Journal of Applied Christian Leadership

Volume 9 | Number 1 Article 4

1-2015

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Recommended Citation

Wu, James (2015) "Collaboration in Delivering the Adventist Health Message in China: a Single Case Study," *Journal of Applied Christian Leadership*: Vol. 9: No. 1, 30-40.
Available at: https://digitalcommons.andrews.edu/jacl/vol9/iss1/4

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Cover Page Footnote

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This feature article is available in Journal of Applied Christian Leadership: https://digitalcommons.andrews.edu/jacl/vol9/iss1/4

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COLLABORATION IN DELIVERING THE ADVENTIST HEALTH MESSAGE IN CHINA: A SINGLE CASE STUDY

Abstract: The Adventist health message has been shared in many different ways by various institutions of the church. However, rarely is there collaboration across multiple organizations. This article describes how hospitals, universities and church entities worked together to reach the community with healthy lifestyle options. Basically the collaboration worked through four foundational activities: sharing of resources, training of health workers, operating lifestyle centers, and using the existing union governance structure. The collaboration provided outreach services in the following ways: lifestyle programs, wellness expo, health and gospel evangelism, mass media, and cooperation with NGOs.

Keywords: *Organizational collaboration, Adventist health, China*

For about 150 years, Adventists have been health promoters, first in the United States, then Europe, and, by the early 1900s, throughout the world. They have established hospitals and clinics and have raised community awareness on health-related issues. A special report in *National Geographic* magazine (Buettner, 2005, 2008) noted Adventists among the population groups with the greatest longevity in the world. This report grows out of research funded by the U.S. National Institute on Aging. Other longevity studies related to lifestyle have documented repeatedly the remarkable link between longevity and the Adventist lifestyle (Belloc & Breslow, 1972; Breslow & Enstrom, 1980; Doblmeier & Juday, 2010; Fraser, 2003). The China Study (Campbell & Campbell, 2006) found similar results among the people in China. However, most Adventist organizations run health programs individually and independently; collaboration among organizations or institutions is not common.

The Chinese Union Mission (CHUM) of the Seventh-day Adventist Church has been running a series of rather successful healthful lifestyle programs for the

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past 10 years. These programs, in particular the NEWSTART lifestyle program, have received recognition from local government health bureaus in different communities and even from the World Health Organization (WHO). Evidence-based research on these programs and the follow-up monitoring of health indicators of the participants provide scientific evidence that the Adventist health lifestyle can be a promising solution to some global health problems, as underpinned by the WHO resolutions to combat non-communicable diseases (NCDs).

The CHUM Adventist health lifestyle programs are unique in that they function within an organizational structure that includes several different institutions working together to deliver health programs. Two Adventist health lifestyle centers located on the campuses of Taiwan Adventist College and Hong Kong Adventist College, and another one at Xiamen in the Fujian Province of China, are the result of the collaborative leadership of the colleges, hospitals, local Seventh-day Adventist conferences, the CHUM health department, and the Chinese government.

This article describes how the collaboration functions. An understanding of how the collaboration works was gained by interviewing 12 leaders from the institutions that are involved, including CHUM, hospitals, colleges, local conferences, a publishing house, and local churches. Two focus groups were also conducted. It was found that leaders from these institutions collaborate in two primary ways: through foundational activities and service activities.

Foundational Collaborative Activities

The institutional leaders described four foundational activities that were critical to the delivery of a collaborative model: sharing of resources, training of health workers, operating lifestyle centers, and using the existing union governance structure.

Sharing of Resources

Most of the leaders identified finding and sharing of resources as the most extensive activity that happened in the collaboration. Both college presidents indicated that their college campuses and facilities are used for lifestyle programs and training. For example, the former men's dormitory at Hong Kong Adventist College has become the lifestyle health center. The union provided funding to refurbish the men's dormitory into a lifestyle health education center with 16 standard rooms; the hospital supported the health center in design and equipment, program running, and client referral to the health center for lifestyle change.

