of Old Testament prophecy (Gibbs & Bolger, 2005a). The modern era of hermeneutics can be characterised by a systematic theological approach to Biblical study. Systematic theology focuses on God's immanence and the ability of humans to know and understand divine nature and plan. The Bible is viewed as infallible with key doctrinal beliefs including the fall of man, Jesus' virgin birth, physical death and resurrection, atonement for sin, and the literal second coming of Christ (Bielo, 2009). Systematic theology is deemed by its proponents to be scientific with rational arguments, proof and logical apologetics (Bielo, 2009).

Interpretations of the Gospel in the era of modernism tend to preference the death and resurrection of Jesus over the life and mission of Jesus. Consequently, individuals practising modern expressions of Christianity emphasise their personal experience of God, with the Gospel construed as being about personal salvation (Gibbs & Bolger, 2005a). The modern understanding of the term ‘salvation’ is an individual’s relationship with God in the 'here and now', with the future hope of going 'home' to God (in heaven) and finding peace (Wright,

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[9] Weber adopted the phrase “disenchantment of the world” based on work by Friedrich Schiller on the modern condition of society where he discussed the “de-divinization” of the world. For Weber the disenchantment of the world is due to increased “rationalization” which increases as science advances; overriding prior beliefs in the work of God and scientific naturalist explanations (Angus, 1983; Artigas, 2002).

[10] There is much discussion as to when the period of modernity commenced. The journal Modernism/Modernity by John Hopkins University Press concentrates on the time period of modernity from 1860 to the mid-twentieth century (see http://www.press.jhu.edu/journals/modernism_modernity/). Modernity is discussed in the literature in relation to the industrial revolution and the period of Enlightenment (Friedman, 2001).

2007). As John Stott writes, "the mission of Jesus was a rescue mission. He came into the world to save sinners (1 Timothy 1:15)" (Stott, 1975b, p. 125). Therefore the mission of the modern Christian is captured in the word ‘evangelism’, meaning to spread the good news of Jesus and salvation which brings personal freedom (Stott, 1975a). Bielo (2009) describes this modern evangelism as including: "handing out Bible tracts, street preaching, delivering the finely tuned personal conversion narrative, presenting the Gospel via logical apologetics, and using church events as an entree´ into the Christian community (p226)." This emphasis on conversion is also echoed by Tim Keller, an American Christian apologist, who contends that 20th century evangelicalism in America ignored "culture and put all stress on conversions and on the spiritual growth of individuals" (Tim Keller, as quoted by Mcknight, 2012, para 1).

In this thesis I use the term new modern to recognise that society is currently experiencing a technological era of thought and practice, and hence churches have adapted to remain relevant and engaging. Simon Coleman (2006) writes that this engagement with modern technologies is one of the factors that has increased the profile of the Protestant church, particularly in the US (Cannell, 2006). In the course of writing my thesis, I engaged with a number of evangelists and theologians over Twitter and Facebook and received regular updates regarding their church activities and posts to their blogs.

The new modern church is reflected by, but not limited to, the phenomenon of mega churches. Mega churches are defined as a Protestant church with a congregation of over 2000 members (Maddox, 2012). In Australia, the congregation of Hillsong Church in Sydney exceeded 20,000 in 2008, and it has international offshoots in Kiev, Stockholm, Moscow, Cape Town, London, Paris and New York (Maddox, 2012). Writing of her experience of attending a mega church for the first time, Maddox (2012) comments:

> A smiling teenager, whose casual dress, immaculate grooming and bubbly demeanour could have come straight out of a soft drink advertisement, greets you in the car park. 'Is this your first time here? Welcome to the house of God! Have an awesome day!' Security men, with black earpieces and uniform T-shirts, try to appear simultaneously friendly and inconspicuous. You hear the music well before you reach the auditorium; inside, the sound is a physical shock. More expertly styled figures bounce rhythmically or sway gently on the stage, one arm raised, eyes half-closed, while the band plays pop-rock very loudly and coloured lights swirl and strobe over the dancing audience. It's ten on a Sunday morning and everyone is scrubbed clean and wholesome, but the ambience is a weird reworking of a night club or rock concert, minus the scents of sin, smoke and alcohol (p.148).

The mission of these churches does not differ markedly from the traditional churches, and not all new modern churches are mega churches. Regardless of size, the worship services remain an important component of the practice of new modern churches. In attempts to make traditional churches more accessible to the general public, the level of formality in services and Sunday attire have changed significantly. New modern churches have taken the desire to remain relevant and appealing further by incorporating, for example, live tweets from congregation members which appear at the bottom of the Power Point during services, rock bands, comfortable seats, a decrease in formal liturgy practices, and an increase in informal preaching methods utilising Power Point and YouTube clips. The goal, however, is still to bring people into church and to mediate their individual salvation from sin.

THE EMERGING CHURCH

Gane (2002a), in his analysis of three postmodern theorists, Lyotard, Foucault and Baudrillard, highlights that postmodernism is not the linear progression in time from the

modern. Rather the "postmodern disrupts modernity and its related narratives from the inside...it evades modern linear time by working concurrently in the future (post) and past (anterior), combining the past and future in the form of the 'what will have been'. Postmodernism is the invitation for us to unlearn history as a narrative of linear progress" (p86). Hence, postmodernism is typified by the desire to critically examine all things – religious traditions and customs, political ideologies, scientific development, economic growth, education, institutions (the State, schools, church, family), and even the ideals of change. This process of critical reflection can create a sense of disenchantment with all things and events which leads "to the de-absolution of all secular ideals that, having criticised religion, had set themselves up as new certainties and had acted as powerful forces for social change" (Willaime, 2006, p. 79).

Christianity is not immune to this disenchantment, and as a result a new cultural generation of churches has taken form. The emerging church has often been discussed in terms such as postmodern, but also post-Protestant, post-evangelical, post-liberal, neo-charismatic and post-charismatic (Bielo, 2009). From the 1970s through to the mid-1990s, a new approach to studying biblical texts was adopted, influenced by theologians such as Richard Foster (1995), Dallas Willard (1998), Stanley Hauerwas (1991), Walter Brueggeman (1993), Miraslov Volf (1997), and Nancey Murphy (1996), and more recently, N.T. Wright (2007). These writers are critically examining the modern and traditional interpretations of the Bible while seeking to understand the context of when the Bible was written. This method of study is termed narrative theology - a method that views the Bible as a "collection of stories, themselves built of stories that admit tension, contradiction, and confusion. The proper context for reading is not 'the Bible,' but particular narratives belonging to particular genres, occurring in particular books, written by particular authors for particular audiences" (Bielo, 2009, p.222).

A disjuncture between systematic theology and literal theology (the theological approaches of new modern churches and traditional churches respectively) and narrative theology can be seen in the understanding of what is meant by the phrases 'Kingdom of God' and 'Kingdom of heaven.' Systematic theology interprets these phrases as references to the eternal heaven, a place of paradise ‘saved’ souls go to when believers die. Heaven and hell are literal places in traditional and modern understanding of the texts. Different verses from different narrative contexts of the Bible are often used together to answer key doctrinal questions. In contrast, narrative theology interprets these phrases, 'Kingdom of God' and 'Kingdom of heaven' in the context of the history of Israel. "Salvation’ is therefore not about ‘going to heaven’; rather it is ‘being raised to life in God’s new heaven and new earth" (Wright, 2007, p. 210).

This salvation is beyond coercing individuals to believe specific theologies about God. As Wright (2007) suggests, "salvation is heaven’s rule, God’s rule,…put into practice in the world, resulting in salvation in both the present and future, a salvation which is both for humans and, through saved humans, for the wider world. This is the solid basis for the mission of the church" (p.217). Whereas modern Christian thought was predominately concerned with the idea of how to get to heaven, post-modern thinking questions how the church brings the values of heaven (justice, love, mercy) to earth.

Church mission is one of community and society, and less about the individual. The difference between the traditional and new modern churches and the emerging church is reflected in the words of Synder in the distinction between 'church people' and 'Kingdom people'. 'Church people' adhere to the ideas and thoughts of modernism whereas 'Kingdom people' embrace postmodern thinking:

> Kingdom people seek first the Kingdom of God and its justice; church people often put church work above concerns of justice, mercy and truth. Church people think

> about how to get people into the church; Kingdom people think about how to get the church into the world. Church people worry that the world might change the church; Kingdom people work to see the church change the world (Snyder, 1983, p. 11).

Bosch (1991) writes that the "organisational structures of the church, its associated welfare agencies and schools, need to work in a way that serves society, as the church is intimately bound up with God's cosmic-historical plan for the salvation of the world" (p.378). The emerging church recognises that Christianity is no longer the dominant worldview of Western culture, and that many view Christianity to be "anachronistic, irrelevant, destructive, or worse" (Bielo, 2009, p. 226). Hence, one of the tasks of the emerging church is cultural and linguistic translation (Bielo, 2009). Unlike traditional or new modern churches, these churches do not necessarily meet in church buildings. Instead they meet in cultural centres such as cafes, pubs and other public spaces. Emerging churches "destroy the Christendom idea that church is a place, a meeting, or a time. Church is a way of life, a rhythm, a community, a movement" (Gibbs & Bolger, 2005b, loc 2953). As Lyons writes, "their faith activity isn't restricted to 'religious' activities, but carries over into every day of the week and each aspect of their careers, relationships and social lives" (Lyons, 2012, pp. 47 - 48).

♦ ♦ ♦ ♦

In this chapter I have outlined the mission paradigms of three different expressions of church. For the traditional church, the church is viewed as the Kingdom of God, and it is hence the mission of the church to bring people to the church and to be a mediator of salvation. In the new modern church, disenchantment is seen in terms of material culture and institutional hierarchy within the churches and therefore these churches incorporate technology with the desire to remain relevant to society. New modern churches therefore utilise social media and a less formalised approach to church services. In becoming more popularist, new modern

churches have increased numbers of church membership which in turn through congregation tithes and collections, contributes to the viability of this church expression. Church mission is interpreted within the context of the individual with individual salvation, forgiveness of sin, and the belief of heaven and hell as literal places that people are sent to when they die.

The emerging church is a relatively new phenomenon in the Christian church, with post-modern thinking framing how these churches have interpreted biblical texts. The emerging church is fundamentally distinct to the previous expressions of church. Emerging churches recognise that societal disenchantment relates to how the church operates and the confinement of Christianity to the structures of the church. Therefore, understanding that disenchantment with the church relates to how the church operates and the confinement of Christianity to the structures of the church. Emerging churches have turned away from questions of congregation numbers and conventional practices of church and instead look to having a role in supporting society and those who live in it. The church mission of emerging churches is understood as bringing heaven to earth, and being involved in restoring God's world; thus the practice of these churches may align more with upstream approaches to health promotion. The theological and missiological paradigms discussed in this chapter are critical to understanding different expressions of church, including the nature and extent of their efforts to promote health and wellbeing. The mission paradigms of the different church expressions have been incorporate into the typology (figure 12.1) in the final chapter of this thesis. In the following chapter, I outline the methods I have utilised to explore the role of churches in promoting health and wellbeing.

Chapter 4

METHODOLOGY

I remember being five, wearing voile dresses with white lace socks and black patent leather shoes to morning church services. I attended Sunday School and sang Christian songs and learnt the words to the Lord's Prayer. When I was a teenager I attended a youth group on a Friday night where we played games and ate pizza. I volunteered as a Sunday School teacher and wrote dramas, played the piano and sang for church services. Then, I started attending church services on a Sunday night with other young people – the music was loud and the sermons were informal and I was able to wear jeans and sneakers. As a young adult, I spent six years of my Friday nights as a youth group leader hanging out with high school students. While I cannot remember the specifics of every church event, activity or service, these were part of my everyday life. Attending these is an important part of my personal and cultural identity.

I was challenged, however, to look at church differently when learning about the principles and practices of public health, the values and approaches of health promotion, and the social and cultural determinants of health. In understanding this, I was stimulated to examine what I knew and understood of local churches, and re-examine what was ordinary to me yet extraordinary to many other public health and health promotion practitioners. Through my involvement in churches, I had observed that some church activities could be regarded as health promoting: youth groups fostered social connection and support; exercise and walking groups promoted physical activity; advocacy sought to address the welfare of asylum seekers and refugees.

In undertaking a preliminary literature review to explore whether churches had engaged formally in health promoting activities, I identified a wealth of research on CBHP conducted in the US (see Chapter two), yet nothing on the local church and health promotion in Australia.

A number of critiques have been published in the academic and popular literature of church stances on moral issues in conflict with public health, but in contrast no publications have considered church practices that might be aligned with health promotion approaches. Because of my personal engagement with Christianity, Australian churches, and church members, I felt I was in a position to undertake studies in this area. I speak the language, understand the ethos and share an interest in and passion for the work of churches in local settings.

Throughout my PhD research, I have been inspired by the work I have witnessed by the local churches. I have identified the potential of churches to engage in health promotion, yet I have also identified significant limitations and challenges. In this chapter, I outline the research processes and methods of analysis that I used to capture the stories, thoughts and critiques of local churches and health promotion in Victoria.

THE RESEARCHER

Human perception is subjective; it can differ markedly between people who, when looking at the same scene, will observe different things (Patton, 2002a). Our observations of the world, people, events and circumstances are influenced by our interests, values and biases, and cultural and social background (Patton, 2002a). My experiences at my own church and my knowledge of other churches influenced the observations that I made and my approach to the analysis of the research data. However, I am not unique in this situation. Kouritzin and colleagues (2009) address this issue of 'positionality' in which researchers intentionally and explicitly “situate themselves relationally, socially, personally, and politically in their

research…not only in relation to others, but in relation to their own sense of identity (ethnicity, gender, native/non-native)" (p. 4). This type of research is commonly referred to as 'insider research', wherein the researcher shares with participants' identity, language and experience (Dwyer & Buckle, 2009; Kouritzin, Piquemal, & Norman, 2009).

My time in the field was peppered with statements such as "oh, you know this person?" or "I don't need to explain this church terminology to you." I identified myself as an insider and by positioning myself in this way my participants treated me as someone who shared their beliefs. The advantages of being an insider include faster and more complete acceptance of the researcher by the participants, which may allow a greater depth of data to be collected (Dwyer & Buckle, 2009); greater knowledge of the setting and the processes within the setting (Asselin, 2003); an understanding of the culture of the setting; and the ability to ascertain the accuracy of responses to questions (Hockey, 1993).

However there are also disadvantages or cautions: the tendency of the researcher to believe that he or she knows the culture of the setting, population or community so well as to fail to question its underlying premises or to view the setting from a different perspective; difficulties associated with the objective collection and analysis of data; perceptions, expectations and concerns about confidentiality by study participants which may influence how and what participants divulge; and role confusion where the researcher may step into the role of the participants under study (Asselin, 2003).

THE RESEARCH

The theoretical drive of the study is inductive, and so, following Morse (2003), its purpose is to describe and explore the role of the church in health promotion. The local church has not been explored previously as a setting and partner in health promotion efforts in Victoria and consequently this research is exploratory in nature and consistent with this, I chose to employ

a qualitative research methodology to understand the context of the local church and health promotion. Denzin and Lincoln (2005) describe qualitative research as “a situated activity that locates the observer in the world":

> It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (p.3).

In the course of undertaking this research, I immersed myself in the world of churches, both those with which I was familiar (Baptist and Churches of Christ) and churches with which I was unfamiliar (Catholic, The Salvation Army, Uniting and Anglican). I sought to understand what it meant to 'be church' and how this played out in health promoting practices in their local community. This approach aligns with a constructivist paradigm, in which the epistemology is defined as “the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context” (Crotty 1989 as quoted in Golafshani, 2003, p. 603). The church is the social context. The aim of the inquiry is to understand and re-examine the constructions that the participants and I, as the researcher, hold in relation to the local church as a setting and partner for health promotion (Guba & Lincoln, 1994).

The research questions and design are based on assumptions informed by my knowledge and experience of churches. The first of my assumptions is that churches are involved in activities

or programs which promote health and wellbeing. The second is that churches are likely to have an ethos of social justice based on Bible teachings, and therefore, both the stated mission and the practices of the churches are likely to respond to the identified needs of vulnerable individuals, families and communities. I outline the research aim and questions that defined the study below:

Aim

To explore the mission and practices of local churches in Victoria to determine whether these align with health promotion approaches

Research Questions

1. How do different churches describe their mission, and how is this given expression in ways that address the social determinants of health?

2. To what extent and in what ways do church practices promote health and how does this vary in different expressions of church?

3. To what extent and in what ways are local churches involved in partnerships and collaborations for health?

4. What tensions, challenges and limitations exist in local churches undertaking health promotion?

Sampling

I employed stratified purposive sampling and theoretical sampling for my study. Stratified purposive sampling aims to select cases that illustrate variation in the phenomenon (Ritchie, Lewis, & Elam, 2003). In this research, only Christian churches were sampled and therefore these churches had a shared set of core beliefs. However, I reasoned that there would be significant variations in church mission and practices and thus church expression (see

Chapter three). This sampling method fits with the concept of theoretical sampling, which involves sampling on the basis of emerging concepts identified and developed from the data (Llewellyn, Sullivan, & Minichiello, 2004). Neither of these sampling techniques seek to establish generalisability to the broader population (Rice & Ezzy, 1999) although the findings in relation to the phenomena of church engagement in health promotion may be generalisable.

The Christian church was chosen as the focus of this study as Christianity is the largest religion in Australia (Australian Bureau of Statistics (ABS, 2012). I define the local church as a gathering of a group of people who meet together on a regular basis for teaching, worship and community activities and social interactions (termed fellowship or community). Eligible Christian groups were those that had participated in the National Church Life Survey to enable me to compare data where possible (Bellamy & Castle, 2004). The National Church Life Survey (NCLS) was developed by ANGLICARE (Diocese of Sydney), the Uniting Church in Australia NSW Board of Mission, and the Australian Catholic Bishops Conference. The only survey of its kind in Australia, the NCLS investigates church characteristics including congregation members, church leaders and church activities, and has been conducted five times to date: 1991, 1996, 2001, 2006, and 2011. From these participating Christian churches, six groups were represented in the sampling. A brief overview of these church denominational groups was provided in the introduction of this thesis; here I outline the rationale for their inclusion in this study.

I chose to include the Catholic Church because it is the largest Christian group in Australia (Bellamy & Castle, 2004) and is an example of a traditional church. The Protestant group were represented through the Uniting, Anglican [11] Baptist and Church of Christ denominations. The Uniting Church denomination is unique to Australia and was formed in 1977 through the merging of the Methodist, Presbyterian and Congregationalist denominations (Humphreys & Ward, 1988). The Church of Christ denomination was chosen to represent a contemporary less hierarchical denomination in comparison to the other protestant denominations (Humphreys & Ward, 1988). The last group, the Salvation Army, was chosen because of its high profile in social justice and social welfare, therefore offering different perspectives on the role and activities of the church in health promotion.

RESEARCH STRATEGY

I spent the first six months of my PhD candidature reviewing the literature on CBHP. I was confronted by the gap in research on Australian churches and health promotion, and hence felt that my initial data collection needed to focus on fact finding and familiarisation before I could develop the research inquiry further. Therefore, data collection occurred in three distinct but iterative phases, with each phase building on the knowledge and themes gained from the previous phase.

Phase 1 - Exploration

The first phase was one of exploration, wherein I conducted a document mapping exercise and in-depth interviews. The aim of this phase was to identify the themes underlying church involvement in promoting health and wellbeing, and to map the funding and partnerships of

[11] There is contention regarding whether the Anglican Church should be considered Protestant, Catholic or Reformed Catholic. The Anglican Church is not Roman Catholic so differs in beliefs and practice to the Catholic Church. Unlike the Roman Catholic Church, the Anglican Church does not recognise the Pope as the head of the Church, priests are permitted to marry and prayers are not directed to the Virgin Mary (Anglican Church of Australia, 2012). The Catholic Church and Anglican Church separated in 1534 however in many respects their practices remain similar.

local churches, church affiliated agencies and church affiliated organisations with secular non-government, government and for-profit agencies. I defined a church affiliated organisation as a large welfare organisation founded by the church or members of the church and/or government. The document mapping exercise consisted of three components, as I describe below:

Component 1

For the first component of the mapping exercise, I obtained the 2007/2008 annual reports of ten organisations affiliated with a number of different denominations, listed in Table 4.1 and one church affiliated agency. Church affiliated agencies are smaller than church affiliated organisations and are not incorporated under the Associations Incorporation Act, 1981 (Vic.) (Associations Incorporation Act 1981; version 72). I selected these organisations as they represent leading welfare organisations in Australia. Each report specified sources of funding and support which was imported into an Excel spread sheet for analysis.

Table 4.1: Church Affiliated Organisations and Affiliated Denominations

CHURCH AFFILIATED ORGANISATION	AFFILIATED DENOMINATION
Anglicare	Anglican
Brotherhood of St Laurence	Anglican
Baptcare	Baptist
Jesuit Social Services	Catholic
Sacred Heart Foundation	Catholic
St Vincent de Paul	Catholic
Melbourne City Mission	Uniting
UnitingCare	Uniting
Wesley Mission	Uniting
Salvation Army	Salvation Army

Component 2

The second component of the mapping exercise involved obtaining the 2007/2008 annual reports of local government councils in Victoria, and reports for the same period of a selection of foundations and trusts. This component aimed to determine the funding relationships between churches or church affiliated organisations and funding bodies. The 2007/2008 annual reports of all 79 local government councils in Victoria were sought and downloaded from the council websites. The reports for five councils could not be found on their websites and the majority of reports did not specify individual grant recipients, however the grant recipients often acknowledged this funding in their annual reports. I also examined the 2007/2008 reports of a selection of philanthropic foundations and trusts (Sidney Myer Foundation, Helen MacPherson Smith Trust, Melbourne Community Foundation, Jack Brockhoff Foundation) and VicHealth.

Component 3

The third component of the mapping exercise involved the analysis of the strategic plans of the Primary Care Partnerships (PCPs) in Victoria. In 2000 the PCP strategy was initiated resulting in 31 Victorian PCPs bringing together over 800 agencies. The primary aim of the PCPs is to improve the health and wellbeing of Victorians by improving the experience and outcomes for people who use primary care services and reducing the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people's need for support (HDG Consulting Group, 2008; Statewide PCPs Chairs' Executive., 2009).

Three areas of practice for the PCPs are (Statewide PCPs Chairs' Executive., 2009):

1. Integrated health promotion: Development of health promotion capacity of agencies and the coordination of health promotion programs and resources to improve health outcomes for members of the community

2. Service coordination: Improvement of health service coordination through tool templates, data standards, orientation programs, electronic referral, etc to improve the accessibility of the health system to make more effective use of health resources

3. Integrated Chronic Disease Management: Provision of a coordinated approach to the planning and delivery of health services for consumers with chronic disease to reduce the demand on the acute sector.

The strategic plans of the 31 PCPs were examined for listed partner or member agencies, which were either local churches or church affiliated groups or organisations.

Qualitative Scoping Interviews

To supplement the findings from the annual reports, I interviewed local church leaders and staff of church affiliated organisations and agencies. Purposively sampled local church leaders and individuals from church affiliated organisations were chosen to gain specific information and insight into the phenomenon of interest (Patton, 2002b). Although they were not chosen to be generalisable or representative of the wider population, they provided me with the opportunity to identify preliminary themes and thus they, together with the document analyses described above set the basis for the later phases of data collection (Patton, 2002b). The directors of eleven church affiliated organisations, identified in component one, were sent an invitation letter to participate in the study. Churches were identified through church directories and websites, or via recommendations from church affiliated organisations on the basis of their known participation in health promoting programs or activities. Two church

affiliated agencies were also identified and invited to participate due to their strong links with a number of local churches.

Two qualitative interview schedules were developed: one for the local church leaders and the other for staff of church affiliated organisations/agencies (Appendix 1 and 2). Of the eleven church affiliated organisations/agencies invited to participate in an interview, five agreed and interviews were conducted with a nominated staff member from the organisation. Five interviews were also conducted with local church leaders providing sufficient data to progress to the next phase of the study. The qualitative interview schedule included questions regarding the mission of the local church or church affiliated organisation/agency, the participants' understanding of health promotion, the role of the specific church in health promotion and the work of the church in the community, and an exploration of partnerships and funding. I used the findings from this first phase to construct the interview schedule for the qualitative semi-structured telephone interviews in phase two.

Phase 2 - Description

Qualitative Semi-structured Telephone Interviews

The local churches were selected via purposive sampling and snowball sampling. The directors of the church affiliated organisations recommended churches that were participating in activities promoting health and wellbeing, and after each interview, I asked the participant to nominate churches other than their own which they perceived as health promoting. Churches were also selected on the basis of congregation size, and rural and urban location, to ensure an adequate representation of churches in different contexts (Table 4.2). The telephone interview schedule addressed themes relating to how the church leader defined health and health promotion, church activities or programs which promoted health and wellbeing, the resources of the church in relation to staffing and volunteers, funding sources

and partnerships with other community organisations or agencies, and barriers and opportunities for the church to participate in health promotion (Appendix 3). A time for the interview was set up with the church leader in advance via email or phone. The interviews took an average of 40 minutes, the shortest being 20 minutes and the longest 80 minutes.

Table 4.2: Sampling Framework for Phase 2 Telephone Interviews

Denomination	Location		Congregation Size			Total
	Rural	Urban	Small >100	Medium 100-1000	Large 1000+	
Anglican	1	4	1	2	2	5
Baptist	2	4	1	4	1	6
Catholic	0	3	0	2	1	3
Church of Christ	0	6	4	1	1	6
Uniting	0	3	2	1	0	3
Salvation Army	2	0	2	0	0	2
TOTAL	5	20	10	10	5	25

Phase 3 – The Case Studies

Case studies of selected churches were undertaken to explore the emerging themes of CBHP, and to further investigate and to document church activities and programs which promote health and wellbeing in the community. Case studies explore contemporary phenomena in-depth within real life contexts (Yin, 2009), to address research questions which commence with a 'how' or 'why' with the 'case' ranging from individuals, organisations, processes, programs, neighbourhoods or events (Yin, 2009). While some researchers describe case studies as a method, others refer to the case study as an 'approach' (Stark & Torrance, 2005; Yin, 2009). A 'case' is studied in its real life context, and therefore a number of variables can be explored; thus a combination of evidence sources and research methods are used (Yin, 2009). The local church is the unit of analysis in this study. The phenomenon of interest is

health promotion activity in the context of the local church. To investigate this phenomenon, I utilised a multiple case study design, with cases chosen to provide insight (Stake, 2005).

Cases were deliberately chosen with a positive bias, in that only churches involved in health promotion activities were invited to participate, and hence the sampling was theoretical. Based on the phase 2 qualitative telephone interviews, I identified cases that would potentially provide in-depth insight into health promotion opportunities and activities conducted in local church settings. I used theoretical replication logic, a term used by Yin (2009), which indicates that the sampling of cases sought to capture distinct theoretical conditions. In this study, I expected different findings based on predictable variances of theoretical conditions such as church expression, denomination, church size, church location and congregation demographics. Based on findings from previous literature and my own experiences, I hypothesised that churches most likely to engage in health promoting activities would be emerging and new modern churches comprising of larger and younger congregations in urban locations. Theoretical replication logic therefore increased the chances of identifying patterns of churches of difference or similarity in the health promoting nature due to different church characteristics.

The framework guiding the selection of cases was the continuum of health promotion approaches as detailed in Chapter one, with the process of selection represented in Figure 4.1 (below). The framework spans the primary care/disease prevention approach, the health education and behaviour change approach, the participatory health education approach, the community action approach, and the socio-ecological health promotion approach (Keleher, 2007b).

Two churches corresponding to each health promotion approach were identified and the church leaders of these churches were invited by email to participate in the case study phase.

In total, eleven church leaders were contacted to participate in this phase, with one of these church leaders declining to participate due to pressing time commitments. Each case study involved document analysis of annual reports or newsletters; semi-structured qualitative interviews with staff members and/or key volunteers (Appendix 4); focus groups with church volunteers (Appendix 5); and direct observation of church activities (Appendix 6) related to health promotion as described in chapter one (Table 1.1) and two. Direct observation was utilised to provide additional information of health promotion activities undertaken by each local church (Yin, 2009); I documented the type of activity conducted; eligibility of participation (church member versus non-church member); number and description of people attending; engagement of volunteers and leaders, and the processes and protocols followed. These observations were written up as field notes along with summaries of conversations which I had with those attending, and personal reflections on how the attendees reacted to me. A number of different data sources were utilised in this research, as outlined in Table 4.3 below.

Ethics

Ethics applications for a low risk project involving humans were submitted for each phase of the study to the Monash University Human Research Ethics Committee. The phase one ethics application was approved in January 2010 (CF09/3382- 2009001824), with an amendment for approval for phase 2 granted in April 2010. Approval for phase three was obtained in July 2010 (CF10/1735 - 2010000959). The contact details of the directors and church ministers were obtained via publicly accessible church directories and websites. The senior minister of each church and directors of the church affiliated organisations submitted permission letters to indicate consent for staff to participate in this research. An invitation to participate and an explanatory statement was emailed to ministers and directors with a follow up email being sent two weeks later. The consenting ministers were asked to distribute the explanatory

statement and my contact details to other staff members and volunteers. Those interested in participating were asked to either indicate this via email or a telephone call. Explanatory statements for each phase of the study are included in Appendix 7.

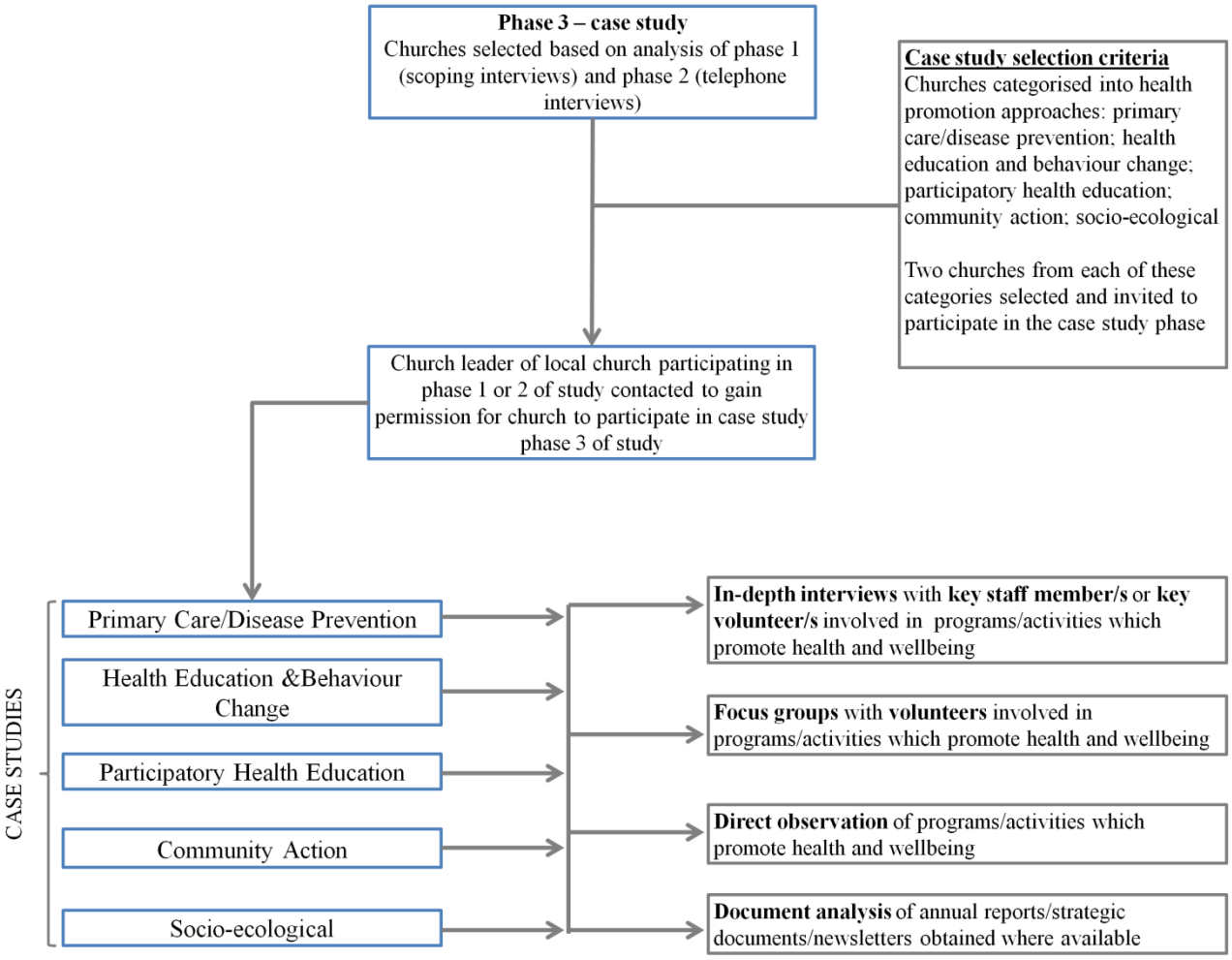

Figure 4.1: Case Study Flow Protocol

Table 4.3: Data Sources of Research Project

STUDY PHASE	DATE	DATA SOURCE	DATA COLLECTION STRATEGIES	PARTICIPANT NUMBERS
Phase 1 - Exploration	April-Oct 2009	Documents	Annual reports of funding agencies, local government councils and church affiliated organisations, strategic plans of primary care partnerships	
	Jan - March 2010	Qualitative scoping interviews	In-depth interviews with local church leaders and individuals from church affiliated organisations in Victoria	5 local churches 5 church affiliated organisations
Phase 2 - Description	April - June 2010	Qualitative telephone interviews	Qualitative semi-structured telephone interviews with church leaders of 25 Victorian churches	25 church ministers
Phase 3 – Case Studies	July - Dec 2010	Qualitative Interviews	Face-to-face qualitative in-depth interviews with the church staff and/or key volunteers of 10 case study churches	37 interviews
		Focus groups	Focus groups with church volunteers	10 focus groups
		Observation	Direct observation of case study churches in their conduct of health promotion activities	17 direct observations
		Document analysis	Annual reports and/or church newsletters	12 document analyses

RIGOUR IN QUALITATIVE RESEARCH

It was with hesitant steps that I entered the field for my research. I was known in some of these church communities, and my background and experience in churches was what drove me to do this research. As mentioned above, I identified as an insider to this research as I shared experiences, religious affiliation and language with the research participants. In undertaking this research, I was required to be true in what I captured and interpreted, and reflexive in acknowledging my own biases that may have coloured my approach and interpretations. Insights in qualitative research generally stem from the personal experience of the researcher. What begins as a hunch ends as a claim (Altheide & Johnson, 2011). As discussed above, I had research assumptions that were based on my experience of growing up attending churches. My hunch was that churches, by virtue of 'being church,' were involved in work that was health promoting. In the results and discussion chapters of this thesis, my

hunches are translated into claims. The logic of my study and how knowledge came about needs to be evident; hence, below, I outline the considerations and steps taken to ensure rigour.

To be able to demonstrate the trustworthiness of this research, I need to account for my methods and interpretations (Merriam, 1995). As I have stated earlier, qualitative methods were chosen as I considered my research question to be hypothesis building rather than hypothesis testing; I sought to understand the phenomenon and I was interested in the perspectives and experiences of participants (Merriam, 1995). Criteria used to assess the trustworthiness of research conventionally include concepts of validity and reliability (Lincoln & Guba, 1985; Shenton, 2004). Hammersley (1990) broadly defines validity as "truth: interpreted as the extent to which an account accurately represents the social phenomena to which it refers" (p.57). Validity assesses whether the instruments and tools utilised in the research accurately measure what they were intended to measure and therefore whether the findings can be trusted (Golafshani, 2003). Reliability is a consequence of validity, and is concerned with whether the research results are consistent and whether the outcome is an accurate representation which can be replicated or reproduced under a similar methodology (Golafshani, 2003). Primary data were collected for this research through interviews, focus groups and observations. The interview questions for this study evolved as the study progressed, and accordingly, the process was iterative. I spent 12 months collecting data, and as my understanding and responsiveness to my participants and to the culture and ethos of the various churches developed, so did my line of questioning. For example, in the early interviews for phase 2, I included questions regarding the qualifications a church leader might look for in hiring someone to undertake health promotion activities. This question was dropped after the first couple of interviews, as it was clear that church leaders did not necessarily view their activities as health promoting and therefore did not perceive the

relevance of this question. By ‘being church’, they were health promoting, and therefore activities that were health promoting were not easily separated from other activities that were part of the core mission of the church.

Credibility ensures that the findings and interpretations of the data are plausible and reflect reality (Lincoln & Guba, 1985; Shenton, 2004). Strategies for this include triangulation, prolonged engagement, persistent observation, negative case analysis, referential adequacy and member checking (Lincoln & Guba, 1985; Shenton, 2004). Triangulation of the data is evident in this research through the multiple methods of data collection, including the three phases described above, and the conduct of interviews, focus groups and observations. In all, 42 interviews and ten focus groups were conducted, and these were supplemented by the observations of 17 activities (see Appendix 6). These various data sources led to the confirmation of key themes and confidence in the findings, for example themes that emerged in interviews with church leaders were either supported or contested in focus group discussions.

Shenton (2004) writes that "the development of an early familiarity with the culture of participating organisations before the first data collection dialogues take place (p.65)" contributes to the credibility of the research. This is where my experience with local churches and my status as an inside researcher aids credibility; it provided the basis of prolonged engagement with the culture of local churches. Prolonged engagement with churches was also achieved through the case study phase as the ten case study churches were involved in more than one phase of data collection. These ten churches were the case studies in which significant time was spent conducting interviews and focus groups, and attending activities and programs. Subsequently, there were many instances where I interacted with the same people on more than one occasion, thereby facilitating the development of interactive and deeper relationships with participants.

Through participant observations, I was able to validate what was proclaimed as truth in the interviews and focus groups, including by watching activities and programs, attending church services, and scrutinising how church members interacted with members of the community. These observations also assisted my understanding of how I was perceived by the churches in this study, and by community members attending programs. A process of reflexivity that I describe below is based on one of my fieldwork entries, conducted in the early days of my data collection for phase 3:

> I attended the church service at Redgum Church of Christ. The attendees come from the lower socio-economic pockets of Redgum and many struggle with mental and physical health problems. I wore skinny jeans, chunky heels and a jacket, as I was attending the church service at my own church immediately afterwards. I regretted this choice as soon as I entered, as my clothes were noted upon by more than one participant. My clothes were a distraction to the participants: they identified my status as someone 'not on their level.' I was the 'lady from the university.' A few weeks later I attended the food bank at Redgum Church of Christ. Despite needing to lecture that morning, I wore cargo pants with sneakers and a baggy jumper. During my data collection and participant observation, I was better able to blend in more easily, and consequently, the responses I gained from people were markedly different. I was not there to help them; rather they were there to help me, help me understand and provide me with their insights and information. The power balance had shifted.

My reflection above demonstrates the complexity of insider research and issues of positionality. This experience from the field involved a shared experience of a church service, however during this process the participants and I became acutely aware of our differences in social position. I was attending my own church service afterwards and had dressed according to the middle class norms of this service. The attendees at Redgum Church of Christ were

experiencing poverty and health issues and therefore their dress and manner reflected their circumstances in life. Despite being an insider in some aspects (religious background, familiarity with church culture and practices), there were social facets that were not shared with my participants including generational, socio-economic and ethnic differences. These complexities are increasingly being discussed in the research literature (see for example Borbasi, Jackson & Wilkes, 2005; Ganga & Scott, 2006; Mullings, 1999).

Throughout my candidature - during data collection and analysis, and in the construction of my results chapters - I engaged with a number of Christians, both paid church staff members and volunteers, to test my thoughts and concepts. These people were not participants in the study, but they were embedded in the cultural and social context of churches in Victoria. They were able to challenge and also affirm my thinking and so contributed to a process of member checking. In addition, regular meetings with my supervisors and presentations of my research at conferences and seminars during my candidature enabled the academic community to challenge and critique my interpretations and affirm the applicability of my findings to the work of health promotion. This process served to strengthen my data analysis, as I continually asked: 'What do I know?' 'Why do I know this?' and 'What does it add to the field of health promotion?'

While I purposively sampled churches with a positive bias, to properly examine church-based health promotion, I also employed stratified and theoretical sampling to allow for a diversity of church contexts. Although I did not use negative case selection, the Catholic churches in this study acted as examples of the 'low engagement.' A diversity of church cultures, theology, ethos and community were evident in my sampling and consequently in the findings of this thesis. This is illustrated in the results chapters, presented below.

ANALYSIS

As I have already noted, there is a lack of literature exploring church practice and alignment with health promotion actions in Victoria, and in Australia in general. While I was able to draw some insights from the CBHP literature, published in and about churches in the US, this work had little application to Australia. Hence an inductive approach to data analysis was adopted. While the analysis of the data was guided by the framework of health promotion action developed by Keleher and Murphy (2004) to help categorise the type of health promoting activities churches were involved in, the method of inquiry was an iterative process.

The process of iteration occurred via the three phases of data collection. Data analysis was continuous, with emerging themes explored and tested in each phase. Although I conducted data analysis concurrently with my data collection, I analysed the data separately in greater detail the following year. I coded and recoded transcripts, continually working back and forth between data sources as actions, processes and themes emerged to test applicability and consistency.

The concept of social justice, a value both of health promotion and in Biblical teachings, was an important anchoring point in this study. Health promotion practice and church mission are therefore both influenced by social justice ideals. As stated by Charmaz (2008):

> An interest in social justice means attentiveness to ideas and actions concerning fairness, equity, equality, democratic process, status, hierarchy, and individual and collective rights and obligation. It signifies thinking about being human and about creating good societies and a better world (p 206-207).

A social justice lens is applied to examine the collective and individual experiences of the setting with emphasis on resources, hierarchies, policies and practices (Charmaz, 2005,

2008). For this analysis, I was asking questions such as: What church resources are available for health promotion practice? How are these utilised? Who makes decisions in relation to church resources? According to which and whose criteria of need are these decisions made? Who are these resources available too? What are the social hierarchies of the churches in this study? How do these hierarchies affect social action? What are the 'rules' of church practice? How do these practices align with health promotion?

The practice of qualitative analysis consists of open coding, axial coding and selective coding (Rice & Ezzy, 1999). Coding is the technique in which the transcripts and written notes are conceptualised line by line by the researcher (Orona, 2002). I transcribed all interviews and focus groups, and these transcripts were loaded into Nvivo 8 and later, Nvivo 9 (QSR International, 2012). Notes of direct observations were also entered into Nvivo. In my first coding round, I identified actions and processes. For example, I categorised all church activities and programs discussed in the interviews and focus groups and observed in the participant observations. Decision making processes, partnership and funding processes, and church mission statements were also coded. In the second round of coding, I focused on line-by-line coding for themes and narratives. This included exploring theological stances and teachings, beliefs, attitudes and assumptions. These were consistently compared to the first round codes. This process was conducted iteratively, with themes that emerged in later transcripts applied to earlier transcripts. The third round of coding enabled me to make conceptual links between the themes and codes of round one and two. Through this process of coding, I developed a mid-range theory in relation to church practice and health promotion, which I present in the discussion chapter of this thesis.

In the following chapters, I present my analysis of the world of churches in which I was immersed as I conducted fieldwork. I describe the processes of church practice and action, and explore how this can be conceptualised into health promotion action. I have chosen to

capture the essence of my data analysis in stories from the field. I hope that in providing these stories, readers will gain insight into how these churches were involved in promoting health and wellbeing. In writing about them, each suburb, local church, church affiliated organisation/agency and participant were assigned pseudonyms to protect identity and maintain confidentiality. A table listing the pseudonym church names and key characteristics are set out at the beginning of this thesis.

