ALIVE! Five African American Churches and a Medical Institution Join Together to Prevent Premature Deaths

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Premature death refers to an individual's dying prior to reaching eighty years of life. It has been well documented that many premature deaths in the United States are caused by poor diet and lack of exercise,[1] two factors that have a major impact on many potentially debilitating chronic illnesses—illnesses that disproportionately impact African American communities. For example, while African Americans make up 12.7 percent of the total US population and non-Hispanic European Americans 61.5 percent,[2] African Americans ages 18–42 are twice as likely to die from heart disease as their European American peers; African American ages 35–64 are 50 percent more likely to have hypertension than European Americans in the same age range.

Behavioral recommendations to combat premature death usually address exercise, suggesting 10,000 steps or 150 minutes of physical

[1] The top two causes of premature death in the United States in 2010 were poor diet and lack of exercise (18 percent) and tobacco use (15 percent). See graph, drawn from J. Michael McGinnis, "Actual Causes of Death, 1990–2010," Workshop on Determinants of Premature Mortality, September 18, 2013, National Research Council, Washington, D.C., published in Mark Mather and Paola Scommegna, "Up to Half of U.S. Premature Deaths Are Preventable; Behavioral Factors Key," Population Reference Bureau, September 14, 2015. Available at http://www.prb.org/Publications/Articles/2015/us-premature-deaths.aspx.

[2] According to 2017 results of the American Community Survey. Accessed through the U.S. Census Bureau's American Fact Finder site, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_DP05&src=pt.

activity each week. Dietary recommendations advise a reduction in the intake of salt, processed sugar, and total saturated fats and an increased intake of fresh fruits and green leafy, orange, red, and yellow vegetables. Reasons for poor diet vary. For poor people of all racial and ethnic groups, food deserts and lack of financial resources often lead to high carbohydrate, low protein diets with few green leafy and red, orange, and yellow vegetables. Culture and tradition also influence diet. It is not unusual, for example, for some African American communities to have menus high in carbohydrates, fried chicken and fish, and overcooked leafy vegetables that are depleted of needed vitamins and minerals. Foods rich in carbohydrates such as macaroni and cheese and candied yams can also present nutritional challenges.

In the fall of 2014, a team from Rush University Medical Center's Department of Preventive Medicine and pastors of five African American churches in the Chicago metropolitan area joined forces to launch an initiative called ALIVE! (Abundant Living in Vibrant Energy) to support congregational members in developing improved health behaviors to minimize health risks caused by poor diet and lack of exercise that could lead to premature death. This article describes the development and implementation of that initiative. It narrates the genesis of the ALIVE! initiative, beginning with its precursor Sabbath in Community and culminating in an ambitious congregational project, using a community-based participatory research (CBPR) approach. After detailing the church- and individual-level intervention components of the research design, I conclude with an overview of the outcomes. One of the key findings of this study is that use of a CBPR approach of church involvement as well as the integration of Bible study with nutrition education contributed significantly to the success of the initiative.

The Genesis of the ALIVE! Initiative

In 2011, the staff of the Department of Preventive Medicine (DPM) at Rush University Medical Center (RUMC) was seeking a path of outreach for teaching communities how to minimize the ramifications of certain chronic illnesses. On October 6, 2011, RUMC's Department of Community Affairs, in cooperation with the DPM, held a forum for faith community leaders, "Care of the Flock: Teaching and Preaching for Better Health Behaviors." Participants included clergy, rabbis, imams, lay ministers, chaplains, and pastoral counselors. The forum was designed to improve faith leaders' understanding of health disparities and the negative

impact of unhealthy habits on the physical, spiritual, psychological, and social well-being of their parishioners.

At the end of the session, Alan V. Ragland, senior pastor of Third Baptist Church of Chicago, expressed to Elizabeth Lynch, associate professor of Preventive Medicine at RUMC, how much he appreciated the forum. Ragland shared his observation that too many pastors have a poor grasp on their own health needs and the potential dangers of neglecting healthy eating habits, exercise, and rest. He suggested that before faith community leaders could begin preaching to others about improving health behaviors, they needed help understanding what behaviors they needed to adopt for their own optimal health and decreased stress. Evaluations from other participants echoed the desire for more education focused on clergy self-care. This request began an exciting and challenging journey for the forum's executive team who partnered with a group of pastors for an initiative focused on improving clergy health behaviors: Sabbath in Community.