The two Adventist hospitals have been giving institutional tithe (10%) from their net profits to the union for many years, supporting the ministerial and

health ministries. However, both hospitals have also set aside another 5% of their net profits specifically for medical missionary and lifestyle programs. In Hong Kong, the hospital and the union (using the hospital institutional tithe) allocated around 10 million Hong Kong dollars (around 1.3 million US$) to initially fund the collaboration. A similar situation exists in Taiwan between the Adventist college and hospital. Taiwan Adventist College contributed a good piece of land on which the hospital and the union worked together to build a well-furnished and well-equipped health center on the college campus.

One college president, however, raised a concern. She pointed out that it was not just the sharing of resources that counts, but involvement, collaboration, and long-term participation of all institutions—even down to the local church level. This makes it a true collaboration. The key element was to "stay long enough" and to work closely with the local church leaders until they owned the programs. "We have collaborated with the local church leaders until even the government officials in that district realized our good influence on the health of the community," she stated.

Training of Health Workers

Training is another basic collaborative activity that the leaders articulated; training undergirds the delivery of quality lifestyle programs in different locations and settings. Collaboration in training involves planning and need assessments. Other training activities identified by the leaders were (1) the placement of college health majors in the hospitals, (2) college health department faculty conducting health seminars to train local church health officers, (3) union and conference health directors conducting certificate courses at local churches to train volunteer health workers, and (4) the union, hospital, college, and conferences all working together to help interested local churches become health education centers. "The training and learning process with the local church leaders and members," said one college president, "was vital to the sustainability of the implementation of the health lifestyle programs, especially in the community."

The training includes increasing people's understanding of the importance of knowing and practicing health principles. "We must be true to ourselves," declared one college president, speaking of his endeavor to encourage the college faculty and staff to live healthfully. "If we do not practice healthy lifestyle ourselves, how can we expect others to practice it?" The same experience was described by the union president, who has enjoyed practicing the Adventist health lifestyle from his youth. And the publishing house manager shared his strong belief in the Adventist health message: "We have a church that has a holistic message to take care of the spirit, mind, and body of the people." He put effort into printing many Adventist health lifestyle books, vegetarian cookbooks,

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and menus, and has supported graphic designs for many health Expo booths. What he appreciates most is the core value of the Adventist health message.

In the focus group discussion, the leaders agreed that being good examples as leaders gives a stronger message than mere promotional talks. For the institutional leaders and local church leaders to live the health principles gives a genuine truthfulness to the promotion of Adventist health lifestyle. "It was not by positional power or authority per se, but the power of personal choice," explained the union president. For some in leadership, living the Adventist health message began early in life, while a deepening of understanding and practice often occurs during the training and outreach activities.

Operating Lifestyle Health Centers

The third foundational activity that allows the institutional leaders to work together is the operation of the health centers. This is the fundamental infrastructure needed for the promotion and implementation of lifestyle programs. There is collaborative leadership and management in the operation of the three lifestyle health centers in Hong Kong, Taiwan, and Xiamen, China. Creating a well-balanced and experienced managerial and service team of workers is a challenge. The presidents of the union, the hospital and the college described several different approaches that have been tried within the past 10 years. The complexity of collaboration is highlighted in deciding which entity—the college or the hospital—takes the lead in managing the health centers. Presently, it seems that the hospital leadership provides the most workable management system.

Utilizing the Union Organizational Structure

The fourth basic activity was the union organizational structure that allowed the institutional leaders to communicate and to work together in executive committees, the board of directors, and annual meetings. The institutional leaders shared a common understanding that the Adventist church structure is a convenient way to allow the leaders to share a common agenda and to become owners of the Adventist lifestyle programs. The church structure has many committees and boards on different administrative levels—the General Conference, the division, the union, the institution, the local conference, and the local church. Leaders are members of committees or boards, sitting on one another's committees. During these meetings, they are able to become participants, users, facilitators and coordinators of the health programs.