The following chapters correspond to the research questions and the emerging themes from the data. The findings of each results chapter, in conjunction with the framework of health promotion action (Keleher & Murphy, 2004) led to the development of a typology. The typology, titled "Typology of Christian Churches by Health Promotion Approach" characterises the health promoting activities of the churches in this study and how this is associated with variables such as church mission and church expression (see chapter 3), understanding of health (see chapter 5), partnerships (see chapter 6), church hierarchy and community engagement (chapters 7-11).

Each chapter highlights how church mission is associated with the health promoting nature of local churches from downstream to upstream action. Chapter five responds to the first research question, and examines how church mission leads to or inhibits health promotion practice and engagement with social determinants of health. In Chapter six, I describe the partnership networks and funding sources accessed by local churches. In chapters seven to nine, I present examples of the downstream and midstream health promoting work of churches. Chapter seven describes the work of churches in health education and health literacy; Chapter eight examines how churches are involved in fostering social inclusion and Chapter nine explores the role of churches in addressing material determinants of health. In Chapter ten, I illustrate how some local churches are involved in upstream actions to address the social determinants of health. In Chapter eleven, I discuss themes associated with the

challenges, limitations and barriers of engaging with churches in health promotion. To conclude this dissertation (Chapter twelve), I present a typology which I have developed from my research data and analysis. This typology captures the different characteristics of local churches and their health promotion activities. It provides stakeholders with a tool to assess the suitability of local churches for health promotion action, and a framework for how to engage with local churches in health promotion.

Chapter 5

THE MISSION OF THE CHURCH AND THE SOCIAL DETERMINANTS OF HEALTH

Milltown is a residential and industrial suburb located on the outskirts of Melbourne. Driving to Milltown I am accompanied by trucks, utility vehicles and cars that push the limits of speed. The suburb was regarded as one of the ten most disadvantaged areas in Victoria (Vinson, 1999) and still is ranked as a low socio-economic status area (Department of Planning & Community Development, 2006, 2011). This is highlighted by the quality of the houses that line the streets, the stores that dominate the local shopping centre, and the conversations of residents discussing issues of unemployment, food insecurity and living costs. Milltown Community Centre is both a Salvation Army church and a welfare organisation, the latter is funded by the Salvation Army as well as state and federal Government grants. All Salvation Army corps have their own mission statements tailored to locality. The mission statement of Milltown Salvation Army is to "respect, resource, renew" with a vision statement that emphasises "a place of belonging for everyone." Dale, one of the Captains of Milltown Salvation Army, explained that the 'renew' in the mission statement, relates to the "hope that we have for this community":

> that through everything that we provide here ... as people move forward in their lives they would personally experience some sort of level of transformation and renewal, and that, even on a bigger level, … could play some part in renewing the community in a positive way as well.

The red and blue building of the community centre is modern; the space is open and light. When I enter the building the reception desk is in front and slightly to the left. The

receptionist, Nicole, greets everyone who enters and she is always smiling. Cameron, a volunteer, is hovering at the entrance, eager to be helpful to those who enter. He has cerebral palsy; he wears a neck brace and walks with a limp. Despite it being a cold day, Cameron is wearing shorts and a T-shirt. He has a bushy beard and he is difficult to understand, communicating in grunts and energetic arm movements. He seems enthusiastic about his role as a volunteer, and does not leave his post the whole day.

To the right are four large comfortable blue chairs and a very big, comfortable blue velvet L-shaped couch. Cushions are scattered over the couch and chairs. There is a red circular carpet and a coffee table with the day's newspapers on it. Next to the couch and against the wall, near the entrance to the computer room, is a bookshelf with some books including a Bible and a range of Christian books including self-help books and books about Christian faith; none were specific to the Salvation Army. The bookcase also has a shelf of pamphlets about health services, and upcoming courses and training opportunities, and a variety of health promotion materials such as booklets on depression and anxiety, and drug and alcohol assistance. On top of the bookshelf there are a collection of board games. The atmosphere feels like one of a home, a comfortable place to hang out, a place that is open to everyone. The chairs all face each other so that no one would be sitting on the outer. When I walk to sit on the couch, I feel like I'm entering their circle.

On the other side of the computer training room, there is a table with Fair Trade[12] tea and coffee. There is also a table with two large bowls of fruit. Notice boards are positioned on the main walls and these display newspaper articles about the centre, Salvation Army training

[12] Fair Trade is a movement concerned with justice in trading. Fair Trade products ensure safe working conditions, appropriate wages for workers; proper access to the trade market and that production complies with environmental standards. See www.fta.org.au for more information.

college information, biographies of the officers-in-charge, a poster advertising the street soccer program coordinated by the *Big Issue,*[13] and a poster advertising a local drum school.

Mick is the volunteer kitchen hand at the Milltown Community Centre. He is tall and muscular with piercing blue eyes. Due to his height, I can't be certain, but there appears to be a nail protruding from the top of his bald head. He is well dressed in slacks, a shirt and a cotton vest with black polished shoes. Mick used to be homeless and suffered from agoraphobia. After a stint in a homeless shelter, he was given a house across the road from the Community Centre. His social worker encouraged him to attend the centre to socialise with people. Mick started coming and as he spent more time at the centre, he decided that he should start volunteering to be helpful and pass the time constructively. Mick started working with Josie, a qualified chef who also volunteers at the centre. She coordinates the midday community meals which are run twice a week on a Tuesday and Thursday.

Mick and Josie's relationship is characterised by Josie's encouragement of Mick and Mick's respect and awe of Josie. Josie talks about how Mick has developed a lot of skills in the kitchen. When he first came in, he didn't function well in the kitchen as it was a foreign environment for him; now, she says, he is the fastest potato peeler around, he is reliable and shows initiative, and is gaining confidence in his abilities. Mick describes how volunteering gives him a sense of satisfaction, knowing that he is helping to prepare meals for people in need, that he is helping someone else. He talks about how being a volunteer and working with Josie has improved his lifestyle: he eats better, socialises well and his mental illness is under control. Mick tells me proudly that he is going home to prepare his evening meal of crumbed

[13] *Big Issue* is a social enterprise that aims to provide opportunities for employment and social connection for those experiencing homelessness or marginalisation. The Community Street Soccer Program uses "the positive power of sport to change lives. www.bigissue.org.au

lamb cutlets and vegetables. He always leaves at about 3pm, before the school kids arrive to use the computers for their homework and to access social network sites. They "push his buttons" and he can't handle them. However, at the same time, he talks about how when he is in the town centre, kids will recognise him and call out to him. Working at the community centre has embedded him within the community life of Milltown. No longer a stranger, volunteering at the centre has changed his life: "It's all connected; I'm feeling 100% positive whereas I was only 10% positive when I first came, so it has helped me in a lot of ways which is good!"

Reflecting on the work of Milltown Salvation Army, Dale says:

> It's sort of just exciting when you think about different people, some people we've been involved with have been, you know, ritually abused since they were children, chained to clotheslines out the back in storms, sexually abused, medically abused; it just goes on and on and on and on. The most horrible things that you could possibly imagine, has happened to so many people here, and they are just moving forward, it's nothing my wife and I do. [However] when you've got a place that upholds the sort of values the Salvation Army has, like dignity, compassion and hope, it just changes lives, people just become more connected with each other and ....yeah it's an amazing place to be (Dale, Captain, Milltown Salvation Army, rural).

♦ ♦ ♦ ♦

In this chapter, I seek to explore how churches understand the mission of the Christian church and how this influences their understanding of health and health promotion. An evangelism-focused mission and the Kingdom of God focused mission represent two theological stances influenced by a literal, systematic or narrative interpretation of biblical texts. The mission of

traditional and new modern Christian churches has been interpreted in terms of salvation, whereby the church exists to tell people about Jesus and convert them to Christianity so that people will be saved with eternity spent in heaven. The focus for these churches is the individual and his or her salvation (Bielo, 2009). For these churches the Bible is interpreted in light of its application throughout church history. While many still believe and operate within this context, there has been a substantial shift in thinking in recent decades. As one participant said, "church is changing … [there's] a different way of being church" (Margaret, Minister, Longbourn Uniting Church, urban).

Postmodern society is characterised by critical examination and questioning. A re-reading of Biblical texts in light of the cultural and historical contexts in which the text was written has led to different interpretations of the Kingdom of God. This is coupled with an understanding that while the Bible was compiled for the church, it was not directed to the church today, and therefore it is vital to understand the social context influencing the early church and its foundational texts. Consequently, churches aligning with a narrative approach to Biblical texts have shifted in their understanding of church mission (Bielo, 2009). Church mission is no longer viewed as being concerned only with articulating the need for salvation and acceptance of Jesus Christ as one's personal saviour. Instead, the mission of the church has broadened to be concerned with transforming lives and transforming society by "bringing heaven to earth" (Andrew, Senior Minister, Ashridge Baptist Church, urban).

Churches adopting a Kingdom of God mission believe that they are called to bring hope, justice, mercy, compassion and love to "all people regardless of habits, clothes, race or even creed" (Ayesha, UNOH Worker, Redgum Church of Christ, urban). These churches focus on the life of Jesus and seek to emulate his service to people who are poor and marginalised. Churches with a Kingdom of God mission most readily focus on community and engage with upstream health promotion activities and programs. They may concentrate

activities on particular populations, for example advocacy on behalf of asylum seekers, people who are homeless, impoverished or troubled, refugees and migrants, isolated members of rural communities, problem gamblers and international students. In addition, churches operating with a Kingdom of God mission strive to change the culture and social structures of their community. I elaborate on this below, and return to this theme in chapter ten.

Churches with an evangelism-focused mission show a preference for downstream or mid-stream health promotion activities. The mission statements of these churches focus on individual health and wellbeing, with the goal of bringing individuals into relationship with God:

> To connect people to the life of God (Megan, Children's Pastor, Perrington Church of Christ, urban).
>
> Leading people into a mature relationship with Jesus as Lord (Cohen, Youth and Young Adults Minister, Murcutt Anglican Church, urban).

Engagement with downstream and midstream health promotion for these churches involves running health seminars, providing health information and education, and providing avenues for social support through activities such as youth groups, craft groups, and mother's groups.

THE BIBLICAL BASIS OF CHURCH MISSION

Understanding the drivers behind the church's work in community is important in order to recognise the boundaries of engaging with churches in health promotion. Therefore, I asked church leaders and volunteers what inspired them to engage with the community and particularly those in need. The prevalent response from this line of questioning was quoting Biblical verses as the rationale for their church mission and work in community. These verses ranged from commandments, teachings and practical examples of the work of Jesus, and a

call to justice and mercy. The most common Biblical verse was Mark 12:31 – "Love your neighbour as yourself":

> It's just acting out the commandment...love our neighbour (Maureen, Community Care Pastor, Grantham Rise Baptist Church, urban).

> And the greatest commandment is to love God and to love your neighbour as yourself (Trevor, Senior Minister, Sunderland Church of Christ, urban).

> It's very simply...because Jesus says love our neighbours – and they are our neighbours (Mitchell, Associate Pastor, Tinworth Anglican Church, urban).

A second commandment from Matthew 11:5 – "the blind see, the lame walk, the lepers are cured, the deaf hear, the dead are raised to life and the Good News is being preached to the poor" - was also echoed in the words of participants:

> The Lord's mandate was to enable the lame to walk, the blind to see...etc etc...and that's what our motivation is...we want to be here to help people in their need (Bruce, community meals volunteer, Fortescue Church of Christ, urban).

Old Testament teachings too were heard in the words of those interviewed:

> Micah 6:8 The invitation to do justice, love mercy and walk humbly with our God (Rachel, Café Manager, Aurorville, urban)

> Isaiah 61:4 They will rebuild the ancient ruins, and restore the places long devastated. They will renew the ruined the cities that have been devastated for generations. So it's all about rebuilding the city...reclaiming the city (Robert, Captain, Burghley Salvation Army, rural).

> Psalm 146:7-9 The Bible says go into the world and feed the poor, and look after the hungry and free the prisoners and look after the lost. That's the church's mission. That's what we should be doing (Nigel, Minister, Meryton Anglican Church , rural).

The Biblical basis for a church's mission varied among the traditional, new modern and emerging churches. The two dominant types of mission that emerged were the evangelism-focused and Kingdom of God mission. A discussion of these two mission paradigms and the understanding of these by church leaders follows.

Evangelism-Focused Mission

As discussed in chapter three, new modern interpretations of the mission of church are 'salvific,'[14] focusing on the death and resurrection of Christ and the personal relationship an individual has with Christ. This sense of mission can be demonstrated in statements made by church leaders and the formalised church mission statements as the proclamation of God, connecting people to God and developing an individual's relationship with God.

> The mission is to proclaim the word of God to people, to create a sense of God's presence in their lives, to do that spiritually to, for me to be of service to people, to help create a sense of the presence of God for them both as a community and also individually (Les, Priest, Edgecote Catholic Church, rural).

> Leading people into a mature relationship with Jesus as Lord (Cohen, Young Adults Pastor, Murcutt Anglican Church, urban).

Such statements demonstrate an internal orientation in mission. There is an ongoing tension for churches whose members believe in social justice and community engagement, yet feel

[14] Church terminology to indicate salvation focused

the need to also verbally communicate to others the significance of the death and resurrection of Jesus for the sins of the world. In these situations, churches use community-based activities as a "means to an end" with the end point being "a channel or conduit...by which, with their permission we are able to share the gospel*"* (Trevor, Senior Pastor, Sunderland Church of Christ, urban). This gospel as interpreted by traditional and new modern churches as - "the good news of Jesus, having died on their behalf" (Trevor, Senior Pastor, Sunderland Church of Christ, urban), as opposed to the emerging church gospel of "bringing heaven to earth*"* (Andrew, Senior Pastor, Ashridge Baptist Church, urban).

Kingdom of God Mission

A 'Kingdom of God' mission has, at the forefront, the values of justice, mercy and compassion. Giddens (2006) posits the need for a greater calling for humans to be involved in self-sacrificing work for the greater good of the collective community. This greater calling of the Kingdom of God, compels churches into action to transform communities for good. It changes the church's "outlook on wealth and poverty because Jesus was on about the marginalised and the poor" (Brian, Associate Pastor, Ashridge Baptist Church, urban). The following quote from Andrew, Senior Pastor at Ashridge Baptist Church, illustrates the values of the Kingdom of God and the ethos that is a characteristic of the Ashridge congregation.

> Okay, it comes down to our belief that God has made every human being equal in his sight and is impartial, and the world is broken, and evil is real and present, and there is great inequities (sic). Human beings don't treat each other as they should all the time. And so we believe that God in his Kingdom has come, and one day he's going to remake the entire world. But in the meantime he calls people to buy into justice, and redistribution and compassion and mercy, and to indeed partner with him in

> transforming this world for good until he comes again one day and does it in complete [i.e. completely].

Further encapsulating this idea of the Kingdom of God, Ashridge Baptist Church has a number of vision statements and catchphrases based on narrative readings of the Bible. These include *"*living out heaven on earth," "partnering with God in transforming His world for good," and "loving mercy and seeking justice" (Andrew, Senior Pastor, Ashridge Baptist Church, urban).

This belief in the Kingdom of God manifests itself in a number of different ways. For Redgum Church of Christ, founded through the parachurch[15] organisation Urban Neighbours of Hope (UNOH), Christians deliberately choose to live in areas of disadvantage. In doing so, they hope that they can offer support and encouragement, and act as role models of a healthy and functional life, to those who are vulnerable and disadvantaged in the neighbourhood. The UNOH prayer captures its organisational mission, a mission based on a understanding of the Kingdom of God. Members pray that they will find "fresh ways to love...[their] neighbours from the front line of a world mired in urban poverty." They acknowledge that God's "hope is released when [God's] will is done, in [their] neighbourhoods as in heaven."

The UNOH workers live in situations of self-imposed poverty. They sell or give away their nice clothes, gadgets, electronics, and excess possessions and move into communities of need. Their homes are not just for their own families but are open to the members of the community who want to chat, need a meal, or a place to stay. The UNOH volunteers who leave the comfort of their middle class homes to work with the poor of society describe a

[15] Parachurch organisations can be businesses, not for profit organisations and private associations in which Christians from different denominations work together for welfare, justice, community and evangelistic efforts.

disconnect with their previous social class. While visiting the foodbank run by Redgum Church of Christ, I spoke to a young volunteer, Sarah, who had recently returned to her home suburb in Brisbane for a holiday. Her family lives in a middle class suburb and she felt she "didn't belong." She felt people in her lower social class UNOH neighbourhood had a greater sense of community because the **"**desperation of people here means that they do talk to each other, they do rely on each other and that is community" (Sarah, volunteer, UNOH student and Redgum Church of Christ, urban). Redgum is a church, a foodbank, a drop-in centre and a playgroup, and a collection of vibrant individuals and families who have made the community their home who in their everyday lives, seek to speak hope and offer life.

♦ ♦ ♦ ♦

The church service of Redgum Church of Christ is not typical. The congregation meets in an old Uniting Church hall. I arrived at the church service at the same time as two older men. The smell coming from them was overwhelming and I found myself breathing small shallow breaths. They were very friendly and kept up a steady stream of conversation. The shorter man with the walking stick, Harry, was the most talkative. He had white hair. The other was taller, with a small pointed beard, balding, his middle bottom teeth missing. They were roommates at a supported residential service nearby.

The Uniting Church hall was fairly small, set up with four round tables with chairs around them. There was a section to the side which could be sectioned off where the kids played. There was also a kitchen. People flooded into the space and started moving around the furniture to create a large circle of chairs for people to sit. Harry showed me around: "This is the kitchen, these are the tables, where you want to sit? We make tea and coffee, and have food after, where you want to sit?" He was quite difficult to understand so most of the time I just smiled and nodded. Then Sarah arrived. She is a bubbly and enthusiastic young person in

her early twenties. She went straight over to Edith, a much older lady, and started giving her a back massage while wishing her happy birthday. Edith was sitting opposite me in the circle, so Sarah, looking up from her massage caught my eye, smiled and said "Hi." She introduced herself and then later came and sat next to me. I watched the many small ways Sarah touched the other women; a massage, squeezing someone's arm, a pat on the back; reaching out to establish physical contact to say "you are valued." Sarah is a submerge[16] student in her first year with UNOH. She studies one day a week and then "just spends time in the community" for the rest of her time.

More people joined the circle, all of whom appeared to be poor. The UNOH staff aspired to be among them and with them. They did not want to be distinguished from them, and so they dressed in track suit pants and second hand clothes, like other community members. Some of the people coming to Redgum have disabilities and/or addictions. A few were deaf. There were some young guys as well as older people – yet they all appeared to be very comfortable together. Redgum, to them, was a safe, supportive and welcoming environment.

The transformation of communities and neighbourhoods from places of despair to spaces of hope is a theme that was echoed by other church leaders and church volunteers. For example, Sandra, a volunteer at Grantham Rise Baptist Church, spoke of "hopes of transforming families and people and through that transforming the community." The life of Jesus as portrayed in the Bible was identified as the guide for these local churches and their congregants:

[16] Submerge is a one year program coordinated by UNOH involving neighbourhood engagement, spiritual teaching and academic study (UNOH, 2012).

> As a Christian, we are encouraged by the example that Jesus Christ led and made, and one of those things was certainly His desire to assist the disadvantaged in the community. And it just so happens that we are living in a community surrounded by a significant proportion of disadvantaged people. It gives us that wonderful opportunity to put our faith into action (Scott, volunteer, Grantham Rise Baptist Church, urban).

♦ ♦ ♦ ♦

There exists a continuum from traditional and new modern evangelical churches to socially aware emerging churches. For some of the churches operating in the middle, social justice is used as an action orientated approach to communicate the gospel in that "when people ask us, 'what drives us?' ...we can be honest with them and say it's our belief in Jesus" (Benjamin, Senior Pastor, Sudbury Baptist Church, urban).

Emerging churches are more likely to be outward focused and are willing to engage with others in the community, based on a broader understanding of the Kingdom of God. These church members refrain from 'preaching' or evangelising in the sense of telling people about Jesus and their need for salvation. This is often articulated in not wanting to "beat them over the head with our Bibles or aggressively try and convert them or anything" (Dale, Captain, Milltown Salvation Army, rural). Instead these churches seek to find "where God is at work in the community and [then get] on board" (mission statement, Hangleton Church of Christ, urban):

> It comes down to understanding what the mission of the church is…The churches that actually do anything of value in terms of the wellbeing of people are the ones who are ...outward focused, looking at what's in the local [community] and connecting or providing in the local sense and local community...The ones that do really well don't

> necessarily do it in the name of the church. They just do it." (Melissa, Community Engagement Officer, Beriah Mission, urban)

Churches with evangelism-focused mission statements tended to operate at the downstream end of health promotion, whereas the emerging churches operating within a Kingdom of God mission showed evidence of an upstream approach. Whether a church is emerging, new modern or traditional did not always align with the denomination of the church. An influence upon whether a church worked within a downstream or upstream framework was how health was conceptualised and whether the church recognised and understood the social determinants of health.

CONCEPTUALISING HEALTH AND HEALTH PROMOTION

In the course of various discussions over 12 months, I asked participants in the study how they conceptualised health. The majority of church leaders understood health as being "not just about physical things" (Michael, Minister, Oakham Mount Baptist Church, rural), but a concept that encompassed physical, emotional, social, mental and spiritual wellbeing:

> I would probably say simply physical, emotional and spiritual wellbeing (Trevor, Senior Minister, Sunderland Church of Christ, urban).

> At first I started thinking about the wellbeing of a person – physical and mental health state. And then after giving some thought to it I thought the wellbeing of a person, which is the state of their heart, soul and mind (Rachel, Café Manager, Aurorville Baptist Church, urban).

> I would put it in terms ... couching it terms of wellbeing of each individual which includes physical, mental, spiritual (Margaret, Minister, Longbourn Uniting Church urban).

The churches in this study were concerned with spiritual wellbeing, and hence the concept of health extended beyond just the physical, as was reflected in the language and thinking of all church leaders. However, there was also the sense that the church was in the minority with its focus on the dimension of spiritual health. For example, one church worker stated "our Western society spends a lot of time on developing the mind and body... but not so much the heart or the soul" (Rachel, Cafe Manager, Aurorville Baptist Church, urban).

While the different dimensions of health were identified, some church leaders felt it was important to communicate the need for wholeness and balance. It was not enough to be thinking of each of the dimensions separately, with the church leaders articulating a need for equilibrium and for all the health dimensions to be working together. Health was achieved through "wholeness in body, mind and spirit" (Paul, Minister, Luckington Anglican Church, urban), or through the "balance of the body, mind and spirit...working well together" (Peter, Priest, Ponden Catholic Church, urban). Consequently, despite church leaders identifying the spiritual dimension of health as their core business, there was the recognition that a holistic approach is required when responding to an individual as "there is no use taking care of spiritual health if other people's immediate needs aren't met" (Megan, Children's Pastor, Perrington Church of Christ, urban). The church leaders were unanimous in their desire to not be viewed as people just concerned with the spiritual: "We don't see people as just one part like the spiritual part, we see whole people" (Margaret, Minister, Longbourn Uniting Church, urban).

In expressing their views and beliefs about health and health promotion, the language of church leaders oscillated between health and church activities at the individual level and at a broader community or organisation level. For church leaders who described their perceptions of health at the individual level, engagement with health promotion was downstream. For other church leaders, health was expressed as an inclusive concept with reference to the

community, and hence their church activities incorporated downstream, midstream and upstream components. Overall there was the belief that people belonged to community and therefore, while there may have been a focus on individuals, health at a community level was a by-product, as "health is the wellbeing of the people in the community" (Mary, Pastoral Associate, Downton Catholic Parish, urban).

Health promotion was not a term used by people in the church. How participants conceptualised health promotion therefore led to a broad range of ideas and concepts. For the most part, participants believed that the aim of health promotion was to "encourage people to have a healthy lifestyle" (Jenny, Pastor, Grantham Rise Baptist Church, urban). However how participants believed this might be done, and to what extent, varied greatly. For some churches, particularly the traditional churches, health promotion was about telling people how to be healthy, raising awareness of health issues, or providing health education for a specific purpose (eg. health ageing).

Telling People, Raising Awareness and Providing Education

A core practice of churches is teaching and therefore sermons are an important component of a church service. Teaching is an important aspect in the Christian faith which is reflected in the belief of some church leaders' that the practice of health promotion was "telling the people how they would achieve [a healthy lifestyle]" (Peter, Priest, Ponden Catholic Church) or "anything [that] teaches or shows people how to live a better lifestyle" (Ayesha, UNOH Worker, Redgum Church of Christ, urban). This comment by Ayesha may seem didactic however this is not the case when read in the context of the rest of the interview. The UNOH workers and volunteers at Redgum Church of Christ desire to see people living healthy lives and therefore will talk to individuals about behaviours or activities that may be inhibiting their health and wellbeing. For example the need to be doing exercise, eating healthy foods,

accessing health professionals and treatment for physical and mental health conditions. There is no emphasis on evangelism and these conversations occur within relationships that are formed with members of the community (see chapter seven and eight).

Health education is an approach to health promotion that can assist individuals to develop understanding, knowledge and personal skills to improve their health (Murphy, 2004a). Churches have also been involved in advocating or raising awareness of social issues, as I illustrate in the chapters that follow. This was also reflected in definitions of health promotion. A few church leaders believed that health promotion was about "making a general awareness in the community of the health issues that surround us" (Richard, Men's Shed Coordinator, Hangleton Church of Christ, urban).

In thinking about health promotion and how it might be incorporated or understood in church terms, church leaders related it to principles, guidelines, programs and activities that were specifically designed to promote and improve health:

> Health promotion is the introduction of principles and guidelines that enables individuals and communities to improve their sense of wellbeing (Trevor, Senior Minister, Sunderland Church of Christ, urban).

> A program that encourages people to participate to their full potential (Margaret, Minister, Longbourn Uniting Church, urban)

However, for other church leaders, health promotion was communicated in the sense of ideals such as "help[ing] people not only deal with life but enjoy it, cope with it" (Harry, Minister, Lincolnshire Baptist Church), as opposed to specific initiatives or projects. Health promotion as a notion of advocacy for health was also described by a few of the church leaders as "advocacy for that state of wellbeing" (Andrew, Senior Pastor, Ashridge Baptist Church,

urban). Often the language that was used to define health was then used to conceptualise health promotion, with words such as holistic, wholeness and balance dominating their discourse. Health promotion is "promoting the wholeness and fullness of someone's life" (Megan, Perrington Church of Christ, urban) and "health promotion would have to be holistic" (Michael, Minister, Oakham Mount Baptist Church, rural).

Medicine versus Social Ecology

Although health was seen by some church leaders as a holistic concept capturing the dimensions of physical, mental, social, emotional and spiritual wellbeing, other church leaders conceptualised health promotion in relation to physical health only. Health promotion was seen to address or prevent physical ailments. This derives from the belief that health promotion was about "supporting people in their day to day living and enabling them to enjoy their lives unencumbered by physical or medical disabilities" and that health promotion was "essentially preventative rather than the treatment of disorders or disease" (Les, Priest, Edgcote Catholic Church, urban). The emerging churches, influenced by how they understand church mission, tended to recognise the connection between the social determinants of health as a basis for promoting health and wellbeing. To be healthy, people needed a "healthy lifestyle, proper employment, good food, good recreation" (Michael, Minister, Oakham Mount Baptist Church, rural). Promoting health was seen as more than the biological basis of disease as "health is also reflected in the dynamics of family of origin and also the expressions of friendships that people form and other networks where people feel that they have value and a sense of worth and belonging" (James, Senior Minister, Fortescue Church of Christ, urban).

The Role of the Church in Health Promotion

At the end of interviews, I asked the church leaders questions about the role of the church in promoting health and wellbeing in the community. All felt that the local church did have a role in health promotion. For some, promoting health and wellbeing was something which "they do quietly" (Paul, Minister, Luckington Anglican Church), and was not "front or centre" in their vision or mission. Others felt that promoting health came about through normal church activities, as "a by-product" (James, Minister, Fortescue Church of Christ, urban) of people gathering, and this aided social and emotional wellbeing. The role of the church in promoting health and wellbeing was also articulated in terms of *who* the church engages with; churches "pick up the lost people, the forgotten people in the community, [and] people with mental health issues" (Pamela, Minister, Benbow Church of Christ). However, there was also the recognition that the church is not the only setting concerned with the health and wellbeing of individuals and communities. There is a nexus of agencies involved; churches "are not the only sole custodians of that ... Everyone has some sort of franchise into the community's sense of wellbeing overall" (James, Minister, Fortescue Church of Christ, urban).

Yet church leaders did feel that "if they develop their understanding well, [they] do have a unique role" (James, Minister, Fortescue Church of Christ, urban), by virtue of their concern with spiritual health and their holistic understanding of health. How they promote health may vary, but at the heart of it, church leaders felt that they offer more than programs or activities because the "by-product obviously of church events, activities, worship services [is that]…people gather together. So there's that social and emotional wellbeing as well, and this would be quite specific to churches" (James, Minister, Fortescue Church of Christ, urban). In a society of individuals experiencing loneliness, social isolation and loss of self-esteem, "churches have quite a strategic role in building a lot of things that aren't necessarily high in

heavy duty program delivery but actually can work on the sense of, well, who am I, do people notice me, have I got a place, am I held in esteem no matter who I am, and do I feel alone?" (James, Minister, Fortescue Church of Christ, urban).

Dale, from Milltown Salvation Army, elaborates on the role of the church in health promotion and its relationship with church mission:

> I think that the local church tends to focus a lot on salvific things so it's all about the eternal destination of the person, which I'm not saying is also the role of the church. But [the] Salvation Army from its very founding years of Catherine and William Booth was involved in physically helping people and recognising that if someone was going to be able to consider things of the spiritual nature, they would need their physical needs met, and it is in the most basic sense of food and shelter...It's something that we are certainly involved in trying to provide in people's lives. So I do think [health promotion is] the role of the local church, I think it's also the role of the local government, I think it's the role of the state and federal governments in our country to seek to provide this for people. I think anyone regardless of their faith, or in the case where people profess to have no faith, I still think any responsible person has an ethical duty to promote health on an individual and societal level...I do think, my feeling and understanding I guess in answering the question theologically, yes the local church needs not only to play a key role in it [health promotion] but be a leader in the community in that way (Dale, Captain, Milltown Salvation Army, rural).

♦ ♦ ♦ ♦

The capacity and willingness of churches initiate or engage in health promotion activities is influenced by how church leaders understand church mission and conceptualise health. The participants in this study believed that churches had a role to play in promoting health and

wellbeing in the community. In trying to address community need, the churches classified as emerging worked most directly to address the social determinants of health. Traditional and new modern churches tended to adopt a downstream and midstream understanding of health promotion. This is further illustrated in the typology (figure 12.1) in chapter 12. Church activities and their alignment with health promotion principles will be described in the following chapters. The description and exploration of these activities by health promotion approach is summarised in table 12.1 in chapter 12.

Chapter 6

THE PARTNERSHIP TRINITY - LOCAL CHURCHES, CHURCH AFFILIATED ORGANISATIONS AND THE COMMUNITY

Intersectoral action is a key concept in health promotion practice. The Jakarta Declaration for Health Promotion in the 21st Century in 1997 identified the need for equal partnerships for health between government sectors, government and non-government organisations, civil society and the public and private sectors, to address health disparities (Keleher, 2007c; World Health Organization, 1997). The partnerships approach has been part of a broader transition in public health from service delivery to a community-based paradigm (Roussos & Fawcett 2000; Laverack & Labonte 2000). Within this paradigm, partnerships may take many forms, including community coalitions, service networks of public and private providers, government agencies, civil society groups and welfare agencies (Roussos & Fawcett 2000). In 2009, the 7th Global Conference on Health Promotion, held in Nairobi, released a call to action which identified partnership with civil society as a strategy for closing the implementation gap in health and development through health promotion (World Health Organization, 2009). The 2010 Marmot Review - *Fair Society, Healthy Lives* collated evidence for decision-making regarding strategies to address health inequalities. Marmot and his collaborators (2010) identified the need for local responsibility for health inequalities, and again emphasised the work of local government, public sector partners, the police, fire service, third sector and private sector organisations in the delivery of interventions and programs.

In this chapter, I describe the partnership relationships between church affiliated organisations and agencies, local churches and other sectors of society to promote health and

wellbeing. I examine why and how these partnerships are formed as well as the funding sources local churches and church affiliated organisations and agencies access to engage in health promoting work. I have included church affiliated organisations and agencies in this discussion as a number of local churches work closely with these organisations.

PARTNERSHIPS

The nature and types of partnerships differed for church affiliated organisations and the different expressions of local churches. As illustrated in Figure 6.1 and Table 6.1 below, the church affiliated organisations have formal relationships with different levels of government, and government organisations, such as the Victorian Primary Care Partnerships (PCPs), and not-for-profit peak organisations including the Australian Council of Social Services (ACOSS) and Victorian Council of Social Services (VCOSS). The relationships range from contracts for service, to being a member organisation (for example members of ACOSS, VCOSS and PCPs).

Church affiliated organisations are involved in advocacy to government on social issues such as support for marginalised or vulnerable populations such as asylum seekers, refugees, migrants, people with disabilities, the elderly, and people who are homeless (Brotherhood of St Laurence, 2012; Jesuit Social Services, 2007; UnitingCare Australia, 2011; Wesley Mission, 2012). Some of these organisations are also contracted by state and federal governments to provide employment services, aged care service and welfare services (Gregg, 2000b; Maddox, 2005; UnitingCare Australia., 2012). The contractual relationship of church affiliated organisations with government has been criticised by policy makers and academics, with concerns that in light of contractual interests, church affiliated organisations will be unable to advocate against government policies that they perceive as entrenching disadvantage (Gregg, 2000; Frumkin and Andre-Clark, 2000; Maddox, 2005). Gregg (2000)

has argued that these contracts sought to advance political agendas, often did not align with the core mission of the church affiliated organisation, and put these organisations at risk of enforcing government policies for which they are not equipped. These contracts pressure church affiliated organisations to become increasingly bureaucratic and professionalised (Keevers, Treleaven, & Sykes, 2008; Webster, 2002), which can negatively impact on their grassroots nature and connection with local communities (Carey, Braunack-Mayer, & Barraket, 2009).

The local church, particularly new modern and emerging churches, operate at a grassroots level and have partnerships with a range of services and organisations, such as health services, welfare/community services (including church affiliated organisations), schools and tertiary education institutes, and conduct community outreach activities such as Men's Sheds,[17] soup kitchens and community meals. The traditional churches in this study appeared to conduct fewer health promoting activities and programs for the wider community and had formed less partnerships particularly with secular organisations. However members of traditional churches contributed to the welfare of community members by volunteering in church affiliated organisations (such as St Vincent's de Paul, Jesuit Social Services). The focus of traditional churches for health promoting activities tended to be their own parishioners, as I discuss in later chapters of this thesis.

Participants at the local church level tend to describe the nature and structure of their partnerships with other organisations and agencies as networks, examples of cooperation, or

[17] A Men's Shed is defined as "any community-based, non-profit, non-commercial organization that is accessible to all men and whose primary activity is the provision of a safe and friendly environment where men are able to work on meaningful projects at their own pace in their own time in the company of other men. A major objective is to advance the well-being and health of their male members." (http://www.mensshed.org/what-is-a-men%27s-shed/.aspx)

relationships, as rather than formal partnerships: "There's no formal partnerships... I'd just describe it in terms of cooperation (Walter, Minister, Marshland Uniting Church, urban).

> It's a networking, more than working with (Anne, Community Care Minister, Belton Baptist Church, urban)

> We certainly have relationships with them. In terms of formally partnering with them I don't think we could say that we are in that place at the moment (Henry, Minister, Peverell Anglican Church, urban)

> None of them have been formalised in the sense of going for joint funding or things like that (Mitchell, Minister, Tinworth Anglican Church, urban)

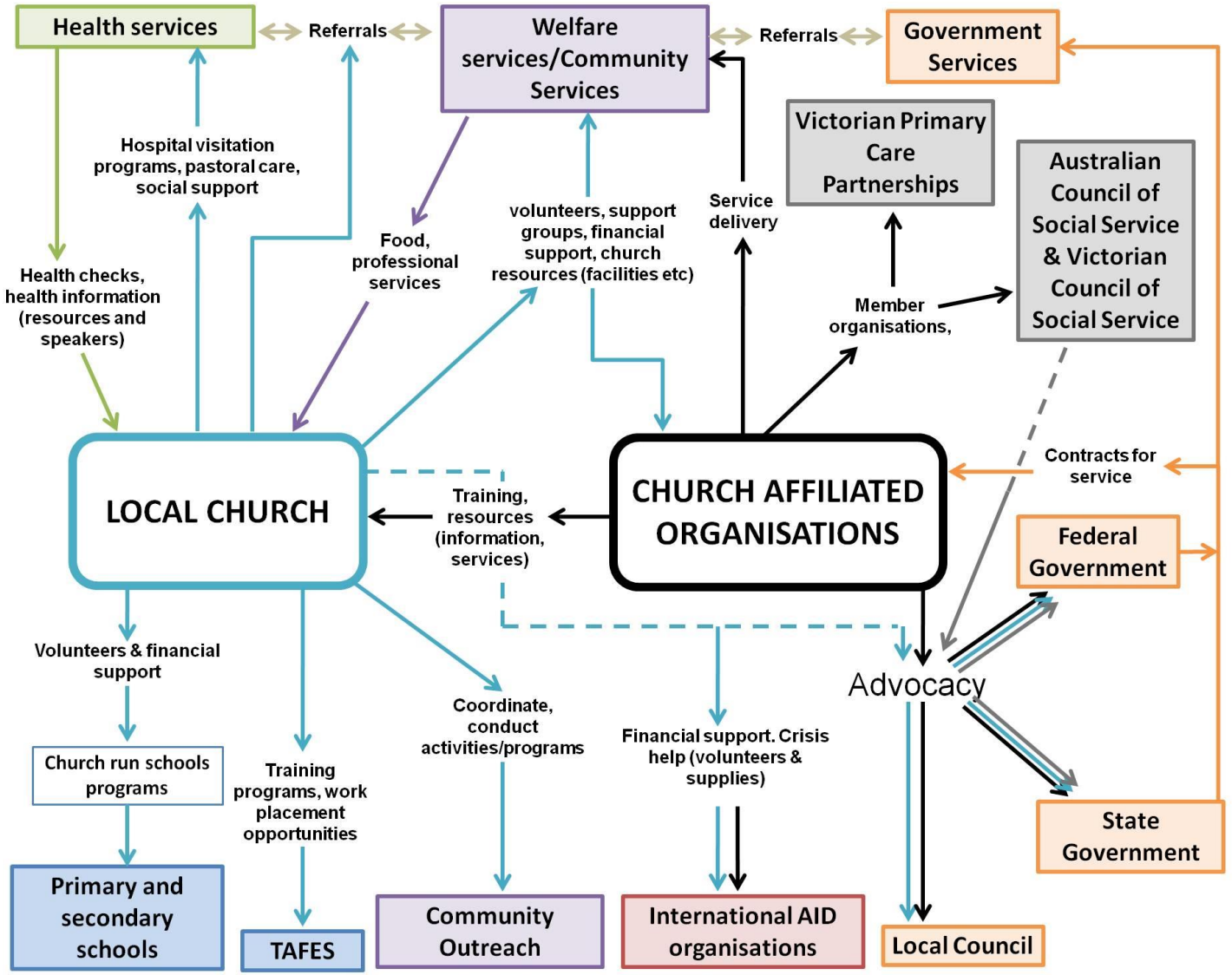

Figure 6.1: Partnerships Between the Local Church and Church Affiliated Organisations

Table 6.1: The Organisations Across Different Sectors Partnering with Local Churches and Church Affiliated Organisations.

CHURCH AFFILIATED ORGANISATIONS
- The Salvation Army
- Brotherhood of St Laurence
- Wesley Mission
- Sacred Heart Mission
- UnitingCare
- Anglicare
- Melbourne City Mission
- Hotham Mission
- BaptCare
- Jesuit Social Services
- The St Vincent's de Paul Society
- Mission Australia
- Good Shepherd

HEALTH SERVICES
- Maternal & Child Health Network
- Private Hospitals
- Public Hospitals
- Nursing Homes
- Community Health Services
- Retirement Villages

WELFARE SERVICES COMMUNITY|SERVICES GOVERNMENT SERVICES
- VicRelief- provides food emergency relief and support programs through a network of community organisations including local churches
- Second Bite (distributes surplus food and produce to community organisations)
- Shift (Supporting Homeless Families in Transition)
- Workways (not-for-profit community services organisation)
- Neighbourhood House
- Carlton Family Resource Centre
- Carlton Baths
- YMCA
- Operation Stitches
- WaveCare
- Cornerstone
- Cancer Council Victoria
- Carer's Victoria
- Open Doors (pregnancy loss support group)

CHURCH AFFILIATED SCHOOLS PROGRAMS
- Kids Hope mentoring program (in partnership with World Vision and primary schools)
- Life mentoring program (Secondary school program)
- Lunch time programs (games/activities)
- After school activities
- School based chaplaincy

COMMUNITY OUTREACH
- Women's Refuge
- Soup Kitchen
- Public Housing Commission Estates (church runs activities and programs)
- Men's Shed
- Neighbourhood Renewal Houses

INTERNATIONAL AID ORGANISATIONS
- Compassion Australia
- World Vision
- AusAid

CREATING PARTNERSHIPS

The relationships between local churches and church affiliated organisations and agencies can be described as ethical partnerships (Carnwell & Carson, 2005). These partnerships are characterised by a sense of mission and shared values, through combined efforts for advocacy for social issues or on behalf of vulnerable populations: *"*It could be around social justice issues, it could be around community efforts, working with Indigenous people*"* (Trevor, Minister, Sunderland Church of Christ, urban). Local churches, for example, support the work of church

affiliated organisations and agencies through the contribution of financial and practical volunteer support for welfare and community development programs, and may provide crisis relief, again practical and financial, in the event of war or natural disasters.

One church articulated the shared ethos using the metaphor of DNA. When one party resonates with the values and actions of the other, there is a willingness to support and promote each other.

> It's just all sort of loose partnerships based on the fact that we fund them or we send people to them and we identify with them from a kind of DNA ... we say these organisations [are ones that] we want to support because ... we can relate to them. We want them to be promoted (Cohen, Minister, Murcutt Anglican Church, urban).

The initiation of partnerships may come either from the church or from other organisations.

> It goes both ways ... we approach them ... they approach us. You know we do certain things that they don't do and they do things we don't (Robert, Captain, Burghley Salvation Army, rural).

> No one has actually approached us at all, but what we find is that it mostly works the other way around – we support the other groups. So like with the asylum seekers and social justice, people approach us that there's a need and then we might go out and do something to help meet that need. It doesn't usually work the other way around (Alison, Parish Nurse, Downton Catholic Church, urban).

The above quote from Alison indicates that traditional churches, such as Downton Catholic Church, are not proactive in initiating and forming partnerships with other social and community

groups. New modern churches and emerging churches are more likely to seek conversations with other organisations to assess synergies and see how activities can be complemented.

Shared clientele was a strong theme in the development of partnerships. This clientele included carers, people with depression, asylum seekers, students, and people facing food insecurity. Churches work together with other organisations to ensure that efforts are not duplicated, and to further their work through shared resources and expertise. Mitchell, a minister at Tinworth Anglican Church, highlighted the "distinct community" of the neighbouring public housing estate. Due to the specific needs of its residents, such as lack of medical support, poor literacy, food insecurity and discrimination and stigmatisation of the residents of the housing estates, different community groups and organisations developed services specific for this population.