The Sabbath in Community initiative involved twelve Christian clergy in a nine-month program focused on four health concerns: (1) spiritual disciplines, (2) nutrition, (3) physical activity, and (4) stress management. Pastors are often insensitive to their own need for self-care—a neglect that puts them at high risk for obesity, cardiac issues, hypertension, increased stress, depression, and burnout, all of which can shorten life span. Self-care in body, mind, and spirit must be stressed; amid the busyness of shepherding congregations, pastors often fail to appreciate that even Jesus took time for deliberate solitude and time alone in prayer (Mark 1:35).

The Sabbath in Community programming began with a retreat in January 2012 to facilitate bonding among participating clergy. The gathering began with a devotional and a guest plenary speaker who, through examples and open discussion, helped participants explore their relationships with God, self, and others in deep and meaningful ways. Through discussion and reflection, this plenary session opened a level of vulnerability and common ground that the clergy welcomed. The recognition of their common work and shared experiences of internal spiritual and emotional dryness allowed them to quickly engage each other in spiritual transformation that awakened them to new possibilities of spiritual praxis, not only for themselves but for their families and their congregations.

The remainder of the program consisted of the twelve pastors and the program executive team meeting together for two-and-a-half-hour sessions. The group met twice monthly for the first two months, followed

by monthly meetings over the next seven months. Meetings opened with Scripture reading and group reflection regarding how participants were applying what they had learned in the previous sessions. This was a very rich component of our time together, as the clergy shared from their deep faith about the benefits they were experiencing as they practiced new health behaviors.

These sessions gave clergy participants space to truly internalize Scripture, using the text as a vehicle for reflection on their own needs. This was a shift for many whose reflection on Scripture for the purposes of teaching and preaching was commonly focused on the external needs of their congregations or communities. During the sessions, participants often used Scripture as a lead-in to conversations about self-care and God's Spirit at work in them. The communal reflection allowed the clergy to internalize Scripture in ways they had not done consciously in a long time. The use of Scripture in this setting brought energy, truth, new insights, and revelations to those gathered. They began to appreciate their right to Sabbath time and made new commitments for self-care as a result of these insights.

Each session also included group practice of mindfulness meditations and low-impact exercises. Participants were encouraged to set a goal of reaching 10,000 steps a week. Dietary lessons focused on eating three (primarily) low-carbohydrate vegetables each day. This was reinforced by our evening meals together, which consisted of recipes participants could use to prepare different kinds of vegetables. Non-invasive data (height and weight, blood pressure readings, and waist measurements) were recorded periodically. Questionnaires regarding food preparation and exercise and twenty-four-hour food logs were also used. An executive team member took general notes on key points of group discussion, being careful not to breach confidentiality. Participants were paired to provide mutual support and encouragement to one another. A list of participants' favorite Scripture verses and spiritual sayings was compiled and distributed.

By the end of the twelve sessions, participants had formed open and honest friendships. They had permitted themselves to take a day off, to play golf or partake in other non-ministry activities. This time away helped them appreciate themselves as whole beings, needing time for relaxation and hobbies that fed body, mind, and spirit. Some participants lost weight and reduced the amount of processed carbohydrates and fried foods they had been eating on a regular basis. No one gained

weight. Several of the clergy were able to reduce their cholesterol medications, and laboratory results showed decreased A1C levels for those with type 2 diabetes. The program impacted the pastors' congregations as well, as hospitality ministries implemented their pastors' suggestion that churchwide events include more vegetables and serve broiled or baked meats rather than fried. Overall, the clergy made great strides toward the important truth Kirk Byron Jones expresses: "I am no less precious to God than the work I do or the people I serve."[3]

Concerned that the pastors might not be able to sustain their newfound healthy behaviors, the executive team suggested they invite two partners from their leadership teams to encourage their perseverance in healthy eating and exercise behaviors. As a result of this suggestion, the ALIVE! initiative was conceived.

At the end of Sabbath in Community, five of the clergy participants, who pastored African American congregations, invited the RUMC executive team to bring a healthy behavior awareness program to their congregations. The executive team saw this as an excellent opportunity. It would allow congregants to not only support their pastors' healthy behaviors but also to learn spiritual and practical behaviors that would support their own health. The agreement between RUMC researchers and these five African American pastors was especially significant because of the disparities between African American and European American health outcomes described above. In light of these striking disparities, this partnership provided an opportunity to learn what would reduce the exacerbation of chronic illnesses and support healthy behaviors, thereby reducing disparities and preventing premature deaths.