These meetings, if used properly, encourage and enhance collaboration. "Our church has a very complete organizational structure," emphasized the publishing house manager. "However, in the past six years I have seen collaboration mostly on evangelistic activities and not enough on lifestyle and healthcare. The

challenge was self-interest and the lack of clear role and function for each institution." This statement points to the ongoing challenge of collaboration. It is not necessarily easy to collaborate, but often when the focus turns to actual activities that require collaboration to be successful, working together becomes more natural.

Collaborative Service Activities

Since the purpose of Adventist health lifestyle programs is to improve health, it became apparent that most of the collaborative activities were service oriented to best meet the health needs of the people. The institutional leaders discussed how they have been involved in many of the health programs in order to extend their services to other organizations, local churches, and communities. Five different aspects of this outreach were described in the data: lifestyle programs, wellness expo, health and gospel evangelism, mass media, and cooperation with NGOs.

Conducting Healthy Lifestyle Programs

Common lifestyle program activities in which leaders served collaboratively were vegetarian cooking, baking, and nutrition classes, fitness and exercise classes, stress management seminars, nature and mountain hiking, and programs on major lifestyle-related diseases such as high blood pressure, high cholesterol and high sugar. Day camp, weekend, and live-in camps lasting one or two weeks are some major health behavior change lifestyle activities that involve all the institutions. The eight health principles of NEWSTART are the core values for health behavior change. These activities need coordination and support among the health leaders and their subordinates, and also between institutions (like hospitals and colleges) and the local conferences and local churches within the union.

Involvement in the Wellness Health Expo

The Wellness Health Expos that were conducted in Taiwan, Hong Kong, and Xiamen, China, were major activities that required collaboration. Many hours of planning and preparation were invested in these events. All the union institutions contributed to making the events successful. For example, more than 4,000 participants took part in Wellness Health Expo 2009. "The importance of teamwork, listening, and negotiation skills, as well as balancing different needs and sharing credit for success" (Schiavo, 2007, p. 203) with other institutions was emphasized in the process of conducting the Wellness Health Expo among the union institutions.

The Adventist Institution Wellness Health Expos conducted in 2006, 2007,

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and 2009 had two main purposes. First, the Expos joined all the institutions under the Chinese Union Mission of the Seventh-day Adventist Church in Hong Kong in "the process of convening, exchanging information, and establishing and maintaining strategic relationships" (Schiavo, 2007, p. 199). Second, through conducting the Expos, the institutions shared the wellness concept and principles of the Adventist health lifestyle with the community of Hong Kong.

The idea of organizing an Adventist Institution Wellness Health Expo came during a meeting when all the institutional heads met in early 2006 at the beginning of a new term in office. The leaders reviewed the function of the union structure of the Seventh-day Adventist Church and reflected upon their mission and ways to accomplish it. The recommendation to organize the Wellness Health Expo was approved by the various institutional committees before reaching the union committee for final approval. A budget was allocated by the union, with matching funds from the institutions. A steering committee with representatives from all institutions was appointed by the union committee to plan, implement, and evaluate the outcome of the Wellness Health Expo. The union played an important role in leading the collaboration of the institutions. The institutional leaders were encouraged to put the resources together and to fulfill the mission. In the Wellness Health Expo programs, participating institutions tried to build all the booths and activities around the theme of the Adventist health lifestyle. All those creating displays, games, demonstrations, counseling, and performances were given instructions to make sure that the shared theme was followed. Awareness and promotion activities before, during, and after the Expo were well planned. Carefully selected newspapers, health magazines, public billboards, posters, and handbills to advertise the programs were effectively implemented. Collaborative leadership among the leaders of the union institutions was clearly seen in the process and outcome of the Wellness Health Expo.