> [T]heir services really tend to focus on the housing estates rather than the wider Tinworth community, and so what tends to happen is that…everyone gets to know each other. And also those agencies, they get together every now and again and talk, and so I'm part of that group … it's not formal, it's very organic (Mitchell, Minister, Tinworth Anglican Church, urban).

> I'm in regular contact with the emergency relief officer there, and particularly because the people who come to our weekly lunch and other programs also access food vouchers and financial relief through emergency relief. And sometimes we just kind of have to ... if we know that there a particular crisis happening in somebody's world ... [we] have a conversation about it ... so we are not doubling up on the help that is offered, [to ensure] that we can access the most appropriate help for the people concerned (Pamela, Minister, Benbow Church of Christ, urban).

Coalitions and partnerships tend to be created with the recognition that different groups bring different resources (human and material), connections, influence, size and wealth (O'Neil, Lemieux, Groleau, Fortin, & Lamarche, 1997). The majority of coalitions were formed with other church affiliated agencies, organisations or local churches. But in addition, there were partnerships with local schools, community groups such as Men's Sheds, Returned and Service League (RSL),[18] Neighbourhood Houses (local organisations that provide social, educational and recreational activities for communities), community health organisations, local councils and to a lesser extent, hospitals and universities. The formation of these partnerships came from an understanding that firstly there are many groups in society which are concerned with individual and community health and wellbeing, and secondly, consistent with research on the social determinants of health, partnerships with other groups and sectors is required to address health holistically:

> [Churches] are not the only sole custodians of [promoting health and wellbeing]. You've got whole networks of really good people and well meaning, everything from preschools and kindergartens to community health centres and community centres and sports complexes too for that matter. Everyone has some sort of franchise into the community's sense of wellbeing overall. Um, but I think churches, if they develop their understanding well, do have a unique role (James, Minister, Fortescue Church of Christ, urban).

[18] The Returned Service League began during the first world war and is a support organisation for those service or who have served in the Australian Defence Force. The RSL's mission statement is: "To ensure that programs are in place for the well-being, care, compensation and commeration of serving and ex-service Defence Force members and their dependents; and promote Government and community awareness of the need for a secure, stable and progressive Australia. www.rsl.org.au

> In my experience, you can't do that sort of work unless you connect with a whole range of different agencies, it might be the community health centre, it might be the Men's Shed, it might be the Neighbourhood House, it might be the university (George, Director, LutherCare).

A main driver in forming coalitions or partnerships was the sharing of resources (O'Neil et al., 1997). The quote below from Nigel, the minister at Meryton Anglican Church, illustrates how he has accessed resources from the not-for-profit organisation VicFood Relief to meet the needs of the Meryton community.

> Well, we just found that we had increasing numbers of people knocking on the door asking for assistance, and we had no funding arrangements to do it, so it [money] sort of started coming out of my pocket, and then it started to be a little too expensive. And so we started a plea in the community for people to donate groceries for us, initially through our church and then a little bit wider out, and so people started to donate us things, but that failed to meet the need in quantity. I actually had contact with VicFood Relief when I worked in Melbourne, and so I rang them up to see if we could work out some arrangement here, and strangely enough they said they would deliver it to me for nothing! So we went from there. So we have a weekly order. So I mentioned before that we have a big unemployment problem and so people struggle. And you see, we are an hour away from the next biggest [shopping] centre. Although the shopping here is quite good, we are an hour away from the next biggest centre and if people have only got a old car and no car at all, well then they can't get out. (Nigel, minister, Meryton Anglican Church, rural)

Churches often have facilities such as kitchens, halls and rooms that can be utilised by other groups. Traditional churches tended to hire out facilities to community groups for diverse purposes, including generating an income from the rent in some cases, however the connections they had with these groups were minimal.

> Well, there's, for example ... people hire the hall ... the karate group hires the hall ... a dance group, they hire the hall on a Monday or Tuesday night, parishioners are involved or their children are, so it's open to the community (Les, Priest, Edgcote Catholic Church, rural).

In contrast to the above, new modern church Sudbury Baptist Church hires basketball stadiums from a local recreation centre to run its Basketball Association. The Sudbury Baptist Basketball Association was established over 20 years ago and currently has 70 teams from the Sudbury area and surrounding suburbs: "a lot of church people play, but over half of them would not be [church people] and every week we would have 500-600 people attending" (Benjamin, Senior Minister). Benjamin explains how he saw sport as an opportunity to connect with the community as "sport in Melbourne is fairly religious here." The Basketball Association focuses on fun, skill development, fitness and community connections.

The need for expertise also drives local churches and church affiliated organisations to partner with other groups and sectors. As I discussed earlier in this chapter, church affiliated organisations offer a professionalisation of services due to their government contracts for services (for example employment services, aged care, youth services). They are able to meet requirements, for example, for accreditation or PBI status and therefore are eligible for

government contracts and philanthropic funding. For example, LutherCare consists of smaller agencies which evolved from local churches:

> Usually what happens is that they [churches] get to a certain point and then they say really, this is much bigger than a congregation project now, and we are really struggling, so we really think it needs to be formalised. So then there is a whole a range of things, constitutions and different things that they can adopt off the shelf really and then they can badge [LutherCare] (George, Director, LutherCare).

Partnerships between local churches and community organisations enable a "bottom up sort of approach" to programs. Local churches described grassroots partnerships at the community level with other organisations and institutions which are either active in the community, such as schools, or which share with the church a similar ethos of social justice. These partnerships often occur organically, evolving from shared activities or spaces, or arising from a common commitment to support identified vulnerable groups or individuals. Recognising these synergies, local churches enter into partnerships with organisations that bring together complementary capabilities (Austin, 2000). For example, World Vision, an international aid and development organisation, trains local churches to conduct the Kids Hope[19] mentoring program in primary schools. The school provides the educational and social environment for the children; the church, through a team of volunteers, is able to provide emotional and social support for vulnerable or at-

[19]Kids Hope is a mentoring program designed and coordinated by World Vision Australia and is a partnership between local churches and primary schools. Kids Hope seeks to assist children and their families who have been identified by primary schools as requiring additional support. The program aims to improve opportunities for children in the areas of education, self-confidence and wellbeing.

risk children complementing the support of teachers. Harry, the minister at Lincolnshire Baptist Church, described the KidsHope program:

> [The program is] about one church relating to one school. So we relate to a school here ... and we provide ten mentors who are trained and each one has one student in the school and so they give up one hour each week for a student. So our ten mentors are spending one hour each with a student in the school, providing mentoring support with the full cooperation of the principal and the school and it's not a religious activity as such, it's a support activity for that child (Harry, Minister, Lincolnshire Baptist Church, rural).

THE CATALYST FOR PARTNERSHIPS

Butterfoss and Kegler (2002) posit that the catalyst for the formation of partnerships or coalitions may be an opportunity, threat or mandate. In most circumstances, a lead agency will initiate the partnership through the provision of technical assistance, financial or material support, credibility, networks and contacts (Butterfoss & Kegler, 2002). From the interview data, the main themes that emerged in relation to the formation of partnerships were funding and responding to a community need. As described in chapter five, church leaders and members of the emerging churches are strongly motivated to respond to community needs and have the resources to address these needs:

> I think the church has ... enough people in the church to say, let's actually work together, partner together ... let's do something for the community, a community need, a felt need. And let's tap into that and say we want to promote health and wellbeing on a holistic level ... We want to help do this, we want to run this ... another element that we believe is

> essential to wholeness and health is through the spiritual aspects as well (Mark, Youth Worker, EmpowerYouth, urban).

Partnerships can be established opportunistically and on a temporary basis, for example in the face of a community tragedy. This was particularly evident in Victoria following the bushfires of February 2009, in which 173 Victorians lost their lives, 78 towns were affected and 7562 people were displaced (Victorian Bushfires Royal Commission, 2009; Parliament of NSW, 2009). Churches quickly partnered and collaborated with other groups to provide essential services and to rebuild the community after the bushfires had devastated their towns. For example, in the town of Kinglake, where 47 people died and 500 homes were destroyed (Victorian Bushfires Royal Commission, 2009), a little Uniting Church miraculously survived the fire. The church congregation was tiny, "almost non-existent, there's about ten people … but ten wonderful people…and they said, well we have to do something for our community." LutherCare had a youth program called the Big Red Bus which used to tour the Goulburn Valley region. The program had been defunded, but the bus remained. The members of the Kinglake Uniting Church borrowed the bus from LutherCare and refurbished it, with the help of Telstra [an Australian telecommunications company], into a telecommunication bus with computers, internet access and telephones. The bus was parked next to the church building: "it became an immediate hub for people connecting with friends [and] family, doing business, you know, because they lost their computers, it was used 24/7 almost in the first few weeks [by towns folk living in temporary accommodation]." Because the bus became a community hub, people from around Victoria began to donate meals, and so the ten church members decided to develop a community meals program. This ran for weeks. The outcome is that the church now manages temporary

villages to house the individuals and families who had lost homes, and enjoys strong local credibility in the community.

Sudbury Baptist Church, a new modern church located in the Peninsula region of Melbourne, has key partnerships with the local hospital and school. The partnership between the church and hospital enables nurses to attend church programs such as mother's groups and youth groups to provide health checks, screen for chronic conditions (e.g. glucose testing of diabetes, blood pressure checks), and speak about other health issues. These programs are attended by people from Sudbury Baptist Church and the wider community. The partnership was established following discussions within the hospital about engaging with community, which led to Benjamin, the senior minister, being invited to speak about church programs and to explore how the hospital could assist the church in its community work.

> We were made aware by one of their staff that the hospital was looking for health partnerships in the community, and she felt that some of the stuff that we were doing would be of value to [the health service], whereby they [staff] could come and help and support these programs. Obviously they get their name broadcast out there, but it's helping them achieve their health outcomes in the wider community if they attach themselves to our programs. So we went and made a presentation and that's about three years old now, that partnership, or maybe four (Benjamin, Senior Minister, Sudbury Baptist, urban).

Sudbury Baptist Church also has a partnership with one local school in which the church co-contributes funds to enable the school chaplain, who is a trained psychologist and is considered a staff member, to assist with the youth programs of the church. Sudbury Baptist Church also runs

a mentoring program called the Life Program in four schools, including one school identified as "the worst school in the area" (Maree, Administration Assistant, Sudbury Baptist Church, urban). The program consists of a team of volunteers who are provided with set class time to teach students life skills, covering topics such as self-esteem, respect, team work, attitude, relationships, encouragement and mental health. The volunteers are also involved in mentoring students and providing emotional and social support (see Chapter eight).

EmpowerYouth, a small church affiliated agency, established sporting clinics in a disadvantaged suburb, but found it difficult to form partnerships. Mark, a youth worker, understands that it is at times difficult to bring others, including local churches, on board with a program while facilitating a sense of ownership and participation:

> I find it hard to meet and say "let's partner" without it just being "just come and join what we're doing." I think a partnership should actually mean partnering and how can we work together, rather than you just come on board with what I'm doing (Mark, Youth Worker, EmpowerYouth, urban).

Community meetings which enable open communication between different community groups such as schools, councils, and health services were able to facilitate the formation of partnerships with the church. These community meetings also supported better coordination of services. Dale, the Captain of Milltown Salvation Army Church, an emerging church, articulated the importance of this coordination in deciding when to implement a second community meal program.

> CAOS which is an acronym for Community Agents of Sustainability … They are probably the main social group where some of the ministers and many of the social service providers get together to just share information about what they're doing, and you

> can have the opportunity to say what you're doing and that helps you to be connected in that sense. I guess the thing that we are trying to do, well, one of the key things with all those groups is to be well networked, so if someone walks in and wants something that you don't provide, rather than saying "sorry we don't provide that," you can give them specific information on how to get that for that individual person and perhaps for the community as a whole. Or you are trying to create the healthiest type of service delivery that's not unnecessarily segmented, and in many cases we are happy to make the phone call and tee it up for the person rather than say, "go over there, they do that." So specifically, say when it comes to food, when we chose, we didn't just go 'Tuesdays suit us to do another community meal. We spoke to [another local] church and said, well you're doing Mondays and Fridays, right? Well, we are doing Thursdays so we thought our [additional] community meal would have to be either Tuesday or Wednesday ... So I guess that sort of element of networking [helps] to try and meet the needs of the community (Dale, Captain, Milltown Salvation Army, rural)

FUNDING FOR PARTNERSHIPS

For the church affiliated organisations, funding can be a catalyst for partnerships to deliver services with other agencies working with the same clientele:

> Many of our programs that we are funded to provide are partnerships ... For example, um, you know we are in a partnership with three other organisations to deliver the program for adults getting out of jail. We are in a series of different partnerships in different metropolitan regions in Melbourne to provide youth justice [programs] but always with at least two other partners, so many of our programs we deliver in partnerships (Emily, Director, Ignatius Social Services, urban).

George, the director of LutherCare, described a lead agency model of funding and partnerships. The government will fund a joint tender in which LutherCare is the lead agency, with the role of coordinating other organisations to deliver services. For example, the government recognised the work that LutherCare does in the area of child services, such as child care and kindergartens. To avoid having to manage the different community groups involved in delivering child services, LutherCare was funded as the lead agency to coordinate the other community groups to deliver appropriate services.

In figure 6.2, I illustrate the funding sources for local churches, church affiliated agencies, and church affiliated organisations. Participants communicated that the source of funding was socially and morally important to them. For example, LutherCare will not "take funding from the TAB [gambling], or Crown Casino ... or from Phillip Morris [tobacco]". Similarly. the minister of an emerging church located in an area crippled by problem gambling stated that he does not apply for state government funding as "all the money comes off the back of pokies which we have seen devastate, particularly this community and other communities, and so we feel that we can't justify taking that money" (Michael, Minister, Oakham Mount Baptist Church, rural).

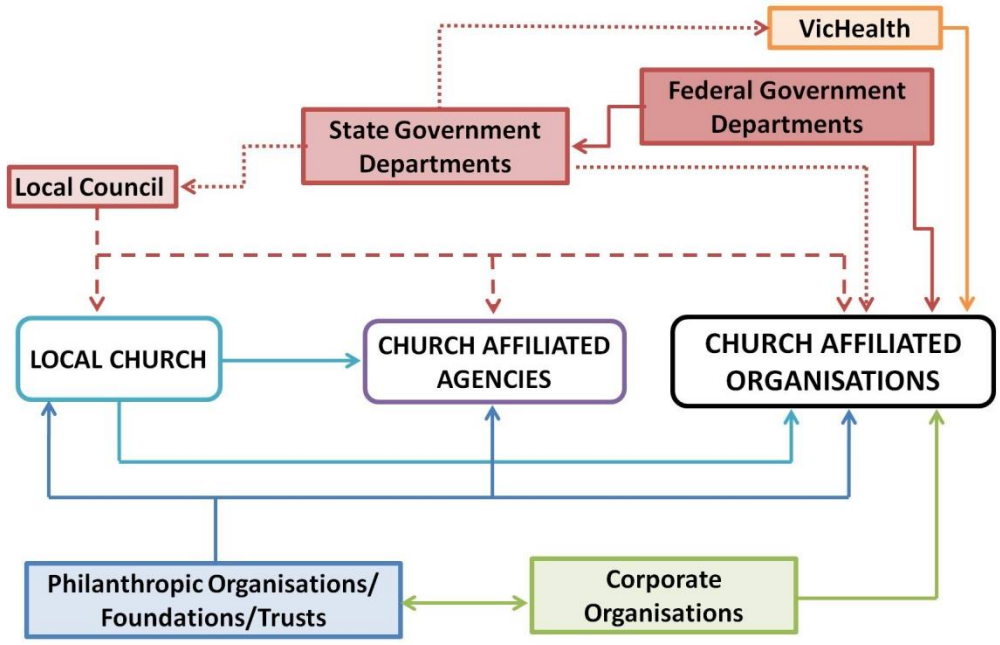

Figure 6.2: Funding Sources Accessed by Local Churches, Church Affiliated Agencies and Church Affiliated Organisations

PARTNERSHIP LEVEL BY CHURCH EXPRESSION

The extent to which churches partner, and with whom they partner, differed by church expression. The traditional churches predominantly partnered with schools and health services such as hospitals, nursing homes and palliative care services. To a lesser extent, they partnered with the local council and other local churches in the area. Traditional churches also had strong ties with church affiliated organisations such as St Vincent's de Paul, Jesuit Social Services and Good Shepherd:

> I go up [to the school] once every couple of weeks and celebrate mass with one of the classes or the school. For example, tomorrow we have got the whole school involved in mass, parents come along to that ... I occasionally call into the staff room, see the

> teachers, go around to the classrooms just to call in and say hello. And then there are meetings, like there are educational board meetings that I'm very involved in. I just keep in touch, principally through um the two school principals and the teachers. But then they have social gatherings. Last week they had a gathering for the new Preps [preparatory year level] who were starting, so all the parents and the children they had about a couple of hundred parents and children there. So those kind of social gatherings are very important part so I kind of go along and just mix in (Les, Priest, Edgecote Catholic Church, rural).
>
> We have a new nursing home that's opened up [in partnership with] this parish, we now have four nursing homes that we visit and take communion to (Alison, Pastoral Nurse, Haworth Catholic Parish, urban).

New modern and emerging churches formed partnerships with community groups and sectors beyond the health or education sectors. Participants from new modern churches described partnerships with schools, hospitals, nursing homes, neighbourhood houses, the YMCA [Young Men's Christian Association],[20] local RSLs, family resource centres, the local swimming pool, and the community health service.

> The YMCA has done a variety of youth programs and we've run camps together and we volunteered in some of their programs ... The Family Resource Centre which is a council-run social work and community service place, and once again, they will often refer

[20] The YMCA commenced in Adelaide, Australia in 1851and has been involved in providing social care and welfare services. Today the seven core services areas of the YMCA include health and wellbeing, sports and recreation, aquatics, youth services, children's services, camping and outdoor education, accommodation. www.ymca.org.au

> people to us, if they need pastoral care as opposed to professional care ... They might say to people you can go on the [church] camp or they might say, here are some people who need meals, can you guys help out, or these people are really lonely, can anyone visit them? They are probably the two organisations that we've had the most contact with, and that's been long term (Mitchell, minister, Tinworth Anglican Church, urban).

The partnerships of emerging churches were quite extensive and included schools, welfare and social service agencies (including church affiliated organisations), World Vision, local tertiary and training institutes, community based youth and family Services, soup kitchens, charity organisations, Men's Sheds, neighbourhood renewal projects, other local churches, local council, SecondBite[21] and Foodbank Victoria[22], state government and community health: "Definitely the [local] council particularly the local Community Renewal Project and the community planning and development section of council as well" (Jane, Community Engagement Coordinator, Ashridge Baptist Church, urban).

> And we are quite involved with the different agencies in the town as well. Like Uniting Care, St Vincent de Paul, WorkWays [not-for-profit community service] ... and many others that are in the town as well which I can't remember off the top of my head. It's quite a good community. Like ecumenically, the churches are all working quite well together and the agencies, welfare agencies and social agencies, and employment

[21] SecondBite sources excess fresh food and produce from supermarkets and food stores that would otherwise go to waste. The organisation facilitates the safe and timely distribution to agencies and people in need.

[22] Foodbank Victoria is a not-for-profit organisation that provides food, emergency relief and support programs through a network of approximately 600 community organisations. VicRelief and Foodshare are partner organisations with Foodbank Victoria.

agencies, they all work in really well together (Robert, Captain, Burghley Salvation Army, rural).

We started developing up an internet kiosk and we discovered that Melbourne University in this process has a volunteer program for students and the Melbourne University version of this is that students can get themselves onto a website and they're matched up to a particular voluntary job or they can be formed into teams to be given projects. And we were one of the latter and we sat down with the students beginning of last year, here's our project folks, we want to establish an internet kiosk. And they went about some technical work with the computers, developing policies and procedures, we went and found some money and developed the corrals and the physical layout and had an excellent relationship with the Melbourne University students (Samuel, Minister, Derby Uniting Church, urban)

Emerging and new modern churches were more likely to establish medium to high level partnerships, as I now describe, compared with traditional churches (see Figure 6.4). The partnership level of the churches is reflected in the levels of community engagement, which in turn was influenced by how a church defined its mission. Levels of partnerships were defined by the following criteria:

Low level partnerships

- Church partnerships with other churches or denomination-owned organisations – i.e. Catholic schools, Catholic church affiliated organisations
- Services specific to people who share the same denominational background - e.g. Catholic churches coordinating pastoral care visits at hospitals for Catholic patients only

Medium level partnerships

- Church partnerships with other churches from a variety of denominations or church affiliated organisations
- Three to five collaborations with other sectors of society – schools , hospitals, nursing homes, local government

High level partnerships

- Church partnerships with other churches from a variety of denominations, or church affiliated organisations
- Greater than five collaborations with other sectors of society – schools, hospitals, nursing homes, local government

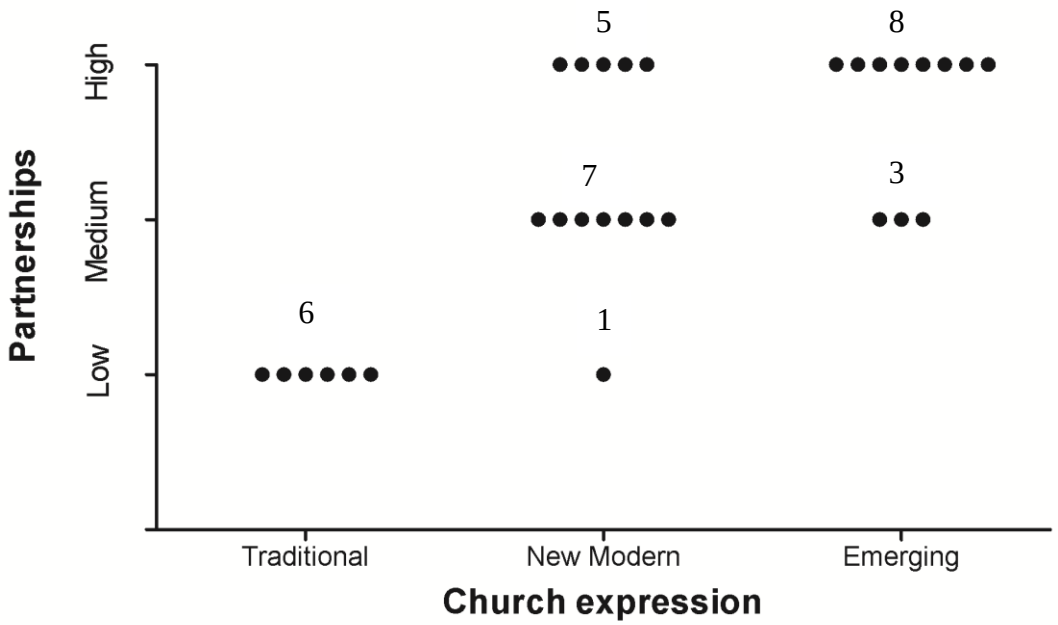

Figure 6.3 Partnership Level by Traditional, New Modern and Emerging Expressions of Church

As I highlighted in chapter five, emerging churches are outward focused and hence seek to engage with the broader community. Therefore, these churches are well positioned to form partnerships with government agencies and other sectors of society. For example, Milltown Salvation Army has partnerships with community groups including Community Legal Aid, drug and alcohol rehabilitation groups, the local TAFE[23] and financial counsellors, the government agency Consumer Affairs, and other local churches and church affiliated organisations. Most new modern churches have medium level partnerships, particularly with local schools, health services, and by providing pastoral care in retirement villages and nursing homes.

Traditional churches were found to have limited capacity for cross-sectoral partnerships which may be in part due to the complex nature of decision making based on the hierarchy of the denomination (see chapter one). These churches can be characterised by an inward focus on activities and programs targeted for those in the congregation or to individuals and families who profess allegiance to the denomination. For example, while some of the traditional churches were involved in pastoral care visitations at hospitals, nursing homes or retirement villages, only people identifying as Catholic were eligible for Catholic pastoral support. Les, the priest at the Catholic Church in Edgecote (located on the outskirts of Melbourne), described the partnership between his parish and the Catholic school next door. Parish-based schools are common for Catholic churches in Australia (Angus, 2003; Rymarz & Graham, 2006). These schools are

[23] TAFE or technical and further education institutions provide predominantly vocational tertiary education courses with the highest award being an advanced diploma. Common courses include business, hospitality, tourism, construction, engineering, information technology, art and design and community work. www.education.vic.gov.au

associated with a local parish and the priest and parishioners are involved in providing social, emotional and spiritual support to the students. Les also highlighted the coming together of different church denominations in the town for World Prayer Day (held on the first Friday of March) as an example of a partnership. In general, however, the support offered between the different church denominations and community groups in relation to activities and programs was minimal, and I did not feel this level of engagement warranted the classification of a partnership:

> There's a gathering to pray in an ecumenical spirit, yeah, so that's humanism basically. It's basic acknowledgement of each other, coming together to pray with each other, to recognise what we can bring to the community through what we do as a church community, so there is an interaction there in various ways ... I've mentioned like the ecumenical prayer service, Victorian Council of Churches World Day of Prayer. Beyond the spiritual, or the faith connection, I'd say we don't have any direct association with particular groups.
>
> We would advertise programs that are being run by particular groups ... encourage people to take part in them, but as a church community I don't think we necessarily connect with ... those activities that are going on … And we would advertise any of those programs that are going in the community. So in that sense we link in. We have a connection with the CFA [Country Fire Authority]. We are often supportive of those organisations, SES [State Emergency Services] CFA, you know offering a donation, there are parishioners who are involved in [volunteering in these] activities so in that sense we are connected ... So um I can think of people who work, who are volunteers with the CFA, they are part of this community but they are offering themselves to the wider community.

♦ ♦ ♦ ♦

In this chapter, I have described the rationale and catalyst for partnerships formed with local churches and church affiliated organisations and agencies, and provided evidence of the different levels of partnerships by church expression. I have also documented the partnership networks of church affiliated organisations with firstly local churches, and secondly other community groups and sectors. However the emphasis of my thesis is on the local church and in this chapter, I examined how churches operationalise their mission by connecting with other organisations and institutions in the community. Emerging churches and new modern churches demonstrated mid to high levels of partnerships, and were therefore in a position to engage in collaborations for health promotion. These findings have been incorporated into the typology presented in chapter 12 (see figure 12.1). I discuss the challenges and limitations of partnering with local churches in relation to utilising resources (both material and human) in Chapter eleven of this thesis.

Chapter 7

"Body Mind and Spirit – Working Well Together"

Health Education and Health Literacy

Benbow is a suburb characterised by avenues of affluence but also streets of poverty. Million dollar homes overlook the waterfront while the back streets are lined with public housing. The congregation at emerging church Benbow Church of Christ reflects this diversity; the church programs primarily target those who are disadvantaged in their community. Zoe, a volunteer from the church, has initiated a number of programs that are accessed by individuals from the wider Benbow community and she describes Benbow Church of Christ as a church with "a social conscience:"

> We live in a community. We have various groups of people coming to our church as part of our church family and most of them feel strongly about [the importance of] a social conscience in the broader community.

Five years ago, the church started a community meals program. William, a volunteer from the church, is the cafe manager. William is a rough looking character; he has tattoos and the air of someone who won't tolerate nonsense. He grew up in institutions and he has spent time in prison, but he has turned his life around and is a member of the church. He brings to the community a street-wisdom that the minister, Pamela, does not have. As she says, "He knows everything that's going on and he also knows how to speak to those people in a way that I couldn't because I would be speaking down to them, but he can because he is one of them."

The church building sits on a street corner overlooking Benbow Bay. On the door of the church is a sign stating that, for the safety of others, those under the influence of drugs or alcohol will be asked to leave. The building is shabby but useable, with a large main hall equipped with a kitchen, stage, tables and chairs, two large fridges and a freezer. William collects food from supermarkets and also receives food donations from Foodbank Victoria and SecondBite. These food donations are for community meals. The weekly meal, called Helping Hand Café, is volunteer-led. Approximately 40 people from the Benbow community attend the meals each week.

The tables have all been set up and quite a few people are already eating. George, a volunteer and regular participant in the various church programs, asks if the table set up is good. He proudly tells me that he has been appointed table manager. I ask him what this position entails. He tells me that he is responsible for setting up the tables each week, the table cloths and the salt and pepper shakers. This week George has organised the tables in a U-shape, "it makes people feel welcome, I think."

Pamela, the minister, and I sit down at a table with Daniel, a young man in his mid-twenties, and engage him in conversation. Pamela asks how he is going, and encourages him with his attendance at the Helping Hand Learning program for adult literacy. Daniel shows us his latest story which he wrote in his notebook, about his bicycle. The adult literacy program grew out of the Helping Hand Café:

> People would come up to you quietly and say, 'I got this letter the other day. Could you help me read it or help me fill out this form.' So we became aware of a number of adults

> who struggle with literacy. Some couldn't read anything, or only basic things, or couldn't write their own name (Pamela, Minister, Benbow Church of Christ, urban).

Zoe felt that the church needed to do something in response to this. She also recognised that literacy went beyond learning to read and write.

> A few of them came to me with documents saying, look I got this in the mail from Centrelink, I don't know what it says – could you tell me and could you help me work out what I have to do. And so I started doing a bit of that. And a few people said to me, would you be able to teach me to read or would you be able to teach me how to use a computer (Zoe, volunteer, Benbow Church of Christ, urban).

The Helping Hand Learning program has now been running for three years and is attended by approximately half a dozen people each week. Each person accessing the program has different goals and requirements, and hence the sessions are designed to cater to individuals, with each client matched to a volunteer:

> Each of them have quite specific needs. Some of them have [a] mental illness; some of them have in combination with mental illness, other disabilities. Some of them have, you know quite serious problems. We've had a couple of really serious schizophrenics do some really interesting things in [the] learning [program] (Zoe, volunteer, Benbow Church of Christ, urban).

The program has a broader focus than academic literacy:

> People think that they want to learn to read, and that is important, but it's not only that. A lot of them have got problems that mean that they are not able to mix socially very well.

> And they don't like rules and they don't have a history of success in the school or the education environment at all. It's a big failure to them. So my big issue is that it's nothing like school, even though a couple of them call it school. It's a totally different environment. It's an adult learning environment. And we talk about what we want to learn and what we need to learn in order to get to that point. A couple of people have said to me, don't even put me near a computer, I don't want computers, don't put them near me...They are now working away with computers quite happily. Not that I ever made them do it, I just set up games and all sorts of interesting things, maths games you know, literacy games on the computer and they decided that they liked to have a go (Zoe, volunteer, Benbow Church of Christ, urban).

The program teaches people how to use money, how to shop for their groceries using a budget to make sure that they have enough money at the checkout counter. Zoe has set up email addresses for all clients, taught them how to send and receive emails, and how to use the internet to find information. Through one to one interactions, Zoe and her volunteer team have been able to gauge where each person is at and work with them to achieve the life skills they wanted to learn:

> I save all the [supermarket pricing] books and I give it to them and they write their [shopping] list on it and estimate the cost and then they look in the books and find the exact cost. They estimate and work out how much money to take with them and then they look at the actual cost and see if they have enough money. And if they haven't, which thing will they leave behind. But it's done on what's available at the supermarket right now. We talk about weights and measures and all that sort of thing (Zoe, volunteer, Benbow Church of Christ, urban).

The impact of Helping Hand Learning and Helping Hand Cafe extends beyond learning to read or eating a nutritious meal. They are programs designed to foster community ownership, relationships and empowerment - values that align with health promotion. Sally is aged in her thirties and has a round smiling face. She has a learning disability and her facial expressions show a child-like wonder of the world. Sally is a volunteer, happily meeting people as she helps at the Helping Hand Café and attends the Helping Hand Learning program. Initially Sally came to the cafe as a community member; however she has worked as a volunteer with her husband for the last few years. Last year, while she was volunteering at the café, William, Pamela and Zoe noticed that Sally was not well. She had a body wracking cough that had lasted a number of weeks. Zoe and Pamela encouraged Sally to go to the hospital and Zoe went with her. At the hospital, Sally had an x-ray and the hospital staff discovered that she was nearly six months pregnant. Sally was shocked. While staff and volunteers at the church had noticed her weight gain, they had encouraged Sally to watch what she was eating and had not entertained the idea that she could be pregnant.

The baby was born three months later, and Sally desperately wanted to keep him. As both Sally and Nicholas have mental disabilities, they were sent to supported accommodation for new parents so that they could access help in looking after their newborn son. However, despite spending two weeks there, Sally and Nicholas struggled to provide adequate care for their son and the child was given up for adoption.

Sally did not take this well. She didn't understand why her baby was taken away. One morning Zoe observed Sally walking around Benbow, pushing a pram with a teddy bear in it. Her face showed her distress and confusion. Zoe and another volunteer Sarah came alongside Sally. Over the following weeks and months, they helped Sally to write about how she was feeling and to

write about her son. The program has given Sally words to describe her emotions and her love for her son. Zoe and Pamela have also facilitated opportunities for Sally to see her son and his adoptive parents.

I look over to Sally, standing next to the pot of steaming food, smiling as she serves the next person in line at the café. Her life has been difficult; her situations at times have been beyond her comprehension. Yet through the care and support of the team at Benbow Church of Christ, Sally has support, friends and opportunities.

♦ ♦ ♦ ♦

In this chapter, I seek to describe various church activities that promote health education, healthy behaviours and health literacy. These activities encompass health promotion approaches from downstream (disease prevention) to midstream actions (health education and empowerment), which is further illustrated in the typology presented in chapter 12 (see figure 12.1). The church has historically been involved in welfare relief (see chapter nine) and social support activities (see chapter eight); however in this chapter, I demonstrate how the local churches have engaged in activities that address disease prevention and issues of access to health services. The church activities described in this chapter align with the literature base from the US (see chapter 2) with an emphasis on promoting healthy eating and physical activity within the church environment, coordinating health seminars and support groups, linking individuals and communities to health care and providing support through pastoral care.

DISEASE PREVENTION

The primary care disease prevention approach to health promotion is characterised by activities which aim to improve biological risk factors and personal behaviours through screening and

advice (Keleher, 2007b). In the churches included in this study, disease prevention was usually undertaken through activities such as encouraging healthy eating and promoting walking groups and sporting teams for people struggling with overweight and obesity and associated health problems:

> Part of the stuff we do is to encourage people, we do have a number of people [here] who are quite ... unwell or diabetic, or they are physically overweight. So to encourage them to go walking is another thing that we do with some of the church members ... in our minds we think about a holistic approach to people's healing and wellbeing ... we want to model good healthy eating as well as healthy lifestyle choices (Ayesha, UNOH Worker, Redgum Church of Christ, urban).

Ayesha describes how her husband, John (also a UNOH worker), was involved in assisting Jim, a regular participant in Redgum Church of Christ activities.

> Jim was incredibly unhealthy and morbidly overweight, morbidly obese so he was really not healthy at all. John took it upon himself to work together with him and his doctor ... Jim had had a lifetime of just bad habits of fried foods, fatty foods so in response to this dilemma, John said 'look let's try and teach this guy how to cook healthy and how to eat healthy.' John went to Jim's house and they went shopping together and they cooked together and John showed him...this is an example of a really simple healthy meal (Ayesha, UNOH Worker, Redgum Church of Christ, urban).

At Benbow Church of Christ, Zoe, has initiated two programs that can be considered health promoting: an exercise program and the adult literacy class, described earlier. Zoe identified that the catalyst behind the exercise program was her realisation of the benefits of exercise:

> A few have got weight problems. George has diabetes as well as weight problems, as do a couple of the others. And all of that means that these are needs that if we don't look at some way of trying to help them meet those needs it's going to impact their lives in other ways. So what we are trying to do is holistically support and assist people who quite often can't or don't know how to do it for themselves and who don't even realise how much benefit that they get until they actually stick at it and start to feel the benefits. So some of them come just for company and then they suddenly realise that they are getting benefits (Zoe, volunteer, Benbow Church of Christ, urban).

Ayesha and Zoe both articulated the belief that disease prevention is key to the holistic care of a person and community and therefore were important activities for churches to be involved in. Disease screening activities were demonstrated in screening programs for key health risks and conditions such as hypertension, hyperlipidemia and diabetes. For Sudbury Baptist Church, a new modern church, disease screening and health checks were conducted in partnership with the local hospital where "they [staff from the local hospital] will come and do health checks at some of our programs, blood pressure tests, diabetes tests, they provide clinicians to come and speak to mother's groups on various aspects of health" (Benjamin, Senior Pastor, Sudbury Baptist Church, urban).

Within the Catholic Church system, parish nursing is increasing in Australia after its success in the US and Canada. I interviewed one parish nurse who worked at a large urban Catholic church in the suburb of Downton. Alison, the parish nurse at Downton Catholic Parish described her title as a "pastoral nurse," as the church felt that "the parish was too limiting and [that] there are connotations of it just belonging to a Catholic parish whereas the role is interdenominational. And it's also a community role." Downton Catholic Church is a traditional church and despite

Alison saying that her role included the wider the community, the activities she described were predominantly for those who attended the parish.

Alison explained her role and responsibilities as “health promotion, health education and health maintenance.” The description of the health promotion arm of her role fits with disease prevention and health education in that she would organise health promotion days where “after Sunday services we ran a blood pressure testing screening.” Health maintenance involved visiting people at home when they were sick and ensuring they were accessing appropriate services. Attending physician appointments with patients was also part of her health maintenance role, whereby “if people are sick and the family needs support, they ask me to go along with them to be another set of ears particularly with doctors.” In this sense, she often helped in decision making about care options by providing an objective insight into what the doctor had communicated to the family and patient.

The other component of the parish/pastoral nurse role was that of health education. These corresponded to activities which promote health literacy. For example, a parishioner at Downton Catholic Parish, with mental and physical health co-morbidities was having difficulty knowing when to take his medications and the dosage of different treatments required. The pastoral nurse went to the pharmacist and obtained a dose set box made up for him so that he “was able to say ‘okay, well, this is what I take at this time and this time." The health education role also included the nurse conducting health risk assessments of parishioners, providing information on prevalent health problems such as diabetes and cardiovascular disease, and referring participants to general practice, community health and other appropriate services:

> So, for example, I had a lady who came in the other week and she just happened to run into me outside and was telling me about these different health issues and then she came in here and we did this health risk assessment. And there was, she was very overweight, and had problems with gout and all these other things. And so I was able to give her information about diabetes and healthy eating (Alison, Pastoral Nurse, Downton Catholic Church, urban).

PRIMARY CARE

Primary care activities included counselling services and facilitating access to other health services. Tinworth Anglican Church, an emerging church, is actively involved in working with residents of housing commission flats in an inner city suburb. Through time volunteered by various church members, Tinworth Anglican Church has been able to provide the services of a doctor and other allied health professionals:

> They don't have a clinic but [the doctor] will be sort of informally working with people, with their physical health … [We] have physios, and ... have OTs [Occupational Therapists] who are part of our community, and they help people out in a voluntary capacity as well (Mitchell, Minister, Tinworth Anglican Church, urban)

Six churches had a professional counselling arm associated with their church which provided free or low cost counselling for people in the community.

> Friday morning we also have free counselling so we've got a trained qualified counsellor here [who] is able to see people and help them work through emotional or social issues (Dale, Captain, Milltown Salvation Army, rural).

> We've got an actual counselling organisation...that is run by the church (Cohen, Minister, Murcutt Anglican Church, urban)

> We do have a formal counselling centre and we provide psychiatric, psychological, financial, legal and general counselling and relationship counselling. And that is available not only to the church members but to the broader community as well (Trevor, Sunderland Church of Christ, urban).

For a number of the other churches, informal counselling services such as pastoral counselling[24] were offered to congregation members. For Peter, a priest at a local Catholic parish, there was a sense that community services in the area of mental health have declined, and consequently churches have had to step up to fill the gap:

> It's one area where we are finding that the wider community is not very good. They used to have really good services going back about six or seven years, a couple of the hospitals but now these services have declined, they are not available, which is ... it's a really big area because grief counselling, that whole notion of death is very difficult for people to really grapple with especially with a young person…We don't feel that the wider community is providing enough services in those areas. We have to pick up a lot of that stuff…What I'm saying is for example I come across someone who is not going through the normal cycle of grief and is stuck and it then become depression. What is happening is now, we haven't got enough services to be able to refer them on. Once upon a time St Vincent's Hospital had a great grief counselling unit, but now a lot of these services are

[24] Pastoral counselling differs from traditional counselling in that it incorporates spiritual beliefs into counselling sessions.

> ... I don’t know what reasons are behind it - it might be funding cuts (Peter, Priest, Ponden Catholic Church, urban).

Churches in the past have been criticised for their approach to mental health (Leavey et al, 2007) and there are anecdotes of priests and ministers praying for individuals and then telling them that they are healed and that they no longer need to access professional mental health care or to use medication. While Luke asserts that this is not the approach undertaken by Grantham Rise Baptist, he does highlight the option to access prayer and what is termed ‘theophostic counselling’. Theophostic counselling is now more commonly referred to as theophostic ministry, to distinguish this from counselling. The ministry is controversial and has both supporters and opponents in churches. The process focuses on "identifying maladaptive cognitions, asking God to take the client to the "source and origin" of the pain, and in that place asking Jesus to reveal His truth to that client in regards to these lies in whatever way the Lord chooses" (Garzon & Poloma, 2005, p. 388):

> I’ll never say, well we believe that God can heal you therefore give away your medication, disregard your doctor’s advice, don’t continue with counselling. We will never say that, but I see God as being part of a holistic sort of package. We will say, if people want to engage with us in conversations, that’s a key point, if they want to engage in conversations about how God might fit into the picture, then we might say, ‘well continue taking your medication as the doctor prescribes, continue on with your drug and alcohol counselling,…and if you like too, why don’t you engage in some theophostic counselling, which is what is termed prayer ministry in Christian circles. But we are talking about trained people so I’m not talking about just sitting down and having a bit of a pray about stuff, we are talking about people who are trained very specifically to be

> able to counsel people and engage with God around perhaps some of the issues that might be contributing or have traumatised them in the past, that might be contributing to some of their behaviours today. So that's what I mean about holistic (Luke, COACH Executive Director, Grantham Rise Baptist Church, urban).

Ayesha, the UNOH worker from Redgum Church of Christ, also describes the need for a holistic response from the church with the recognition that it shouldn't just be about prayer and the belief that God heals, emphasising the responsibility to refer people to appropriate care:

> For example, if someone is suffering with post natal depression, then knowing where to help to link that person in is stuff not only happening socially in our local church ... joining a support group ... I know of one running in Berwick, and seeing a psychiatrist and getting medication, and that's a holistic response. And I think the danger is that churches would, I'm not saying churches necessarily do this, but there has been I think a mistake of praying and believing that God will heal and not actually taking the responsibility of looking at medication support or referral to good doctors and then it can happen that the person can get so desperate that they commit suicide. That's the worst case scenario. So I think we have a responsibility to be able to know how to refer people on. And I think churches are getting a bit more savvy in this area – they've got counselling services now and all sort of things set up like that and they are realising that they need a bit more of a holistic response to people – so that's good – that's encouraging (Ayesha, UNOH Worker, Redgum Church of Christ, urban).

HEALTH EDUCATION

Health education and behaviour change approaches to health promotion seek to impart knowledge about identified risk factors through providing information, targeted behaviour change campaigns and health education programs (Murphy, 2004b). This approach addresses psychosocial and behavioural risk factors. In the context of the church, health education and behaviour change were demonstrated through health seminars or workshops that aimed to improve life skills, to encourage people to adopt particular health behaviours (e.g. increase physical activity, eat healthy and nutritious meals, reduce alcohol intake) or seek help for health related issues. This was common practice among the study churches, particularly traditional churches:

> We had a men's health seminar last year – specifically looking at the middle age and onwards, because this is an aging parish and there are many people who are moving into retirement and their mental as well as their physical health is important at that time. So they need some encouragement and assistance to realise that they are not alone in this. That it is something that other people go through (Victor, Priest, McManus Catholic Parish, urban).