The pastors' partnership enabled the researchers on the executive team to gather data on the impact of improved healthy behaviors in the categories of diet and physical activity—i.e., the two categories highlighted by research over the last twenty years as leading causes of premature deaths in the United States. The working hypothesis was that increasing vegetable intake to three cups per day would result in improvements in the specific health issues that plague African American communities. The issues that contribute especially to health risks are hypertension, diabetes, kidney disease, high cholesterol levels, and obesity. Accompanying behaviors to

[3] Kirk Byron Jones, *Rest in the Storm: Self-Care Strategies for Clergy and Other Caregivers* (Valley Forge, PA: Judson Press, 2001), xii.

boost the nutrients and fiber in the vegetables included walking 10,000 steps per week to reduce toxins in the body, and drinking eight to ten glasses of water per day (unless otherwise directed by the attending physician) to promote the flushing of toxins out of the body. Improvements were measured through changes in medication (dosage and/or usage), weight, blood pressure, and cholesterol levels. The National Institute of Health provided a three-year grant to the Department of Preventive Health of RUMC to develop and implement a congregational initiative.

The executive team considered faith communities to be critical partners in the development of an initiative to support change for better health behaviors. While researchers and clinical specialists know what behavioral changes must occur to improve health outcomes, it is the people in the faith communities who know the history, cultural norms, weekly activities, and special celebrations of the congregation as well as the best practices, language, and approaches for guiding the concrete implementation of project goals. Moreover, the church provides a community of mutual learning, support, and encouragement as participants practice new behaviors for important health improvements. As the spiritual leader of the congregations, the pastors set the vision through worship themes, sermons, approved Bible studies, and faith-related workshops and also gave input for program activities. For all these reasons, it was clear to the executive team that there must be a collaboration of researchers, medical and behavioral doctors, clergy consultants, and the pastors and a core of leaders from each of the five churches to develop and implement the ALIVE! initiative for the congregations. The decision was made to use a CBPR method, a collaborative approach to research. A CBPR board was formed, comprised of the following essential groups:

- Lay leaders. The congregants chosen by the pastors after completing Sabbath in Community advised the RUMC executive team on meaningful approaches to the participating churches (e.g., common foods in their communities and how to create healthier versions of these recipies).

- CBPR coordinators. Pastors assigned one person in their congregation to oversee the activities of the ALIVE! project. Coordinator responsibilities included scheduling activities and room assignments for small groups and churchwide activities and ensuring that audio-visual equipment was operative for meetings and that materials were distributed to the group

facilitators one week prior to meetings. Coordinators also did any needed trouble-shooting for program arrangements and staffing of meetings.

- CBPR facilitators. Persons in the congregation presented the materials provided by the executive team for Bible studies and the nutrition and exercise components of the project.[4] The facilitators were trained in small group facilitation and followed up with absent members to support and encourage them. Facilitators were also responsible for completing fidelity forms for each session to ensure consistency of presented materials across the five churches.

- Field workers. With approval from the pastors, staff members of RUMC's Department of Preventive Medicine attended worship service, churchwide events, small group question and answer sessions, and Bible studies and conducted group and individual interviews. Their purpose was to see, feel, and appreciate the spirit and culture of the people of the church.

- Executive team. Staff from RUMC's Department of Preventative Medicine used information and suggestions from the above groups of dedicated persons to design the ALIVE! project.

The researches and the CBPR board were equally involved in the development, tools, and approaches to the research process. Without the input from church participants, the researchers would not have understood the nuances of the theology or cultural norms of the faith communities nor what each community valued in its life together as the body of Christ. The unique strengths each member brought to the development sessions were recognized. We did not use formal titles of education or position, reflecting our belief that every person at the meeting had important insights to bring to the design discussions and decisions.[5] The agreed upon program goal was to provide education tools to support participants

[4] In three of the congregations, pastors led the Bible studies.

[5] Nina B. Wallerstein and Bonnie Duran, "Community-Based Participatory Research Contributions to Intervention Research: The Intersection of Science and Practice to Improve Health Equity," *American Journal of Public Health* 100, Suppl 1 (April 2010): S40–S46. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837458/.

in improved dietary and physical exercise habits. All churches involved agreed that the initiative was an important component of achieving social change that would improve health outcomes and lessen health disparities.

