Chapter 2

Adventist Health and Wholeness in Africa: A Call for a Change of Strategy

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Seventh-day Adventists (SDAs) have been at the forefront of promoting health and wellbeing. Health facilities, built and operated by the SDAs, exist globally. However, due to the escalating cost of care, health services in Adventist health facilities in Africa are becoming inaccessible. This paper emphasizes the need for a more preventive-focused, culturally-friendly, church-committed, leadership-driven, African health empowerment agenda for the people, by the people and with the people, coordinated by church-hired, district-based health educators/promoters.

I. Introduction

Long before the adoption of Primary Health Care (PHC) in 1978 (Alma-ata, 1978), as the strategy for achieving *Health for All by the Year 2000* (HFA/2000) (WHO, 1979), Seventh-day Adventists (since 1863) (Robinson, 1965), had consistently promoted, through her renowned health reformer. Ellen G. White's reforms unlocked a health system that would help members lead a socially-satisfying and spiritually-uplifting life; suggesting that the concept of *Health for All* was conceived by the Seventh-day Adventist (SDA) church 115 years

before its universal adoption at Alma-ata, Kazakh Republic, former USSR (Aja, 2002). However, the Alma-ata Declaration has evolved through the years to include other top level international health development plans such as the Millennium Development Goals (2000-2015) (United Nations, 2018a), and the ongoing Sustainable Development Goals (2015-2030) (United Nations, 2018b), aimed at improving the depreciating overall human conditions.

In Africa, the SDA church maintains a network of health facilities, and offers high quality medical services to immediate communities where they are located, and beyond. However, due to escalating costs of care, distance, cultural barriers, etc, these services are inaccessible. It is costly to acquire medical, surgical and paediatric equipment, with supportive laboratory and diagnostic technologies required to offer qualitative services, including highly skilled personnel needed to smoothly run clinical services (Ransome-Kuti, Sorungbe, Oyegbite, & Bamisaiye, 1990). It is, therefore, hypothesized, that Adventist health ministry, beyond clinically-oriented care, can benefit a wider range of people, including the less privileged majority who live and work in the rural and remote areas several kilometres away from the facilities. The existing occasional, "hit-and-run" health talk approach and the seemingly "holiday-driven" medical outreaches are unsustainable.

More so, health issues, particularly in rural African communities, are becoming more and more alarming. For example, 19.4 million people live with HIV in east and southern Africa and 6.1 million in western and central Africa (UNAID, 2018). Meanwhile, the battle against malaria and non-communicable diseases are still raging. Dealing with them requires new direction and reorientation. The hospital-based, curative approach alone cannot fully address the poor health situation. To achieve the strategic goals of health for all SDA church members in Africa, there is the need for a well-articulated community-oriented, church-centred health education strategy. This paper is, in no way, advocating for the elimination of hospitals or curative care facilities from our health care delivery system; rather we are proposing a preventive-curative mix.

II. Adventist Health Ministry: The Way Forward

The SDA church places a very strong emphasis on the close relationship between physical, social and spiritual health; a legacy consistent with biblical standards. Long before now, Ellen G. White, an apostle of health promotion, had noted that:

"Too little attention is given to the preservation of health. It is far

better to prevent diseases than to know how to treat it when contracted" (White, 1942).

To say that the Seventh-day Adventist church has more health resources than any other church in the world may not be an overstatement. These health resources are delivered and applied differently in different settings. In highly literate settings, such as the United States of America and Canada, church members are able to access health resources via online and other media. No wonder today, studies show that Seventh-day Adventists in North America are healthier than the general population (Shultz, 1983, pp. 247-259; Shultz, & Leklem, 1983, pp. 27-33; Hunt, Murphy, & Henderson, 1988, pp. 850-851). But in Africa, where majority of the people are not literate, access to these resources are limited. They rely only on occasional "health talks".

It is, therefore, necessary at this period of our history to consider an approach that would enable the SDA membership in Africa to, not only obtain basic health information, but also translate acquired knowledge into actual practice (behaviour), on a sustainable platform. Thus, a community-based, church-centred health education program co-ordinated by District Health Educators (DHEs) is hereby recommended.

The framework for a community-based, church-centred health education and management already exists in the Seventh-day Adventist church's organisational system. The Adventist Health Ministries (AHM) department co-ordinates and supervises health programs in the churches (General Conference of Seventh-day Adventists, 1986). Every local church is expected to have one. This arrangement is so unique because it offers every local church the opportunity to plan and address local health problems based on existing cultural values, attitudes, and behaviours. However, in many SDA Unions, Missions/Conferences, few churches have functional local Adventist Health Ministries. In some, it is virtually non-existent. For those that have functional health ministries, the *modus operandi* is characterized by occasional health activities, organised during meetings, seminars and crusades. Thus, recruitment of full-time paid, community-based trained district health educators as a way to further strengthen Adventist health ministries in Africa is long overdue.

III. District Health Educators (DHEs) – An Asset to the Church

DHEs are likely to complement the efforts of church pastors in

ministering to SDA church members and the community. Living and working in the community would create more opportunities for the DHEs to interact more with members and others, particularly on health-related issues; thereby supporting them to lead socially-satisfying, spiritually-uplifting, and economically productive lives. Healthy church members are more likely to contribute more to the economic life of the church.