The 'health' seminars/workshops run by the new modern and emerging churches tended to be broader in focus, addressing not only physical health but also emotional and relational health. Helen, the women's ministry worker at Fortescue Church of Christ, talked about a night for women about depression and another session where they had a speaker from the police come and talk about women's safety. Other sessions run at this church included one with a "GP ... talking about hormones and health care and that sort of stuff."

While some of these programs are run for church members and not necessarily widely advertised to the broader community, other programs are open to non-church attendees:

> Parenting courses or the marriage courses ... generally are for in house but ... what happens is people bring their friends as well ... last year we ran an evening on youth and depression. And that's for parents, how to spot [depression] in your kids. And that was really popular; it was about 80 people and ... a lot of people were bringing friends to that (Cohen, Minister, Murcutt Anglican Church, urban).

Some churches advertise extensively their health information nights in efforts to engage with the wider community:

> We've got one coming up in the first week of June which is on autism and Asperger's. So we will be advertising that through schools, preschools, churches, other organisations, scouts, girl guides. Just trying to promote another layer of conversation in the wider community for people who work with children or youth or adults in different capacities and it might be handy to have a greater grasp of Asperger's and the autism spectrum and some of the practical outcomes that people can build into their programs of learning or interaction that may be better suited to people who experience life in that spectrum (James, Minister, Fortescue Church of Christ, urban).

The pastoral nurse at Downton Catholic Parish ran programs under the umbrella of health promotion which included grief seminars, a resuscitation program in partnership with Ambulance Victoria, and a wellness program. In the wellness program, Alison ran a session on physical health which centred on what happens "if you don't look after your health, if your body

becomes too stressed." The program also included a session conducted by a psychologist and other people who presented information about prayer and meditation:

> The parish priest came and talked about the church's role in all of that. And then we actually had a day on how you manage your stress, so we had different methods, practical ways of managing stress, so, for example, the psychologist did an exercise on mindfulness (Alison, Pastoral Nurse, Downton Catholic Church, urban).

PARTICIPATORY HEALTH EDUCATION

The participatory health education approach to health promotion aims to provide health information and social support as well as develop personal skills via empowerment. These aims can be achieved through health development, education sessions, social marketing and the settings approach to health promotion (Keleher, 2007b). Every church participated in activities which could be classified as being part of a participatory health education approach ranging from providing health seminars to address the needs of congregation members to coordinating support groups for key issues in the community. This spectrum of activities is demonstrated by Table 12.1 in chapter 12. Wallerstein (1988) distinguishes empowerment education from traditional health education with the former being about efforts which involve people and communities identifying their problems, assessing the social and historical cause of the problems, dreaming of a healthier society and developing strategies to address the issues:

> Through community participation, people develop new beliefs in their ability to influence their personal and social spheres. An empowering health education effort therefore involves much more than improving self-esteem, self-efficacy or other health behaviors that are independent from environmental or community change; the targets are

> individual, group and structural change. Empowerment embodies a broad process that encompasses prevention as well as other goals of community connectedness, self-development, improved quality of life, and social justice (p.380)"

Below, I outline examples of participatory health education evident in this study. I describe how a new modern church is involved in support groups for cancer patients, and how two emerging churches provide support for people experiencing depression and families who are dealing with alcohol and drug abuse. These groups were always open to people from the wider community and are not restricted to church members.

Milltown Salvation Army, an emerging church, hosts a family alcohol and drug support group. Alcohol and drugs have impacted the small town of Milltown, with many families grappling with how to deal with addiction.

> Fortnightly on a Thursday night we have a family support group which is for people who have family members affected by alcohol or other drugs. So they can just come in and get support again with someone who is trained in that area and um have a safe space to sort of share the experience they are going through. (Dale, Captain, Milltown Salvation Army, urban)

The facilitators of the cancer support group at the new modern Longbourn Uniting Church, describe their group as being "a safe place for people to come and learn about cancer, be able to freely talk about their cancer ... Sometimes when you get cancer you don't want to burden the family anymore and this is a place where they can come on their own if they want and there is no one here that they are going to upset (Betty, Cancer Support Group Coordinator, Longbourn Uniting Church, urban). The cancer support group at Longbourn Uniting Church is registered

with the Cancer Council of Victoria, and hence the majority of the members are not associated with the church. However, it is run through the church and the group has access to church resources in terms of the building as a meeting space and social support via church members who have volunteered their time over the years. The coordinators of the group described some of the recent sessions which covered topics such as exercise, food to eat when experiencing nausea, and the power of positive thinking. Allied health professionals also came to meetings to talk about their services. Betty reflects on one recent successful session, a juice night held to address nutrition needs of people with poor appetite:

> We had a juice night – we bought fruit and vegetables and we made juices that they would like, that if they were feeling ill they might like. And we had a new lady come last meeting and she was very interested in it and she was taking that away with her and she thought it was a very good idea for her. And she was full on asking questions about how to cut them up and have them in the fridge and how often should I have it ... and that was a really positive thing for her.

A number of churches ran depression support groups or church services specifically catering for those with depression. Aaron, the initiator and coordinator of MindHealth and Blur (see below) at Ashridge Baptist Church, has battled with depression for a number of years. He previously worked in the construction industry; since his diagnosis with depression, he has become actively involved in promoting mental wellbeing in the church. He also works part-time at a community health service as a peer support worker for people with mental health issues and is undertaking a TAFE course in mental health.

MindHealth is the umbrella name for the activities and programs of Ashridge Baptist Church designed to promote mental wellbeing. Andrew, the senior minister at this emerging church came up with the term MindHealth to move away from the stigma that is associated with mental health, depression and anxiety. It aims to communicate the need for all people to work at being mentally well. When I visited Ashridge Baptist Church, it was advertising a MindHealth seminar for people to come and ask questions about mental health problems, whether for themselves or a family member or friend: "We look at limiting the amount of junk food we eat and alcohol we drink and maintaining the right weight, but we don't often think of creating the space for mindfulness and meditation (Aaron, MindHealth Coordinator, Ashridge Baptist Church, urban)."

Blur is a support group for people who are experiencing mental health problems. Aaron describes the group as "a venue for people to be able to unpack what is going on in their life, how their health is going, what issues they may be having around medication." The group provides support and encouragement for those attending both church members and others from the wider community. Aaron gives the example of Amanda, who attended Blur regularly but did not disclose her situation or her struggles. On one night, there were 3-4 people there and one of the girls, Lucy:

> Was talking about issues of self-harm that she was having at the time which was difficult and she was pretty upset. Amanda, just out of the blue said, look you just need to know that you can get past that stuff and this has been my experience. She talked about her issues with self-harm and how that started to resolve itself, and how she could control it. And to me that is exactly what the group is there for (Aaron, MindHealth Coordinator, Ashridge Baptist Church, urban).

I met Aaron at a café near Ashridge Baptist Church. He had just finished having a coffee with Candice, who was struggling with anorexia and drug and alcohol issues. I was struck by the extent of support that is offered to individuals accessing MindHealth, as Aaron tells me:

> With Candice, it's been anything from spending 2-3 weeks living with us, the family, when she was having a particularly hard time and now I'll catch up with, I see her each week, but I catch up with her one on one every couple of weeks, sometimes more, sometimes less - just to talk about how she is going and talking about different strategies and that is where it is at now.

Lincolnshire Baptist Church is a new modern church located in a rural town, comprised predominantly of blue collar workers who are employed locally. The senior minister, Harry, describes the town as isolated from vital social and health services. Harry noted that there were people in the congregation who were suffering from depression, but there were no support services in Lincolnshire for them to access. Harry told me how he addressed the congregation:

> Look, I need to tell you I'm concerned about the fact that we don't have any means where by which we can support somebody suffering from depression. We have people in the congregation, some of you have told me that this is a reality for you, I know that families are needing to cope with those who are suffering from depression, and I'm also concerned that too often people who do not suffer from depression take the view of 'get over it tomorrow is another day, everything will be okay' and I know that is dismissive of what is a very real issue.

A couple of months after Harry's announcement, two people attempted suicide and one succeeded. Harry sadly tells me how the woman who was successful was "a very dear friend …

and I thought … this is not good, we really have to do more than talk now." In partnership with the local rotary club[25] Harry, initiated a mental health awareness evening. This has evolved into a monthly support group attended by some 20 people.

> We started, our first meeting was in February this year – we had a presentation by a counsellor on depression – just picking up an aspect of it – which went very very well. The second meeting in March … the local Catholic priest who suffers from depression and makes no secret of that, he came along and told his story which was absolutely amazing. And then last month we had another counsellor in town talking about depression. She was outstanding, and I would say that three quarters of the people there certainly don't come to our church, and one of the things that we've said is that the only barrow we are pushing is the wheelbarrow of hope. And on our promotional leaflet, we've made it very clear that while we've launched this as a community service. We are not seeking or requiring any affiliation with the church. So we are trying to make it very plain that this is something for everybody, not at all dependent on a church connection.

In addition to depression support groups, a number of churches in this study (Redgum Church of Christ, Fortescue Church of Christ, Grantham Rise Baptist Church - Oasis church service) ran church services that were tailored to people experiencing mental health problems or disabilities. These services were simple, generally short and did not include a long sermon. Bible teaching was communicated in stories or brief talks and congregation members sat in chairs arranged in a circle. These services sought to be inclusive and non-threatening. Volunteers and staff exerted

[25] Rotary clubs are a network of businesses and professional and community leaders. The clubs are non-political, non religious and are open to all people. The ethos of Rotary is to 'pay it forward' and to have a positive impact in communities. www.rotaryaustralia.org.au

much effort to ensure that everyone felt welcomed, particularly those who may find social situations uncomfortable.

HEALTH LITERACY

The concept of health literacy has emerged from the disciplines of clinical care and public health. Health literacy in clinical care is understood as a risk factor with definitions describing individual literacy competencies which facilitate or restrict health and clinical decision making (Nutbeam, 2008). In public health, health literacy is viewed as an asset and an outcome of health communication and education efforts. Nutbeam (2008) describes public health actions to improve health literacy as being focused on "developing age and context specific health knowledge, and the self-efficacy necessary to put that knowledge into practice in ways that enable people to exert greater control over their health and health-related decisions" (p.2074). In public health, the definition of health literacy is not confined to the access of health services or management of health conditions, rather it reflects the broader social determinants of health and seeks to empower individuals and communities to recognise and modify these determinants (Nutbeam, 2008; Kickbusch, 2001).

While church members do not use the term health literacy, a few emerging churches described activities which promoted the health literacy of church and community members. Health literacy activities within churches ranged from assisting individuals to read and complete forms, to attending medical appointments with individuals, encouraging them to seek medical advice for their problems, and ensuring that they understand medication instructions from their doctor. As discussed in Chapter eight, intentional relationships with individuals within the church and the community open opportunities for church members to assist people to access health and support services.

> 'Form Assist' is a program that allows people to come in who are having trouble filling out forms of any description, and the staff and volunteers are able to help them complete the form (Dale, Captain, Milltown Salvation Army, rural).

> [Church volunteers will] accompany people to hospital visits or people with mental health problems [who]...need an advocate, need somebody who knows how the systems work, and speak up or keep a person calm so that they can actually access the help that they need, or just to be there to hear what a doctor or health professional is saying to be able to kind of jot things down and then talk to the person afterwards (Pamela, Minister, Benbow Church of Christ, urban).

> Like, for example, recently I spent a whole day in emergency with someone from the other parish and she had problems hearing, she missed half of what the doctor was trying to tell her and so I would repeat it to her in Maltese as well, because it was the language but also the hearing problem (Mary, Pastoral Associate, Haworth Catholic Parish, urban).

In particular, Pamela, the Minister at Benbow Church of Christ, actively promotes health literacy. She described how through the course of developing friendship and trust with women in the church and community, "they will say something that triggers in me a question to ask them" about situations of sexual abuse. When this happens Pamela personally takes the women to CASA (Centre Against Sexual Assault) for counselling. She organises and attends the appointment with the women if they request it as "sometimes they just want someone else there." She notes that the incident of sexual abuse often occurred years ago "maybe as a child, maybe as a young woman, [however], it's never been dealt with ... I don't know if you ever fully recover from those scars but certainly I've seen women develop in confidence, self-esteem, and it's gone

a long way to contributing to their health, their ongoing health. And that's just a real privilege and that's silent work because you don't ever talk to anybody about what goes on in those sessions."

Pamela also spoke of George, a friendly community member who is now a regular attendee at all of the church programs. George wasn't well and Pamela was worried that it was related to his diabetes as he was finding it difficult to read the text on his computer. In response to this concern, Pamela went to the doctor with George. Through her support and promptings, the doctor was able to work out that George wasn't taking his medications correctly.

> He was taking the right medication but he was taking it completely wrongly. He's meant to take one in the morning and one at night. He was taking two at night and then if he didn't feel well he was taking another one. So his sugar levels were all over the place, so we then went with him to the chemist and got the tablets put into a Webster pack and so now he knows when he has taken them and he knows morning and night. It's clear for him. That sort of stuff happens as a result of being in contact with these people regularly. I knew his eyes weren't right and he was having headaches. And so we go, and that's what you can do, you've got that option.

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In this chapter, I have illustrated how churches are involved in downstream and midstream health promotion action through disease prevention activities such as health seminars, the promotion of exercise and healthy eating, and parish nursing services, were common activities for traditional churches. Despite their lack of familiarity with the discourses around health literacy, emerging churches were involved in this field also: referring individuals to appropriate health and social

services and at times accompanying people to doctor visits. In addition to promoting community health services, some emerging churches resourced communities by running primary care services at no cost or low cost. Support groups, particularly for mental health problems, were also a common for new modern and emerging churches. The findings from this chapter have contributed to the development of the typology presented in chapter 12. In addition, table 12.1 highlights which churches have been involved in different types of health education and health literacy activities. In the next chapter, I explore how local churches are involved in fostering social connection and providing social support.

Chapter 8

SOCIAL INCLUSION AND PASTORAL CARE

'A PLACE OF BELONGING FOR EVERYONE'

The community centre is located in the centre of the housing estate, known to local residents of Grantham Rise as a place that is rough and unsafe. The estate is comprised predominantly of Public Housing Commission houses, and is populated by people who according to social workers, have been placed in the "too hard basket." There is a lot of stigma associated with having an address at this housing estate, so much so that there is talk of changing its name.

It is about 5:15pm on a Wednesday in October when I pull into the gravel car park of the community centre. I am here to observe the community meals and the Oasis church service run by emerging church Grantham Rise Baptist Church. There are kids running around yelling and laughing. The chatter of people and smell of food leads me to the pottery room, the craft room of the centre and the location of the community meal and church service. I am greeted by an older lady as soon as I enter the room. The room feels like an artist's cove with paint splatters on the floors and walls, sinks for washing up, and long work benches. In the corner are a husband and wife singing and playing guitar and bass, providing background music to the bustling activities in the room. There are five rectangle tables covered with red and white checked table cloths.

I sit at one of the tables, opposite a large man wearing shorts and a T-shirt. He grunts at me. Volunteers engage him in conversation, asking how his week was and how he had been feeling. The food is being served, the children first. The food isn't healthy food, particularly the food for the kids who were served pizza and chips and pasta. Not many vegetables. The volunteers

explain to me that they serve the kids what they know they will eat, as often it is the most substantial meal they will get that week. Once the children have been served, the adults are served in a buffet style: casseroles, pasta, lasagne, processed meats and salads. There are 56 kids registered as participants in the children's program associated with the church, a high percentage of whom are known to the Department of Human Services due to child protection issues.[26] Volunteers run activities for them in a separate hall next to the pottery room, after they have eaten.

Approximately 30 to 40 adults attend the meal and church service on a regular basis. Maureen, the coordinator of the Oasis church service, provides me with the basic demographics of the group: drug addicts, former sex-workers, people with drinking problems, people with mental health problems, and others who are socially isolated; people who don't fit in with the rest of society. I sit opposite an older woman, Phyllis, at the dinner table; she has her plate piled up high. She keeps apologising for the amount of food she has taken, as she explains that she is struggling to provide enough food for her family. She works a day a week as a cleaner, but needs more work to support herself and her family. Katie, a volunteer, sits down next to me and starts talking to Phyllis as well. The conversation weaves in and around family and children, problems with teenage boys, and work.

After everyone has eaten, the tables are packed away and Maureen organises the chairs to be set up in a circle. Approximately 30 chairs are set up, but we keep adding chairs as more people join in. This is the church component of the evening. We start by singing some simple songs, led by

[26] Child Protection Services is a section of the Victorian Department of Human Services. They are notified in situations where there is evidence of abuse or neglect of children.

the husband and wife music team. Tambourines are handed out, although mainly the volunteers take these up. After three songs, there is a time for people to share what has been happening in their lives. Greg attends regularly. He is of short stature, dressed in worn clothes – he is hunched over, almost folded in two, with unkempt hair and beard. Life hasn't been gentle to him. His mother has died quite suddenly, and he is distraught, rocking backwards and forwards in his chair. Maureen hands Greg a card signed by the volunteers and regular attendees, and tells everyone the time and location of the funeral. Greg is touched by this and is fighting to hold back tears. He also has cancer and is undergoing chemotherapy. Another regular, a buxom woman who has just finished her studies in office administration, had been helping out in the church for work experience. She speaks animatedly and enthusiastically of her work experience and the volunteers encourage of her, saying what a great job she has been doing. Her friend died on Sunday, and so people are offering support to her as well. The conversation moves to those in their group who are unwell. They welcome back people who haven't been along in a while – particularly one woman, Melissa, who has been quite sick. There is a sense of joy that she has returned to the group. One volunteer tells the others about the new chickens that she has bought which lay eggs for her and her family. There is laughter as she relates these stories.

After the sharing time, Simon, one of the volunteers, delivers the sermon. The volunteers are from a mix of age groups, mostly middle age or older. Simon's sermon, 'It's Friday, but Sunday is coming', is simple but very powerful. He talks through the Easter story, how Jesus died on Good Friday, yet people did not realise that Sunday was coming, that there would be new life and that death and brokenness would be conquered. Simon talks about how it was a 'Friday' when he watched his own son die in his wife's arms, with his son's new wife standing by. They were in a remote village in a developing country and they did not know where the nearest

hospital was. It was their Friday, but Sunday was coming. Sunday for his son was coming, a Sunday of no pain, a Sunday that brought hope. Simon then talked about his friend Liam, who is homeless, has schizophrenia, often goes into a catatonic state, and can be quite violent. Liam has no job, bad health, and his brother and mother have both died. The social workers and police talk about how Liam has no future. But this is Liam's Friday, Simon explains, and Sunday is coming. Simon then addresses Greg: "Greg, this is your Friday, your mother has died, you are undergoing chemotherapy and it hurts, life just hurts so bad, but here is your encouragement ... Sunday is coming." Simon emphasises that 'Sunday' is a core promise of the Bible. It offers hope. There is recognition that we all need someone to say that things will get better. For every Friday, there is the promise of a Sunday.

After the sermon, we celebrate communion to acknowledge our Fridays, but to also look to the Sunday. Communion consists of red cordial in little cups and two chunks of bread, passed around by one of the volunteers. We eat the bread and hold the little cups and drink the cordial together once everyone is served. After communion we sing some more songs, one of which is 'Our God is an Awesome God'. During this song, Greg starts crying and Melissa, whose own life has been one of pain and struggle, puts her arms around him and speaks comforting words to him. Everyone keeps singing while Melissa speaks with encouragement and love to Greg – reaching out to him. Broken people loving each other, broken people needing each other, and in their brokenness finding community, hope, and love. The volunteers look on and smile and continue to sing.

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Simmel (1905) argued that "the faith which has come to be regarded as the essential, the substance, of religion, is first a relation between individuals" (p. 366). Much has been written about the social connections and ties observed in churches and the impact this has on the health and wellbeing of individuals (Brown, 2003; Eng, Hatch, & Callan, 1985; Nooney & Woodrum, 2002; Taylor & Chatters, 1988). Research has shown, for example, that the social support between church members mediates the stress of financial strain to a greater degree than social support from secular sources (Krause, 2006). Churches also have been identified as a source of social capital (Kawachi, 1999). In this chapter, I describe the relational aspect of local churches that I observed in this study. I illustrate how churches foster social connections, offer friendship networks to those who are alone, provide pastoral care, and endeavour to build intentional relationships. This chapter thus provides a basis for understanding the social dynamics of local churches that can be a harnessed as a resource in health promotion practice. In this chapter, I also seek to demonstrate how local churches are involved in health promotion actions that build social capital and create supportive environments.

SOCIAL SUPPORT AND CONNECTION

Providing avenues for social connection and support was important for the majority of churches in this study. People were recognised as social beings and so the impact of the social dimension of health on the physical, mental, emotional and spiritual health was acknowledged. Pamela, the minister at emerging church Benbow Church of Christ, described how church activities of social support affect the self-respect, self-esteem and confidence of attendees:

> To me, health and wellbeing is very tightly linked up with self-esteem and self-respect ... We are looking to build the self-esteem and self-respect of some of these people. They change the way they dress. They drop swearing ... we offer them alternative ways of

> communicating ... Many of these people have never learnt how to manage emotions. Well [we've] got a place there where people can talk about how they feel. They can actually write about it or get up and tell a story about it … we are helping people to deal with their feelings ... So it's all about being able to mix with other people, being able to communicate with others, to being socially acceptable to being valued as a human being, to being physically and mentally healthy.

The unique role of churches in providing social support was highlighted as participants articulated their interest in the person as an individual, as opposed to their particular skills or talents, as may be the case for groups like sporting clubs.

> I think because our common denominator is an interest in the person ... and the relationship - if the other factors change, like a loss of a job or something else, whereas with a sporting club you have to pay your membership, if you can't pay that you can't be a member or if you get injured you can't play. If ... the circumstances change we are actually more likely to rally behind them and provide community support rather than [going] 'well that interest that we had, that has changed.' That won't matter. It is actually the investment in the relationship. I think that is valuable in what churches provide quite well (Jane, Community Engagement Officer, Ashridge Baptist Church).

In conjunction with a focus on the individual, Bible teaching prompts churches to engage with difficult social groups who may be ignored or excluded by others in society. I commenced this chapter with the story of the Oasis church service run in the middle of a housing estate in the traumatised streets of Grantham Rise. Grantham Rise Baptist is a large urban church with a

church building typical of Melbourne megachurches.[27] The building has a warehouse feel, plenty of rooms, a large auditorium, offices, a playground and plenty of parking for the masses who attend on Sundays. When I interviewed Maureen, the coordinator of the Oasis Housing Estate Church, she explained how Oasis was set up in response to a group of people who felt uncomfortable attending the megachurch. Many people experiencing addiction problems or those from poor backgrounds, would not feel comfortable in a middle class suburban church, and hence emerging churches such as Grantham Rise Baptist Church, ran alternative church services (often not in church buildings) to reach out to these marginalised individuals:

> We've got drug addicts, ex-prostitutes and um ... yeah people with drinking problems, and, you know, the socially isolated who wouldn't fit in with the normal church. And these people would never perhaps talk to their neighbours and most of them are from the worst streets and they come here and it's an environment where they feel accepted for who they [are] …Where they feel that they are not judged. They come and feel part of the family. And so there is an amazing feeling of community connectedness there (Maureen, Community Care Coordinator, Grantham Rise Baptist Church, urban).

Social support and inclusion is fostered for many churches through activities such as playgroups, mother's groups, youth groups, and Bible study groups, church services, mentoring programs, Sunday school, community meals, craft groups and disease/illness support groups:

[27] Megachurches are typically Protestant churches and are defined as such if church attendance exceeds 2000 people over the weekend (Hartford Institute for Religion Research, 2006).

> We provide childcare for preschool age children, and it's time out for mums for two hours twice a month…We will have a speaker, we will have a craft [class], we will have morning tea and have discussion group time. We often get referrals from the local maternal child health nurses for particular people who are struggling in one way or another (Clara, Woman's ministry worker, Fortescue Church of Christ, urban).

> Chat and craft group which we have for elderly people. And once again, giving them a sense of value and purpose, and helping them to stay mentally active as well, which is important in your health (Megan, Children's Pastor Volunteer, Perrington Church of Christ, urban).

Meryton Youth Group

Youth groups for high school aged children are common in most churches. During my data collection period, I visited the youth group of the Anglican Church in Meryton, a rural town in the mountain regions of Victoria. The saw milling industry in Meryton was closed down approximately eight years ago, and the population of the town has since decreased from about 5000 people to 2500. Most of the residents left in the town either work at the hospital, the supermarket, the Department of Sustainability and Environment or in the dairy farming industry. But with a high unemployment rate, many young people move to the city as soon as they are able. The town is remote and isolated with limited access to social and community resources and is characterised by disadvantage, drugs, alcohol and violence. A number of the young people at the youth group are from low socio-economic status families and single parent families.

The children of this town are hurting. I listen to their stories, told by 16 year old Sam, a youth group volunteer and local. He tells me about Ryan, a 13 year old with 57 criminal charges on his

record. Ryan stole a hunting cross-bow from the back of a truck and was arrested for this; he is now in juvenile prison. Ryan used to come to the youth group occasionally. His younger brother Rick had dinner at Sam's house recently and ate three bowls of chicken stew in the time it took Sam to eat half a bowl. Sam observed that Rick ate with his fingers as he didn't know how to use a knife or fork. It is not unusual to see Rick and his three year old sister Sasha walking the streets at 10pm at night. Then there is Matty, the 11 year old who attends youth group but has not been toilet trained. He soils his pants daily. I am not sure whether Matty is suffering from brain damage or a learning disability or is experiencing neglect. It might be a combination of all three. Sam tells me of a single mother of some of the older kids attending the group, who recently had another child. She stays indoors all day smoking marijuana, with her newborn in a basket next to her.

Sam's tone when describing the children of Meryton is not judgemental; the children are powerless. He is, however, critical of their parents, the adults of the town who, according to Sam, should know better and do better for the younger generation. Sam has a high regard for Nigel, the minister of the Anglican Church. While Sam doesn't identify himself as being religious, he appreciates the way Nigel has created a community and values the people of Meryton. The youth group was Nigel's idea four years ago, when he realised that many of the young people fell through the gaps of professional support services. On their first night, 54 young people attended. It has grown since then, with attendance on average of 100 children on any given night.

The youth group is held in the old Uniting Church hall. The program starts at 4:30pm for the primary school children. Approximately 50 children attend the first session within which there is no structured activity. When I arrive, kids are running around everywhere. The leaders are very busy running around with the kids, and games develop on the fly. For example, the leaders start a

soccer game outside and some kids start building a fort with ballot boxes left over from the state election the previous weekend. Some start a basketball shoot out in one corner of the hall. There is a lot of energy and all the kids participate – no one is just sitting down doing nothing. The leaders are very engaged and have a great rapport with the kids. Most of the youth group leaders do not go to the church; they are volunteers from the wider Meryton community.

The leaders bring their own interests to the youth group. One woman coordinates the craft table in a separate room for the quieter less boisterous kids; a teacher comes along to play chess; a young man teaches those who are interested how to break dance. There is a mix of ages from primary school – from prep (children aged 5-6) to grade six (11-12 year olds). The children have unregulated access to lollies, chips and soft drinks which ramps up their energy levels. Popular music is being played through an old stereo and speakers, competing with the children in the hall, yelling and laughing. There are balls flying everywhere as the basketball hoop is located inside the hall and a tennis ball is being thrown from people on the stage to people on the floor. The church hall is in fairly bad condition and this helps the kids feel free to run around. No one is precious about the space.

There are two Koori[28] workers who come and hang out with the kids. Many of the kids identify as Koori – although it's hard to tell because of mixed heritage. The age of the leaders varies from adolescents like Sam to volunteers aged in their 80s. Despite this however, the leaders get along

[28] The term Koori is used by Aboriginal people from Victoria, parts of New South Wales and Tasmania. The word is how Indigenous people describe themselves 'I am Koori'. Most but not all Aboriginal people residing in Orbost are from the Kulin nation and are historical settlers of the area.

well with each other. Nigel, the Anglican church minister, is in his 60s, yet he runs around with the kids as well as checking in with the volunteers.

At 5:45 pm, the kids are ushered inside for a Bible talk by Bessie, a 70 year old volunteer. She is a small woman with an easy smile and a passion for the young people of the town. She wants to help in the only way she knows how, to teach children from the Bible. A young girl Stacey, and her boyfriend from the Assemblies of God (AOG) church, run the singing segment. Two little children hold up the words to the songs which are written on large pieces of paper. Stacey tells the young people that there will be a prize for the person who sings the best. The first song they sing is 'Our one and only God'. The accompanying music is played on CD. The children all clap their hands and sing along.

Bessie presents a brief Bible talk with the aid of a large puppet which one of the children uses. Bessie's message is simple, and I get the sense that it is a message that is repeated often. Her message to the children is that they are valued, and she encourages them to be good to one another. Bessie uses a tape recording of MC Walker rapping out the Bible verse: "In Jesus Christ, God made us new people so that we would do good works."

Stacey finishes with some more singing. The leaders lead the kids in grace – which is pretty much 'I love JC (sic) and thank you for our food'. The kids are told to wash their hands. Dinner is pizza, pasta, vegies, chips and sausage rolls. It's not the healthiest meal, but as Nigel says, at least they are eating something. For many of the young people, this is their only substantial meal for the day.

After dinner, the primary school children are supposed to be picked up and the secondary school children file into the hall. The number of secondary school students attending is smaller, but still

there are around 30. It is rambunctious and crazy, with the occasional fight and wrestling match. The leaders spend most of the time on high alert, keeping an eye out and ensuring that the kids do not get into strife.

I leave the hall at 9pm and drive down the deserted quiet streets of Meryton. I observe how there is no space for these young people except that old Uniting Hall and the youth group coordinated by Nigel and his team. This sentiment is echoed in the reflections of Meryton youth group volunteers:

> I think it's had quite a good impact on the community ... it gives the kids somewhere to go. And you know that the kids are getting a good feed. We have a big under privileged type of people that need that extra help. It's somewhere for the kids to go, they are not just roaming the streets (Harriet, volunteer youth leader, Meryton Anglican Church, rural).

The Koori youth worker volunteers her time at the youth group because they have got "all the at risk kids here." She highlights the need for the youth group:

> If they didn't do something with them, especially in a small town and they are already in contact with the police, juvenile justice ... they will be going to jail if we don't do something ... this is reducing those sorts of behaviour by giving them their own space (Chantelle, Koori Worker, Meryton).

The Meryton Youth Group provides a space for these young people to socialise in a safe environment. Nigel and the volunteers work hard to connect with the children, to know their names and their stories and to offer support and guidance when appropriate. Instead of restricting the youth group to only those who attended the Anglican church, Nigel has opened the doors to

all people of the town to attend and volunteer and in doing so has created and fostered community.

The church service at Meryton Anglican Church is traditional. Nigel wore long robes and entered the service swinging a thurible. Hymns were sung from hymn books accompanied by an organist, the Bible was read from the pulpit and people were invited to the front to partake in communion. However during the week Nigel roamed the town in jeans and sneakers with earrings glinting from his ears. As I have described above, he energetically leads the youth group and encourages other members of the community to be volunteers. He is passionate about providing spaces that care for the hurting children and youth of Meryton. Instead of classifying Meryton Anglican Church as a traditional church, I have categorised them as emerging as the values and beliefs that underpin why and how they engage with society illustrates an ethos consistent with emerging churches. This example highlights how churches may demonstrate aspects of more than one church expression. Overall, much of the work and activities of Meryton Anglican Church focused on creating opportunities for social connection and support.

Churches in this study pursued different and creative avenues of social support. For example, Milltown Salvation Army church ran "an African drumming group, like therapeutic drumming which is fantastic and sounds great right throughout the building" (Dale, Co-captain). Overall the social support activities at the new modern and emerging churches were in response to community needs and engaged the community well. Their activities were open to everyone, with an emphasis on those who did not attend church regularly so as to overcome the perception of churches being insular. In Chapter eleven I highlight and discuss some of the challenges associated with church social support activities such as youth groups and community meals in including issues of value conflicts, alternate agendas, risk management and the coordination of

volunteers. Here I focus on describing how churches strive to provide pastoral care and foster intentional relationships with members of the church and wider community.

'BEFRIEND THE ALIEN'[29]

Ethnic and racial differences can lead to social exclusion and discrimination in many contexts (employment, education, relationships). New modern church, Sunderland Church of Christ is located in the heart of the City of Melbourne and has approximately 40 nationalities represented amongst those attending their church activities and services. Trevor, the pastor of the church, has observed that there are certain groups of people who do not normally interact, but the church provides an avenue where they can do so. He talks about how for some international students, there is a desire to get to know individuals from cultural backgrounds that differ from their own: "For example, a person may say 'I'm a Filipino but I do not want to interact with other Filipinos – I know how they live, I want to interact with others.'" The students appreciate the ability to socialise with individuals and students from other cultural and ethnic backgrounds.

Tinworth Anglican Church, an emerging church, is located near high rise housing commission flats in Melbourne and has adopted the Biblical mandate, love the alien, welcome the alien. In Melbourne, the Horn of Africa communities have experienced profound and sustained social exclusion and therefore Tinworth Anglican Church believes it is important to have people say "Welcome to Australia and we are going to help you settle in and find furniture, we will help your kids learn how to read and things like that" (Mitchell, Minister, Tinworth Anglican Church,

[29] Leviticus 19:34 "The alien living with you must be treated as one of your native-born. Love him as yourself, for you were aliens in Egypt. I am the Lord your God" (NIV translation)

urban). Part of the mission of Tinworth Anglican Church is to be there for the emotional, physical and spiritual needs of their neighbours in the housing commission flats. The church coordinates homework groups, sewing groups, and trips to the local market, as well as special events like camping trips during the holidays. The purpose of these activities is to connect with the vulnerable residents of the estates:

> There are some really broken people, some really lonely people and some when I say broken ... I mean the refugee stories ... some of the damage ... that people have emotionally, physically, spiritually come through… all those experiences (Mitchell).

♦ ♦ ♦ ♦

John is a UNOH worker who lives with his wife, Ayesha, and their two young girls down the street from the hall in which emerging church Redgum Church of Christ is located, in the suburb of Buckley. He is a tall man, with a small fluff of beard and a firm hand shake. John spends a lot of his time with the Sudanese boys in the community. Over 50% of the population in this suburb are born overseas and in recent years there has been in increase in refugees from North Africa and Sudan. John noticed that a group of Sudanese boys of high school age would regularly get drunk in a nearby park. The Buckley UNOH team started hosting barbeques in the park, bringing along plenty of sausages and bread to feed these young boys. The Sudanese boys started to chat to John about sport, but most were guarded about their past and their experiences. However John was on occasion offered glimpses into their horrendous memories of unspeakable violence, their siblings shot, their mothers attacked. John tells the story of one of the boys, Samir, who has a large deep scar down one arm. Samir and his mother were captured by rebels. The rebels yelled at his mother to give them money, but she had none, and so they slashed Samir's arm so deep

that he could see his bone. John is burdened by their pain. These boys have terrible memories and John can see that their drinking is a means to forget. But they drink too much. There are many anecdotes of the youth who have died in Melbourne as a consequence of their drinking, stories of those who are now in jail. Yet there are some Sudanese boys who have made good decisions. One boy has been sober for a year, another is in rehabilitation. John takes some of the other Sudanese boys to visit the boy in rehabilitation, and even though he only understands a little bit of Arabic, he understands them saying 'you look good'.

John's work in Buckley and at Redgum Church of Christ is driven by his desire to see these boys, and others, make good decisions. The Sudanese boys always say that they will quit drinking soon but sometimes soon does not come. I ask John whether he explicitly brings up the issue of alcohol, and he said 90% of the time it comes up naturally – they never force it because the boys will sometimes withdraw. The Sudanese boys have social workers and community workers assigned to them, but their support and help finishes at 5pm on a weekday. John is there to hang out in the park at the elusive time after business hours when the boys are drinking. He is there to be their friend as they remember their past; he hopes to show them an alternative way to deal with their pain.

PASTORAL CARE

Another avenue of social support is pastoral care and this was practiced in varying degrees by all churches participating in this study. In many churches, a staff member or volunteer was appointed the role of overseeing pastoral care activities. For the Catholic churches, pastoral care involved visiting Catholics in hospitals, nursing homes, or at home sick, and taking communion to them:

> People appreciate that we take our time to visit them ... a lot of the people that we visit are mostly on their own, and obviously they do feel lonely and for us to go there for that one hour and to be with them, I'm sure that does something for their wellbeing ... And sometimes even if it's not just communion that we take to them, sometimes it's just to be there. They may say, today I'm not ready to receive communion, but can you spend some time. And we do that as well, because that is important (Mary, Pastoral Associate, Haworth Catholic Parish, urban).

The pastoral nurse who has received training in pastoral care defined pastoral care in relation to the spiritual growth of a person and not merely about the practice of religion:

> It's got nothing to do with religion. It's about spirituality. And whether people express their spirituality to religion, that's fine, but not everyone does. And what do you do with people who are atheist and have no belief? There are other ways of helping them find meaning ... in their life, whether it's through nature, whether it's through art, whether it's through their cat or dog ... Spirituality, the psychological, and also helping physically. You're just tying the whole lot together (Alison, Pastoral Nurse, Downton Catholic Church, urban).

This did not fit with the observations of the other Catholic parishes, for whom the bringing of the Holy Communion and discussion of Biblical texts, were seen as key components to pastoral care. Pastoral care was provided for people within the Catholic congregation of the church, and for Catholics living in nursing homes, hospitals or through connections with the local school. For the Protestant churches, pastoral care is about journeying with people, being a friend and a support

person for people during difficult times in life, regardless of religious or congregational affiliation.

> Pastoral visits, that's really important. There are some really lonely people and again mentally unwell people, and pastoral visits just spending time with those people is important for people's health (Mitchell, Minister, Tinworth Anglican Church, urban).

Staff members responsible for coordinating pastoral care saw their role as empowering members of the church to pastorally care for each other. In particular, the Bible study group (also referred to as home groups and life groups) were important avenues for pastoral care.

> I think a lot of it is putting people in a supportive environment. As a pastor you can be part of that supportive environment, but you realise more and more that you are only a very small part of it and your job is to mobilise the people in the community to be the pastoral carers. So the home group becomes a really important part of pastoral care. If a person is aligned with a home group, we can be pretty confident that they are not going to fall through the cracks - in terms of if something is going wrong in their life there is somebody who actually knows and put their hand up and say this person needs help (Brian, Pastoral Associate, Ashridge Baptist Church, urban).

Churches were careful to distinguish between pastoral care and counselling, and respondents made it clear that counselling is a professional practice. Some churches trained the members involved in pastoral care to ensure they understood the components of pastoral care and its boundaries.

> I'll say pastoral care ... I won't use the word counselling because counselling is a technical word that can only be used by people who have completed approved education

> and passed examinations. You need to be licensed to be a counsellor ... So we have about 30-35 people who have been trained to help people, just to come alongside, to seek counsel, to receive support to have receive prayer. As part of that training for pastoral care the individuals are trained to identify when they are out of their depth and need to be able to pass on ... so that is exercising wellbeing not just for the person who seeks support, but also the person who is willing to give support. We don't want that in turn to become a problem because they are out of their depth in a situation which they are counselling (Trevor, Senior Minister, Sunderland Church of Christ, urban).

Tinworth Anglican Church is sandwiched between the middle-upper class homes of an inner city Melbourne suburb and bleak brown housing commission high rise flats. This church has worked hard to provide pastoral care for people living in the flats, despite it being a difficult and at times an emotional undertaking. Mitchell relates the story of one volunteer from his church, Emily, who had been involved in the pastoral care of a young woman called Brittany, aged 15. Brittany was considered by Child Protection Services to be an "at risk" child. She had been subject to abuse from within her family, had been fostered at different stages of her life, and was currently living with her mother yet was still being sexually abused by men outside the family. Brittany had learning difficulties and problems at school, which were compounded by her moving schools on a regular basis. Emily had been meeting with Brittany for ten years every Friday night, from the time Brittany was about five. Because she had been identified as at risk by a number of different service providers, Brittany had a total of 12 different case workers from a variety of professional services, including social workers, doctors, police, and Emily. When Brittany was 13 or 14, her life had reached a crisis point and a meeting of all case workers was called. Emily was invited. The professional case workers were sitting in a room at a table discussing what

needed to happen. They eventually came up with a plan, but realised that they could not implement it. The only person who could implement the plan or talk to Brittany about any of their concerns was Emily. Emily's relationship with Brittany differed to those Brittany had with the professional case workers. So the case workers asked Emily, 'Can you try and sort this out? Can you encourage her to do this and take advantage of this and follow these recommendations?' As Mitchell reflects:

> I think that was really a great story, a great encouragement for [Emily], but it sort of shows why I value what the church can offer that a whole lot of other professional health services can't offer, and that is at 5 o'clock they go home, but we live with people and we fill that gap between a service and family … Often people will treat us like family. And that's the difference between being people who are called to love rather than being people who are called to do a job or provide a service. And so we provide services because we are loving … It's actually the loving thing that is our distinctive. And that's a healthy thing. Love's very healthy.

INTENTIONAL RELATIONSHIPS

As I talked to participants and witnessed the running of church activities and programs, I observed the phenomenon of intentional relationship building. Much effort and time was expended on connecting with and supporting people who are vulnerable and marginalised. For Redgum Church of Christ, intentional relationship building was fostered through members moving into the streets of disadvantaged communities, to be embedded in the culture and local contexts of need. Many of their community connections and social activities are unstructured. As the church is located in the heart of the Buckly and the workers and volunteers live in houses on its streets, a fluid and flexible response is possible to people in the neighbourhood: an invitation

to dinner in their homes; walking around the streets together; sitting with the Sudanese youth in the park (as illustrated above). A similar pattern of intentional relationships was described by Mitchell, the minister at emerging church Tinworth Anglican Church.

> I think the distinctive thing ... is that we have very close relationships with people and we think of ourselves more as being part of the community rather than being service providers ... most of [the] things are not formal provisions but they are in their homes, or when we are visiting people might just ask us whether a person could come around. The few things that we do, that are organised and formal, will always happen on community spaces.

Emerging churches were more likely to use community spaces to promote social support and connection when compared to new modern and traditional churches for which activities were generally based in church facilities. The desire to create and maintain relationships with individuals from the community was consistent for all church expressions; however how this was undertaken by churches in this study differed.

Mentoring Programs

Formal structured church programs for intentional relationship building include Meryton's youth groups, described earlier in this chapter, and mentoring programs, outlined below. A number of churches had mentoring programs aimed at empowering others. This included one-to-one mentoring of younger church members by older church members; programs designed for primary school or high school students, and mentoring of families or vulnerable adults.

The church mentoring programs in this study adhere to mid-stream health promotion actions such as fostering the development of personal skills, encouraging social connections and capital

and seeking to empower and create resilience (Keleher, 2007b). A wide range of programs fall in this category, but here, I provide two examples: the Life Program, run by new modern church Sudbury Baptist Church in a local school, and the COACH [Creating Opportunities and Casting Hope] Community Mentoring Program, which is run by emerging church Grantham Rise Baptist Church.