This was a massive undertaking, for both the churches and the executive team, but God's Spirit was with us. We decided that we needed God's anointing for the work. A commissioning ceremony was held November 15, 2013, for the advisory board, field workers, church coordinators, and small group facilitators, all of whom would go through a similar program that the twelve clergy had experienced. The commissioning also included the researchers from the Department of Preventive Medicine at RUMC; the director from the Department of Religion, Health, and Human Values; the director from the Department of Behavioral Health; the senior pastor of Third Baptist Church of Chicago; and me, his associate pastor of pastoral care and program development. Families of all team members were invited to witness this occasion. (This also began extra church work for them!) It was a holy time, greatly appreciated by all present.

Beginning in January 2014, the full CBPR team met weekly for encouragement, support, and training informed by feedback sessions held in each of the participating congregations. Through question and answer sessions with potential participants, the research team gathered data on eating habits that shaped program design. The training was completed September 2, 2014. The full team met in mid-September to enjoy fellowship, develop a schedule of meetings, establish time-frames for the work, and name the initiative. The name decided was ALIVE!, an acronym for Abundant Living in Vibrant Energy! Our prayer was that we would develop, with God's help, an initiative to give many people a new life of healing and wholeness as they adopted those program components that would help them develop better health behaviors. In mid-September 2014, ALIVE! was launched in the five cooperating churches.

The Intervention Design

One misunderstanding regarding health improvement is that when people know better, they automatically do better. Researchers often grapple with the question, "The people know what they have to do to live healthier; why don't they change their habits and behaviors and live better?" In Paul's epistle to the Romans, he provides a succinct explanation: "I do not understand what I do. For what I want to do, I do not do, but what I hate, I do….For I have the desire to do what is good, but I cannot carry it out. For what I do is not the good I want to do; no,

the evil I do not want to do—this I keep on doing….What a wretched man I am! Who will rescue me from the body of death? Thanks be to God—through Jesus Christ our Lord" (Romans 7:15, 18b–19, 24–25, NIV). Most people do not change their behaviors simply because they know they should. They do need to know that their current behaviors are life-sapping rather than life-giving, but change requires deep-rooted acceptance that they are worth the effort of developing a new mindset and new disciplines that will help them live with more meaning, purpose, energy, and joy. Changing unhealthy habits can be hard, yet change is necessary if one is to stop lifestyle behaviors that lead to premature death and minimize the exacerbation of chronic illnesses.

Church-level intervention. Church-level intervention included the following activities that involved entire congregations:

- Sermons. The pastors addressed health-related topics in their sermons at least once a month. The five pastors discussed the topic for the preaching moment, so that topics and Scriptures were coordinated across the congregations, usually pairing it with the Bible study theme for that month.

- ALIVE! Bible study. A twenty-four-week curriculum used Scripture to emphasize the spiritual importance of taking care of one's physical body and provided spiritual guidance and support for needed behavior changes. The Bible study materials for the participants included reflection questions for individual participant and other questions for group discussion. Field workers took general notes, being careful to guard the confidentiality of class participants.[6]

- Bulletin inserts. Inserts with healthy eating tips, recipes, and announcements for churchwide activities were included in bulletins each month, with more frequent announcements as needed.

- Churchwide healthy eating activities. Activities organized by the church advisory board members were offered to the whole congregation (e.g., a workshop on emotional eating and a veggie smoothie contest).

[6] See pages 67–68 for an outline of the Bible study sessions.

Participants in these activities did not have to sign a participation agreement or complete food logs or have personal data monitored (e.g., blood pressure).

Individual-level intervention. Congregants who volunteered for the individual-level intervention signed a contract to participate in a variety of activities and agree to field workers monitoring specific non-invasive data across the nine-month period (e.g., height, weight, blood pressure, waist measurements).[7] Telephone interviews regarding meal planning and twenty-four-hour logs of all foods eaten with portion sizes were periodically recorded. Small group sessions allowed participants to give feedback to the researchers regarding class content and videos. Participant feedback was invaluable, as it allowed the researchers to modify activities to best suit participant needs and ensure clarity of information communicated. Specific small group activities included but were not limited to the following:

- Nutrition skills. These were presented within small covenant groups and included videos, demonstrations, and open discussions regarding culturally relevant nutrition education, food preparation, and healthy eating skill-building and modeling (e.g., buying, storing, and preparing vegetables). Participants learned to read food labels with increased awareness of the amounts of salt, sugars, and fat often hidden in shelf and refrigerated sections of grocery stores.