Conducting Health and Gospel Evangelism

One important theme of activities shared among the leaders was the collaboration of health and gospel evangelism between hospitals, colleges, local conferences, and local churches. Some leaders stressed the importance of not only participation but ownership of the program. The pastor in Taipei shared his experience of working with the hospital for two consecutive years:

> Previously we only invited the hospital to help out in our evangelistic meetings by asking our doctors to give health talks. However, in our recent evangelism, we had a steering committee consisting of the hospital chaplains, the publishing house manager, and our church elders who worked together to brainstorm, plan and come up with the program. We all owned the evangelistic program this time!

According to the hospital president and the senior pastor, the one-week meetings were conducted Monday to Thursday in the hospital auditorium and then transferred to the local church for Friday and Saturday of the same week. Displaying a spirit of joint ownership, the pastor expressed that the participants showed interest and commitment, which was different from the previous year. The owners (hospital and church) were interested in running the evangelistic series again the next year, thus, the program was sustained.

The "In Search of Health" evangelistic series was an important collaborative service activity in Hong Kong. The hospitals, a local church, and a Christian media evangelism organization worked together to share the Adventist health lifestyle. They rented a public exhibition hall with a seating capacity of 700 for the first two evening meetings, followed by three consecutive weekend meetings at the local church, which seats 300. Health and gospel messages were shared by physicians, dieticians, pastors and evangelists. Scores of volunteers and health workers were involved in the collaborative service activities. The institutional leaders gave their full support.

The stories told by the pastors showed that group prayers and teamwork in gospel and health evangelistic series were vital and inspiring. "Without the earnest prayers offered by the prayer groups, our efforts would not have power," said the pastor in Taiwan. "We had prayer groups from our church and from the hospital. We worked together first in prayers."

Promoting Health via Mass Media

Mass media collaboration is another theme shared by the leaders. In Taiwan, according to the hospital president, the hospital has allocated space for the union to set up a studio to produce programs for Adventist Hope TV. Many of the hospital's doctors, dieticians, and health educators are involved in program production to promote healthcare and a healthful lifestyle. The union also remodeled two of the college classrooms into a recording studio to produce programs for Adventist Hope TV. Spiritual as well as healthy lifestyle programs are produced with collaborative efforts between the union and the college.

Mass media health service activities through the Internet are especially strong and well established in China. The union has contracted with an Adventist media company in China as an agent to enhance the collaboration. Special websites dedicated to health were established.

The publishing house involved the institutional leaders to publish health books and magazines. The leaders of the head office in Taiwan and a new branch office in China actively collaborate in resource sharing and promotion activities. Institutional leaders contribute chapter contents and forewords of vegetarian cookbooks and health-related books. Hospital presidents actively

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support the involvement of their dieticians in these publications.

Working With Community NGOs

Involving the hospital staff and the community with non-government organizations (NGOs) was a theme shared by the president of the hospital in Taiwan as well as the health center manager. There was actually collaboration with NGOs such as the Taiwan Adventist Foundation, the Buddhist Hospital, and the Diabetic Association for activities that involved the hospital staff in the community. The union and the hospital founded the Taiwan Adventist Foundation to promote and to implement healthy lifestyle programs in the community, especially among the aboriginal tribal villages in the mountain areas of Taiwan. Local churches located in the remote mountain villages became activity centers for health screening, cooking classes, and other health programs sponsored by the Foundation. In China, health programs were conducted by Adventist Development and Relief Agency (ADRA China), funded in part by the union and the hospitals in Hong Kong.

"It is our hospital policy to involve our staff in the community," explained the hospital president. "We provide the largest fitness center among hospitals for our staff to keep fit. Our staff canteen provides only healthy vegetarian menus and bakery products. Our staff are proud to share their health experience with the community." The hospital president and health center manager further described their experience working with the Buddhist hospital on promoting vegetarianism and collaborating with the Diabetic Association, other charity foundations, and the community vocational colleges for healthy lifestyle promotions that reached out into the community.