The Life Program

The Life Program is a mentoring program run every Friday during the school terms at a local high school, described as a rough school in a low socioeconomic status area. The program includes; informal hang out time during the BBQ breakfast and at lunch time, class time teaching, class time small group discussion, and integration with the youth group and associated events. Sudbury Baptist Church employs a full time pastor, who oversees the Life Program and the associated youth group. He leads a team of volunteers, most 18-25 years of age, who he describes as committed and passionate:

> [They] will drive half an hour and pick [kids] up and bring them to [the program] and take them back after, shout them Maccas [MacDonalds] and chat to them about life...they just get to be able to be like big brothers or sisters to them. There are couple of guys my age who are more like father figures to them. So it's just having that male in their life. Or great girls who will talk to them about self-esteem issues (Craig, Youth and Young Adults' Pastor, Grantham Rise Baptist Church, urban).

The Life Program is deliberately implemented in "the troubled classes or the classes that are out of control," and the church team goes in to teach students "Biblical principles such as respect, encouragement, love, team work, having a purpose for life ... [as well as] topics like depression"

(Craig, Youth and Young Adults' Pastor, Grantham Rise Baptist Church, urban). The Life Program team does not and cannot evangelise or proselytise, as the school is a government school and such actions are prohibited. The class session involves mentor group time, where each leader will meet with two-to-three students in order to discuss the topic of that week or reflect on what the speaker has said. At the end of the class, the group facilitates an 'encouragement circle' for five or ten minutes. The students pass a ball around and as they throw the ball, they are asked to say an encouraging statement to the person to whom they are throwing the ball too.

> A lot of the time, it is getting the kids to learn how to say something nice. They are not used to saying something nice. Teach them how to encourage because they just don't do it. They don't have people [to] encourage them (Craig, Youth and Young Adults' Pastor, Grantham Rise Baptist Church, urban).

The school is very supportive of the program due to its impacts on student behaviour and school attendance, and it supplies the resources for the BBQ breakfasts and the class time; the Principal adjusts the timetable for the Life program team.

> They are seeing that kids are starting to come to school on days that Life Program is in there, respect levels changing, respecting themselves and each other and the school, and so they are seeing some real good outcomes that they wanted (Craig, Youth and Young Adults' Pastor, Grantham Rise Baptist Church, urban).

The students are also encouraged to attend the youth group which the church runs on a Friday night, and the yearly weekend camp attended by 250-300 students. The camp is at a beach

location and consists of adventure activities such as games and water sports, group chat times and youth church services.

When I asked how the Life Program promotes health and wellbeing for the students, Craig, the youth and young adults' pastor, explained that his aim was to teach them to be "better citizens":

> We are teaching them life skills ... and teaching them to have hope. A lot of them are brought up in an environment where they just do what their parents have done. We shake that up and say life doesn't need to be that way, and there are good people who care for you, and it is basically hope. Don't get ripped off ... ... they are the hope of where we are going next and so it is significant. And when you see young people catching it, getting it, you see them, they start flying, they are different people, there is a joy to them.

According to research participants, the program does have a ripple-on effect. Some of the current volunteers used to be students for whom the program was run for:

> I started off in life program in year eight and I pretty much went along with it every year, ... and I wanted to give back what I got out of it and so that pretty much was what it was for me. I wanted to change kids' lives the way the leaders, back when I was a kid, did for me (Sammy, volunteer, Life Program and Youth Group).

Some of the volunteers involved in the Life Program worked four days instead of five so they had the time and energy to commit to being a volunteer. They were passionate about their capacity to connect with vulnerable young people and to transform them through the care, attention and teaching of the program.

> There are so many rewards and reasons for doing it. I think just connecting with the kids, seeing the change that happens in such a small period time, like in eight weeks how a kid can go from being scared, shy and in the corner to being, happy, warm, encouraging and loved. You just go – it works! It's just cool to see them come through that journey in such a small period of time (Tessa, volunteer, Life Program and Youth Group).

COACH Community Mentoring Program

The COACH Community Mentoring Program (COACH), piloted in 2004, aims to equip and train Christians with good interpersonal skills, good communication skills, knowledge of life experience and wisdom to walk alongside disadvantaged families in the local community, offering support to people who are quite isolated and do not have the benefit of healthy family support and relationships. Luke, the Executive Director of the COACH program, has a social work background and worked in the community welfare sector for 20 years. Consequently he understands the gap left by professional services when funding constraints or other demands mean that a family that has been supported for 12-18 months is taken out of the welfare system. COACH is seen as a "mechanism or a means of being able to support those families that are moving on out of the community welfare sector and providing a bit of a safety net for them" (Luke). COACH is also positioned as an early intervention program for "families … that they are on the verge of breaking down, or they are on the verge of losing their house, or they are struggling with a mental health issue, but it hasn't hit the critical point" (Luke). The COACH program targets vulnerable families with at least one child aged 12 years or under, with the rationale that there is a greater window of opportunity to effect generational change. The program is described as a "friendship with a purpose." The parent/s of the family articulate life goals that they would like to achieve in the next 12 months: these can range from improved

domestic skills, financial management, parenting skills, to improving job prospects. The COACH family is then assigned mentors, often a husband and wife team who have children. The mentors then engage with the COACH family to achieve their life goals.

When articulating the health benefits of the program, the executive director drew on his knowledge and experience of the welfare sector and highlighted that by intervening and providing support in a timely manner, the life circumstances of people may change:

> In my estimation ... we're providing some support in a timely way that's assisting a person to be able to cope with their life circumstance and arrest maybe their slide backwards or downhill. And at the same time, we mitigate in some way against the deterioration in mental and emotional health problems and mitigate against dependencies on substances, you know alcohol or drugs or whatever (Luke, Executive Director of COACH, Grantham Rise Baptist Church, urban).

Luke has seen people and families change from states of chaos to control:

> People having a sense of better emotional and mental health, having a sense of better control over the problematic substance use, you know, that sort of stuff. So to me, that's how we are promoting [health] by targeting families at a point in their lives where things haven't got too far out of control or conversely if they have and they have had case management somewhere and they have re-established a workable foundation, it's at that post crisis end where we can, as I said before, support people in a way where they are not regressing back to where they once were. (Luke, Executive Director of COACH, Grantham Rise Baptist Church, urban)

The mentors undergo training conducted by Luke and Ben, a church staff member who is a drug and alcohol physician. Through their involvement in COACH, the mentors are supported and followed up by the church staff to ensure that they understand their role as one of empowerment, where they aim "to assist, not direct, to help facilitate or enable the client to make their own decisions" (Luke). The mentors are involved in the program for a number of reasons, but most see COACH as a "wonderful opportunity to put our faith into action" (Henry, COACH volunteer). Therefore, involvement in COACH is also an expression of church mission, a theme explored in chapter five.

Katie's story is one of the many success stories from COACH. Katie is a single mother of two boys (aged 10 and 14 when she engaged with the COACH program). She was diagnosed with schizophrenia and dissociative identity disorder. Prior to commencing COACH, she was living in a cabin in the local caravan park, she was smoking marijuana, she was unemployed, obese, suicidal and incontinent due to medication she was on. Her housing situation was unstable and the cabin was in a state of squalor. She only had custody of her oldest child, and the living environment she was able to provide for him was not healthy. Her psychiatrist told her that she would never work again:

> I was pretty sick mentally. I have schizophrenia and DID [Dissociative Identity Disorder]. I was pretty crook. I was smoking cannabis 24/7. I was in a smelly horrible little caravan cabin sort of thing with my older son. I didn't have my younger boy with me at the time. It was just, it was just one nightmare that dragged on. It was the same thing every day. Smoke dope smoke dope smoke dope and hope that I don't die overnight sort of thing. And sometimes it was even, I hope I do die that night ... you know ... it was pretty dismal (Katie, COACH mentee).

Katie had three life goals that she wanted to achieve with the support of the COACH program. She wanted to improve her parenting skills, particularly in relation to discipline and strategies to address the behavioural problems of her children, to manage her finances better, and to enhance her employment opportunities. Three years later with the support of three mentors, Katie's life has been transformed. She now lives in a private rental house and has custody of both her children. She is a healthy weight and due to changes in her medication she is no longer incontinent. Her mental health has improved and she is following her treatment regime. She owns her own business and works part-time cleaning. Her finances are managed by state trustees to ensure that all bills are paid on time and that she has sufficient funds for essential items. Katie has experienced improvements in her self-esteem, confidence and domestic skills, and she has reduced her marijuana use. Her children show her more respect, and she has learnt how to spend quality time with them. The quote below illustrates Katie's thoughts on the COACH program:

> I almost feel as though I've been shaken upside down get rid of all the crap that has come out of my pockets, and been put back on my feet right ... and then every now and again someone will come along and say, hang on, that doesn't belong in your pocket, get rid of that one, deal with that issue, and let you have time to resolve the issues you've dealt with ... the challenges that I have been given in the COACH program have never been unsurpassable.

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The churches in this study provided a number of different avenues for social support and social connection. Some emerging churches were deliberately located in pockets of disadvantage and vulnerability to foster informal connections, while other emerging and new modern churches ran

formal structured programs designed to emotionally, spiritually and socially support adults, children and families. The theme of intentional relationship building was observed in the attitude and the approach that churches took in their informal and formal programs for social support. Underpinning the intentional relationship building was the desire, particularly by new modern and emerging churches, to provide care and to support individuals, despite their life circumstances, creeds or backgrounds. Traditional churches however, and commonly Catholic churches, tended to be more insular in their approach to social support and pastoral care. Their activities were usually only accessible to members of their congregation or to individuals who identified as Catholic. Overall, churches act as a resource for health promotion through existing programs that foster social connection and social capital in the community.

Chapter 9

‘To Help People in Their Need’- Addressing Material Determinants of Health

I arrive at the food bank of Redgum Church of Christ at 9:45am on a Tuesday. The food bank, held in the same hall as the church service on Sunday afternoons, does not officially open until 10am, however the place was already buzzing. Approximately 25 people were milling around, sitting at tables waiting for food parcels to be handed out. A team of volunteers are in the kitchen, busily preparing food parcels, tea and coffee.

I sit on a chair at the back of the main room to observe what is happening. At the opposite end of the room there is a play area for the children: a table set up with play dough and pencils, crayons and pictures for colouring-in over a large piece of tarp to control the mess. About half a dozen children are running around. The other three tables are occupied by adults of different nationalities and ages. There are more men than women, most apparently Anglo-Saxon. However, there are at least three Sudanese woman and a number of South Asian people. It is captivating to watch these different people come together, chatting to each other as they eat breakfast. Toast with jam, peanut butter and vegemite.

The food bank works as follows. People receive a raffle ticket and when their number is called they can then collect their food parcel. The food parcels include basic provisions such as bread, cereals, pasta, rice and spreads, and also hygiene products. The volunteers at Redgum Church of Christ hand out the food parcels, greeting each client with a smile and a small conversation.

As I was sitting and observing the activity of the food bank, Victor, a local resident in his 70s, comes over to have a chat. From his manner and conversation, I sense feelings of shame. He shares openly his negative view of the government and complains about the unequal distribution of material resources and tax benefits: communities such as Buckley struggle at the lower end of the spectrum. Victor came to Australia as a migrant in the 1960s, and would send food home to his family in the UK. Now the roles have reversed. He is on a pension, and it doesn't give him much so his family in the UK send him money. It is not a position he imagined he would be in.

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In his book, *Urban Churches, Vital Signs: Beyond Charity Towards Justice*, Nile Harper states that charity is a great Christian virtue based on sacrificial love which "ordinarily deals with personal needs of an immediate nature" (2005, p. 298). However, charity does not address the root causes of social inequities, injustices and human suffering (Harper, 2005). Churches in Australia have a history of being involved in providing acts of charity and welfare, and as I describe in this chapter, this role has not been relinquished. Most of the churches in this study had at least one activity or program that could be considered welfare or charity. The emerging churches, however, were also involved in advocacy to change policies, social structures and behaviours that sustain systemic injustices. I outline the activities of these churches in Chapter ten. Here, I focus on how the acts of charity of churches work to address the material determinants of health.

The role of the Christian church in the early years of Australia was as the guardian of social order (Thompson, 2002). With support from the government, the first Christian chaplains, Richard Johnson and Samuel Marsden, attempted to convert both European and Aboriginal

inhabitants to Christianity, imposed sanctions on sexual immorality, enforced compulsory church attendance for convicts, and worked to ensure laws against public loitering and trading during the times of church services on Sunday (Dickey, 1980). The church and its members also recognised that there were insufficient resources for sustenance and nourishment, and that many in their community were hungry, orphaned, without shelter and living in poverty. Local churches in the period following colonisation helped to pave the way for the establishment of organisations and welfare reforms aimed at improving the health and morality of Australia such as The Benevolent Society of New South Wales, an early welfare organisation with church roots (Dickey, 1980). It began with emergency relief in 1813, predominantly through providing food to families to supplement government rations (Dickey, 1980). The Salvation Army began its work in Australia on the 5th September, 1880[30] with the proclamation from John Gore: "If there's a man here who hasn't had a square meal today, let him come home to tea with me" (The Salvation Army, 2009, para 2).

The right to food, water, shelter and clothing is recognised as a human right (Braveman, 2006). These material determinants encompass the physical environment including the location and quality of housing, ability to buy food, clothing and other basic necessities, and the neighbourhood environment (CSDH, 2007b). Health promotion theory and practice recognises that material determinants are prerequisites for health (World Health Organization, 1986). Individuals and communities experiencing material deprivation have increased vulnerability to "inadequate public health infrastructure, less access to social networks and other forms of social support, fewer opportunities for recreation, leisure and physical activity, reduced access to

[30] The Salvation Army was established in East London, 1865 by William Booth

resources such as education, books, newspapers, and the Internet, less exposure or participation in the arts and culture - all of which contribute to human development over the lifespan" (Keleher, 2007a, p. 53). In this chapter, I focus on how the churches in this study worked to address material determinants of health, in particular food, housing and clothing. I first describe how the churches identified and defined vulnerable individuals and communities.

DEFINING THE VULNERABLE

Historically churches dispensed aid to those they believed were deserving – 'the respectable poor' – for example orphaned children, women who had lost their husbands through early death and were impoverished (Dickey, 1980), which is based on Old Testament and New Testament Bible verses.[31] Orphans and widows become the objects of church care because they were without men, and in patriarchal societies such as those of the early church, were without support. However in contemporary society, the demographics of need have changed. In Australia, the prevalent needs are not that of the orphan, as there are societal systems in place such as adoption and foster care, or the widow, who is able to enter the workforce or receive appropriate government pensions.

To remain relevant, interpret and operationalise church mission, churches have reoriented their programs and activities to address the needs of contemporary society. They have had to identify new areas of needs which include people dealing with addiction, domestic violence, loneliness and mental illness. The personal and social factors that lead to situations of entrenched poverty

[31] Deuteronomy 10:18 - He defends the cause of the fatherless and the widow, and loves the alien, giving him food and clothing; James 1:27 - Religion that God our Father accepts as pure and faultless is this: to look after orphans and widows in their distress...

have become the key action areas of church affiliated organisations and local churches. They are involved in providing material aid, as I discuss in this chapter, as well as addressing the systematic and structural causes of poverty (see Chapter 10). George, the Director of LutherCare, defined the vulnerable as follows:

> Whoever is vulnerable at the time, I don't think it's a set group. We've found that particularly in recent times, in the recent 12-18 months, there are a whole lot of new people needing support and extra things and services and who are not the traditional ones that you would predict ... Centrelink beneficiaries who are major users of services or people in outer areas who are overstretched financially, whatever, they were traditionally the major users of services, single parents male and female, homeless people, so that's the traditional sort of range. But increasingly we are seeing people from the lower, if you want to use class sort of terminology, the lower and middle classes who are really pushed into particularly things like meeting school expenses and things like that... these sort of people [are] coming in and saying "we feel terrible, we've never asked for help before but we really need help. I can't afford the uniforms, I can't afford the books or I can't afford the school camp that I really want the kids to go on because it's so important." Or their housing has fallen apart because they just can't afford it, somebody has lost their job and that's it, and we're in trouble because our margins are so tight, so um, and obviously the pressures on families... We are in a culture that is so well off in so many many ways, and yet there are so many people who are marginalised at least at some time or another.

George tells the story of an elderly couple in their 80s, who were renting and had health problems. The rent was increased and they couldn't afford it, and they were evicted from their

home. They came to one of the service centres of LutherCare, despairing. They had nowhere to go:

> So all of sudden we have these people in facilities we would normally use for emergency housing for homeless people, transient people, you get the picture. So it gives a sense of where it's shifting. It can be anybody, as somebody said to me the other day, one step here or there it could be you or me ... so the vulnerable has a very broad definition. (George, Director, LutherCare)

Ayesha described the vulnerable people who access the services at Redgum as being "broken":

> There is some brokenness … there's some basic physical health problem, or there's emotional stuff going on or whatever, so I think as a church we hope to be able to provide in a way for people to experience healing, for the whole person including their emotional, spiritual and physical … There are quite high levels of social isolation, you could say, and people struggling with mental health issues or drug addiction (Ayesha, UNOH Worker, Redgum Church of Christ, urban).

Anne, the community care worker at Belton Baptist Church, highlighted the need to reach out to those who are isolated, to let them know that someone cares:

> The people that we mainly see are people who from ... [for] one reason or another are now living on a Centrelink benefit. We have all ages and stages from teens to elderly people who because of relationship breakdown, mental illness, various other reasons are now marginalised, who often don't have family support, who often don't have good relationships because of what they've been through, are often alone in the community and need that extra support ... [we need to] allow them to know that they are of value, that

they are not just discarded by society, that there is somebody out there who does care for them.

The church leaders described the tension of wanting to assist those who are vulnerable and in a sense ‘deserving’ of their care, yet also not wanting to be taken advantage of by people who they believe 'play' the charity system.

LOAVES AND FISHES

Many churches in this study had some form of food bank or food pantry to redress food insecurity. Food insecurity occurs when peoples' ability to source and prepare food is compromised, food access is poor in terms of quality, variety and price, or food supplies are not sustainable or socially acceptable (Temple, 2008). It is estimated that in a given 12 month period, 5% of Australians will experience food insecurity, with 40% of those considered severely insecure as they do not have enough money to purchase food and will therefore go without food (Burns, 2004; Temple, 2008). Some population groups are at a higher risk of experiencing food insecurity: unemployed and low income earners; single parent families; rental households; young people and CALD groups (Burns, 2004; Temple, 2008). Sudden life disruptions such as death, disease, divorce and unemployment also result in additional stress being placed on household resources, and may contribute to food insecurity (Temple, 2008). The local churches in this study conducted varying levels of emergency relief and food pantries. Below I outline some examples of how churches were involved in resourcing the community, families and/or individuals with food, or supplying cooked meals for those who are not in a position to cook for themselves. These activities are examples of downstream-midstream health promotion action as they operate at the individual level:

> Tuesday and Thursday we have emergency relief so people who are struggling financially can come and make an appointment and see someone and actually receive help in the way of food vouchers or helping them to pay bills that they are not able to pay. (Dale, Captain, Milltown Salvation Army, rural)

The variety of foods and the flexibility to allow clients to choose his or her foods differed between expressions of church. In traditional and new modern churches, set food parcels tended to be given to families or individuals, with only a few churches catering for special food requirements such as food intolerances and ethnic background. Belton Baptist Church, for example, provided gluten free and lactose free foods in their hampers, and lentils and Asian grocery products for those from South Asian background. In contrast, Derby Uniting Church, an emerging church, has a 'supermarket' so that individuals can take what they need off the shelves, and so choose which products they need and want:

> So there's a food pantry in the front of the church where people can make their own choices –we have to go and buy the staple food, flour or sugar or pasta or milk and eggs, and then we get other food from Victorian food bank. We would see people give away stuff to 30 people a day, sometimes it would be more, but of that order (Samuel, Minister, Derby Uniting Church, urban)

Samuel, the minister at Derby Uniting Church, also described the produce market that his church runs in the courtyard of the local housing estate. This market enables estate residents to access fresh fruit and vegetables at reasonable prices, benefiting those who may suffer from mobility difficulties and providing social connections for many of the new migrants and other residents. In doing so, Derby Uniting Church addresses food insecurity at a broader level than the

individual, by changing the food environment of the suburb. It therefore operates at an upstream health promotion level.

While many churches were involved in cooking and delivering meals, these were for the most part directed at members of their congregation. However, emerging church Ashridge Baptist Church, offered food hampers and cooked meals for individuals in the wider community who may not be struggling financially, but who are experiencing emotional or social difficulties which prevents them from sourcing and cooking food. In addition the Domestic Taskforce are a group of volunteers who provide cleaning and gardening services:

> We have a community cupboard and we make hampers and give to [these] people who are in a rough time, someone is ill, or new baby or something has changed in their direct community structure that may increase their stress levels. Their regular routine is thrown out which can cause stress and hardships and they need that extra community support. And so I would say hampers and food distribution and [the] Domestic Taskforce would help with that (Jane, Community Engagement Officer, Ashridge Baptist Church, urban).

Congregation members at Sudbury Baptist church were also involved in cooking meals for people, both in their church community and in the wider community, who were experiencing hardship, illness, death, or the birth of a new child:

> [We] have a group of ladies who cook three days a week and drop casseroles off ... I can go tell them that my next door neighbour is having a hard time. She lost her son in a car accident last year so we provided meals for [her] for the week. Got them a food hamper because she is a single mum (Benjamin, Pastor, Sudbury Baptist Church, urban).

Dale, the Captain at Milltown Salvation Army, talked about the food insecurity which he noticed at the community centre. High school students flock to the centre to use the computer room, where they have free access to the internet and Microsoft Office programs. During the after-school period, the staff and volunteers at the centre were often approached by hungry school children who had not eaten during the day and did not know if they were going to eat that night.

> Once we started the youth internet time - it would have been 12 months after we opened - a lot of the girls, especially the teenage girls, would come out and say, do you have anything to eat, and we would say, oh yeah, we can manage that, and they would say, haven't eaten anything today, Dad doesn't get paid until tomorrow, or Mum doesn't get paid until tomorrow. That was something that really stuck in our minds. Let's provide this: even if it's just fruit it's better than nothing at all! And fruit is a healthy option. Occasionally if we are lucky and we get things like sausages, [and] we cook that up for the kids after school, and they usually dive on it ... [it] was just really heart breaking because I just couldn't imagine sending my kids to school with no lunch. So obviously there is a real need for that (Dale, Captain, Milltown Salvation Army, rural).

The rural churches in particular worked with other local churches in their town to provide a network of care. This prevented any competitiveness in their programs and activities, and ensured that individuals and families were cared for holistically. While one church may have access to food, another might have access to clothing, and hence the network would enable a vulnerable family or individual to be provided, if needed, with both:

> Well, the churches have got together and set up a whole support group of welfare groups which they have called Loaves and Fishes – arising from Jesus feeding the 5000 – and we

> cooperate in that, we are members in that. It arose from an awareness that in this country town, people in need would go from one priest to a pastor to the next asking for finance, asking for food, accommodation and we figured – there's something wrong here – there's a system in a sense being played and churches are being put at odds with each other here. So we decided to collaborate and cooperate and so we've set up a shop front, we've set up a food bank. Every Sunday our people bring food along which goes to the food bank. It's all, it's managed, it's open every day of the week from 1 to 3 [pm], people in the town know that if they are without food or if there is some special need, if they attend between 1 and 3, their needs will be met. So, um, with that kind of profile, people know that that's a service that the churches are providing (Harry, Minister, Lincolnshire Baptist Church, rural).

The new modern and emerging churches emphasise empowerment in their provision of food parcels and so take a midstream approach to food insecurity. This often requires church staff and volunteers to ask questions to explore why someone is seeking a food parcel in the first place. Consequently, services such as financial counselling and employment assistance are often also offered:

> We've got ... a program called 'Back on Track,' where people come in for help with food. It might not always be about food, that might be the presenting problem, but when you get behind it, you see all the other issues come out, and we bring people in here and just talk to them. What's going on? How come you are here? It might be something simple like spending too much on bills or drink ... and we will help ... we can help with food once every three months, but we can help on an ongoing thing on a weekly basis. Have people sit down and we have budget counselling and we try and empower them to see

> "Where do you think the money is going?" and they usually point out, cigarettes or pokies, or sometimes it's big stuff. It might be car problems or school books (Maureen, Community Care Minister, Grantham Rise Baptist Church, urban).

There is also a referral process to other services to ensure that people access all that they are entitled to from the federal government support agency, Centrelink,[32] or other government social services:

> Often people don't know what they are entitled to, so they don't know which doors to knock on to get what they want. So what we do is we actually give, we tell them where they can go, and what are their rights within the school system. We also encourage people to become um ... we want to support them but we want to encourage them to be independent. And so as we build a relationship as we look at their budget, when they keep coming to us with the electricity bill, gas bill, whatever, we try and encourage them to be self-reliant (Anne, Community Care Minister, Belton Baptist Church, urban)

SHELTER

Housing is associated with other key determinants of health including the social gradient, individual and family health and wellbeing, social inclusion and cohesion and community functioning (Williams, 2003; World Health Organization & Public Health Agency of Canada, 2008). Housing stress or insecurity is deleterious to the health and wellbeing of individuals and families, and negatively influences their economic and social participation. Risk factors attributed to housing insecurity and housing stress includes those discussed above in relation to

[32] Centrelink is a government support system which delivers a range of payments and services for Australians experiencing life change (i.e students leaving home, people with disabilities, single parents, unemployment)

food insecurity, highlighting the multifaceted impacts of adverse life events (Braver & Jenvey, 2012). These risk factors interact with other factors such as mental health problems, substance abuse, intellectual disability, unemployment, low education and lack of social support and connectedness (Braver & Jenvey, 2012). In a report for the Australian Housing and Urban Research Institute, Hulse and Saugeres (2008) describe three dimensions of housing: housing mobility, housing instability, and feeling unsafe. Safety fears can be related to issues such as domestic violence (Sharam, 2009), crime concerns (Evans & Wells, 2003) and poor quality of housing (Bratt, 2002).

Andrew, senior minister at emerging church Ashridge Baptist Church, talks about a lead tenant initiative for women experiencing housing insecurity due to domestic violence or mental illness:

> We are just starting up housing – lead tenant housing – because the whole nature of homelessness in the outer east, so 5000 people homeless on any given night with no fixed address. We realise the main issue for that is domestic violence and mental health (Andrew, Minister, Ashridge Baptist Church, urban)

Lead tenant housing is a model where a house is purchased or rented by the organisation or local church, with a mentor and responsible adult the main tenant of the house. These housing solutions align with midstream health promotion strategies. For example, at Ashridge Baptist Church, a husband and wife wanted to establish a lead tenant house where they would be able to support individuals by offering shelter, social support, and food security. Another housing model is where churches look after properties and charge little or no rent to residents, while also ensuring that the residents are socially connected.

> The church has an old building which houses about five young Sudanese guys and a west Papuan family, and there is someone who owns some properties in Richmond and so we administer that – we've got an Indian family there and an East Timorese family and a bloke who is down on his luck a bit. And we look after those properties (Victor, Priest, McManus Catholic Church, urban).

Housing managed by new modern Marshland Uniting Church is leased to students who may be from rural Australia or overseas. The church minister, Walter, believes that the provision of housing and support offered to students can ease the transition of living out of home and going to University.

> We have two student houses in local areas. The house is owned by the church and students who come from the country for tertiary study can live in those student houses so they have access to an immediate supportive environment, ...we find that can be a very big jump, particularly for country kids who might be coming to Melbourne and feel a bit swamped and overwhelmed (Walter, Minister, Marshland Uniting Church, urban).

Many of the clients accessing the welfare services of Grantham Rise Baptist Church were in precarious housing situations, including living in caravan parks. However, through engagement with the COACH mentoring program (see Chapter eight), a number of clients transitioned from situations of unemployment to employment and their housing circumstances consequently also improved.

CLOTHING AND FURNITURE

Tattered and worn clothing is a visible sign of poverty (Sauerwein & Cohen, 2000). Inadequate clothing, such as lack of jackets and closed footwear in winter months, has implications for

health and wellbeing. Additionally clothing is an expression of identity and culture, and therefore influences mental health and social acceptance (Bhui et al., 2008; Guy & Banim, 2000). The participants in this study described the different initiatives they have to provide clothing to those fleeing situations of domestic violence or experiencing poverty or crisis. For example, The Salvation Army Church in Burghley, an emerging church, works with the local women's refuge to provide clothing and furniture to women escaping situations of domestic violence:

> There's a women's refuge which we do some work with as well. Some of the ladies come in there and they've usually come from a background where violence has been involved, and they are escaping that situation. They are not from the Burghley area most of the time; they actually come in from outside and are just trying to get away from that lifestyle. Usually they come with nothing and the ladies bring them over and the stuff that we have at our thrift shop is actually really really good. So it's not what you think of an op shop as being like. The clothing in there – you get [brand name] stuff that has been donated … and there's new clothing that gets donated as well. And so some of the ladies come over from the women's refuge and they get three or four outfits from there, they get bedding and stuff for their kids as well. Just trying to set up as well. And we also have furniture at our community centre as well, so if someone needs to be set up in a house, we actually can help with that – we just donate it. If it's for a good cause and they haven't got the money, then we will just donate it, but if they want to pay for it, then we are quite happy for them to pay for it as well. So yeah ... but if they haven't got the money, we don't push them for it. We just try and help them the best we can (Robert, Captain, Burghley Salvation Army, rural).

A few churches in the study ran opportunity shops. While the funds raised through these enterprises supported various community activities, clothing and furniture items were also given free of charge or at very low cost to those in need: "We have an op [opportunity] shop. That provides affordable clothing or free clothing for anyone who is sent along and all the profits go back into community services" (Andrew, senior minister, Ashridge Baptist Church, urban). Georgia, a volunteer at Ashridge Baptist Church, coordinates the soup kitchen that is run through the church. She described the process of providing clothing through its op shop for people who are in need:

> [Ashridge Baptist Church] owns an op shop and it does very well and the revenue from that actually runs a lot of what we do in the community and overseas. If I come across someone who comes along with old ratty clothes and needs a sleeping bag, I can tell them to go to the op shop and have a chat to the person there and everything is all free for them. So I have had a lot of people who have used that. We were thinking of giving vouchers, but that is a saleable[33] item. So it's all just saying, Georgia sent you. Other times, we have a family of four children, they are a middle class family who found themselves in dire straits, and so I met them at the op shop and fitted them out with so much stuff and it was all free. So it's lovely to have that, those connections. (Georgia, volunteer, Ashridge Baptist Church, urban)

Milltown Salvation Army opens the community centre on a Saturday once a month for a monthly market:

[33] The person could sell the voucher for money

> We also hire the centre out on Saturdays when it's free and we have a monthly community market where we set up one of the far rooms as an op shop, just for the day, and the community comes through and we just sell stuff really cheap to them so like all clothing $1, just bits and pieces, whatever is available. So that we'll happen to have 150 people come through on that day (Dale, Captain, Milltown Salvation Army, rural).

Martha, one of the volunteers at Milltown Salvation Army, sifts through the clothes that are donated to the centre and prices them for the market. Expensive items which can be sold privately on websites such as e-bay are separated out, as these funds can go back into the community centre and activities such as the free community meals:

> I shouldn't say this, but we are selective … if we get anything extremely good in, we won't put it out in the market, we usually sell it privately; that way we can get more money for it. So that's one thing that we do here ... if we get anything with a brand name or a designer label, we have had brand new Dolce and Gabanna windcheaters, hoodies, yeah…brand new, never been worn. And they are worth between $150-$200 each! So we get some brilliant clothes here. And I'm usually selective with the good clothes, I don't put them out in the market, I'd rather sell them privately and get more for it ... But it helps us out. We made nearly $500 last Saturday. And that money comes back into here [to support the various activities of the centre].

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In this chapter, I have described how local churches are involved in addressing the material determinants of health. Churches and church affiliated organisations have historically been involved in welfare and charitable acts, and hence this is one area where all churches -

traditional, new modern and emerging - engaged to some degree. Local church leaders and volunteers expressed the desire to help those who they perceived as deserving of their services, based not on their Christianity but on whether they are 'genuine'. In the example of food banks to address food insecurity, traditional and new modern churches provided forms of emergency relief. Emerging churches such as Derby Uniting Church, however, changed the food environment of the community by coordinating a community market in the courtyard of the housing estate, thereby providing access to fresh fruits and vegetables and a setting for residents to connect socially. Similarly in the situation of housing, traditional and new modern churches provided access to houses whereas emerging churches adopted the lead tenant model whereby a mentor and role model is provided as additional support to vulnerable or disadvantaged individuals. As demonstrated in the typology presented in chapter 12 (figure 12.1), emerging churches were involved in addressing issues such as food insecurity and housing availability through community action and sociological health promotion strategies. Table 12.1 provides an indication of the types of welfare activities to address material determinants of health provided by churches in this study.

Chapter 10

‘Bringing Heaven to Earth’ -

Transforming Communities and Advocating for Change

In every denomination, there are people who are absolutely genuine about doing God’s thing. But I think there is this ... there is a very nominal element in churches. The expectation that they have is - that you would go on a Sunday and give a bit of money and you have done your thing. I think we have a bigger responsibility, and Andrew [senior pastor] tends to have a few things that he says regularly. One of the phrases that he uses is that we are ‘partnering with God to transform the world for good.’ And he says that often and … keeps it in the front of our minds. God has a picture for us that is way beyond the boundaries of our building. [It’s] been a good thing for us [as a church], not owning a building … you don’t have anything that is yours, [and therefore] you do see the church as people making a difference.

So [the church] partners with God for transforming His world for good … That’s the outworking of our faith. We want people to have a real experience of Jesus and come to know him, but the outworking of that is not just a nice relationship with God, but that it’s much bigger … In probably the last 10-20 years, people have come to terms with what Jesus meant when he talks about the Kingdom of God … If our understanding of [church] grows in relation to the Kingdom of God ... our work in the world is actually [about] building the Kingdom … [then] we can partner with God right now in making a difference in the world ...

> That's a very liberating view of the gospel. Whereas we might have had a narrow gospel in that you need to believe in what Jesus has done on the cross … and if you believe in that you are saved, you are forgiven, you will go to heaven – that sold the gospel incredibly short. You are liberated by God for a new life that actually involves you in partnership with Him in transforming His world for good. It adds a new dimension and it hasn't changed our message one iota, we are still totally dependent on His saving grace and the cross is still central, but it makes sense, why did Jesus become vulnerable? Why did He sacrifice his life to bring us back to God? So that we can actually be His agents in the world (Brian, Associate Pastor, Ashridge Baptist Church, urban).

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In chapter five of this thesis, I outlined the impact of church mission on how churches conceptualised health and health promotion. Emerging churches, such as Ashridge Baptist Church, understand church mission as involvement in transforming the world for good - bringing heaven to earth. Several churches in this study were involved in supporting asylum seekers, gambling reform, or providing care and support to international students, at the grass roots level and through advocacy with different levels of government. Such involvement did not seem to differ by church denomination, although the level at which the church engaged with the issue (downstream versus upstream) was influenced by whether a church was traditional, new modern or emerging. In this chapter, I use the examples of asylum seeker advocacy and support, community development in Papua New Guinea, and community action to increase employment opportunities for new migrants in Melbourne, to illustrate how churches operationalise their mission to address socio-political determinants of health.

CHURCHES AND THE SOCIAL POLITICS OF ASYLUM SEEKERS

Six churches, a church affiliated agency and a church affiliated organisation in this study supported asylum seekers through financial support, specific ministries and programs, and advocacy. Of the churches involved, five were either traditional or new modern churches (Marshland Uniting Church, Miners Bend Uniting Church, Ponden Catholic Church, McManus Catholic Church, Sunderland Church of Christ) and one was emerging (Redgum Church of Christ). The church leader of Sunderland Baptist, a new modern church, described how members of his congregation identified a practical need of asylum seekers, and the efforts implemented to address this need:

> When you get access to Australia and a visa to say you are an asylum seeker, while your application is being processed, you are not allowed to work and so these people are not able to live off any income. Now when you think about that, if I have a family, maybe husband, wife and one or two children ... How do I live? How do I buy tram tickets? How do I get my met cards? How do I get my phone cards? How do I buy food? Because they are not allowed to work, they are not allowed to receive income; it's all on donations ... We now have a ministry where on Friday and Saturday, we give free meals. People sit around and talk for 4-5 hours so they [the church] give[s] them a social environment ... there are food parcels that are given out...so we provide a meal, we provide food parcels, we provide some met cards and phone cards to help the people out (Trevor, Senior Minister, Sunderland Church of Christ, urban).

One small church affiliated agency, Beriah Mission, is involved in work with asylum seekers. Melissa is employed as the community liaison officer for the organisation, and describes the role

of Beriah Mission as providing housing, and case work and emergency relief for people seeking asylum in Australia.

The organisation is involved in advocacy:

> We work on a multitude of levels. So we do on the ground work, so support services for our clients, then at a state level we are involved with a lot of different organisations and the communities get together who are across the board asylum seeker agencies on a state level... We're going to meetings, housing meetings or cross congregational different agencies get-togethers, so we are at that level. We will [also] advocate different local Members of Parliament...to raise awareness about the issues that asylum seekers in our communities face. So that our policies on a local level are campaigned for, so that they know this is an issue in our community .... And then at a federal level is where some of our bigger advocacy happens. We're on the board of one of the advisory committees to the minister (Melissa, Community Liaison Officer, Beriah Mission).

Beriah Mission is tightly connected to local churches, including some of the churches in this study, and other community groups. Melissa, the Community Liaison Officer, has the role of "going out and doing speaking engagements and speaking about who [the organisation] is and what we do, and talk to all the different organisations and churches and school groups that invite us out to come speak to them." Through their connection with local churches, Beriah Mission is able to source housing for asylum seekers. These are either church manses[34] that are no longer in use by a church, or spare houses owned by people who are willing to donate the house to Beriah

[34] House provided for the minister by the church, also termed vicarage, rectory or parsonage

Mission. The importance of the local church in supporting social justice initiatives such as the plight of asylum seekers was emphasised by Melissa: "We wouldn't be here without the church ... we wouldn't have half the housing if we didn't have the church"

In 2010, Beriah Mission was managing approximately 25 houses donated in the metropolitan Melbourne region. This number fell to 15 houses in 2011, possibly due to the global financial crisis and the need for local churches and people to rent the house privately. In response to this housing short fall and research supporting the Beriah Mission housing model, a call was put out to churches and community groups to assist it to source 100 houses to be used as transitional housing for asylum seekers.[35] Melissa notes the ecumenical understanding of the organisation with houses being donated from Uniting Churches, Anglican Churches, the Frankston Brothers [Christian Brother Priests in Frankston] and the Quakers.

Through Beriah Mission's connections with local churches, communities are educated about the plight of asylum seekers. This raises public awareness of the issue to combat the negative and at times hostile political and media messages. A challenging aspect of Beriah Mission's work is raising sufficient funds to support asylum seekers, as Melissa explained: "The media can be a barrier sometimes ... But then, it's sensationalism, so what are you going to do ... [It's] about public awareness and it's about the money ... You know, we could do more if we had more money."

Federal Government funding for the work of Beriah Mission is limited or non-existent. The staff and volunteers at Beriah Mission understand that they are working in a niche area, working with

[35] Further information about the housing challenge can be found at http://hothammission.org.au/?p=13

asylum seekers who have often already been turned away from Australia, and hence it is unlikely they will receive support from government for their programs and activities.

> In the past there hasn't been any funding for us, because effectively you are funding people who have been told no, who are trying to reapply through other ways so I don't know that the government would put money into that ... so basically what that would be ... the government funding people who they have already said no too (Melissa).

THE GLOBAL AND LOCAL PRESENCE OF A CHURCH

The work of Beriah Mission and Sunderland Church of Christ illustrate social and political action in the issue of asylum seekers. Many churches in this study supported advocacy efforts internationally, often through aid organisations, as well as operating at a grass roots level in their local context. Below, I provide the example of Sudbury Baptist church - a church that works at both the global and local level to promote change in one of the key determinants of health – education. This new modern church is involved in supporting students at high schools where there are issues of school disengagement and interpersonal problems in classrooms and where children are from poor and/or dysfunctional families (parents in jail, drug and alcohol problems). This is done through their life program, which has been described in detail in Chapter eight. Sudbury Baptist is also involved in supporting education attainment in informal settlements of Port Moresby, Papua New Guinea (PNG).

Sudbury Baptist is located in a rapidly developing peri-urban area, 40km southwest of Melbourne. The church offices are based in portable buildings that have been renovated into comfortable rooms in the middle of an undeveloped field. Currently the church meets in a

community building hired on a Sunday. This is temporary, as Sudbury Baptist Church recently purchased a block of land to build a church for their services and associated activities.

Sudbury Baptist has established five churches in PNG to enable a local presence in the community. These churches are positioned in areas of PNG characterised by poverty and violence. My first interview with the senior pastor was postponed as the pastor's son from one of the PNG church's was murdered; he was bashed with an iron bar and died three days later. Benjamin, the Senior Pastor, believes that the culture of PNG is one of "revenge killings", an "eye for an eye is part of their way of life." Benjamin believes that if Omah, the Senior Pastor, had not intervened, there would have been a tribal war. Instead of retaliating with a revenge killing, Omah chose to turn the other cheek.

Sudbury Baptist Church has been involved in building and running schools in different villages in PNG to teach numeracy and literacy. The church has also set up a children's fund which includes a sponsorship program which supports 50 Papuan children to attend primary school. The sponsorship program has also provided five young adults with the opportunity to undertake tertiary education, and "four or five" young adults have commenced training in different trades.

> [The] Children's program, which basically teaches hygiene, health, puts food in kids mouths, also resources the community with water tanks ... Churches based in the area [have] put kids through school and then through university ... The process that [Benjamin] has come up with is that the kids that he takes in, even the little toddlers … they get immunised … you get them through school and follow them through to university and then release them. So the process is that if you get one kid out of the family - it can change the family. Because if they can get a job, they can go on and

> support the family and they come out of the poverty cycle (Peter, Youth and Young Adults Pastor, Sudbury Baptist Church, urban).

Peter has visited the Sudbury churches in PNG a number of times. The pastors of these churches live in the slums in PNG and look after the "poorest of the poor" in the community. Peter tells me how on one of his visits to PNG he asked the locals what it is that they want most. All of them responded saying that they want their children to be educated because that is what will bring their family hope. The child sponsorship program is run by volunteers from the Melbourne church; the two most recent volunteers were a nurse and community worker who have spent the last three years in PNG. The goal is, in the near future for the program to be managed by Papuans, and hence locals are being trained to deliver and maintain the sponsorship program.

Funds for the child sponsorship program are generated through a partnership with Compassion Australia[36] and also through a café that the church runs in the main high street of the suburb. The café is designed to give the church a local presence and provide opportunities for social connection seven days a week. However, its primary goal is to support the work of the church in PNG. Pictures, booklets, and brochures outline the different programs the church conducts in PNG, while educating patrons and raising awareness. Local businesses, such as the real estate agent and pharmacist, support the children's fund through regular patronage at the cafe and the donation of medical supplies which are sent by the church to PNG. The coffee served at the café is Fair Trade, with beans originating from the Eastern Highlands. The café also sells wares at a

[36] Compassion Australia is a Christian organisation specialising in child development and child advocacy. The organisation works in partnership with local churches from 26 developing countries to foster the spiritual, economic, social, physical and emotional development of children living in extreme poverty. More information about the work of Compassion Australia can be found at the following website http://www.compassion.com.au

competitive price that have been made by people in PNG to generate an income for them and their families.

The café is embedded within the community. Other church cafés are often within the church building. Televisions mounted on the walls document the work being conducted in PNG, so that patrons can see where the money from the café is going. Behind the café counter, a large sign proclaims the mission of the café: “Creating a great café experience in support of a great concern for the poor.” The mission of Sudbury Baptist church is to "grow people with a passionate concern for our world". Their work in PNG, the Life Program (high school mentoring program) and through the cafe reflects this mission and highlights how the mission of a church guides how a church works with and in communities.