- Self-management training sessions. Led by trained facilitators from each congregation, these sessions focused on goal setting, self-monitoring, and problem solving. "B-SMART" (behavioral, specific, measurable, achievable, relevant, time-oriented) goals provided a framework for supporting participants in setting reasonable goals.[8]

- Group support. These sessions gave participants opportunities to share what was working for them and ongoing barriers they experienced to healthy food preparation, exercise, and goal setting. Group members brought recipes, and sometimes dishes, supporting lessons learned in the group setting.

[7] In order to protect confidentiality, participant names were not used in the research data that was gathered.

The executive team developed session materials with input from the advisory board, and uniformity of content was assured through facilitators' completion of fidelity sheets that included checklists of points to be covered in each session. While churches had flexibility in scheduling ALIVE! components, all five churches completed sessions within the same month. At the end of each session, the congregation's coordinator collected fidelity sheets and facilitator summaries and sent the reports to the executive committee for documentation by the analyst or field workers.

The Importance of Bible Study in Changing Behaviors. The pastors of the five churches enrolled in the ALIVE! project all agreed that linking behavioral changes to Scripture would be critical to achieving the hoped-for program outcomes. The Bible study series provided a way of grounding the people of faith in something they could trust. Sessions joined scriptural insights to practical guidelines and resources for healthy behaviors. The series had to be designed with cultural sensitivity. For many, the hardest part of change is getting past personal, familial, and cultural influences that have not served them well. The pastors of the five African American churches for the ALIVE! project along with Alan V. Ragland and Clayton Thomason, chair of RUMC's Department of Religion, Ethics, and Human Values, gave their input and support in the development of a curriculum we hoped would address barriers to the healthy behavior changes.

One core intent of the Bible study series was to strengthen participants' willingness to make positive behavioral changes through scriptural understanding. This included a deeper understanding of who and whose (God) they are; a general understanding of the complexity of the nutritional needs for their bodies, minds, and psycho-social connections to remain healthy as possible; an acceptance of God's constant presence with them to fortify them for the struggles they would experience as they practiced new disciplines; and an awareness of the empowering force of the Holy

[8] "B-SMART" goals focus on a concrete *behavior* to change ("walk one mile per day" rather than "lose weight"), naming *specifically* how the individual will achieve the goal ("I will take the stairs instead of the elevator"). The individual should attach a number to the goal so that it is *measurable* ("I will aim for 10,000 steps"), being sure that the number is *achievable* ("I only took 6,000 last week; better aim for 8,000 this week instead") and the specific behavior is *relevant* to their real life (e.g., it may not be a good goal to forgo the elevator for stairs if your work or home does not have stairs). Finally, goal-setting should be *time-oriented,* setting a specific timeframe for the goal. ("I will achieve 10,000 steps by week twelve.")

Spirit within and available to each of them to help them develop the disciplines needed for behavioral changes.

The Bible studies also allowed participants to confront demoralizing and life-defeating thoughts and feelings that were shame-based, causing low self-esteem, and spirits of anger, rage, and unforgiveness toward self and others. Sessions led participants in developing of a list of biblical texts that brought new positive responses to old, self-defeating memory tapes that kept them bound in unhealthy thinking and actions. The studies fostered in participants the right and will to develop a "can do" commitment to life-giving behaviors and attitudes. They helped participants organize their days and lives in ways that relieved stressors they had control over, and let go of the things over which they had no control, trusting that God was working even when they could not yet see it. Overall, the Bible study lessons sought to bring participants into a closer relationship with God and to help them accept that they were worth the new energy and zest for life behavioral changes would bring.

These themes were emphasized as much as possible in the selected Scriptures for study (see chart below). The format of each Bible study included (1) an introduction to the lesson, (2) the background and historical perspective for the presented Scripture, (3) Scripture elaboration or commentary, and (4) questions for personal reflection and group discussion. Clergy suggested aligning the Bible study series with the liturgical calendar (e.g., the seasons of Advent, Christmas, Epiphany, Lent, and Easter).

Scripture Used for Each Bible Study Session

1 In God's Image and Likeness	Genesis 1:26–2:3, 7
2 The Faithful God of Relationship	Psalm 139:1–18
3 Commitment	Mark 1:29–38
4 Planning and Engagement for Abundant Life in Health	Nehemiah 1:4–2:20
5 Gathering/Feasting/Sharing/Thanksgiving*	Deuteronomy 16:13–17; Acts 2:42–47
6 Hope and Joy/Forgiveness and Reconciliation*	1 Peter 3:10–16; Isaiah 40:28–31
7 Waiting and Anticipation/Love and Peace*	Luke 1:26–56; John 3:15–21

*These lessons were used during the Thanksgiving and Christmas seasons.