Challenges Connected to the Academic Literature

Several authors help to explain some of the challenges faced by the collaborative approach. For example, the collaborative theories of rational choice and the socialized choice theories by Hill and Lynn (2003) identify the importance of shared organizational goals and values. Not only must shared goals be identified, but they must be communicated to all involved. The four-stage model proposed by Jackson and Reddick (1999) seeks to strengthen the process of collaboration by addressing the challenge of the lack of information sharing and communication.

One of the most critical obstacles encountered in this study was that collaborative leadership took time to build trust. The six-step community empowerment model of Yoo et al. (2004) has the underlying value of showing how to do collaboration. The issue addressed in this study was that the institutions in CHUM had been doing health programs independently in the past and had not

learned to trust others. The problem of mistrust, due to the lack of communication and poor decision-making processes, was reported from the frontline level rather than the leadership level. This mistrust hindered the effective implementation of the Adventist health lifestyle programs despite the agreement among the institutional leaders. Institutional leaders were not seen as being involved enough with the frontline staff, and top-down communication was weak. So leaders were asked to share more, to explain and to communicate more, and to give a few more incentives. Strengthening the human relationships of the frontline staff with the staff of the institutions participating in the collaboration was a challenge.

Resource allocation was a frequently discussed challenge in this study. Many institutional leaders had to convince their administrative teams to set aside funds for working with other institutions. The question asked by some administrators was, "Why do we need to use our resources to support the activities of other institutions? We do not have enough resources for our own programs."

This tension was most pronounced in the development of a budget to support the implementation of the lifestyle programs. Each of the leaders had to negotiate with other institutional leaders the percentage of resources their institution would contribute to the shared budget. There was tension between the union and the subsidiary institutions, who felt that the union should shoulder the bigger share of the needed resources. Meanwhile, the union felt that the hospitals, being the more affluent institutions, should contribute the greater share. Agreeing upon a budget to implement collaborative Adventist health lifestyle programs was a challenge that called for wisdom and leadership skills. Could it really be demonstrated that collaboration would enhance the overall performance of all the stakeholders and bring better outcomes? Sowa (2008, 2009) offers a three-perspective theory that combines resource dependence, networking, and an institutional perspective approach that sheds light on the importance of paying attention to the perspectives of all collaborators.

Another challenge that related to resources was the challenge of breaking even financially in the implementation of Adventist health lifestyle programs. There was a mixed feeling that lifestyle programs were not evangelistic programs, and that they should not drain institutional resources but should create revenue and be self-sustaining. The concept of medical missionary outreach programs was not embraced immediately by all institutions in the collaboration.

The drifting apart of healthcare medicine focusing on acute care from preventive lifestyle health services has been a challenge. The collaborating leaders in the implementation of lifestyle programs need to consider a strategy to integrate lifestyle medicine with acute care mainstream medicine. Lifestyle medicine is not alternative medicine, as some think. Rather, it should be a component of

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integrated holistic patient care that includes acute care, rehabilitation, prevention, lifestyle, screening, diagnosis, and treatment all working together for patient-centered healthcare services. Medicine today should not be just acute care, disease-centered medical services.

In their editorial in the *American Journal of Lifestyle Medicine,* Rippe, Angelopoulos, and Rippe (2009) state their support of this perspective:

> No viable health care reform will occur in our country to achieve better health care outcomes and control costs until we get control of the lifestyle issues that are driving both poor health outcomes and enormous expense.
>
> We in the health care community have both an enormous responsibility and opportunity in this area. The evidence is no longer debatable that positive lifestyle decisions profoundly affect both short- and long-term health and quality of life.
>
> In the name of health reform, old and worn out excuses about lack of time, knowledge, and /or lack of reimbursement for failing to guide our patients toward healthier lifestyle must come to an end. It is time for us in the medical community to embrace the abundant evidence that already exists that regular physical activity, proper nutrition, weight management, smoking cessation, and other lifestyle-related habits and practices profoundly affect not only the health of our patients and their economic well being but also the very financial stability of our country. (pp. 423-424)