CHURCH WORK ADDRESSING STRUCTURAL DETERMINANTS OF HEALTH

The framework of the social determinants of health illustrates how structural determinants influence the health behaviours and opportunities of individuals and populations. These structural determinants create or maintain the social hierarchy of society, due to their associated influences of “power, prestige and access to resources” (CSDH, 2007b, p. 26). The structural determinants which constitute the social determinants of health inequities, include elements reflecting social stratification (education, housing, income, and occupation) as well as social constructs such as race, gender, ethnicity and social class (CSDH, 2007b).

Frohlich and colleagues (2001) argue that the social meaning of context needs to be understood in order to properly grasp the association between context and disease. While the structural determinants of health have been highlighted by medical and social epidemiologists for a number of decades, sociologists have emphasised the need to understand the “recursive and co-

dependent" relationship between structure and agency (Frohlich et al., 2001, p. 788). Risk factors are reinforced within context (Frohlich et al., 2001). Therefore discussions and explorations of the relationship between "agency (the ability for people to deploy a range of causal powers), practices (the activities that make and transform the world we live in) and social structure (the rules and resources in society)" is vital (Frohlich et al., 2001, p. 781)

The recognition of agency, practices and social structure in relation to migrant and refugee unemployment in Australia can provide insights into how this problem can be addressed. In Australia, migrants and refugees can experience difficulties in finding employment, and are often subject to underemployment due to retraining requirements and the non-transferability of qualifications (Correa-Velez, Spaaij, & Upham, 2012). Racially and culturally visible migrants are confined to the employment niches of low paid and low status jobs (Colic-Peisker & Tilbury, 2006; Inglis & Stromback, 2007), employers and employment service staff demonstrate subtle forms of discrimination toward visibly identifiable refugees and migrants (Tilbury & Colic-Peisker, 2006; Hawthrone, 2002; Fozdar & Torezani, 2008). Jupp (2002) found that the lack of employment opportunities and associated levels of long term unemployment in refugee communities is associated with social exclusion and acculturation stress. These studies provide a basis for understanding the context of structural determinants for migrant and refugee populations.

I provide an example below of the work of Derby Uniting Church in relation to unemployment amongst refugees and migrants from the Horn of Africa. The Commission for the Social Determinants of Health found that active employment strategies and policies were more effective than passive employment policies, particularly in relation to vulnerable groups (CSDH, 2007b). Examples of active employment policies include training and support for unemployment

individuals to gain employment, provision of social safety nets, and ensuring access to health and social services and other forms of available support (CSDH, 2007b). These policies intervene in the labour market to create and maintain employment opportunities. In contrast, passive employment policies include for example unemployment insurance which provides an income in periods of unemployment (Schulze-Cleven, 2011). Derby Uniting Church has established its own employment service to assist migrants and refugees in finding and keeping work.

Derby Uniting Church is located in an inner suburb of Melbourne. It is an old church building with wooden pews, stained glass windows and a wooden pulpit. The building has a number of smaller rooms and halls that I encounter while walking the maze of corridors with Samuel, the minister. He shows me the computer hub, the hall in which they have community meals and also social activities, the food pantry. He then flings open the back doors of the church and sweeps his hand over the view of the public housing commission high rise blocks. "This is our backyard", he exclaims, "and these are our neighbours." Every effort has been made to get to know the neighbours. However, the neighbours are not always friendly. Samuel shows me a brick that was thrown at his head as he unlocked the doors of the church one weekday morning. This has not deterred him from wanting to know his neighbours and understand how, as a church minister, he can help.

A congregation member from Derby Uniting Church conducted research to understand the needs of the high rise residents, and through this research, discovered issues of unemployment, particularly for people from the Horn of Africa. They found that people who immigrated were experiencing social problems. The migrants were usually living in housing estates with a number of family members in cramped quarters while studying to obtain local qualifications to find employment. However it was found that they were having difficulty negotiating employment,

either through employment agencies or being faced with racism and discrimination at workplaces. Samuel believes that some residents found it difficult to maintain employment as they were not familiar with Australian workplace culture. Samuel decided to adopt an activist model of job placement to address this social need and in 2009 established the Derby Employment Opportunities Project:

> So we set out … trying to find the jobs and then match people to the jobs … The normal social inclusion model is, 'oh you will need to do a course' and people just accumulate endless certificates … courses, and [they] just still can't get a job. We endeavour to relate to employers.

Samuel gives the example of how Derby Employment Opportunities Project worked in partnership with Uniting Aged Care and Australian Unity to assist women who had achieved aged care certificates to obtain employment in a new aged care facility. Derby is not the only church operating in a manner that promotes and equips people from vulnerable groups for employment. As described in earlier chapters, a number of churches provide community meals where they provide meals for members of the community who are socially isolated and experiencing food insecurity. At times the volunteers who help to cook, serve and clean-up have been community members who had previously accessed the meal as an attendee. Milltown Salvation Army and Benbow Church of Christ have trained four of their volunteers in food handling and hospitality, with the result that two have attained employment in the food industry.

The role of local churches and church affiliated organisations in the coordination and provision of employment and allied health services, training and education opportunities, and disease prevention strategies has increased in the last few decades. The Australia government has moved

towards the privatisation of former state services to reduce the escalating costs to government of maintaining the welfare state. Many of these services being outsourced to church affiliated organisations. For example, the Australian Government owned Commonwealth Employment Service was privatised in 1999 with most of the direct activities outsourced to organisations such as the Salvation Army, Wesley Mission (Uniting Church), Centacare (Catholic Church), and Mission Australia (Anglican Church) (Singer, 2000; Warhurst, 2006). These organisations are also seen as a resource to address public health issues. Bretherton (2010) observes that public health issues such as obesity, anti-social behaviour and parenting challenges cannot be addressed by central government policies and regulations as they require cultural and social changes. Therefore governments are increasingly enlisting faith groups to tackle these issues as these groups "are seen as repositories of the kinds of cultural, moral, and social resources vital for effecting change (611)".

However the use of church affiliated organisations in the delivery of public services can be influenced by government agendas and policy goals which can create tensions of "mission drift" with organisations increasingly becoming professionalised to align with government expectations. Mission drift occurs when an organisation becomes increasingly concerned with aligning with government policies hence reducing their connection with communities and their ability to advocate on key social issues (Carey & Ayton, in press; Fyfe & Milligan, 2003; Milligan & Conradson, 2006; Kenny, 2008). Advocating for Change

Churches in this study demonstrated their role in advocacy both at an individual level and at a community level. Advocacy through community action is a key strategy of health promotion (Keleher, 2007b). Church advocacy is tied in with the mission of emerging churches, serving poor and marginalised people and fighting for social justice.

> We've got a major role of standing up for people; giving people a voice, that whole advocacy which fits into, you know some moral areas. We have a campaigner downstairs who does a lot of stuff on gambling and also does stuff on land mines so you've got the church speaking out on issues like that, the licensing whether you extend the licensing of clubs, just what we need in Victoria, more of them, um...so you've got church and church agencies standing up on issues like that, speaking on behalf of, we hope, telling the stories of, people who are experiencing those issues on a ground level (George, Director, LutherCare, Urban).

At times advocacy is operated at a practical level. For example, Milltown Salvation Army invited the local Consumer Affairs and Legal Aid Services to conduct their work out of the community centre, so that those accessing the church facilities can also utilise these services. Sunderland Church of Christ, located in inner city Melbourne, has a large international student population and has been involved in advocating for international student rights at the local, state and federal levels of government. The church also works with a number of church affiliated organisations and non-church groups such as the Indian Consulate, Traveller's Aid and the Victorian International Refugee Centre, to address and resolve issues surrounding inadequate training colleges and discrimination against international students. The senior minister at this church describes the issue as one where students are told:

> Go to Australia and you will make a killing, however we are finding, particularly around health matters, but also schooling, simple things like food, there is a fair bit of discrimination, not intentional....that's the kind of conversation that we have had with [Government Minister], people from Traveller's Aid, people from a number of the church organisations, consulate people, like the Indian consulate was involved in that, people

> from the Victorian International Refugee Centre was part of that. So we work not only with Christian organisations, but also other organisations that do not carry the name of Christianity to address social, community problems (Trevor, Minister, Sunderland Church of Christ, Urban)

CHURCH OUTREACH AND COMMUNITY ENGAGEMENT

The Ottawa Charter for Health Promotion (WHO, 1986) highlighted the need to 'strengthen community action' as a key action area. A strategy for this is to "draw on existing human and material resources in the community" (p. 3). To understand if and how local churches can be utilised as a resource for health promotion, it is important to explore how they engage with communities. As I have illustrated, new modern and emerging churches have an ethos of engaging with the wider community; these churches utilised community spaces, or opened their churches to other community groups and members. Church leaders and volunteers from emerging and new modern churches would use words such as 'outreach' to describe their community activities:

> Our youth groups ... [are] trying to outreach all the time, like how can we reach the community? It's better to go into the community. But those sort of things are outreach type things – our activities ... because churches are quite activity based. Activities are really trying to get out into the community and what can we do and how can we connect with these young people? So all our youth things are outside [the church] and secular (Katrina, Pastoral Care Minister, Grantham Rise Baptist Church, urban).

For some churches, being part of the community was a key component of their faith:

> As a church, we look at ourselves and believe that we have to be part of the community around us and so we are sort of moving from thinking that people have to come in to us to realising that we need to go out into the community to, um, be with people, stand alongside people, not necessary to convert them all the time, just to be a part of our community because we believe it's what we are called as Christians to be (Margaret, Minister, Longbourn Uniting Church, urban).

This sentiment was echoed by Pamela, the minister at Benbow Church of Christ:

> Local churches, or our local church, is part of a community here and I kind of like to think of the church [as] having [an] open door, that we have a part to play in contributing to positive life in the community because it actually benefits everybody. We can't do everything, we see a lot of needs that we would love to do something about but we can't but you do what you can.

The majority of churches involved in this research engaged with communities through a range of activities and programs, as described throughout this chapter. One of the emerging churches, Ashridge Baptist Church, had an innovative approach to community engagement. The church does not have a church building and this was a deliberate choice by Andrew, the founding senior leader of the church. The church started eight years ago with 22 adults and their children, who wanted to explore a different expression of church. Ashridge was created with the aim of serving the community, a sentiment which is reflected in its mission statement of "partnering with God in transforming His world for good".

Instead of having a church building which can exclude the wider community from the church, Ashridge meets in a public building in the heart of the suburb. A community health service is

located across the road, other groups meet in the building during the week, and it is a two minute walk to the main street and suburban shops. In eight years, their congregation has swelled to almost 200 adults and 100 children.

Ashridge Baptist has recently appointed a part-time community engagement coordinator. The role of the community engagement coordinator is to "be aware of the needs in the community, specifically those needs that fall under our ... key [interest] areas" (Andrew, Minister, Ashridge Baptist Church, urban). The key social interest areas were decided by the whole congregation and identified as areas that church members felt "called to." These included mental health, social inclusion and homelessness, particularly following domestic violence and mental health problems. The community engagement coordinator explained this process using homelessness as an example:

> Okay, there are a lot of people who are homeless and one of the effects of that is being socially isolated so it's thinking how do we build social inclusion? Building a bridge between the two ... through liaising and also through [church] education and meeting with organisations, individuals or groups ... I think we are quite good at building relationships and providing community support (Jane, Community Engagement Coordinator, Ashridge Baptist Church, Urban).

♦ ♦ ♦ ♦

It is almost 9 am on a Sunday morning in October, and it is unseasonably cold and raining. However the staff and congregation are not setting up for a typical Sunday morning church service. Instead they are sending groups out to participate in various community focused activities. There is the bustle of organising tools and equipment and making sure that everyone is

aware of what will be happening next. This Sunday is what the Ashridge members refer to as a "Community Engage Sunday."

A group of volunteers stay at the building to cook up meals for the local soup kitchen which runs every Wednesday night. Church members are involved in supporting the soup kitchen through cooking and serving food and chatting with those attending. Teams of congregation members head out in cars with gardening tools to a number of properties in the areas to work in the gardens of families and individuals who are experiencing hardship. Andrew tells me that the majority of the Community Engage activities are initiated by congregation members in response to needs that they are made aware of through their work colleagues, schools, and neighbours.

On this Sunday, those remaining head over to the local primary school to run a games and sports day for children in the area. Some of the fathers organise a barbeque to provide food to participants after the morning festivities. Despite the cold weather, a number of children from outside the church have shown up to play soccer, netball, basketball and touch rugby. A cheer squad of adults line the school hall and a few young adults and Andrew take to the court to participate. Jane, the Community Engagement Officer, hands out coloured streamers for the children to tie onto their bodies. Each colour represents a different team. The girls weave their streamers into their hair while the boys tie theirs around the perimeter of their heads, warrior style. The children shriek and squeal as they battle for the ball; the adults yell out words of encouragement, fostering an environment of fun as opposed to fierce competition. In the hall foyer, a few tables have been set up with play dough and paper and coloured pens for children who are not inclined to participate in the other games. The children who are regular attendees at Ashridge came up with the idea for a games day as a way to connect with other children in the

area. They have taken their task seriously and make an effort to ensure that everyone is included and made to feel welcome.

Other Community Engage Sunday activities have included sending teams of people to assist in rebuilding communities devastated by the Victorian bushfires, and providing respite care for parents of children with cerebral palsy. One congregation member is a physiotherapist who works with children with cerebral palsy and she organises for this respite day to occur. Approximately 30 children with cerebral palsy are dropped off at the hall rented by the church. The parents are provided with a list of local cafes where they can go to for lunch and they are given some money for this purpose. They have three hours in which to relax and to eat at their leisure. Each child is matched with two volunteers, and a group of individuals trained in disability care supervise the morning sessions. Activities for the children include painting, cupcake making and music therapy.

The activities and programs offered by Ashridge focus on relationships. The church has what is termed a partnership fund, which consists of $18,000 per annum from the church budget that has been set aside for congregation members to distribute to those in need. For example, if an Ashridge member's neighbour is struggling to pay for his or her car to be fixed, money can be made available. Andrew explains that the criteria for someone to draw on the partnership fund is that there must be a situation of genuine need, the person needs to be a friend of someone from the church, and finally that the money is given in the name of the church or Jesus. The rationale for the partnership fund is based on the link between financial difficulties and mental illness. Andrew believes that providing emergency funds to people in a situation of crisis can mediate some of the financial stress that may contribute to anxiety or depression.

The different churches in this study had varying approaches to how they engage with the community. In contrast to Ashridge Baptist Church, for example, Milltown Salvation Army, also an emerging church, has adopted a community development model where activities and programs are implemented with a focus on sustainability. The Captains hired a community development officer to conduct a needs assessment which informed the development of the programs and activities run at the centre. Shikki, the Co-Captain of Milltown Salvation Army (and wife of the Captain), explained how the model also attempts to empower the community as they "don't want to be setting up a system that then means that the local people fail and we fail our community." She discussed the danger of making the work that they do about themselves and being "the big heroes" recognising that such an approach would leave a "massive hole" in the community.

> It also doesn't allow the people in this community to grow. If you come in and you are the big minister and big social worker and you are so blooming big that it is suffocating it can stop, not always, it can stop people from finding their own potential (Shikki, Co-Captain, Milltown Salvation Army, rural).

♦ ♦ ♦ ♦

Churches included in this study demonstrated that a Kingdom of God mission perspective aligns with a range of upstream health promotion activities (see figure 12.1). This was best demonstrated in the work of churches classified as emerging or new modern. As I have illustrated, churches in the emerging and new modern categories did not restrict their work or activities to fellow members of the congregation or other Christians only. Rather efforts were made to engage with the wider community in ways that promote wellbeing. In some cases the

work of churches moved beyond activities and programs to challenging the social and political structures oppressing vulnerable community groups such as asylum seekers. In the ethos and practice of the emerging and to a lesser degree, the new modern churches, approaches of community development, community engagement and the value of social justice were evident. In working to "bring heaven to earth," these churches are potential partners for health promotion programs and practices.

Chapter 11

THE LIMITS TO ENGAGEMENT

In chapter two, I included a brief discussion of the challenges faced by churches in CBHP, and the difficulties experienced by health promotion practitioners in engaging with churches and conducting CBHP. In this chapter, I focus on the experiences of local churches in relation to the tensions, challenges and limitations in initiating, implementing and maintaining health promotion programs and activities. Church groups and the public health sector have been known to clash on social issues, particularly as a result of differing values and beliefs systems (Chatters et al., 1998). These profound and real challenges influence decision-making associated with government and health sector partnerships with churches, church affiliated agencies and church affiliated organisations in public health and health promotion efforts. Both sectors are uneasy, with suspicion and misunderstanding of the perspectives and assumptions of the other (Chatters et al., 1998; Kegler, Hall, & Kiser, 2010). Despite research indicating that Christian institutions have a role to play in the promotion of physical and mental health (Krause, Shaw, & Liang, 2011), public health practitioners can be hesitant to engage with Christian groups and organisations (Brooks & Koenig, 2002; Chatters et al., 1998; Kegler et al., 2010). Notwithstanding these tensions, there has been considerable success in designing public health interventions that capitalise on the prominent place of the church in communities and in the lives of individuals (Austin & Harris, 2011; Boltri, Davis-Smith, Okosun, Seale, & Foster, 2011; Bopp & Webb, 2012; Steinman & Bambakidis, 2008; Steinman et al., 2005; Wilcox, Laken, Bopp, et al., 2007; Wilcox et al., 2010).

The data for the analysis in this chapter were collected in response to a direct question I asked of participants in relation to the challenges of church involvement in health and wellbeing programs and activities. Below I discuss the main themes arising from this analysis: the societal context, the congregational context, and the theological/mission context.

THE SOCIETAL CONTEXT

In an increasingly secular world, the church is no longer at the centre of society. One of the outcomes of secularisation is that church affiliated organisations tend to have limited ties to the main body of the church. The rationale for the separation of the local churches from the organisational welfare arm of the denomination is to secure government funding and contracts; this can allow the professionalisation of these welfare agencies (Gregg, 2000a; Mendes, 2008). Two participants from the church affiliated organisations claimed that the public were often not aware that their organisations were founded through Christian churches: "Some people frankly, when they turn up, they have no idea that this is a Christian organisation. That's news to them" (Catherine, Minister to the Mission, KyrieCare, urban). George, the director of LutherCare, described the increasing secularisation of welfare agencies, and how LutherCare defied the trend by choosing to say "we don't like that, we are the church, we are part of the church." For LutherCare, efforts have been made to maintain identity and connection with the "faith base," with the "desire [being] to be connected back to the church and [to] build relationships with congregations."

Church perceptions of relevance

Secularisation is reflected in the church's perception that its relevance is questioned. Respondents claim that "the young people of today" regard church as "just sitting in pews"

(Emily, Director, Ignatius Social Services, urban). In response to this threat to its relevance, churches may engage in health promotion work or other activities not typically associated with churches, to increase their significance, community profile and credibility. When I visited the churches in this study, it was common for technology such as Power Point, Twitter and Facebook to be used in attempts to engage with younger parishioners. While using technology might appeal to younger people, participants emphasised that meeting community needs was a way of remaining relevant and meaningful in today's society:

> I guess our current generation doesn't think that the church is the place to go. And I guess what we've got to try and do ... is show ... how can we be relevant in our community? How do we provide? How we've got to meet the community's needs ... I mean, it's health and wellbeing is a way of um ... meeting people's needs and showing them a better way of life, a healthier way of life and how to live life to the full and enjoy it (Nathan, Captain, Wilton Salvation Army, rural).

Nigel, a rural Anglican minister, interpreted the increase in people choosing not to be married as an indication of the church's disconnect with society. He described his willingness to marry people who are not members of the church and who prefer to have their ceremony outside of the church building:

> For instance, people aren't getting married in the church, they prefer to get married elsewhere or outside by a marriage celebrant. Well, I'm trying to break down the barrier that people have about the church because I'll marry people outside as well ... I have two weddings booked for later in the year that aren't in [inside] the church.

Cohen, the youth and young adult's pastor at Murcutt Anglican Church, felt that the church's role of creating community was being taken over by schools. Churches were no longer seen as relevant institutions to foster the socialisation of young people with a greater emphasis being placed on schools.

> So, for example, in the '60s and '70s was when youth groups, the concepts of youth groups really emerged. Churches provided this thing that nobody else really provided, which was socialisation for young people ... [now] school kids, basically their whole lives [are] being taken up with school activities ... you know, extra curricula things ... camping during the holidays or going overseas with school. The schools would provide all of these same programs that we [churches] used to offer like emotional health things … it feels like we are competing a little bit with the schools.

Church perceptions of mistrust

The main theme associated with church perceptions of community mistrust is a fear of "Bible bashing" and coercive conversions to Christianity to access welfare or social services. Local church leaders believed that there was mistrust and negativity toward the church by people outside the church community. The negative perception of the church was described as a key challenge faced by local churches as it often "impedes what [they] love to do"; yet the churches in this study realised that they need to "build up trust and keep going" (Margaret, Minister, Longbourn Uniting Church, urban). The church building was also identified as a barrier to community members accessing services and programs.

> Well, I think some people are reluctant to come inside a church building, ... it might be threatening, they might wonder what goes on, are these people going to Bible bash me,

> you know, that sort of thing, so I think that's a barrier in people's perception. So what we do about that is just to rely on people who do come and access our programs, by word of mouth, they will say, and sometime you hear people say, 'Oh that's the church that does this or does that.' So I think the barrier of the building might be one thing (Pamela, Minister, Benbow Church of Christ, urban).

> It is a church, but it is also a community centre and we are not preaching to you when you come in to have a coffee. We are not going to corner you and say 'Why have you not been to church for however long?' and preach the gospel and Bible at you. I think that was an initial barrier (Dale, Captain, Milltown Salvation Army, rural).

Therefore, even though the church building could be a resource for health promotion activities and programs, it may also be a hindrance if people are unwilling to access programs situated within a church due to concerns that the programs may be an avenue for proselytising.

The response of churches to past social issues also impacts on how the public views the work of churches today. For example, the Catholic Church's stance on condom use to prevent contraception and more recently, HIV transmission, issues of gender equity and women's empowerment, attitudes towards homosexuality and same sex marriage, conflict with the positions of secular organisations and public health professionals. In addition, child sex abuse has plagued the reputation and validity of churches and the response of the Catholic Church to the sexual abuse of children by priests has been widely criticised (Goode et al., 2003; Royal

Commission into Institutional Responses to Child Sexual Abuse, 2013; Parliament of Victoria, 2012).[37]

> I would say that some criticisms that are levelled at churches are well justified. When you think of the misconduct by the clergy and that sort of thing, it is totally abhorrent to the teaching of Christ and what churches stand for (Pamela, Minister, Benbow Church of Christ, urban).

For the participants in this study, reflections on the issue of sexual abuse by church clergy were made with sadness and dismay.

> [The] church has lost a lot of cred [credibility] from the issue with child sex abuse (Samuel, Minister, Derby Uniting Church, urban).

> You've got all of that, in the Catholic Church stuff with priests and young boys and stuff which is just awful and abuse that has happened in the care, when children have been in the care of the church. And so in that sense, I think that's a barrier because people hear that stuff or people have unfortunately experienced a negative side of the church and therefore they don't want any part of it (Megan, Children's Pastor, Perrington Church of Christ, urban).

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[37] Federal government and Victorian government inquiries are currently being conducted to examine the institutional (particularly the Catholic Church) responses to allegations of child sexual abuse. In 2009, a Commission to Inquire into Child Abuse in Ireland was published (also termed the Ryan Report) which concluded that the sexual abuse of children under the care of the Catholic Church was endemic.
See http://www.childabusecommission.ie/publications/index.html.

Church leaders and volunteers acknowledged the negative history of the church and understood why people might mistrust their activities and programs. While there was recognition of these issues, the church leaders did articulate a message of change - that not all churches are the same. For some, there was frustration that all churches are viewed in the same light when often the organisation structure, teaching and theology of denominations and Christian groups differ markedly.

> I know churches can be complete nutbag-villes of just craziness sometimes ... probably here looks crazy to people [on the] outside too. Sometimes [churches] don't help themselves by sending messages that make them look strange or odd ... Because churches are also seen by how they are addressed by [the] mass media ... I guess for organisations that pick up the thread where churches look like paedophilic holiday camps or where churches look like uni-directional escapades in fundamentalism or churches are just on about producing guilt and blame ... and certainly there are churches like that and I know that. So I think sometimes there are perceptions that people can hold in organisations that don't see churches, and don't realise that churches are all different in the same way as just about every hospital or every school in terms of ethos, and their social fabric can be quite different as well. So I don't think that helps all the time and that's why I think churches have to do a lot to make sure they are seen in the wider community to make sure they ... win slowly ... a credible voice. (Ayesha, UNOH Worker, Redgum Church of Christ, urban)

George, the director of LutherCare, also described the tensions of feeling that people believe that churches should not participate in the provision of welfare services due to different views and values. However, George felt "very strongly that the church has a role to work towards the

wellbeing of everyone and to do what [it can] to advocate on a range of things, views or values which aren't quite right." While the church affiliated organisations involved in welfare service provision do not restrict employment of staff to Christians, it is not uncommon for Christians who have been trained in social work or other welfare associated professions to seek employment in these organisations. George emphasised the importance of Christian staff members understanding and operating within the boundaries of their professional work as a social worker even if they are working within the context of a church affiliated organisation.

> You know, if I as a social worker said [to a drug user]... it's evil you doing that, it's the devil in you, and it's really terrible - I would've breached [just] about every social work code of ethics that there was, and the church has to be able to work within that as well... (George, Director, LutherCare, urban)

THE CONGREGATION

The church congregation can also pose challenges and limitations in engaging with health promotion. The predominant themes associated with the challenges of the congregation include differing values and morals, church culture, finding and coordinating volunteers, and risk management.

Tolerance of diversity

Churches are not only organisations or institutions embedded into local communities; they are communities themselves with cultural and social traits that may be more familiar to selected segments of the wider society. Church communities comprised of people from different cultural backgrounds, traditions and experiences found that some members felt uncomfortable interacting with others from different cultural or ethnic backgrounds.

> We are just a church full of people so there are lots of flaws within the [church] community. So there's barriers of fear, barriers of apathy, just speaking about our little community, barriers of getting jack of crossing culture because it's difficult, barriers of being ... treated very badly by some people which has been very sad and hard ...We try and model after a healthy dynamic of how you make multicultural communities and multi-faith communities work. (Mitchell, Minister, Tinworth Anglican Church, urban)

Forming and maintaining a healthy community within the church can be a barrier to church engagement with health promotion, particularly for traditional churches. The church may perceive community engagement as too difficult for people in their congregation:

> Some of the older style churches don't [engage with the wider community] ... they just go along and seem to be very insular, in their worship, they go along and just worship God on Sunday (Maureen, Community Care Pastor, Grantham Rise Baptist Church, urban).

Discordant values

Because church congregations comprise of individuals from different backgrounds, experiences and cultures, different values are bought into the church context. This theme was highlighted by George (Director of LutherCare) in describing the desire for the organisation to establish safe injecting rooms. LutherCare, unlike some of the other church affiliated organisations, has maintained close links with local Uniting churches. Therefore the activities and programs of LutherCare need to have the support of the broader church community. In the situation of safe injecting rooms, congregation members were adamant that they should not to adopt what was perceived to be a radical measure. LutherCare did not proceed with the plans because it failed to gain congregational support.

> The church struggled a few years ago ... [we] wanted to set up a safe injecting facilities and some people in the local church and in the wider church struggled with that. It was too cutting edge at the time, even though they were able to demonstrate that there were programs in Sydney that had done it and that it was a really good thing to do in terms of providing a safe environment for people who are going to do this anyway. It was just too much at that point. This was probably back about 2003/2004, somewhere around there. I think the government was running a strong agenda of trying to get some of these up, and Steve Bracks [former State Premier] was running with it and we were very keen, but it was just too much too quick and people were resistant and it didn't happen (George, Director LutherCare, urban).

In certain situations, therefore, the values and beliefs of church members impede the ability of the church to engage with health promotion and broader public health efforts. Furthermore, some respondents reported that inspiring a change of mindset in the people of their congregation was a difficult task. Below is an excerpt from an interview with a senior church minister of a new modern church in inner Melbourne highlighting the difficulties in dealing with the issue of homosexuality:

> I think at the moment ... [there are] seven male homosexuals who come regularly to [our] church, and one woman who has been in a homosexual relationship for an extended period of time. There would be people in our congregation who would say, 'Well they would have no place in the house of the Lord'... 'They have defiled the house of God', or 'Let them get themselves sorted out before we do things (Trevor, Senior Pastor, Sunderland Church of Christ, Urban).

Trevor did not share these sentiments of homophobia; rather he highlighted why as a church they have "embraced the ministry" and reminded congregants of the "directive to love God and to love your neighbour as yourself." However, the opposing stance of some churches on key social issues such as same-sex marriage, abortion, and homosexuality is a marked disconnect with contemporary health promotion beliefs of justice and equality. While not all churches may subscribe to these values, churches are often viewed as homogenous and therefore health promotion practitioners may find it difficult to distinguish between churches that hold these perspectives and those more tolerant and inclusive in their approach. All of the emerging churches in this study intentionally challenge these notions through practice.

Catherine, the Minister to the Mission, at KyrieCare, a Uniting Church welfare organisation, identified church culture as a challenge as it can be very unfamiliar and strange to those who have not engaged with the church. Catherine tells the story of a young woman, Jess, who worked for KyrieCare and who had not attended church since she was a child. Jess was invited to a Uniting Church service to talk about a KyrieCare program. Catherine went with her and described how within an hour of the church service "without any warning, they walked in with the elements for Holy Communion." Jess turned to Catherine in a panic and whispered, "Help! What do I do? I'm a lapsed Catholic!" Catherine talked her through the Uniting Church position on communion and made it clear that Jess was welcome to participate in Holy Communion in the Uniting Church, but that she would not cause any offense if she preferred to not participate:

> Many old Uniting churches have lovely friendly people who are so well meaning but it's like a particular culture, and if you weren't a member of the Methodist's Young Fellowship or the Presbyterian Social Australia in the 1950s – it's like an alien world. They were all so well meaning, but they had no idea how to actually make someone from

> outside feel at home and feel comfortable ... They had no idea how their Sunday morning activities are totally alien to most of the population (Catherine, Minister to the Mission, KyrieCare, urban).

Volunteers

Another challenge highlighted by participants was that of finding appropriate volunteers from church congregations. As I described in chapter seven, Benbow Church of Christ is located in a suburb comprised of families and individuals from the whole socio-economic spectrum. The challenge for Benbow Church of Christ was that the staff and key volunteers exert a significant amount of time and effort into "people who are unlikely to be able to take leadership roles in the church in the future" (Zoe, key volunteer) as they have mental illnesses and disabilities. While it is part of the mission of Benbow Church of Christ to engage with vulnerable people in the community, as a consequence few are able to coordinate and organise key church activities. The onus tends to fall on the same people to be responsible for church programs, leading to volunteer burnout. Hence, given limited human resources and expertise from within the congregation, there are questions of program sustainability,

Many study participants spoke of church volunteers positively. Some felt there was a fine balance between ensuring that competent and appropriate volunteers were utilised, particularly in programs with vulnerable or disadvantaged individuals, while accommodating the need for more volunteers to ensure program continuation:

> There are people who volunteer but because of their background or their attitude, they are not suitable to be here because we say that all clients and staff we treat as friends ... we

> don’t speak down to them. I don’t believe in that paternal[ist] attitude that some people have (Anne, Community Care Pastor, Belton Baptist Church, urban).

> There are so many people who are in need and there’s only a few who [volunteer] and so it makes the strain on them much more than if you had more people lightening the load (Larry, COACH mentor, Grantham Rise Baptist Church, urban).

> Numbers of volunteers ... if you had more people able to be involved you will be able to do more as well, so it’s a matter of doing what you can with what you’ve got (Pamela, Minister, Benbow Church of Christ, urban).

The need for competent and appropriate volunteers can be a source of tension for church leaders. Church leaders acknowledge the busyness of the members of their congregations, with competing time demands of parents, family, work, church, leisure and rest. While most churches did not have a strategy for addressing these issues, emerging church leaders tried to reduce the demand they placed on people to volunteer in church activities by encouraging them to invest time into the community. This could mean, for example, being a volunteer at the local soup kitchen instead of being in the church band. The focus of volunteer effort is not on the Sunday church service and indeed in the example of Ashridge Baptist Church, every few months a community engage activity is held in place of a church service. These churches recognised that being a volunteer can be a sacrifice for some people and therefore demands need to be managed to prevent burnout and disengagement.

> The barriers are our time and our willingness to get our hands dirty and engage with real people. That’s our barrier, is our time and our busyness and our sometimes it’s a little bit of fear ... they are our main barriers ... that’s why we then make it [community

> engagement] front and centre by having it as part of what we do on a Sunday every eight weeks (Andrew, Senior Pastor, Ashridge Baptist Church, urban).
>
> It's difficult for churches too, because so much of what they do runs on volunteers. So pastors are under all this pressure to have people there to do things like Sunday School and run programs and all that stuff, and there is pressure on them to achieve those things, but often it comes at the cost of someone's health to be putting people in those positions (Aaron, Mind Health Coordinator, Ashridge Baptist Church, urban).

Church leaders also recognised the importance of inspiring and motivating volunteers to be involved and to stay involved in activities and programs that the church conducts: "The biggest thing I think is the volunteer base that you work with, constantly got to cast vision and remind them of why we do what we do" (Peter, Youth and Young Adult's Pastor, Grantham Rise Baptist Church, urban). Participants identified as barriers to involvement in programs "resources, both human and financial" (Walter, minister, Marshland Uniting Church, urban). Melissa (Beriah Mission) echoed this frustration as they "would love to do more," but are restricted as they "don't have the capacity and a lot of it comes down to funding."

Risk management

Because of the types of activities and programs, and their engagement with vulnerable, marginalised and disadvantaged communities, risk management is often significant for church leaders. Churches not only have a responsibility for the health and welfare of staff and volunteers, but also for the community members who engage in their activities and programs. Many churches have strict policies on behaviour and substance use to ensure that the church is a "safe place for everyone" (Pamela, Minister, Benbow Church of Christ, urban):

> Making sure there's no trouble. Last week there could have been about ten fights easy. But not one started. Because there was me and two other guys who were watching and if anything started, they were out. And it didn't happen. You have to be on your toes. I've banned two people since I started. A girl and a guy. So that's not bad in five years. People come here to have a meal. It's not to listen to fights or see fights or ... They come where it's safe (William, Cafe Manager, Benbow Church of Christ, urban).

> Sometimes if they are angry and they are using substances, there is nothing to do but to say 'Would you please leave and come back tomorrow when you are feeling different and we will talk about it then.' And quite often they do and they apologise, but you can't reason with someone who is high on something. You can't do anything with them (Zoe, key volunteer, Benbow Church of Christ, urban).

The need for risk management was viewed by some as essential to their programs, but others saw it as a hindrance. For some staff and volunteers, there was a feeling that those involved in creating church rules and policies aren't always the people who are participating in the programs, and so they lack understanding of what is possible and feasible in terms of risk management:

> I don't mean it unkindly but some of the people make the rules and the standards here ... and don't come to [the program] ... and we are talking about very different people and if you are talking about the children, they are not like little kids that come to Sunday School and sit there with their hands in their laps singing songs to Jesus. These kids have no boundaries. And it's hard to believe in Australia that there are communities like it. I'm stunned ... The barriers I face is a lack of understanding from the rest of the church. It's almost beyond their comprehension that it could be so different. And you can't work ...

> It’s very difficult to work like a normal program, you can’t put it in a box. It’s just not like it’ (Maureen, Community Care Pastor, Grantham Rise Baptist Church, urban).

For the most part, interviewees were cautious about potential risk and were reluctant to mention circumstances where there was an incident that compromised the safety or wellbeing of people. They spoke of hypothetical situations and the policies and procedures they have in place to managed the risks of their different programs. I asked John, one of the UNOH workers, about how he manages the risks posed to his family. He has moved with his young family into a poor neighbourhood where he often hears drunk people screaming at night. He opens his home to strangers often struggling with issues of addiction and mental health problems. John and his wife Ayesha believe that it is important to expose their young girls (aged two and four at the time of interview) to the "realities of life" and that living in the Redgum community would strengthen the faith of their children. They maintain that they are "not stupid about it" and are always careful of who they leave their children with. Samuel, the minister at Derby Uniting Church, is also acutely aware of the dangers associated with the work that they do and that safety can be compromised when working with vulnerable communities.

> Sometimes it can be difficult, and just painful, very disruptive. I have down here the brick that was thrown at me a couple of weeks ago as a memento of that ... it’s just sitting behind that there ... it happens, people who are not well who are under the influence of drugs or pot ... it happens

THE THEOLOGY OF CHURCH MISSION

In chapter two, I outlined the differences and shifts in church mission. For churches working within a traditional or new modern framework, church mission can be salvation focused - telling

people about Jesus, their need to repent and be saved, so that they will have eternal life when they die. Therefore, the use of church social welfare and care services as a conduit for preaching the gospel for traditional and new modern churches needs to be explored.

An alternate agenda

A number of church staff members spoke of conversion as a hidden agenda to churches involved in health and welfare programs. An examination of the motives of churches is important to ensure that community involvement in health and wellbeing "is not just so [they] can get people believing in Jesus" (Benjamin, Senior Pastor, Sudbury Baptist Church, urban). Some churches clearly stated that they "are not consumed with saving souls"' (Cynthia, volunteer, Miners Bend Uniting Church, urban), and agreed that "Christ has called [the church] to be the good news - to feed the hungry and give a drink to the thirsty" (Benjamin, Senior Pastor, Sudbury Baptist Church, urban), as the basis for the church's work in the community. Overall participants believed that if someone asks them what drives them or why they are involved, they can answer honestly with reference to their faith in Christ.

Some churches, mostly emerging churches, were critical of traditional and new modern churches as too "evangelism focused." Emerging churches appeared to be more suited to health promotion activities and programs as they do not subscribe to the belief that church activities are "a recruitment strategy ... [for] more people sitting in their church" (Jane, Community Engagement Officer, Ashridge Baptist Church, urban). Rather, they believe that even though people "may never darken the door of our church at any time ... we won't stop delivering our goods and services because of that" (Brian, Associate Pastor, Ashridge Baptist Church, urban). However, some traditional and new modern churches criticise the emerging churches as having too much of an emphasis on social justice at the expense of sharing the good news:

> The reservation arises from the ... I guess ... losing sight of what the main game is and what I mean by that - there are certain denominations that have a reputation of being very socially aware and addressing, I'd say, community and personal health issues. But they would then fall away from, if you like, sharing the gospel. The good news of Jesus having died on their behalf. And that in itself becomes a source of conflict across denominations but also within local churches. There is always the suspicion that if I promote general health and wellbeing too much, it's again focusing on self to the exclusion of what God has actually called us to do. So I hope I've made that clear, there is always tension in a Christian community. Some people say, if you like, there is a range from social justice right across to only share the gospel. Clearly we need to be in balance as to how we do that, but it's where the priorities lie in which we find the difficulties from time to time. (Henry, Associate Pastor, Peverell Anglican Church, urban)

In speaking to church leaders I observed a tension between communicating the Christian faith to those who identify as having no religion, and also to those who have their own religious beliefs. Whether a church has an alternate agenda to their engagement with broader community, often termed 'outreach' in church (and other circles), is influenced by their understanding of church mission. Mitchell, one of the ministers at Tinworth Anglican Church, describes how his church is involved in engaging with people who were Muslim:

> We do everything under a Christian banner. We don't say we are just people who are here to help you along; we are very clearly saying 'we're Christian.' We also ... we require anyone who are part of our teams to be Christian as well ... So we want to have a really clear Christian ethos ... Most of the people that we work with, particularly the Horn of Africa people, would be Muslim people and absolutely ... there's tension ... there's a

> vibrant dialogue going on there ... But it's not aggressive. It's not unpleasant or anything like that, but it's very active. Those guys are very keen to convince, well anyone really, but us particularly to be Muslim. But we are very keen to say 'no, we're Christian and we think it would be great for you to be Christian too.' It doesn't create problems particularly ... we are not hard lined about that, and certainly there's no requirement ... there's no sort of pressure to take on board anything we say and to be involved in our programs or anything like that. So it's very invitational in culture and we are very … boldly clear about who we are and why we think that's great, but that's not sort of requirement for anyone, you don't have to agree with us to be part of what we do, unless you are part of the team, we don't have any conditions on any of the services that we provide for people.

The emerging churches, such as Grantham Rise Baptist Church, recognise the "whole social justice thing" and that "people have a heart for the lost and heart for the poor ... it's the way God wired them and made them and they just know it's what they have to do" (Maureen, Community Care Pastor, Grantham Rise Baptist Church, urban). Therefore, providing an "avenue for people in the church to work ... to help the poor" (Maureen) is important for churches with this ethos. However, these churches do not view the community or individual that they are helping as "another possibility" or candidate for salvation. Instead, their aim is to "show them love and understanding and be a listening ear to them." They may ask:

> Can we pray for you but that's about the extent of what [they] would say. They will help them with food, pay some of their bills or advocate for them ... but they don't say here is another one we can save (Maureen, Community Care Pastor, Grantham Rise Baptist Church, urban).

One new modern evangelical church recognised that churches can "get so word focused that [they] forget about the deeds of the Kingdom" (Henry, Associate Pastor, Peverell Anglican Church, urban). In other words, there is a focus on preaching the gospel as opposed to demonstrating Kingdom values of justice, mercy and grace, and caring for vulnerable people. Samuel, the minister of Derby Uniting Church, was critical of churches "whose mission doesn't care about what happens" in the here and now.

> In this world that we live in it's all about the other side ... it's all about what happens when you die. So they are not all that interested in health promotion. Oh you know, you are sick, oh you get to go to heaven quicker. So that's obviously a problem (Samuel, Minister, Derby Uniting Church, urban).

♦♦♦♦♦

In this chapter, I have examined a number of key challenges and limitations associated with the involvement of local churches in health promotion efforts. These challenges have been articulated from the perspective of church leaders, staff members and volunteers and address how churches feel they are perceived by society; the need for appropriate volunteers to ensure sustainability of programs, and risk management to protect the safety and wellbeing of church staff, volunteers and community members. A strong theme was the primary mission of churches and how this can either hinder or advance alignment with health promotion values and actions. Emerging churches expressed limitations such as motivating volunteers when many demands are placed on them whereas new modern and traditional churches faced value conflicts. As I highlight in the following discussion chapter, not all churches are suited for health promotion

practice or all types of health promotion action. However, some churches, particularly emerging churches, may provide a unique resource for health promotion in the community.

Chapter 12

UNDERSTANDING LOCAL CHURCHES AND HEALTH PROMOTION ACTION

> Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters (World Health Organization, 1986, p. 3)

Churches are major participants in civil society, contributing to community development and thereby contributing to health. Although local churches and church affiliated organisations have worked to address the social determinants of health throughout Australia's history (Ayton et al., 2012; Mendes, 2008; Smyth, 2003; Swain, 2005), there has been little exploration into the role of the church in health promotion in Australia. The US cultural, social and religious context differs to Australia, and hence research findings from US studies should not be extrapolated and research is needed to explore the role of the church in health promotion in Australia.

The research I have presented in this thesis is not theological, nor was it my aim to contribute to the extensive discourses on the sociology of religion. Rather, my focus was to explore local churches as a resource for health promotion. The Ottawa Charter for Health Promotion states the need to strengthen community action in the implementation of health promotion strategies. Churches provide human and material resources for many communities in Victoria, and may therefore be a viable resource for health promotion. However, it is critical to understand the mission and agenda of local churches in order to meaningfully engage with them in health promotion action. As I discuss in this chapter, while there are some examples of churches which are very active in health promoting activities, not all churches are suited to health promotion or

all types of health promotion action. This study provides a contribution to public health by applying a framework of different health promotion approaches to the churches' current work in Victoria. The findings capture the health promoting work of churches and explains the opportunities and challenges of partnering with the church in health promotion.