8 Listening to the Spirit of Truth Within	John 14:16, 17b; 16:12–15; Mark 5:21–34
9 Faithfulness and the Discipline of Healthy Living	Daniel 1:1–20
10 Led by the Spirit into a Wilderness Place: Sacrifice and Revelation Bring Strength	Matthew 4:1–11
11 Battles and Wrestling and Knowing God's Presence in Sacrifice and Victory	Genesis 32:1–32
12 Rooted and Grounded in Love: Sharing Abundant Life with Others	Ephesians 3:14–21

Final Outcomes and Reflections

A total of 206 members from five African American congregations enrolled in the initiative, and 182 members completed the nine-months. At the nine-month follow-up, the mean number of servings of vegetables participants consumed increased by one. Interestingly, the percentage of increase in vegetable intake was higher in the three churches where the pastor taught the Bible study (52 percent, 55 percent, and 63 percent); in the two churches where an assistant pastor or deacon taught the Bible study, the one serving increase was 39 percent and 33 percent. This reinforced the belief that the active participation of the pastor matters. Weight reductions ranged between three and forty pounds. The weight loss of many participants was evident. Participants reported that their A1Cs, cholesterol levels, and blood pressure readings were lowered. Approximately a quarter of participants were prescribed lower doses of their medications for hypertension, diabetes, and/or cholesterol. One participant gave testimony that she is no longer on medication to lower her cholesterol. Menus for churchwide events included less carbohydrate-heavy dishes and more and varied ways of cooking vegetable dishes as well as baked rather than fried and processed meats. Overall, participants expressed feeling energized and more interested in participation in physical activity since they enrolled in the project.

Several years after the initiative concluded, testimonies continue at Third Baptist Church of Chicago, including experiences of good energy, lowered blood pressure, decreased medications, and weight loss. In 2017 the church's Walking Club set a challenge to see how many collective miles they could walk between June 26 and August 27. Just over 150 people participated. The combined result was 37,564,503 steps, equaling

18,782.2 miles. Together this group of determined "ALIVE! steppers" walked three-quarters of earth's circumference—an accomplishment to be celebrated! The majority of walkers with hypertension noted a decrease in their blood pressure, and those with diabetes reported reductions in their daily blood sugar readings. Participants continued to incorporate more vegetables into their diets and drank more water than before they joined the ALIVE! initiative.

The success of the ALIVE! is likely due to a number of factors. (1) The study was conceived, designed, and conducted by a partnership of researchers, pastors, and church leaders; (2) the intervention incorporated pre-existing spiritual values and coping strategies (e.g., prayer and Bible studies) and was delivered in a format that was consistent with church culture; and (3) nutrition education content was culturally tailored based on pre-existing studies of conceptual frameworks around diet and health.[9]

Health disparities are significantly higher for the African American community than other racial and ethnic group in the United States, including higher rates of diabetes, hypertension, coronary, heart, and circulatory diseases. Yet many communities experience barriers to healthy behaviors, whether caused by cultural diet norms or by social, economic, or environmental stressors. Moreover, people of all races and cultures often do not know what concrete behavioral changes they can make to minimize the long-term, debilitating effects of these diseases. Through culturally appropriate education such communities can break free from the negative impact of illnesses that have permeated their families for generations.

While the ALIVE! initiative was developed specially for the African American community, the CBPR approach can be used for any cultural or ethnic group. Collaboration with members of the participating community provides invaluable input, ensuring program design and content delivery that draws on cultural strengths and values. The CBPR approach celebrates the uniqueness of the community and upholds what is life-giving and sacred to that community. This approach gives participants greater confidence that their family structures, social customs, and cultural norms will be carefully considered in any recommended behavior modifications.

[9] Lynch, "Results of ALIVE," 8. For more in-depth information on the ALIVE! Project go to the website for a plethora of additional information and resources, www.thealiveproject.org.

The church can be an essential partner in this work. As a safe haven for healing and wholeness, the church can equip its members to grow in their trust of God's healing grace and his power to bring wholeness where there has been brokenness. Church communities celebrate times of triumph and hold close those who are experiencing life's trials. They affirm each person's value as a human being made in the image and likeness of God. Congregations can also offer strength for the journey of life by encouraging improved self-care for each of their members—body, mind, and spirit—as the temple of God's Spirit.

"Do not be conformed to this world but be transformed by the renewing of your minds, so that you may discern what is the will of God—what is the good and acceptable and perfect will of God" (Romans 12:2).