Of course, it is obvious that church resources are scarce. With focus on hospital-based system, the resources are not usually enough to procure drugs, provide infrastructure and infrastructure rehabilitation. There is, therefore, the need to invest more on prevention via DHEs. The investment may seem enormous but the benefits are invaluable. To maximize the limited resources, SDA Missions/Conferences may choose from any of the scenarios:

a. Hire a DHE for each district, which is highly recommended.
b. Hire some DHEs and rotate them within the districts. Period of stay in each district should not be less than one year. This approach, of course, is fraught with limitations. The gains made over time by the DHEs may be lost during the rotational period.
c. Divide the Conference into health zones and DHEs to be responsible for the zones. However, the number of Districts/Churches assigned to a DHE within a zone may be overwhelming to the DHE.

Generally, the church should continue to intensify efforts in promoting the philosophy of systematic giving to enhance the financial base of the church organisation. Also, individuals, foundations and church development agencies can be approached to make contributions to the district health education project. This would, in no small measure bring health education to the doorsteps of every church member and the entire community.

IV. Strategy for Implementation

For a successful implementation and sustainability of the DHE intervention, issues related to the recruitment of the DHEs and terms of reference, syllabi, resource materials, supervision, and the role of District Health Committees, and others are discussed below:

1. Recruiting District Health Educators (DHEs)

Many Adventist universities in Africa and beyond offer Bachelor, Masteral and Doctoral degrees in Public Health and other allied health

professional trainings. Graduates from these schools have the capacity to function as DHEs, particularly those with health promotion/health education background. Other allied health professionals may require reorientation.

The terms of reference for DHEs shall include, but not limited to:

- live in the community
- understand and speak the local language
- knowledgeable about the community's culture, attitude and beliefs
- conduct health needs and assets assessment
- understand the health needs of each household in the district
- visit church members in their homes to discuss their health needs
- form support groups based on needs
- plan and execute health programs from time to time
- have good credentials with bias in health promotion/education
- obtain a map of the district, and where there is none, draw own rough map showing location/residence of church members

2. Syllabus

Local health problems vary from district to district. Therefore, health topics should address prevailing health problems in the district. As a guide, the following topics, perhaps derived from a needs assessment, are essential:

- maternal and child health
- education on prevailing health problems
- family planning information services
- immunisation programme
- nutrition and food safety
- water and sanitation (Environmental Health)
- drug abuse education
- oral rehydration therapy
- first aid
- natural remedies
- current public health reports
- dental health
- mental health

These topics should be presented in an attractive and acceptable manner that would lead to behaviour change. Storytelling and drama sketches are appropriate ways of passing on health information, especially in African culture where oral tradition is important (Aja, Umahi, & Allen-Alebiosu, 2011, pp. 1-10).

3. Resource Materials

The Health Ministries Department of the Divisions, in conjunction with the Unions shall supply posters, books, health literatures, audio-visual aids and others via the Adventist Missions/Conferences. The DHEs are expected to adapt these materials to local needs.

4. Supervision of DHE

His/her operational base shall be the Adventist district headquarters. The DHEs shall report directly to the Adventist Mission/Conference Health Ministries department through the District Health committee. However, the DHE shall plan and work closely with other departments of the local churches within the district to achieve greater result, for example, Adventist Youth Ministries (AYM), Adventist Men's Organization (AMO), choir, Adventist Women Ministries (AWM), Personal Ministries and so on.

To provide the much-needed support for the DHE, a District Health Committee (DHC) shall be formed to assist him/her in discharging his/her duties. The Committee shall comprise of the following:

- The District Pastor (Chairperson)
- The District Health Educator (Secretary)
- Local Church pastors, Health Ministries leaders, Branch Sabbath School leaders/elders within the district as members, and.
- Two local leaders (non-Adventists) to represent the community.

The term of reference for the DHC shall be to:

- provide all the support needed by the DHE to identify and address the health needs of the district in which they represent,
- identify human and material resources within the community and/or church to meet these needs,
- mobilise and stimulate the active participation of church members in planning and implementing health programs,
- liase with ADRA and AHM to find solutions to health, social and other problems of the community.

5. Take-Off Program

One of the major problems of planning in developing countries is lack of basic data (World Bank Group, 2015). To correct this, the DHE shall begin by conducting a baseline survey of health problems and situation analysis of health care services in his/her district of operation.

Seventh-day Adventist institutions and public health departments can offer assistance in constructing the instrument for data collection.

V. Conclusion

Education for health should not necessarily be an occasional, part-time, holiday activity. It should be a part of our church's life; a continuous process aimed at bringing about positive changes in health behaviours. Incidentally, each SDA Mission/Conference is divided into manageable local districts with satellite churches and branch Sabbath schools, thereby creating a platform for DHEs to deliver health promotion programs and services.

The Seventh-day Adventist church has a legacy to teach and practice healthful living; a challenge which needs a two-prong approach – the medical/hospital services and community-based health ministry. District Health Educators (DHEs), recruited and paid by the church are needed to implement action-oriented, community-based, church-centred health education programs, supervised by the Health Ministries department of the church. DHEs and Health Ministries Directors need to be well-trained in health promotion to effectively co-ordinate health programs, preferably with a degree in Public Health. Without genuine leadership, the strategy cannot succeed.

The task before us is not an easy one. It requires human resources, materials and money. But what we need most is the commitment, determination, persistence and single-mindedness to pursue more vigorously our health goals using available resources. The health ministry is as important to the church community as the gospel ministry. A DHE-coordinated health education sessions are essential in achieving the goals of the strategic plan proposed by the General Conference Health Ministries department. Implementation of the proposed community-based, church-centred health education strategy, is more likely, in the long run, to contribute to the advancement of the gospel ministry, as the activities of the DHEs spread across districts and communities.

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