I initially sought to understand the church as a setting in Australia, as informed by the existing literature of CBHP interventions in the US. However, during data collection, I found that in some cases church involvement in health promotion was broader than the church congregation, with churches engaging with the wider community to address the social and structural roots of health inequities and inequalities. Hence, I extended my research focus to examine the church as a partner as well as a setting for health promotion. I did not seek to examine the implementation of specific health promotion interventions within the church context. Such an approach would have aligned more closely with the US literature, where the church is viewed predominantly as a setting for health promotion. Rather I sought to describe if, how and why local churches, through 'being church', contributed to the health and wellbeing of individuals and communities.

This is the first study to examine the role of local churches in health promotion in Australia, while seeking to identify the different variables that explain church engagement with either downstream or upstream health promotion approaches. In Chapter five, I discussed how church mission is associated with health promotion action. A church with an evangelism focused mission is more suited to downstream health promotion, whereas a church with a Kingdom of God mission aligns with upstream approaches addressing the broader social determinants of health. In Chapter six, I presented the partnership networks and funding sources of churches to demonstrate how their health promotion practice is operationalised and the extent of church reach into the community. I also explored the resources available in partnering with churches for

the benefit of community activities and engagement. In Chapters seven to nine, I explored the different types of health promotion activities and approaches that I observed. The chapters examine these practices from downstream programs for the prevention of disease and management of risk factors, to social inclusion and the creation of social capital, to being providers of material resources such as food, clothing and housing. In Chapter ten, I presented evidence of how some churches in my study are involved in addressing social determinants of health, for example through advocacy for asylum seekers and international students, the provision of education in PNG and housing for vulnerable communities in Melbourne. Finally, in Chapter eleven, I addressed the challenges of engaging with churches in health promotion. These challenges include perceptions of societal irrelevance and mistrust of churches; the difficulties that arise from managing congregation members and the moral and value positions they hold; available human and material resources, risk management when working with vulnerable populations, and understanding the mission of the church.

Combined with the data presented in each of these results chapters, the literature review (Chapter two) and theological underpinnings (Chapter three), has informed the development of a typology. The typology is a tool to assess the suitability of churches for health promotion and to identify the health promotion approach that is appropriate for different expressions of church. In this chapter I explain each component of the typology whilst drawing on the research questions of this study. I also seek to address the implications and practical use of the typology, the limitations of this research, and future directions in the exploration of the church as a partner and setting for health promotion.

THE TYPOLOGY

The typology has been created through merging an adapted framework of health promotion actions (Keleher & Murphy, 2004) and seven variables that were found to be associated with degrees of church involvement in health promoting activities. The Keleher and Murphy framework relates to health promotion interventions and maps the levels of downstream-upstream action from primary care to socioecological approaches to health promotion (Keleher, 2007c). The majority of CBHP interventions from the US are consistent with downstream and midstream health promotion actions, with the focus on disease prevention through primary and secondary interventions and communication strategies, including the provision of health information and the conduct of behaviour change campaigns (See Chapter two and also Bopp & Fallon, 2013; Wilcox, Laken, Anderson, et al., 2007; Zahner & Corrado, 2004). The CBHP in the US interventions also tended to be aimed at congregation members rather than the wider community.

The churches which participated in this study demonstrated varying degrees of health promoting programs and activities from downstream to upstream. In Table 12.1 I have listed the different church activities by health promotion approach and local church. This is to demonstrate the extent and breadth of church involvement in different health promotion actions. For example it can be seen that all churches in this study were involved in participatory health education actions as church services and church activities (for examples) are a platform by which social support and pastoral care is provided.

TABLE 10.1.1 CHURCH HEALTH PROMOTION ACTIVITIES BY CHURCH EXPRESSION

Health Promotion Approach	Activities	Traditional Churches	New Modern	Emerging
Primary Care/Disease Prevention Aims: Improve physiological risk factors (e.g. high blood pressure,) and personal behaviours	Parish nursingCounselling services Disease screening Sporting teams and walking group	Downton Catholic Parish Haworth Catholic Parish	Fortescue Church of Christ Sudbury Baptist Church Sunderland Church of Christ Longbourn Uniting Church	Benbow Church of Christ Tinworth Anglican Church
Health Education/Behaviour Change Aims: Psychosocial and behavioural risk factors (e.g. smoking, poor nutrition, physical inactivity)	Social support activities – craft groups, youth groups, homework clubs, playgroups, mothers groups, home groups/small groups/cell groups/life groups/bible studies Pastoral Care* Encouraging individuals to adopt healthy behaviours Health seminars Provide health information	Luckington Anglican Church Ponden Catholic Church McManus Catholic Church Minder Bend Uniting Church	Murcutt Anglican Church Meryton Anglican Church Fortescue Church of Christ Sunderland Church of Christ Hangleton Church of Christ Longbourn Uniting Church	Ashridge Baptist Church Burghley Salvation Army Benbow Church of Christ Redgum Church of Christ
Participatory Health Education Aims: Provision of information e.g. healthy choices, social support Development of personal skills via empowerment	Depression support group, play groups, mothers groups, youth groups Participation in church activities Mentoring programs with at risk kids; through schools Visiting nursing homes, the sick, people in hospital Drug and Alcohol programs Training programs – work for the dole, tutoring, adult literacy program Form Assist – helping people fill out forms	Luckington Anglican Church Edgecote Catholic Church Downton Catholic Parish Ponden Catholic Church Haworth Catholic Church McManus Catholic Church Minder Bend Uniting Church	Lincolnshire Baptist Church Sudbury Baptist Church Perrington Church of Christ Hangleton Church of Christ Fortescue Church of Christ Sunderland Church of Christ Murcutt Anglican Church Peverell Anglican Church Belton Baptist Church Aurorville Baptist Church Marshland Uniting Church Longbourn Uniting Church	Redgum Church of Christ Ashridge Baptist Church Salvation Army Burghley Salvation Army Wilton Benbow Church of Christ Tinworth Anglican Church Milltown Salvation Army Meryton Anglican Church Oakham Mount Baptist Church Grantham Rise Baptist Church Wilton Salvation Army Burghley Salvation Army Derby Uniting Church
Community Action Aims: Action on determinants of health; Sustainable social change; Strengthening community capacity; Empowerment	Partnership with other agencies Welfare activities – food banks, soup kitchens, community meals Advocacy for marginalised /disadvantaged populations – gambling, asylum seekers, domestic violence Being involved in community events/activities Men's shed, Drop in centre, Peace wall Community kitchen	Minder Bend Uniting Church	Sudbury Baptist Church Fortescue Church of Christ Lincolnshire Baptist church Sunderland Church of Christ Marshland Uniting Church	Tinworth Anglican Church Derby Uniting Church Miltown Salvation Army Wilton Salvation Army Redgum Church of Christ Salvation Army Burghley Benbow Church of Christ Grantham Rise Baptist Church
Socioecological health promotion Aims: Redress of inequities Works from health determinants: social, political, environmental	Community engagement and partnerships with other community agencies Community services –provision of accommodation, Employment services, food banks		Belton Baptist Church	Ashridge Baptist Church Oakham Mount Baptist church Milltown Salvation Army Derby Uniting Church Benbow Church of Christ Grantham Rise Baptist Church

*All churches were involved in providing pastoral care to church attendees and/or the wider community

Not all churches have an ethos suited to health promotion in Australia, nor the structures and systems to implement health promotion activities effectively. As I noted in Chapter three, it is important to acknowledge the heterogeneity of local churches. Churches differ markedly on major factors that how they go about 'being church', including values, mission, community engagement and partnerships. When seeking to engage with churches in health promotion, it is important to understand the dynamics of each individual church. This typology is a tool to facilitate such exploration and discussion.

Typologies are an instrument for comparing and classifying organisations into categories without compromising the complexity and diversity within each type. Rich (1992) writes that:

> Classifying organisations into types presents an alternative to the idea that organizations are either all alike or are all individually unique. It provides the basis for midrange theorizing about the forces at work within specified organizational types, and it allows the researcher to form opinions and to develop theories without resorting to "grand" style theories that purport relevance to all organizations (p. 758-759).

Typologies have been used previously in health promotion and public health to understand approaches and practice related to promoting health (Johnson & Baum, 2001; Riley & Hawe, 2009; Whitehead, 2007). For example, Riley and Hawe (2009), in a process evaluation of a large scale community cluster randomised trial, developed a typology of types of community intervention practice. They explain that their typology of practice "is not constructed to represent customary expectations or to test micro-predictions in the immediate sense. Rather, its logic involves the surfacing of fixed relationships among phenomena of interest that allow the analyst to see a meta-theme that might not otherwise be observed" (p. 4). In the same way, this typology

of churches is presented to illustrate characteristics of churches that can then be associated with practice. It draws upon themes previously unexplored in the phenomenon of CBHP, although it is not a tool of prediction: it cannot be used as an indication of hierarchy as the categories are not fixed.

Local churches often demonstrated activities that corresponded to more than one health promotion approach. In the process of categorising the local churches, the dominant approach evident in their practice of 'being church' was utilised. The typology can be used as a schematic representation of the contributions (Petticrew & Roberts, 2003) and attributes of local churches and how these can be navigated for health promotion.

DOWNSTREAM	←			→	**UPSTREAM**
	Primary Care/ Disease Prevention	**Health Education / Behaviour Change**	**Participatory Health Education**	**Community Action**	**Socioecological**
Church mission	Evangelism focused	Evangelism focused	Evangelism focused	Kingdom of God focused	Kingdom of God focused
Church expression	Traditional	Traditional/New Modern	New Modern/Emerging	Emerging	Emerging
Understanding of health	Three main domains of health: Physical, Emotional, Spiritual	Three main domains of health: Physical, Emotional, Spiritual	Holistic health	Understanding of the social determinants	Understanding of the social determinants
Church hierarchy	Top down decision making: decisions and activities driven by minister	Top down decision making: decisions and activities driven by minister	Mutual decision making: minister and congregation members involved in decision making	Bottom up decision making church members drive decisions with support by minister	Bottom up – congregation members drive decisions with support by minister/priest
Community engagement	Limited	Moderate	Moderate	Extensive	Extensive
Partnerships	Low	Medium	Medium	High	High

Figure 12.1: Typology of Christian Churches by Health Promotion Approach

Below I discuss each component (see subheadings below) of the typology to emphasise how these align with the theory, prior research and the findings of my research, and to demonstrate the applicability of this typology to health promotion practice. I then summarise the challenges

of engaging with churches in health promotion and identify the limitations of this research. I conclude this chapter by highlighting future research directions.

CHURCH MISSION AND EXPRESSION

To answer the first research question, I sought to discern how local churches understand their mission and give expression to it through addressing determinants of health. In Chapter three, I outlined three expressions of local churches, which I observed in my research and explored through theological literature, and I outlined their associated mission paradigms - traditional, new modern and emerging. I use the term 'expression' of church instead of 'type' or denomination on purpose. As I discussed in Chapter three and as highlighted in the work of Cannell (2005 and 2006), Christianity can be practiced in various forms representing differences in local culture, beliefs and approaches to biblical scholarship. Studies of Christianity need to allow for this heterogeneity and should not assume that Christian churches are homogenous. Some beliefs are consistent within a denomination, however, the practice of those beliefs may differ within a single denomination and geographical setting. Bouma (2012) identified the external (between denominations) and internal (within denominations and even congregations) diversity of Christianity, stating that these groups are less monochrome than previously believed. The changing ethnic composition of congregations, the increasing educational attainment of members, and associated economic status, all influence the beliefs and practices of churches.

As described above (chapter four), six Christian denominations were recruited for this study: Catholic, Anglican, Uniting, Baptist, Church of Christ and The Salvation Army. The Salvation Army differs from the other churches as it is modelled on a military structure. While the Salvation Army churches are more aligned to a traditional church due to a top down church hierarchy and structured formal church services, their mission, church activities and programs

were more consistent with emerging churches. This may be influenced by their strong values of social justice. Thus it is important to understand of this typology that the category of traditional, new modern and emerging is not restricted or based on denomination. Additionally not every variable is fixed in its association with health promotion action.

There is little description in the US literature regarding the expression (denomination or type) of churches used in CBHP. Most often the churches described, particularly in the studies by Wilcox et al (2007), Bopp et al (2007) and Baruth (2011), are African Methodist Episcopal (AME) Churches. Other studies describe their churches as 'Black churches' or 'African American churches' (Carter-Edwards, Jallah, Goldmon, Roberson, & Hoyo, 2006; Molock, Matlin, Barksdale, Puri, & Lyles, 2008; Resnicow et al., 2002; Yanek et al., 2001). These churches have been utilised by health promotion researchers to capture an African American population and hence these congregations provided access to the target community. My PhD study differed to the US research in that my aim was to explore how and why churches were involved in activities that promote health and wellbeing. Hence, there was not one particular vulnerable community or population to which an intervention was directed. Rather, I was assessing whether church activities were health promoting, and if so, why and how they did so. The churches selected for this study were not restricted to one particular type, denomination or expression of church.

Traditional churches believe that the church is the Kingdom of God, and hence it is imperative that people come into the church for their salvation. Throughout my results chapters, I have highlighted how the traditional church either focused on its own congregation members in health promoting activities, or ran programs in order to draw the community into the church. These churches have historically been involved in establishing and running key welfare organisations in Australia. Indeed, many of the traditional churches have links to church affiliated organisations

such as St Vincent's de Paul, and it is in these organisations which congregation members spent time volunteering and within which community engagement and services were conducted. However, the practice of traditional local churches is usually separate from the broader community. This was illustrated by the pastoral nurse role at Downton Catholic Parish, and the pastoral care activities of the Catholic churches in my sample. Due to the importance placed on receiving communion in traditional churches, the service of visiting the sick prioritised fellow Catholics to ensure that they were able to participate in this religious practice.

The mission of new modern churches is to proclaim the gospel, which is interpreted as the need to believe in the death and resurrection of Jesus Christ and redemption from sin. The focus for these churches is on the individual and the gospel is communicated as individual salvation. I have termed this mission paradigm as evangelism-focused. Church activities that may promote health therefore can be seen as an entry point to the church. New modern churches strive to be seen as relevant, and hence their buildings are contemporary, the services informal, their preachers technology-savvy. These churches generally have the capacity to run many programs that engage the wider community such as play groups, youth groups, mothers groups and welfare programs. Such activities can be, but are not always, used as a means of evangelism through building relationships with individuals, thereby offering opportunities to share Christian beliefs. The mission of the new modern church is to create avenues in which the gospel can be shared verbally.

The mission of the emerging churches is to be 'bringers' of the Kingdom of God (Wright, 2007). The Kingdom of God is not viewed purely as personal salvation (although this is one component): it is understood as bringing the influence of heaven to earth. Therefore the activities of the emerging church are more likely to align with health promotion as the agenda is not

evangelistic. Emerging churches do not hide that they are Christian, but neither do they proselytise.

The emerging church is a new phenomenon in Christianity, reflecting the changing culture of Western society to one that is post Christendom[38] and the postmodern thinking of 'Generation X'. Michael Frost and Alan Hirsch, emerging church proponents, believe that:

> The heart of the problem is that we have been planting churches that are (smaller) carbon copies of the already beleaguered, failing Christendom-style church ... an emerging missional church on the other hand has abandoned the old Christendom assumptions and understands its role as an underground movement, subversive, celebratory, passionate, and communal. Mission is not merely an activity of the church. It is the very heartbeat and work of God. The missional church, then, is a sent church. It is a going church, a movement of God through his people, sent to bring healing to a broken world (Frost & Hirsch, 2003, loc 450)

The emerging church is described as having an incarnational mission whereby the "stuff of everyday life" is where God is encountered. God is no longer restricted to church buildings, and church is not about being in a church building. An incarnational mission "enables God to be encountered back in the real world" (Gibbs & Bolger, 2005a, loc 887).

[38] Post Christendom occurs when Christianity no longer occupies the privileged center of public discourses (Willems, 2013)

Major Gregory Morgan challenges The Salvation Army church to rethink its expression of church. He believes that the practice of Salvation Army churches has become modern and thus has lost the early passion of the denomination:

> We have become programme - and building-centred. Our corps [local churches] operate from buildings which they expect the community to come to, and are surprised at the limited effectiveness of this method. Our social welfare expression has become large, professional and programme-based. But this is a far cry from the early essence of The Salvation Army, which passionately believed in, and practised, incarnational mission (Morgan, n.d., para 16).

The foundation of The Salvation Army is based on principles of the emerging church. As Cleary says of its founders:

> Catherine and William Booth were in the midst of a battle for the world. They believed the world needed saving, that the Good Society required True Religion. The mission of The Salvation Army was to redeem the world - literally, to help make it "good" - to participate in building the Kingdom here and now (Cleary, 2013, p. 69)

Each of the three Salvation Army churches in this study were classified as emerging churches. Emerging churches seek to be a movement as opposed to an institution, seeking to bring the influence of heaven to earth and for that to be their witness (Murray, 2010).

Derby Uniting Church might appear to be a traditional church as the congregation meets in a church building with a steeple and stained glass windows. Wooden pews are set in rows and there is a centre aisle. Formal church services are held on a Sunday morning with communion, singing of hymns and preaching. However the mission, ethos, values and activities of Derby

Uniting Church demonstrate postmodern thinking, and hence I have classified it as an emerging church. Derby is not congregation-focused in its activities (see Chapter ten); this was illustrated by Samuel, the minister, flinging open the back doors of the church building to reveal the towering housing commission flats while proclaiming: "These are our neighbours!" The activities of Derby Uniting Church occur within the church building but also at the housing commission flats.

Redgum Church of Christ is a contrast to Derby Uniting Church in many ways, yet I also categorised Redgum as an emerging church. This church was established through the efforts of a food bank that had been operating in the area by a group of Christians for a number of years. They began as an independent church, but in the past few years, have aligned with the Churches of Christ Victoria Tasmania to access insurance and legal support as a church entity. The church however operates in a very fluid and flexible manner. An informal service is held on a Sunday afternoon in an old Uniting Church hall. The chairs are set up in a round circle, games are played, a brief sermon is spoken, challenges and highlights experienced by the members are shared with the group, and the service concludes with a meal. There is no priest or minister, rather the service is moderated by a group of staff members and volunteers from the parachurch organisation UNOH. As discussed in Chapter eight, the UNOH staff and volunteers desire to be responsive to the needs of the wider Buckley community and they engage in community activities such as meals, the foodbank, and girls' and boys' clubs. They also endeavour to build intentional relationships with those who are vulnerable, as illustrated in the story of John and the Sudanese boys (see page 179-180).

The UNOH workers sell or give away their possessions and live in circumstances of poverty amongst vulnerable communities of poverty in Melbourne, but also Sydney, Thailand and

Auckland (UNOH, 2013). This solidarity with the poor requires the sacrifice of various comforts of the self. The ethos of Redgum Church of Christ is universal acceptance, regardless of race, beliefs or creed, and its members strive to translate ideas of social justice to the disadvantaged streets of Buckley. Derby Uniting Church and Redgum Church of Christ are churches from two different denominations, but in my dissertation, I have classed them both as emerging churches because of their similar values, theological orientation, and their expression of church in their communities.

New modern churches have relatively large congregation sizes and meet in modern well equipped buildings. Previous research has found that large congregations with substantial budgets are more likely to provide social service programs and specialised ministries (Trinitapoli, Ellison, & Boardman, 2009). However, my research did not support these findings. Congregation size did not seem to influence engagement with health and wellbeing activities which were open to community members, rather than specific to church members. A number of emerging churches (Derby Uniting Church, Benbow Church of Christ, Redgum Church of Christ and Milltown Salvation Army) comprised of small congregation numbers, yet their activities were accessed by large numbers of community members throughout the week. It seems that church mission which influences church expression is a greater predictor of church engagement with health promoting activities than congregation size.

Churches classified as traditional tended to operate at the downstream end of health promotion with activities around health information seminars, disease screening and health risk assessments. New modern and emerging churches differed in the types of activities they offered. Their activities were more midstream and upstream in nature and included mentoring programs, social support activities, training programs (for example, computer training programs and

literacy programs) and community development and advocacy. Emerging and new modern churches also engaged in advocacy efforts and the provision of community services such as crisis accommodation and mental health/counselling services.

UNDERSTANDING OF HEALTH

Contention regarding the meaning of health is common as health can have medical, social, economic, spiritual and other components which, in turn, are influenced by gender, social class, science and the environment (Keleher et al., 2007; Larson, 1999). Many different models of health proposed have been utilised over the years, which have reflected the changing characteristics and understanding of the etiology of disease, emerging disciplines, and different notions of health determinants (VanLeeuwen, Waltner-Toews, Abernathy, & Smit, 1999).

Churches were more likely to engage in upstream health promotion activities if they understood health to be more than the physical, emotional and spiritual dimensions of life. Although none of the church leaders articulated an understanding of the terminology "social determinants of health," some recognised the impact of social issues such as homelessness, social exclusion, lack of education and unemployment on the health and wellbeing of individuals and communities, and attempted to address these issues through church activities, programs and advocacy. These churches adopted community action and socio-ecological approaches to health promotion (see Chapter 10) and acknowledged the economic and social structures which precipitated and entrenched disadvantage. Milltown Salvation Army, located in rural Victoria, was involved in running addiction programs and partnering with other community groups to deal with addiction and mental health in their community. Derby Uniting Church set up an employment training program for newly arrived migrants and unemployed Australians living in housing commission flats in an inner city suburb of Melbourne. Cafes and opportunity shops/thrift stores were set up

and run by churches (Oakham Baptist Church, Ashridge Baptist Church, Sudbury Baptist Church, Aurorville Baptist Church, Redgum Church of Christ and Milltown Salvation Army), to raise awareness and funds for community or global issues. Two churches (Sunderland Church of Christ and Fortescue Church of Christ) assisted asylum seekers in accessing food and warm clothes, provided metcards[39] to facilitate transport, and community meals as a means for social support and connection. Additionally, Beriah Mission, a small church affiliated agency with strong connections to local churches, was involved in advocacy for asylum seekers at local, state and federal government levels. These church activities are examples of the church engaging with the social determinants of health with a greater emphasis on community and political context.

Churches that believed health incorporated the holistic components of physical, mental, emotional, social and spiritual were more likely to initiate and implement participatory health education activities such as financial counselling, computer classes, literacy programs, healthy eating programs and life advice. In these programs, an empowerment approach was adopted. Many of the initial program attendees for case study churches Milltown Salvation Army and Benbow Church of Christ became volunteers in the activity. The churches provided volunteers with training opportunities and hence empowered them with a skill set that enabled a few of them to go on to obtain employment. Church activities seeking to tackle issues such as social isolation and lack of support included the Life program (Sudbury Baptist Church) and COACH Community Mentoring Program (Grantham Rise Baptist Church) (discussed in Chapter eight).

[39] Metcard was the brand name for tickets used to access public transport (trains, buses, trams) in Melbourne. These were discontinued in December 2012 and replaced by the MyKi ticketing system.

These programs sought to improve school attendance, self-esteem and confidence, social network and family dynamics, and access to health and social services

The churches operating within a downstream health promotion model understood health as being the three domains of physical, emotional and spiritual health. The programs reflected this understanding and adopted approaches that aligned with disease prevention, and health education actions to health issues. For example, Ponden Catholic Parish, a church with a predominantly elderly population, organised different health professionals to run a seminar on health and ageing. Other churches ran mid-to-downstream health promotion activities such as cancer support (Longbourn Uniting Church) and depression support groups or information sessions for sufferers and/or carers (Lincolnshire Baptist Church, Murcutt Anglican Church, Longbourn Uniting Church). Ashridge Baptist Church, an emerging church, also ran a depression support group called Mind Health (see Chapter seven). This group was open to those outside of the church community and aimed to improve health literacy and provide an avenue for social inclusion. Fortescue Church of Christ also ran a church service specifically tailored for people struggling with mental health issues such as depression and anxiety, and recognised that a church service could be difficult for someone to engage in if they are not feeling comfortable around people. The services are low key and simple, with smaller groups of people attending.

Engagement with sectors beyond health is required to address the social determinants of health meaningfully (Marmot et al., 2010). These sectors have different agendas and missions that guide their involvement with communities and the work that they do. Health promotion knowledge amongst church leaders, for the most part, was poor and limited to simple initiatives such as health education and media campaigns about weight loss to prevent or reduce the morbidity associated with diabetes and cardiovascular disease. However, in interviews, most

church leaders appreciated the broader implications of health promotion as they asked questions in response to my line of questioning:

> Probably it would be it is helpful to think about health promotion from your vantage. So I found it helpful for me to go 'Oh okay in the framework of health promotion, yeah there's all kind of healthy stuff - stuff that promotes health and wellbeing, bio, psycho, social, spiritual - you know dynamics that are provided here [at Ashridge Baptist Church] all the time (Andrew, Senior Minister, Ashridge Baptist Church, urban)

As I discussed in Chapter five, how churches understood health, and consequently health promotion, influenced how they engaged with health promoting activities. Overall churches believed that they had a role to play in promoting health but this was influenced by how they conceptualised health. Churches were involved in promoting health as a by-product of other activities. However, there was the recognition, particularly in emerging churches, that churches have a unique role in that they often seek to befriend vulnerable individuals and communities, and through programs aimed to address underlying causes of poverty and exclusion. Emerging churches appreciated the broader determinants of health such as education, family, social inclusion, unemployment and employment conditions, and were actively engaged in advocacy and provided programs that address these issues.

These findings regarding health promotion conceptualisation and the associated approaches to health promotion are consistent with the previous literature on health promoting settings. Johnson and Baum (2001), for example, developed a typology of health promotion hospitals based on a case study of an Adelaide hospital. The authors distinguished four different approaches to health promotion in the hospital setting: 1) doing a health promotion project 2)

delegating health promotion to the role of a specific division, department or staff 3) being a health promotion setting and 4) being a health promotion setting and taking action to improve the health of the community. Approaches three and four require organisational commitment to extend the role of the organisation to be health promoting. The authors report that the level of health promotion engagement depends on how the hospital conceptualises health promoting hospitals. If the hospital understands health promoting hospitals to be about doing a project, the staff will view health promotion as a marginal role for one staff member or an external person. However, if health promotion is incorporated as a core responsibility of all hospital staff members, the hospital is more likely to integrate health promoting policies, programs and activities into the practices of the hospital, and to be involved in promoting health to the wider community.

In this study, churches which understood that health is influenced by the social determinants of health were more likely to consider that they have a role in health promotion, and to be actively engaged in upstream health promoting activities. Churches that understood health holistically were involved in midstream programs such as social support groups, and churches conceptualising health consisting of physical, emotional or spiritual domains were more likely to be involved in discrete health projects such as educational seminars.

CHURCH HIERARCHY

The settings approach has been criticised by some for propagating a one-size fits all intervention for settings, while disregarding the impact of place and organisation dynamics. Poland (2009) argues for the need to analyse the setting to ensure that interventions are designed, implemented and sustained successfully:

> To optimize the likelihood of success (buy-in, organizational and personal change, etc), careful stock must be taken of the local place-specific context of intervention. A detailed analysis of the setting (who is there; how they think or operate; implicit social norms; hierarchies of power; accountability mechanisms; local moral, political and organizational culture; physical and psychosocial environment; broader sociopolitical and economic context, etc.) can help practitioners skilfully anticipate and navigate potentially murky waters filled with hidden obstacles (p. 506)

The need to understand the values, mission, resources and organisational style and structure of organisations in health promotion partnerships has long been recognised as good practice (Goldman & Schmalz, 2008; Radermacher, Karunarathna, Grace, & Feldman., 2011; Thompson & Stachenko, 1994). For local churches, it is vital to understand not only the expression of church, as described above, but also the hierarchy of the church in terms of power and authority structures.

Research from the early and mid-90's showed that denominations of low hierarchy were more likely to encourage civic and community engagement (Barnes, 2005). Cavendish's (2002) study of Black and White Catholic Churches in the US also found that the internal structure of the church influenced the extent to which churches engaged with the community. Parishes of low hierarchy were more likely to be socially active (Cavendish, 2002). Cavendish refers to a study conducted by Verba et al (1993), which used data from a large scale survey of voluntary activity of the American public with an oversampling of African-American and Latino residents. Verba and colleagues observe that "Protestant and Catholic churches differ ... Protestant congregations tend, on average, to be smaller; most Protestant denominations allow for greater lay participation in the liturgy, and most Protestant denominations are organized on a congregational rather than a

hierarchical basis" (Verba, Schlozman, Brady, & Nie, 1993, p. 481). The lay participation of congregation members in leading church services, ministries and church activities was also more prevalent amongst the new modern and emerging churches in my sample. Consequently, these churches had more flexibility to respond to community needs and initiate and implement health promoting activities. Traditional churches, however, tended to be formalised in their hierarchy and hence relied heavily on the leadership and direction of the church priest.

In many CBHP interventions in the US, the church minister is a key person in establishing and implementing the intervention (Bopp, Lattimore, et al., 2007; Campbell et al., 2007b; DeHaven et al., 2004; Peterson et al., 2002). Sutherland (1995) found that the role of the minister as church leader and spiritual director is vital as the minister is often the person who determines the church's involvement in health promotion activities. The minister bridges the gap between the church members and community health promotion efforts; is able to offer the church facilities for health promotion activities; and is a social change agent, policy maker and program developer. However, in this study I found that lay congregation members played a key role in effecting health promoting activities, mostly with the support and guidance of the minister. For example, the community meal and children's program run in the housing estate of Grantham Rise was initiated by a Bible Study group from the church. With support from the senior minister of Grantham Rise, activities led to the establishment of a food bank, financial counselling and family mentoring program (the COACH program), in order to effectively meet the needs of this community. Such activities now comprise a large component of the church's programs and utilise church resources, staff, and volunteers. The initiative for these activities was from lay church members as opposed to church staff. Hierarchical churches such as traditional churches provide

fewer opportunities for members to develop community engagement skills than less hierarchical congregation-based churches (new modern and emerging) (Campbell, 2004).

In a quantitative study of community action through Black churches in the US, Barnes (2005) found that prayer groups facilitated community action more consistently than sermons or the use of spirituals (African-American music). This is again an example of how the members of the congregation can participate in a bottom-up response to community issues. Barnes calls for further research to explore in greater detail the influence of prayer as a mediator to social action. Sutherland (1995) also found in her role analysis of two case studies of CBHP programs in the US that the church member was important in the initiation of programs, serving on management committees, providing individual leadership, advocacy, service provision (after appropriate training), serving as a role model, and assisting with the institutionalisation of initiatives within church governance structures and processes (Sutherland et al., 1995).

The divergent case in terms of hierarchy in my study is the Salvation Army churches. The Salvation Army adopts a military hierarchy as an organisational structure (chapter one). The Salvation Army churches in my study (three in total - Milltown, Wilton and Burghley), although hierarchical in nature, were classified as emerging churches due predominantly to their understanding of church mission and their incarnational practice in community. The Salvation Army corps in my study were either incorporated as a community service centre (Milltown Salvation Army) or were connected to one (Wilton and Burghley).

An understanding of the hierarchy of the local church is a useful guide for how to engage with churches. A church with a high level of hierarchy will require discussions regarding partnerships or potential health promoting activities with the church leader, or with a nominated staff/church

member with the approval of the priest. At times, as with The Salvation Army, proposals need to be signed off by senior people within the denomination (such as the Commissioners at the Territory level). Knowing the due processes and protocols will aid in respectful and meaningful engagement. Non-hierarchical churches allow church members to initiate and conduct health promoting activities with the support of church staff and council. Therefore health promotion discussions do not always need to involve the senior church staff and do not need to go through approval processes at the state level.

COMMUNITY ENGAGEMENT

Religious organisations are significant contributors to the fabric of civil society. Members of religious organisations are provided with opportunities to participate in society through volunteering in welfare activities, organising events and programs, and (particularly in the US) political activism (Clemens & Guthrie, 2011). Andrew Orton, in his thesis examining good practice in Christian community work, defined Christian community work as "the involvement of individual Christians and church congregations in activities which address the concerns of the wider community, and which are not just for the benefit of the existing congregation" (Orton, n.d., p. 16). Community engagement or community work is predominantly referred to as "outreach" in Christian discourse. Despite being used interchangeably, outreach should not be confused with evangelism. Outreach implies an action; evangelism is a message.

Challies (2004) states that "when a church engages in outreach, it is reaching out to the community in order to meet needs or to let people know of its existence" (Challies, 2004, para 8). Outreach activities include the welfare programs and provision of material aid that I

described in chapter nine, but can extend to creative endeavours such as establishment of nightclubs and the Red Frogs[40] initiative during schoolies[41] in Queensland, which sees Christian volunteers assisting young people to stay safe during and after drinking and partying. At times, an outreach activity may be used as a platform for evangelism, but the two are not necessarily linked.

I have used the term community engagement in my thesis to make the distinction between professions who are involved in community work (for example, social workers) and to adopt the terminology used in both the Christian literature and health promotion discourses. All churches participating in this study were asked whether the church activity or program was open to the community or only to church members. The results can be placed on a continuum. At one extreme in some churches, only members of the congregation were eligible for pastoral care (Edgcote Parish, Downton Catholic Church, Ponden Parish, Haworth Catholic Church, McManus Catholic Church), attendance at health seminars, or access to the pastoral nurse (Downton Catholic Church). These churches tended to be of the Catholic denomination and traditional in expression. An explanation of this observation is that Catholic churches have significant welfare organisations and local churches may view their role as tending to their congregation members whereas the welfare organisations are the 'coalface' of their community work. Mid-way along the continuum are churches where activities are directed at congregation members, but are open to the broader public. For example, the parenting courses, marriage

[40] see http://au.redfrogs.com/schoolies for more details

[41] Australian high school graduates take a week long holiday following final examinations usually in late November. This week is characterised by high levels of alcohol consumption and party behaviours.

courses and depression information night run by Murcutt Anglican Church was for church members but they were welcome to bring friends. At the other end of the continuum, churches provided activities for community members, such as the community meals programs by Benbow Church of Christ and Redgum Church of Christ, the youth group of Meryton Anglican Church and the mentoring programs of Sudbury Baptist Church and Grantham Rise Baptist Church.

The community engagement efforts of churches can also be influenced by a perceived compatibility with the beliefs of different populations or groups. For example, the priest at McManus Catholic Church, while acknowledging that the church had a responsibility for all people, stated that programs were specifically for the Sudanese refugees, as they were more likely to share the Catholic faith and the church had a primary responsibility to this community. These observations are supported by previous research establishing that religious beliefs led people to separate themselves from others and engage only with those they perceived to share their values and principles. Park and Smith (2000) term this "community insularity." These congregations still have members who volunteer, however, their volunteer efforts are directed at the church and not the local community. As Uslanser (n.d) notes:

> Religion, then, has complex relationships to civic engagement. Members of liberal (or non-fundamentalist) denominations are likely to reach out beyond their own faith community to work with others and to help people in need who are different from themselves. Fundamentalists will respond to the spiritual demands to do good works, but will focus their efforts on people like themselves. And Catholics may, if Putnam is correct, be less likely to participate in civic affairs altogether (p. 3).

Church hierarchy and the structure of the church influences the parameters of community engagement. However, this is not the only variable. Other factors include church history in community involvement, denominational polity, socioeconomic status of the members, infrastructure of the local church, church culture, theological interpretations, education levels of the minister and size of congregation (Barnes, 2005). In a study of Black and White Catholic Churches in the US, it was found that the racial composition of the parish significantly influenced whether the church engaged in social services and social action (Cavendish, 2002). An explanation for this observation is the institutional centrality of the Black church in African American history and culture, contributing to community cohesion and political activism during a history of racial oppression (Cavendish, 2002). In a quantitative study of 1 863 Black churches in the US, Barnes (2005) examined the cultural components of the Black church – gospel music, prayers and sermons, and whether this was associated with community action. Community action was assessed via seven variables: 1) community service; 2) youth programs; 3) food pantries; 4) substance abuse programs; 4) voter registration programs; 6) prison or jail ministries; and 7) social issues advocacy programs (Barnes, 2005). Barnes (2005) found that Black Church culture was an important proponent for community action, with church prayer groups and gospel music being highly associated with community involvement. Scripture and sermons were not found to be a significant motivator for community action with focused messages (race issues, liberation themes, social justice) and scriptural applications having a greater influence (Barnes, 2005).

Parks and Smith (2002), in their analysis of 1 738 American church-going Protestants, found that the church played a positive role in empowering church members in volunteering in their neighbourhood, with volunteering more likely to be through church associated activities as

opposed to non-church activities. In Australia, the National Church Life Survey found that church attendees were more likely than non-church attendees to volunteer (57% versus 35%) and volunteering within a church congregation is strongly correlated with volunteering beyond the congregation (National Church Life Survey., 2010).

Volunteers

Church community engagement activities require developing a volunteer base with one of the key health promotion outcomes being the creation of social capital amongst the volunteers and also within the community. Volunteering has been defined as "any activity in which time is given freely to benefit another person, group, or organization" (Wilson, 2000, p. 215). Volunteering requires a significant commitment of time and effort when compared to just being a member of a civil society organisation (Uslaner, n.d.). Sociologists have found that the motive for volunteering based on values is weak and inconsistent, and religious values do little to encourage volunteering (Wilson, 2000). This assertion is supported by the 2004 report by Volunteering Australia, with volunteering due to religious beliefs being the lowest ranked reason for volunteering (Volunteering Australia, 2004). The main motivation for volunteering is altruism (Volunteering Australia, 2004). Personal reasons such as satisfaction, learning or using skills and experience, and for social contact, are other motivators for volunteering.

Park and Smith (2000) assessed influences of religiosity, religious identity and socialisation on volunteering activities in church and non-church programs. This quantitative study found that those who regularly participated in church activities were more likely to be involved in volunteering in both church activities and non-church activities. Those whose parents adopted the label 'theologically liberal' were more likely to engage in general volunteering, as opposed to those whose parents identified as fundamentalists. Individuals who identified with Christian

labels such as 'charismatic' were less likely to volunteer. Overall these results suggest that the relationship between Christianity and volunteering is intricate and not linear.

Altruism is a core value of the teachings of Jesus and can be captured in His commands to "Love your neighbour as yourself", "Love your enemies" and parables such as the good Samaritan (Ma, 2009). This call to self-sacrificial love is termed agape love, and reflects God and Christ's love for humanity (Tillman, 2008). Agape love is promoted in the Bible as a means to ensure healthy community (Tillman, 2008) and to fulfil the vision of the Kingdom of God whereby values of heaven are evident on earth (Wright, 2007). It is agape love that will provide clothing, food and shelter to people in need. There is much variation in how Christian traditions have adopted the term agape in terms of mutuality, altruistic actions and the promotion of self above others; such a discussion is beyond the realms of this dissertation. However altruistic behaviours can and are promoted by local churches. In particular, self-sacrificial ministries and activities were evident in the mission and practice of emerging churches.

Throughout this dissertation, I have illustrated the altruistic nature of and engagement with the communities by churches in my sample. For example, Ashridge Baptist Church with its Community Engage Sundays held every couple of weeks. Instead of a church service, the members of the congregation participate in backyard blitzes, provide respite care of children with cerebral palsy, cook meals for soup kitchens, and undertake other projects identified through their connections with the community. The work of the UNOH workers and volunteers of Redgum Church of Christ, their engagement with vulnerable community members, could be regarded as another example of agape love propagating community action and transformation. Reflected in the stories of many of the study participants are the themes of journeying with people and intentional relationship building. For some church attendees, these activities requires

sacrifice of self, as in the case of UNOH, reflecting a higher calling to a Kingdom mission of healthy communities.

Nezar Alsayyad (2011) asserts that evangelists and preachers have called on their white middle class urban congregations to overcome their separatist and indifferent attitudes to the urban poor and to be involved in social outreach ministries, and he believes that these actions are inhibited by ingrained Christian fundamentalism.

> The legacy of Christian fundamentalism remains strong among white evangelical churches, impeding the institutionalization of outreach efforts with premillennialist eschatological beliefs, lingering scepticism towards social activism, and racially tinged preconceptions about the nature of urban dysfunction ... Consequently, the urban social landscape, particularly the inner city, becomes a complex mission field where competing and overlapping religious impulses converge (Alsayyad, 2011, p. 236)

The relationship between how and why churches engage with community is complex and relates to different expressions of church. As I mentioned earlier, outreach and evangelism are not synonymous, although there is the assumption that all churches will combine outreach with evangelism. This was not reflected in the ethos of all churches in my study, and some church leaders strongly articulated that they were here to serve the poor and marginalised and address inequities and be friends to the lonely - with no proclamation in words of the gospel.

This does not sit well with other churches whose church leaders, mostly from the traditional expression of church, critique emerging churches for focusing on social justice at the cost to the gospel. The stance churches take on this is related to how they understand what the gospel is (i.e. individual salvation to ensure eternity is spent in heaven or incorporating community and

bringing the values of heaven to earth). Proponents of the emerging church believe that traditional and new modern expressions focus excessively on individual salvation and the afterlife.

Creating Social Capital

Robert Putnam has received much political and academic attention for his work on social capital, defined as "the features of social organization, such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions" (Putnam, 1993, p. 167). Voluntary organisations, such as churches, have been identified as propagators of trust contributing to social capital as they create norms of reciprocity, facilitate communication, and encourage community collaborations (Putnam, 1993; Siisiainen, 2000). As described in chapter eight, pastoral care is a core activity for many of the churches in this study. Pastoral care differs to counselling, therapy and social work and it is a practice that extends beyond professional and formalised practice. Oliphant (n.d) defines pastoral care as:

> "the necessary care shown to all members to help them feel part of a community, to feel loved and accepted within the network of personal relationships that make up that community; and it is the caring actions needed to help members resolve difficulties, heal hurts, reconcile differences and forgive transgressions in personal inter-actions within the community (para 3)."

Many of the activities described as pastoral care ventures by churches promoted social support, social connection and social capital. Social capital is a core component of healthy communities as it promotes collective action for mutual benefit (Kawachi, 1999; Putnam, 1995), and provides

avenues for what Putnam terms bridging social capital and bonding social capital (Manderson, 2010; see further below).

Churches create a space for both bridging and bonding social capital. Bonding social capital is evidenced by the friendships formed and the sense of belonging church attendees report from attendance at church activities. The volunteers of the Helping Hand Cafe at Benbow Church of Christ described how the cafe provided them with a place to go and a place to interact with people. Every church in my study ran Bible study groups (also termed cell groups, life groups, small groups). Putnam observed the bonding phenomenon created by Bible study groups in one of the largest churches in the US - Saddleback Church, located in Southern California, in an area that is described as 'friendless' and with a congregation size exceeding 20 000 members. With a church of this size, it would be easy for there to be a reduction in social capital. Gladwell (2005) comments that the social connections that form community may be a causality of congregation growth. He notes that as "the ties among members become increasingly tenuous—then a church as it grows bigger becomes weaker" (para 8). What Putnam noticed at Saddleback Church was surprising. Despite being a large church, social capital was created and maintained through Bible study groups of 8-10 people, who met together regularly for social, spiritual and emotional support, and at times physical activities:

> It's a very friendless place, and this church offers serious heavy friendship. It's a very interesting experience to talk to some of those groups. There were these eight people and they were all mountain bikers—mountain bikers for God. They go biking together, and they are one another's best friends. If one person's wife gets breast cancer, he can go to the others for support. If someone loses a job, the others are there for him. They are

> deeply best friends, in a larger social context where it is hard to find a best friend (Putnam, as quoted by Gladwell, 2005)

Socially isolated places, such as rural communities, also benefit from church activities which draw members of the community together. This was seen at Lincolnshire Baptist Church and also Meryton Anglican Church (see Chapter 8). Fortescue Church of Christ, Redgum Church of Christ and Ashridge Baptist Church provided pastoral care services and activities tailored to individuals struggling with mental illness. Churches were involved in creating an environment where the social space did not demand 'normal' participation, while providing volunteers and leaders who were able to reach out and journey with individuals who were struggling with life circumstances.