The Chinese food culture was observed as a huge obstacle when implementing the Adventist lifestyle programs in the Chinese community. Chinese food is famous for its many delicacies from different parts of China. Restaurant feasts with 12 dinner entrées are common. The Chinese conduct business at the dining table with overwhelming and extravagant food and wine. To build a trend or a culture of the Adventist health lifestyle, especially with a vegetarian or plant-based diet, is difficult and challenging. Some institutional leaders hesitate to promote the lifestyle programs because of the strong Chinese food culture. Many of the local church members, even the majority of the pastors, are not practicing the Adventist health lifestyle. Some of the institutional leaders saw the challenge as too enormous to tackle; they neither welcomed nor appreciated their roles in the implementation of Adventist health lifestyle programs. To build and support a principled culture of Adventist health lifestyle in the local churches, as well as among the pastors, the faculty of the educational institutions, and the staff working in the healthcare institutions, has been a challenging obstacle that requires vision, persistence, and leadership competency.

Finally, what really holds the collaboration together? First, the leaders have been strong in their belief that the health message was sent from God and that it extends the healing ministry of Christ. They believe that the gospel of Jesus should go together with the health message to meet the needs of the contemporary world, especially in the large cities. In the interviews and focus groups,

there was a strong theme of the importance of leadership skills for casting a vision, building the collaboration, and encouraging a team approach. The union leadership was appreciated for its role in the collaboration, but only to the extent that it facilitated the collaboration—not mandating it.

References

Belloc, N. B., & Breslow, L. (1972). Relationship of physical health status and health practices. *Preventive Medicine, 1*(3), 409-421.

Breslow, L., & Enstrom, J. E. (1980). Persistence of health habits and their relationship to mortality. *Preventive Medicine, 9*(4), 469-483.

Buettner, D. (2005). The secrets of long life. *National Geographic, 208*(5), 2-27.

Buettner, D. (2008). *The blue zones: Lessons for living longer from the people who've lived the longest*. Washington, DC: National Geographic Society.

Campbell, T. C., & Campbell, T. M. (2006). *The China study: The most comprehensive study of nutrition ever conducted and the startling implications for diet, weight loss, and long-term health*. Dallas, TX: BenBella.

Doblmeier, M. (Director/Producer), & Juday, D. (Producer). (2010). *The Adventists* [Documentary]. Alexandria, VA: Journey Films.

Fraser, G. E. (2003). *Diet, life expectancy, and chronic disease: Studies of Seventh-day Adventists and other vegetarians*. New York, NY: Oxford University Press.

Hill, C. J., & Lynn, L. E., Jr. (2003). Producing human services: Why do agencies collaborate? *Public Management Review, 5*(1), 63-81.

Jackson, R. S., & Reddick, B. (1999). The African American church and university partnerships: Establishing lasting collaborations. *Health Education & Behavior, 26*(5), 663-674.

Rippe, J. M., Angelopoulos, T. J., & Rippe, W. F. (2009). Lifestyle medicine and health care reform. *American Journal of Lifestyle Medicine, 3*(6), 421-424.

Schiavo, R. (2007). *Health communication: From theory to practice*. San Francisco, CA: Jossey-Bass.

Sowa, J. E. (2008). Implementing interagency collaborations. *Administration & Society, 40*(3), 298-323.

Sowa, J. E. (2009). The collaboration decision in nonprofit organizations. *Nonprofit & Voluntary Sector Quarterly, 38*(6), 1003-1025.

Yoo, S., Weed, N. E., Lempa, M. L., Mbondo, M., Shada, R. E., & Goodman, R. M. (2004). Collaborative community empowerment: An illustration of a six-step process. *Health Promotion Practice, 5*(3), 256-265.

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