Bridging social capital, defined as the connections made by individuals outside of their typical social boundaries (Manderson, 2010), was demonstrated in numerous ways in my findings. Particularly in emerging churches, programs and activities brought in sections of the community that would otherwise have little interaction. Whitehead (2005), in her typology of actions to address health inequalities, describes the need to strengthen communities through social interactions spanning social statuses. Wuthnow (2002) discusses this type of status as bridging, as it spans the gradients of power, wealth, influence and prestige. A pastoral care example of this is the COACH mentoring program at Grantham Rise Baptist Church where middle class high functioning families are matched to vulnerable families from a nearby public housing estate. Much of what the volunteer mentors were able to offer the mentee families was assistance in navigating social systems such as Centrelink, providing access to resources and information and in some instances, connection to job opportunities. As Whitehead (2005) notes, "the underlying theory behind the vertical initiatives is that fostering solidarity throughout society produces a less

divided society, one with smaller social inequalities and hence more equitable access to the resources for health"(pg 474).

Bridging social capital is also exhibited within congregations as different cultures, ethnicities, sexual orientation and age groups come together in a forum that is not promoted in other contexts. Wuthnow (2002) refers to this as identity bridging, as it overcomes the mentality of 'us' and 'them' and facilitates mutual respect. That is not to say that identity bridging is an easy undertaking. As highlighted in Chapter eight, with regard to Sunderland Church of Christ, the congregation members needed to be educated regarding the diverse ethnicities, socio-economic status and sexualities of parishioners. Congregations were diverse in most churches in this study.

Understanding how the church engages with the broader community is important to understand the potential scope of health promotion programs. Churches that run activities and programs for their congregation members are suited to a settings based approach for health promotion. However, churches engaging with the broader community, in which church programs and activities are open to the public, may be more suited to a partnership approach to health promotion. Churches more actively engaged with the community are also more likely to form partnerships with other community groups and social services and hence have a potential role in addressing the social determinants of health.

PARTNERSHIPS

An important focus in this thesis, driven by my third research question, has been the nature and extent of partnerships with local churches to promote health and wellbeing. Two of the priority areas for health promotion in the 21st century identified in the Jakarta Declaration (World Health

Organization, 1997) were to consolidate and expand partnerships for health and to increase community capacity:

> Health promotion requires partnerships for health and social development between the different sectors at all levels of governance and society. Existing partnerships need to be strengthened and the potential for new partnerships must be explored (p. 3)
>
> Health promotion is carried out by and with people, not on or to people. It improves ...the capacity of groups, organizations or communities to influence the determinants of health...social, cultural and spiritual resources need to be harnessed in innovative ways (p. 4)

Later in the Bangkok Charter for Health Promotion in a Globalized World (World Health Organization, 2005), partnerships and alliances with civil society were highlighted as a required action to create sustainable health promotion efforts.

In public health and health promotion, partnerships and collaborative action have been increasingly adopted to address health issues (Roussos & Fawcett, 2000). Some drivers behind public health partnerships include a multi-sectoral approach to the social determinants of health that address determinants outside of the health sphere, and tap into the expertise and resources of other sectors.

Trinitapoli and colleagues (2009) highlight work by Chaves (2004) and Ammerman (2005), noting how congregational practices in health associated programs are impacted by organisational networks and the broader external context. Through such networks and connections, local congregations may learn of firstly, the health and social issues affecting the community, and secondly, of other churches which may also be working to address these

problems (Trinitapoli et al., 2009). The US National Congregation Study of 1230 churches found that churches with religious and secular connections were twice as likely as churches with no collaborations to sponsor health programs (Trinitapoli et al., 2009). These findings are consistent with what I found in my study. The presence of partnerships with external organisations is an indicator of the suitability of a church to be engaged in health promotion.

In Chapter six, I described the level of partnership engagement and partnership networks of the churches. Figure 6.3 (see chapter 6) highlights the different levels of partnership (low-high) by church expression. This varying degree of partnerships is incorporated into the typology (Figure 12.1). Traditional churches tended to have low level partnerships and were less likely than other churches to partner with government or other community organisations. Their services predominantly focused on congregation members (for example, Downton Catholic Parish). These partnerships tended to be at the level of networking. New modern churches were involved with mid-level partnerships and partnered with local schools, hospitals, and other community groups to a greater extent than traditional churches, and the size of church facilities and congregations allowed them to offer resources for health promotion action. Emerging churches in this study showed the highest level of partnerships and collaborations for health. They worked with organisations spanning government, educational and community, sharing resources, expertise and responsibilities. For new modern and emerging churches, partnerships extended from coordination to collaboration type activities.

Catholic churches tended to partner with other Catholic churches and Catholic organisations. Todd (2012), in his ethnographic study of two faith networks for social justice, found that homogenous religious groups (in his case, a network comprising of Christian churches only) enabled greater cohesion and functionality. However, inter-faith networks that bring together

different religious groups shared similar motivations to work for justice, human rights and dignity and hence had common values to enable cooperation and collaboration (Todd, 2012). In my study, Milltown Salvation Army church and Oakham Mount Baptist church were two small churches that work in the same suburb and were part of a inter-faith network of religious groups in the area. Benbow Church of Christ also participated in a network of churches to avoid duplication of services and programs in the area. Todd (2012) also highlighted the importance of theological orientation of churches in influencing engagement in partnerships and collaborations with secular and government organisations for social action. Chaves (2001) found that Liberal and Protestant churches were more likely to participate in such partnerships than Conservative churches, which tended to focus on their own congregation members only. These findings are consistent with results from this research.

Conflicting agendas and resource allocations

Partnerships with any organisation for health promotion should be undertaken after careful consideration of the mission, values, resources and roles and responsibilities of each partnering organisations (Levy, Baldyga, & Jurkowski, 2003; Mitchell & Shortell, 2000). Pertinent to this is recognising the limitations and challenges associated with partnering with churches. Bopp and Webb (2012) researched the role of the mega churches in the U.S as a partner and setting for health promotion interventions, due to their extensive reach and the ethnic and age diversity of congregations. They argued that while mega churches had significant resources and were better equipped than smaller churches, they still faced issues of resource allocation (staff time and facilities) for competing church activities (Bopp & Webb, 2012). They also suggested that to capitalise on mega churches as a partner for health promotion, education efforts, and conversations with church leaders and key stakeholders were needed to highlight the benefits of

churches engaging in preventative health activities (Bopp & Webb, 2012). Within these education efforts and dialogues, it is important to find a common language and to acknowledge the perspectives of churches (Kegler et al., 2010).

Churches also need to accept the value positions and agendas of health promotion organisations, and need to gain an understanding of the terminology used in health promotion and what health promotion action entails. As discussed earlier, how churches understand health and health promotion will either compel them to engage in such activities or limit their engagement. Churches which view health as multifaceted (new modern and emerging) are most likely to appreciate the need for sectors outside of health to participate in health promotion efforts.

As discussed earlier, community engagement methods and partnerships may be a strategy for proselytising and may be used to impose moral values and religious views on vulnerable individuals. Hence, the goal of the partnership needs to be defined to ensure that local churches do not impose an alternate agenda to the work of the partnership (Goldman & Schmalz, 2008) (Goldman and Schmalz, 2008). As Clemens and Guthrie note:

> Although evangelicals are known as staunch individualists, at the same time their strategies of cultivating and utilizing broad-ranging social and institutional relationships are meant to advance regimes of moral governance in civil society that resonate with orthodox Christian sensibilities (p272).

Kegler (2010) noted that participants from the health sector expressed a discomfort in partnering with churches. The discomfort came from suspected alternate agendas from churches and fears that they would encourage healing by prayer. Some of the church leaders and volunteers in this

study also felt that secular agencies were uncomfortable to partner with them because of different values and a fear that they would seek to convert program participants.

CHALLENGES TO ENGAGING WITH CHURCHES IN HEALTH PROMOTION

Much of what has been written in relation to churches, public health and health promotion highlights a discord in values, as documented in relation to reluctance to promote condom use to prevent sexually transmitted diseases such as HIV (Agadjanian, Sen, Agadjanian, & Sen, 2007), the status of women in traditional and conservative churches (Manning, 1999; Scott, 2002) and abortion debates (Martin, 1999; Schenker, 2000). In Chapter eleven I described the themes arising about challenges and limitations in engaging with churches in health promotion in response to the final research question. Unlike Kegler et al (2010), who interviewed representatives from both sides of faith and health partnerships, my findings predominantly capture the thoughts and perceptions of church leaders and members. However, my findings closely align with those described by Kegler. For instance, Kegler quotes health leaders as saying that they would not consider partnerships with churches due to concerns of how they define and operationalise health. Health leaders acknowledged that they were not always aware of the mission paradigms of local churches and have previously imposed health promotion activities on churches instead of working with them to address health issues.

Kegler identified themes of distrust from the health sector and lack of resources from the churches; these were also evident in my findings. Kegler also noted that churches at times did not work well together. The different expressions of churches explored and corresponding church missions may lead to conflicting ideas of how churches should operate in community.

Some of the churches in my study, particularly those which engaged with vulnerable individuals affected by mental health issues, drug and alcohol addictions, homelessness, and family violence and communities (for example, in public housing commission estates, newly arrived migrants and refugees), articulated concerns around risk management for the protection of the church, volunteers and the community. Screening and training of volunteers for activities such as food banks, mentoring programs and community meals were paramount to ensure that volunteers were equipped with appropriate skills and understood the boundaries of their role (Hutchison & Quartaro, 1993; Schmiesing & Henderson, 2001).

These important issues of risk management and liability for church volunteers working with vulnerable populations has been given little attention in the CBHP literature, although much has been written about volunteers and risk management generally (see for example Hannem & Petrunik, 2007; Martinez, 2003). The mission of emerging churches is to see transformation in society, particularly in the areas of injustice and inequities. Therefore many of these churches were engaged in activities such as working in areas considered unsafe (see for example Redgum Church of Christ, Sudbury Baptist Church, Benbow Church of Christ) or with populations that were vulnerable (see for example Grantham Rise Baptist Church, Benbow Church of Christ, Derby Uniting Church). This raised questions around the need for risk management protocols.

STUDY LIMITATIONS AND REFLECTIONS ON FUTURE RESEARCH DIRECTIONS

The scope of my study was limited firstly to Christian churches and secondly to churches in Victoria. I have demonstrated throughout this thesis the heterogeneity of churches, and the findings from this study cannot be uncritically applied to other contexts. Research into the health promotion practices of other faiths is required; this is particularly relevant given the multicultural and multi-faith environment of Australia.

In Chapter four, I outlined the methods employed in this research, including the purposive bias involved in the selection of churches and case churches. I recruited churches that were known to participate in activities that could be considered health promoting. The rationale for this was to capture the health promoting work of churches in what is the first exploration of this phenomenon in Victoria. Consequently, these churches were more likely to articulate a mission and vision in line with new modern or emerging churches as they were more likely to participate in health promoting activities. I took care to include different denominations, church expressions and different locations, and so to include churches from the north, south, east and west of Melbourne, in rural and urban regions. However, further research is required to test the generalisability of the typology and so strengthen our understanding of potential church engagement in health promotion.

Additionally I did not undertake an in-depth exploration of church affiliated agencies and organisations or parachurch organisations. While much research has been conducted on church affiliated organisations in the disciplines of political science, social work and community work, these studies do not explore how their Christian ethos influences engagement in health promotion. Research into the understandings of the health sector and government organisations, and their willingness to partner with churches for health promotion, is another avenue of research inquiry.

I have acknowledged throughout this thesis that I am a practicing Christian and attend a Baptist church in Melbourne. The reaction to my thesis topic has delighted some, confused others and at times, has led to dismissive remarks. Except in the disciplines of religion and theology, Christianity is often regarded as antithetical to academic scholarship (Hufford, 1995) and I resonated with Cannell (2006) where she wrote of her research of Christianity: "It is surprising

how many colleagues assume that a research interest in a topic in Christianity implies that one must be a closet evangelist, or at least "in danger" of being converted - an assumption that would not be made about anthropologists working with most groups of people around the world (loc 61)."

Some of my colleagues assumed that I would use my findings to "preach". I was questioned by others whether, as a Christian, I should be 'allowed' to conduct research into the church's role in health promotion in the community; they argued that I would not be objective. Hufford (1995) asserts that "impartiality in spiritual matters [is] an impossibility ... the tendency to count disbelief as the 'objective' stance is a serious, systematic bias that runs through most academic studies of spiritual belief" (p. 61). Since impartiality is impossible, it is important in research to acknowledge these beliefs and then set them aside to enable our scholarly voice to speak (Hufford, 1995). In my methods chapter, I outlined some of the strategies I utilised to ensure the rigour of my research design and interpretations.

♦ ♦ ♦ ♦

I sought to explore whether churches are engaged in activities that are health promoting, and the factors influencing such activities. The typology I presented in this chapter is based on the literature review, theological discourses and results from the empirical research of this study. I have shown that church expression and mission are key drivers to church health promoting activities. Not all local churches are suited to health promotion or all types of health promotion activity, however, as I demonstrate, emerging churches in particular are well positioned to be involved in health promotion activities and, indeed, are already promoting health and wellbeing. My findings contribute to the health promotion and public health literature on faith-health

partnerships and to understanding of the health promoting nature of local churches. In acknowledging the heterogeneity of churches, I have developed a typology that will guide stakeholders in their engagement with local churches.

In this thesis I have described and discussed how local churches are active civil society organisations. They are involved in community engagement, community development activities and the promotion of health and wellbeing, whether they recognise their work as such or not. The practice of 'being church' is evolving, and there is evidence that church members are leaving the confinement and safety of their church buildings and walking into neighbourhoods and communities in need. In doing so they are addressing the social determinants of health and seeking to transform places of despair to spaces of hope.

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APPENDIX 1: PHASE 1 - INTERVIEW SCHEDULE FOR LOCAL CHURCHES

Church name:

Participant name:

Interview start time:

Participant background

- How long have you been at this church?
- What is your position at this church?
- Briefly describe your role:
- Why did you choose to work at this church?

The mission of the church

- What is the mission statement of your church?
- How was the mission of your church developed?
- How is the mission of your church reflected in its activities, programs, ministries?
- Describe how your church is able to carry out its mission in today's society? What do you feel are the barriers to its mission? What are the opportunities?

As I mentioned earlier, I'm interested in how the local church is involved in promoting the health and wellbeing of individuals and the community. The next couple of questions I'd like to ask you are related to your church and health promotion.

Health promotion and the church

- What do you think health promotion is?
- What activities, programs or services does your church run, which promote the health of your congregation and or the wider community?
- Has your church ever applied for funding via government grants (federal, state or local council), philanthropic trusts or other funding bodies to conduct church activities in relation to community services or health promotion?
- In relation to the core business of the church, what role does the local church have in the promotion of health among individuals and its local community?

The work of the church

- What activities happen at your church in a typical week? (Researcher to tick off all that apply)
    - Sunday school for children
    - Youth group for young people
    - Small group (groups of people meeting during the week for bible study, prayer, fellowship)
    - Sporting activities (sporting teams, walking groups, fitness classes)
    - Counselling
    - Playgroups (MOPS, playgroup)
    - Foodbank, food pantry
    - Craft groups
    - English language classes for newly arrived migrants and other groups
    - Health services (doctors, physiotherapists, nurse, other allied health professionals)
    - Prayer meetings
    - Seniors groups
    - Computer classes
    - Bookshop or library
    - OTHERS
- Has your churched partnered with other organisations or agencies, either secular agencies, other churches or church affiliated organisations?

- If yes, how and why were these organisations/agencies/churches chosen as partners?
- How does your church determine what programs, activities or services to conduct?
- Has your church participated in or supported social service, community development, or neighbourhood organising projects of any sort within the past 12 months? If yes, please describe.
- Does your church do outreach?
- What does your church define as outreach?
- Within the past 12 months, has your church engaged in any human service projects, health ministries, or other activities intended to help people who are not members of your church? If yes, please describe.
- Describe the process of evaluating whether the programs, activities or services are effective?

APPENDIX 2: PHASE 1 - INTERVIEW SCHEDULE FOR CHURCH AFFILIATED ORGANISATIONS

Organisation:

Participant name:

Interview start time:

Participant background

- How long have you been at this organisation?
- What is your position at this organisation?
- Briefly describe your role:
- Why did you choose to work at this organisation?

The mission of the organisation

- What is the mission statement of your organisation? *(Researcher to have copy of mission statement in the event participant cannot recall the mission statement)*
- Why is this the organisation's mission?
- How was the mission of this organisation developed?
- How is the mission of your organisation reflected in its activities, programs and services?
- Describe how your organisation is able to carry out its mission in today's society?
- What do you feel are the barriers to the mission? What are the opportunities?

As I mentioned earlier, I'm interested in how the local church and church affiliated organisations are involved in promoting the health and wellbeing of individuals and the community. The next couple of questions I'd like to ask you are related to your organisation, the local church and health promotion.

Health promotion and the organisation

- What do you think health promotion is?
- What activities, programs or services does your organisation run which promotes the health of individuals or the community?
- In relation to the core business of the local church, in your opinion what role does the local church have in the promotion of health among individuals and its local community?

The work of the organisation

- Does the organisation partner with other organisations or agencies, either secular or church affiliated? If yes, how and why were these organisations/agencies chosen as partners?
- How does the organisation determine what programs, activities or services to provide?
- Describe the process of evaluating whether the programs, activities or services are effective?

APPENDIX 3: PHASE 2 -TELEPHONE INTERVIEW SCHEDULE FOR LOCAL CHURCH MINISTERS

Demographics

1. What is the denomination of your church?

2. What is the size of your congregation on an average week (can include multiple church services)

☐	≤100
☐	100-500
☐	500-1000
☐	1000+

3. What is the postcode of your church location?

4. What is your position at the church (e.g. parish priest, senior pastor, youth pastor, youth worker, community care co-ordinator, church member)?

5. How many years have you been in this position/at this church?

6. How many staff members do you have at your church?

☐	1
☐	2-5
☐	5-10
☐	10+

7. What is the mission statement of your church?

Health and Health Promotion

8. How would you define health? (Probe if needed: what does health mean to you? Is it physical health? Is it more than physical health?)

9. How would you define health promotion? (Probe if needed: what is needed for good health and wellbeing?)

10. How important to your church is health promotion?

☐	Not important
☐	Not very important
☐	Slightly important
☐	Important
☐	Very important
☐	Unsure

11. Please describe any programs or activities that your church conducts which promotes health and wellbeing? (Probe if needed: emergency relief, mother's groups, play groups, youth groups, counselling, pastoral care, health services, health education)

12. Do any of these programs or activities engage with the wider community (i.e. with people outside of your parish or congregation)

☐	Yes
☐	No
☐	Unsure

If yes, which ones?

Personnel and resources

13. a) In your church, who is responsible for running programs or activities which promote health and wellbeing? (tick all that apply)

☐	All staff members
☐	Staff members with training or qualifications in health or welfare
☐	Volunteer/s from the congregation
☐	Community health and welfare groups/individuals run programs at the church
☐	No one
☐	Other (please specify)

b) Do any of your staff have training or qualifications in health or welfare?

14. What qualifications does (or would) your church look for when employing someone to run health and wellbeing programs or activities?

15. Do people in your congregation/parish volunteer in programs or activities which promote health and wellbeing at your church?

☐	Yes
☐	No
☐	Unsure

16. (If yes), how important are the volunteers in the running of these programs?

☐	Not important
☐	Not very important
☐	Slightly important
☐	Important
☐	Very important
☐	Unsure

Why?

17. Where do you obtain funding to run programs or activities which promote health and wellbeing?

☐	Church offering –
☐	Fundraising – congregational
☐	Fundraising – community
☐	Government grants (local council grants, state government grants, federal grants)-
☐	Philanthropic organisations and trusts
☐	Community groups
☐	Other (please specify)

18. Do you partner with other organisations, agencies or community groups in health and wellbeing programs or activities?

☐	Yes
☐	No
☐	Unsure

19. (If yes), can you please tell me about these partnerships – who are they with and what do you do?

20. Can you share with me the reasons behind your churches involvement in health and wellbeing programs?

21. Do you think that local churches should be involved in promoting the health and wellbeing of the community?

☐	Yes
☐	No
☐	Unsure

22. (If yes), why do you think that churches should be involved in promoting the health and wellbeing of the community?

23. What barriers does the church face in being involved in health and wellbeing programs?
24. What opportunities does the church have in being involved in health and wellbeing programs?
25. Is there anything else that you would like to share with me about the local church and health promotion?

APPENDIX 4: PHASE 3 - INTERVIEW SCHEDULE CHURCH STAFF MEMBER OR KEY VOLUNTEER

Target group: Key staff members and/or volunteers from the church involved in ministries/activities or programs which promote health and wellbeing.

Demographics

- What is your position here at [insert church name]?
- How long have you been in this position?
- What are your qualifications?
- Why did you choose to work at [insert church name]?
- Please describe your role at [insert church name]?

Health and health promotion

- How would you define health?
- How would you define health promotion?
- How does your program/ministry promote health and wellbeing?
- Do you evaluate your program/ministry?
- Please describe the process for implementing a program/ministry?
    - Needs assessment
    - Priority areas

    - Approval process

- Is there a strategic plan for this ministry/program?
- What training is required for volunteers of this ministry/program? Who conducts this training?
- What barriers have you faced in conducting this ministry/program?
- What impact do you feel this ministry/program has on your church? On the community?
- Do you partner or collaborate with other community groups or agencies in conducting your program/ministry?
- Is there anything else you would like to share with us?

APPENDIX 5: PHASE 3 - VOLUNTEER FOCUS GROUP QUESTIONS

Target group – volunteers in a church ministry/program that promotes health and wellbeing

Group number (dependent on available numbers)

- Strengths of the ministry/program
- What is the aim of the ministry/program?
- Who comes along to this ministry/program?
- Why do they come?
- Impact of ministry/program
- What impact do you feel this ministry/program has had on your church? On the community?
- In your opinion how does this ministry/program promote the health and wellbeing for individuals or the community?
- Role of volunteer
    - What are your responsibilities as volunteers?
    - What are some of the positives of being involved as a volunteer in this ministry/program?
    - What are some of the negatives of being involved as a volunteer in this ministry/program?
- Support and infrastructure

    - What training have you received to be a volunteer in this ministry/program?
    - What support does the church provide you with as a volunteer in this ministry/program?

- Reasons for involvement
    - Why are you involved in this ministry/program?
    - How did you get involved in this ministry/program?
    - Why did you choose this particular ministry/program?

- Barriers
- What barriers have you faced in conducting this ministry/program?
- Opportunities
- What opportunities have arisen through this ministry/program?
- Evaluation
- How do you evaluate how this ministry/program is going?
- Is there anything else you would like to share with me?

APPENDIX 6: PHASE 3 - DIRECT OBSERVATION CHECK LIST

Program/Activity Observation Checklist

To be completed during and after the observation of a church program or activity. This can include mothers group, play group, community meal/soup kitchen, church service, food bank, youth group, community outreach activity, exercise class, training programs, support group (cancer, depression etc), church cafe, Bible study group, Sunday School class, social gathering, training activities or other relevant activity.

Program/Activity name:

Time and date:

Activity outline:

- Collect products of program (flyers, newsletters, brochures, manuals)
- Sequence of activities

Participant characteristics:

- Number of participants
- Gender
- Age
- Profession/vocation
- Dress
- Appearance
- Ethnicity
- Other

Participant engagement

- Level of participation, interest

Volunteer characteristics:

- Number of volunteers
- Age
- Profession/vocation
- Dress
- Appearance
- Ethnicity
- Other

Physical surroundings:

- The room – space, comfort, suitability
- Amenities – beverages, food etc
- Seating arrangements
- Facilities

Program leaders

- Leadership role during activity/ministry/program
- Clarity of communication
- Group leadership skills, encouraging full participation
- Awareness of group climate
- Flexibility and adaptability
- Sequence of activities

Nonverbal behaviour (leaders/volunteers/participants)

- Facial expressions, gestures, postures
- Interest and commitment – initial impacts
- Group dynamics (clicks, sub groups etc)

APPENDIX 7: ETHICS DOCUMENTS

January 2010

Explanatory Statement – Church affiliated organisations

Local churches as settings for health promotion in Victoria

This information sheet is for you to keep.

My name is Darshini Ayton and I am conducting a research project with Professor Helen Keleher and Associate Professor Ben Smith in the Department of Health Social Science towards a Doctor of Philosophy at Monash University. This means that I will be writing a thesis which is the equivalent of a 300 page book.

The aim of this study is to investigate how the local church and church affiliated organisations are involved in promoting the health and wellbeing of individuals and the community. Your organisation has been chosen to participate in this study as it is recognised as a church affiliated organisation as it is founded on Christian values and beliefs. Your organisation has also been chosen as it is active in welfare and community work in Victoria. Therefore I am interested in your perspective on the role of the local church and church affiliated organisations in the promotion of health and wellbeing in the community. The results from this study will be used to understand why and how the church and church affiliated organisations are involved in promoting health and wellbeing in the community and how other community organisations can partner with the church and church affiliated organisations to achieve health and wellbeing outcomes for individuals and the community. Your contact details were obtained through the organisation website.

The study involves participating in an interview which will take between 1-2 hours. The interview asks questions about the mission of your organisation, the work of your organisation, your understanding of health promotion and its relation to your organisation's programs, services and activities. The interview will be audio taped and transcribed and I will send you the transcript of the interview for you to approve. While it is not anticipated that participation in this study will cause you any harm or adverse events, if at any stage of the study you experience distress due to the questions asked or from being involved, counselling can be made available to you. You do not have to answer any questions that you may feel uncomfortable with or would prefer not to answer.

Participation in this study is voluntary and you are under no obligation to consent to participate. If you do consent to participate, you may withdraw from the study at any stage. The information collected in this study will be used to write a thesis and research articles. The articles will be submitted to journals for publication and the data may also be presented at conferences. Pseudonyms and codes will be used in any published material and the personal details of you and your organisation will not be published or presented in any form. Your questionnaire will be assigned a code for reference. Data storage practices will adhere to University regulations and will be kept on University premises in a locked cupboard/filing cabinet for 5 years with electronic data being password protected.

If you would like to be informed of the research findings, please contact Darshini Ayton on [redacted] or [redacted]

If you would like to contact the **researchers** about any aspect of this study, please contact the Chief Investigator:	If you have a **complaint** concerning the manner in which this research **CF09/3382 – 2009001824** is being conducted, please contact:
Professor Helen Keleher Head, Department of Health Social Science School of Public Health and Preventive Medicine Faculty of Medicine, Nursing and Health Sciences Monash University, Caulfield Campus Tel: [redacted] Email: [redacted]	Executive Officer, Human Research Ethics Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052 Fax: +61 3 9905 3831 Email: muhrec@adm.monash.edu.au

Thank you,

Darshini Ayton

Consent Form – *Church Affiliated Organisation*

Title: *Local churches as settings for health promotion in Victoria*

NOTE: **This consent form will remain with the Monash University researcher for their records**

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

1. I agree to be interviewed by the researcher ☐ Yes ☐ No
2. I agree to allow the interview to be audio-taped ☐ Yes ☐ No
3. I agree to make myself available for a further interview if required ☐ Yes ☐ No

I understand that I will be given a transcript of data concerning me for my approval before it is included in the write up of the research.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Participant's name

Signature

Date

January 2010

Explanatory Statement – Local church leaders

Local churches as settings for health promotion in Victoria

This information sheet is for you to keep.

My name is Darshini Ayton and I am conducting a research project with Professor Helen Keleher and Associate Professor Ben Smith in the Department of Health Social Science towards a Doctor of Philosophy at Monash University. This means that I will be writing a thesis which is the equivalent of a 300 page book.

The aim of this study is to investigate how the local church is involved in promoting the health and wellbeing of individuals and the community. Your church has been chosen to participate as it is involved in health, welfare and community work in Victoria and therefore I am interested in your perspective on the role of the local church in the promotion of health and wellbeing in the community. The results from this study will be used to understand why and how the church is involved in promoting health and wellbeing in the community and how other community organisations can partner with the church to achieve health and wellbeing outcomes for individuals and the community. Your contact details were obtained through either your church website or the yellow pages.

The study involves participating in an interview which will take approximately one hour. The interview asks questions about the mission of your church, the work of your church, your understanding of health promotion and its relation to your church's programs, services and activities. The interview will be audio taped and transcribed and I will send you the transcript of the interview for you to approve. While it is not anticipated that participation in this study will cause you any harm or adverse events, if at any stage of the study you experience distress due to the questions asked or from being involved, counselling can be made available to you. You do not have to answer any questions that you may feel uncomfortable with or would prefer not to answer.

Participation in this study is voluntary and you are under no obligation to consent to participate. If you do consent to participate, you may withdraw from the study at any stage. The information collected in this study will be used to write a thesis and research articles. The articles will be submitted to journals for publication and the data may also be presented at conferences. Pseudonyms and codes will be used in any published material and the personal details of you and your church will not be published or presented in any form. Your interview will be assigned a code for reference. Data storage practices will adhere to

University regulations and will be kept on University premises in a locked cupboard/filing cabinet for 5 years with electronic data being password protected.

If you would like to be informed of the research findings, please contact Darshini Ayton on [redacted] or [redacted]

If you would like to contact the **researchers** about any aspect of this study, please contact the Chief Investigator:	If you have a **complaint** concerning the manner in which this research **CF09/3382 – 2009001824** is being conducted, please contact:
Professor Helen Keleher Head, Department of Health Social Science School of Public Health and Preventive Medicine Faculty of Medicine Monash University, Caulfield Campus Tel: [redacted] Email: [redacted]	Executive Officer, Human Research Ethics Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052 Fax: +61 3 9905 3831 Email: muhrec@adm.monash.edu.au

Thank you,

Darshini Ayton

Consent Form – *Local church leader*

Title: *Local churches as settings for health promotion in Victoria*

NOTE: **This consent form will remain with the Monash University researcher for their records**

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

1. I agree to be interviewed by the researcher	☐ Yes	☐ No
2. I agree to allow the interview to be audio-taped	☐ Yes	☐ No
3. I agree to make myself available for a further interview if required	☐ Yes	☐ No

I understand that I will be given a transcript of data concerning me for my approval before it is included in the write up of the research.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Participant's name

Signature

Date

Ms Darshini Ayton
PhD Candidate
Department of Health Social Science
Faculty of Medicine, Nursing and Health Sciences
Phone: [redacted]
Mobile: [redacted]
Fax: [redacted]
Email: [redacted]

PASTOR NAME
POSITION
ADDRESS LINE 1
ADDRESS LINE 2
ADDRESS LINE 3

DATE

RE: Invitation to participate in PhD research

Dear PARTICIPANT NAME

I am writing to invite CHURCH NAME to participate in a study about the church and health promotion in Victoria which I am conducting as part of my PhD. I am completing this degree at Monash University under the supervision of Professor Helen Keleher and Associate Professor Ben Smith at the Department of Health Social Science.

The aim of this study is to investigate how the local church is involved in promoting the health and wellbeing of individuals and the community. YOUR CHURCH is being asked to participate in this study as it is active in the community. Therefore I am interested in your perspective on the role of the local church in the promotion of health and wellbeing in the community. The results from this study will be used to understand why and how the church is involved in promoting health and wellbeing in the

community and how other community organisations can partner with the local church to achieve health and wellbeing outcomes for individuals and the community.

Participation in this study will require a representative from your CHURCH to participate in a telephone interview which will take approximately 40 minutes. This person could either be yourself or you can nominate someone else from your church. The interview asks questions about the mission of your church, the work of your church, your understanding of health promotion and its relation to the church's programs, services and activities. I will be in contact with you within the next week to discuss whether CHURCH NAME is willing to be involved in this research project.

I hope that you will find the opportunity to contribute to this research beneficial and I look forward to discussing this with you shortly.

Yours sincerely,

Darshini Ayton

Explanatory Statement – Local church leaders

Local churches as settings for health promotion in Victoria

April 2010

This information sheet is for you to keep.

My name is Darshini Ayton and I am conducting a research project with Professor Helen Keleher and Associate Professor Ben Smith in the Department of Health Social Science towards a Doctor of Philosophy at Monash University. This means that I will be writing a thesis which is the equivalent of a 300 page book.

The aim of this study is to investigate how the local church is involved in promoting the health and wellbeing of individuals and the community. Your church has been chosen to participate as it is involved in health, welfare and community work in Victoria and therefore I am interested in your perspective on the role of the local church in the promotion of health and wellbeing in the community. The results from this study will be used to understand why and how the church is involved in promoting health and wellbeing in the community and how other community organisations can partner with the church to achieve health and wellbeing outcomes for individuals and the community. Your contact details were obtained through either your church website or the yellow pages.

The study involves participating in a telephone interview which will take approximately 40 minutes. The interview asks questions about the mission of your church, the work of your church, your understanding of health and health promotion and its relation to your church's programs, services and activities. The interview will be recorded and transcribed. A copy of the transcript will be provided to you on request. While it is not anticipated that participation in this study will cause you any harm or adverse events, if at any stage of the study you experience distress due to the questions asked or from being involved, counselling can be made available to you. You do not have to answer any questions that you may feel uncomfortable with or would prefer not to answer.

Participation in this study is voluntary and you are under no obligation to consent to participate. If you do consent to participate, you may withdraw from the study at any stage. The information collected in this study will be used to write a thesis and research articles. The articles will be submitted to journals for

publication and the data may also be presented at conferences. Pseudonyms and codes will be used in any published material and the personal details of you and your church will not be published or presented in any form. Your interview will be assigned a code for reference. Data storage practices will adhere to University regulations and will be kept on University premises in a locked cupboard/filing cabinet for 5 years with electronic data being password protected.

If you would like to be informed of the research findings, please contact Darshini Ayton on [redacted] or [redacted]

If you would like to contact the **researchers** about any aspect of this study, please contact the Chief Investigator:	If you have a **complaint** concerning the manner in which this research **CF09/3382 – 2009001824** is being conducted, please contact:
Professor Helen Keleher Head, Department of Health Social Science School of Public Health and Preventive Medicine Faculty of Medicine Monash University, Caulfield Campus Tel: [redacted] Email: [redacted]	Executive Officer, Human Research Ethics Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052 Fax: +61 3 9905 3831 Email: muhrec@adm.monash.edu.au

Thank you,

Darshini Ayton

Please copy and paste the below into a email addressed to [redacted]

By sending this email you are consenting to participate in the project "Local churches as settings for health promotion in Victoria"

PROJECT: LOCAL CHURCHES AS SETTINGS FOR HEALTH PROMOTION IN VICTORIA

NOTE: THIS CONSENT FORM WILL REMAIN WITH THE MONASH UNIVERSITY RESEARCHER FOR THEIR RECORDS

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

1. I agree to be interviewed by the researcher over the telephone
2. I agree to allow the interview to be audio-taped
3. I agree to make myself available for a further interview if required

I understand that I can request a copy of the transcript of data concerning me for my approval before it is included in the write up of the research.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Please ensure that your send this email with your email signature

<ON CHURCH LETTERHEAD >

Permission Letter for "*Local churches as settings for health promotion in Victoria*"

Professor Helen Keleher
Department of Health Social Science
School of Public Health and Preventative Medicine
Faculty Medicine, Nursing and Health Science
Building T3, Caulfield Campus
MONASH UNIVERSITY VIC

Dear Professor Keleher,

Thank you for your request to recruit participants from <insert Church name> for the above-named research.

I have read and understood the Explanatory Statement regarding the research and hereby give permission for this research to be conducted.

Yours Sincerely,

<insert signature>
<insert name of the above signatory>
<insert above signatory's position>

Explanatory Statement – Key church staff members

Local churches as settings for health promotion in Victoria

July 2010

This information sheet is for you to keep.

My name is Darshini Ayton and I am conducting a research project with Professor Helen Keleher and Associate Professor Ben Smith in the Department of Health Social Science towards a Doctor of Philosophy at Monash University. This means that I will be writing a thesis which is the equivalent of a 300 page book.

The aim of this study is to investigate how the local church is involved in promoting the health and wellbeing of individuals and the community. Your church has been chosen to participate as it is involved in health, welfare and community work in Victoria and therefore as a staff member at this church I am interested in your perspective on the role of the local church in the promotion of health and wellbeing in the community. The results from this study will be used to understand why and how the church is involved in promoting health and wellbeing in the community and how other community organisations can partner with the church to achieve health and wellbeing outcomes for individuals and the community. Your contact details were obtained through either your church website or the through the senior pastor of your church.

The study involves participating in an interview which will take approximately 40 minutes. The interview asks questions about your position and role at the church, your understanding of health and promotion and its relation to your church's programs, services and activities. The interview will be audio taped and transcribed. The transcript of the interview will be available to you on request. While it is not anticipated that participation in this study will cause you any harm or adverse events, if at any stage of the study you experience distress due to the questions asked or from being involved, counselling can be made available to you. You do not have to answer any questions that you may feel uncomfortable with or would prefer not to answer.

Participation in this study is voluntary and you are under no obligation to consent to participate. If you do consent to participate, you may withdraw from the study during or directly after the interview. Once the data has been analysed, withdrawal from the study will not be possible. The information collected in this study will be used to write a thesis and research articles. The articles will be submitted to journals for publication and the data may also be presented at conferences. Pseudonyms and codes will be used in any

published material and the personal details of you and your church will not be published or presented in any form. Your interview will be assigned a code for reference. Data storage practices will adhere to University regulations and will be kept on University premises in a locked cupboard/filing cabinet for 5 years with electronic data being password protected.

If you would like to be informed of the research findings, please contact Darshini Ayton on [redacted] or [redacted]

If you would like to contact the **researchers** about any aspect of this study, please contact the Chief Investigator:	If you have a **complaint** concerning the manner in which this research **2010000959: Local churches as settings for health promotion in Victoria - Stage 2** is being conducted, please contact:
Professor Helen Keleher Head, Department of Health Social Science School of Public Health and Preventive Medicine Faculty of Medicine Monash University, Caulfield Campus Tel: [redacted] Email: [redacted]	Executive Officer, Human Research Ethics Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052 Fax: +61 3 9905 3831 Email: muhrec@adm.monash.edu.au

Thank you,

[redacted]

Darshini Ayton

Consent Form – *Key church staff members*
Title: Local churches as settings for health promotion in Victoria

NOTE: THIS CONSENT FORM WILL REMAIN WITH THE MONASH UNIVERSITY RESEARCHER FOR THEIR RECORDS

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

1. I agree to be interviewed by the researcher	☐ Yes	☐ No
2. I agree to allow the interview to be audio-taped	☐ Yes	☐ No
3. I agree to make myself available for a further interview if required	☐ Yes	☐ No

I understand that I can request a transcript of data concerning me for my approval before it is included in the write up of the research.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Participant's name

Signature

Date

MONASH University

Explanatory Statement – Volunteers

Local churches as settings for health promotion in Victoria

July 2010

This information sheet is for you to keep.

My name is Darshini Ayton and I am conducting a research project with Professor Helen Keleher and Associate Professor Ben Smith in the Department of Health Social Science towards a Doctor of Philosophy at Monash University. This means that I will be writing a thesis which is the equivalent of a 300 page book.

The aim of this study is to investigate how the local church is involved in promoting the health and wellbeing of individuals and the community. Your church has been chosen to participate as it is involved in health, welfare and community work in Victoria. As a person who volunteers in a church ministry/program, I am interested in your perspective on the role of the local church in the promotion of health and wellbeing in the community. The results from this study will be used to understand why and how the church is involved in promoting health and wellbeing in the community and how other community organisations can partner with the church to achieve health and wellbeing outcomes for individuals and the community.

The study involves participating in a focus group which will take approximately one hour. During the focus group I will ask questions about the ministry/program in which you are a volunteer; your role as a volunteer in the ministry/program and why you are volunteering; the support you receive from the church and the barriers and opportunities of the ministry/program. The focus group will be audio taped and transcribed. A transcript of the focus group can be provided to you on request.

While it is not anticipated that participation in this study will cause you any harm or adverse events, if at any stage of the study you experience distress due to the questions asked or from being involved, counselling can be made available to you. You do not have to answer any questions that you may feel uncomfortable with or would prefer not to answer. Participation in this study is voluntary and you are under no obligation to consent to participate. If you do consent to participate, you may withdraw from the study during or directly after the interview. Once the data has been analysed, withdrawal from the study will not be possible.

The information collected in this study will be used to write a thesis and research articles. The articles will be submitted to journals for publication and the data may also be presented at conferences. Pseudonyms and codes will be used in any published material and the personal details of you and your church will not be published or presented in any form. You will be assigned a code for reference. Data storage practices will adhere to University regulations and will be kept on University premises in a locked cupboard/filing cabinet for 5 years with electronic data being password protected.

If you would like to be informed of the research findings, please contact Darshini Ayton on [redacted] or [redacted]

If you would like to contact the **researchers** about any aspect of this study, please contact the Chief Investigator:	If you have a **complaint** concerning the manner in which this research **2010000959: Local churches as settings for health promotion in Victoria - Stage 2** is being conducted, please contact:
Professor Helen Keleher Head, Department of Health Social Science School of Public Health and Preventive Medicine Faculty of Medicine Monash University, Caulfield Campus Tel: [redacted] Email: [redacted]	Executive Officer, Human Research Ethics Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052 Fax: +61 3 9905 3831 Email: muhrec@adm.monash.edu.au

Thank you,

[redacted]

Darshini Ayton

Consent Form - *Volunteers*
Title: Local churches as settings for health promotion in Victoria

NOTE: **THIS CONSENT FORM WILL REMAIN WITH THE MONASH UNIVERSITY RESEARCHER FOR THEIR RECORDS**

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

1. I agree to be involved in a focus group ☐ Yes ☐ No
2. I agree to allowing the focus group to be audio-taped ☐ Yes ☐ No

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that I can request a transcript of data concerning me for my approval before it is included in the write up of the research.

I understand that any data that the researcher extracts from the focus group for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

Participant's name

Signature

Date

APPENDIX 8: PARTICIPANT OBSERVATION CHECKLIST

Program/Activity Observation Checklist

To be completed during and after the observation of a church program or activity. This can include mothers group, play group, community meal/soup kitchen, church service, food bank, youth group, community outreach activity, exercise class, training programs, support group (cancer, depression etc), church cafe, Bible study group, Sunday School class, social gathering, training activities or other relevant activity.

Program/Activity name:

Time and date:

Activity outline:

- Collect products of program (flyers, newsletters, brochures, manuals)
- Sequence of activities

Participant characteristics:

- Number of participants
- Gender
- Age
- Profession/vocation
- Dress
- Appearance
- Ethnicity
- Other

Participant engagement

- Level of participation, interest

Volunteer characteristics:

- Number of volunteers
- Age
- Profession/vocation
- Dress
- Appearance
- Ethnicity
- Other

Physical surroundings:

- The room – space, comfort, suitability
- Amenities – beverages, food etc
- Seating arrangements
- Facilities

Program leaders

- Leadership role during activity/ministry/program
- Clarity of communication
- Group leadership skills, encouraging full participation
- Awareness of group climate
- Flexibility and adaptability
- Sequence of activities

Nonverbal behaviour (leaders/volunteers/participants)

- Facial expressions, gestures, postures
- Interest and commitment – initial impacts
- Group dynamics (clicks, sub groups etc)