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ABSTRACT

COLLABORATIVE LEADERSHIP ROLES IN THE IMPLEMENTATION
OF ADVENTIST HEALTH LIFESTYLE: A CASE STUDY
OF THE CHINESE UNION MISSION

by

James Wu

Chair: Erich Baumgartner

ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

School of Education

Title: COLLABORATIVE LEADERSHIP ROLES IN THE IMPLEMENTATION OF
ADVENTIST HEALTH LIFESTYLE: A CASE STUDY OF THE CHINESE
UNION MISSION

Name of researcher: James Wu

Name and degree of faculty chair: Erich Baumgartner, Ph.D.

Date completed: July 2014

Problem

Little is known about the roles of the institutional leader's role in the collaborative implementation of the Adventist health lifestyle programs of the Chinese Union Mission of the Seventh-day Adventist Church in Hong Kong and Taiwan. Such an understanding would provide clues regarding how collaborative leadership and the implementation of Adventist lifestyle programs meet the challenge of non-communicable diseases.

According to the World Health Organization report, about 36 million people died in 2008 of non-communicable diseases, and the trend continues upward. Evidence-based research, such as the China Study and the Adventist Health Studies, provides a strong support for the ability of Adventist health lifestyle programs to combat non-

communicable diseases and ultimately to improve health.

Method

This qualitative case study describes the background, process, and outcomes of collaborative leadership with institutional leaders playing important roles in the implementation of Adventist health lifestyle programs. A purposive sample of 12 leaders from institutions representing union hospitals, colleges, local conferences, a publishing house, and local churches was selected. I conducted personal interviews, convened focus groups, and made observations of all the leaders as they worked. Major themes were categorized and analyzed to create a set of findings that represented the common experience and perspectives of the leaders.

Results

The research resulted in two major findings: the first pertains to the four roles of the institutional leaders—finder, supporter, builder, and owner—in the collaborative implementation of Adventist health lifestyle programs. These four leadership roles are exercised in two groups of collaborative activities. The first group is foundational for collaboration in finding resources, training health workers, and the operation of lifestyle health centers; while the second group comprises the service-based healthful lifestyle programs. The second finding is a complex integrated relationship of factors, metaphorically described as a four-strand woven cord, represented by (a) the four leadership roles, (b) the implementation of Adventist lifestyle programs, (c) the organizational structure of the Seventh-day Adventist Church, and (d) the collaborative leadership skills of the leaders. The primary challenge for the leaders' roles is to find ample resources for collaboration. A significant tension among the leaders in the context

of the union organizational structure is the question who should initiate the common agenda for collaboration and the mechanism of the sharing of resources.

Conclusions

This case study resulted in 10 recommendations for the global Adventist church and her 120 unions. The experience of the Chinese Union Mission could be a model for collaborative leadership in the implementation of Adventist health lifestyle programs to combat non-communicable diseases in order to improve global health. The research also discovered opportunities for further research that may enhance leadership development.

Andrews University

School of Education

COLLABORATIVE LEADERSHIP ROLES IN THE IMPLEMENTATION
OF ADVENTIST HEALTH LIFESTYLE: A CASE STUDY
OF THE CHINESE UNION MISSION

A Dissertation

Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by

James Wu

July 2014

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LIST OF ABBREVIATIONS

AdHeLP	Adventist Health Lifestyle Programs
AHS	Adventist Health System
CHUM	Chinese Union Mission
CR	Constituency Relations
DPAH	Global Strategy on Diet, Physical Activity, and Health
NCDs	Non-communicable Diseases
NEWSTART	Nutrition; Exercise; Water; Sunlight; Temperance; Air; Rest; Trust in God
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

Background of the Problem

Both urban and rural areas of the world are facing health challenges. Urbanization has led to increased consumption of processed food, physical inactivity, heightened stress, drug dependency, and chronic poverty, which are related to poor health (Liubai & Yan, 2009; Sodjinou, Agueh, Fayomi, & Delisle, 2008). Rural areas continue to have needs for better water and hygiene, and acute healthcare (Kjellstrom & Mercado, 2008; Mitlin, 2005; Pettee & Ainsworth, 2009; Zimmer & Kwong, 2004).

These factors increase health problems which can introduce higher risk factors such as hypertension, high cholesterol, hyperglycemia, and obesity, which can lead to non-communicable diseases (NCDs) such as type 2 diabetes mellitus, heart disease, stroke, and cancer. Most of these health problems and NCDs are related to people's lifestyle. Research studies show that by practicing a lifestyle with a healthful diet, getting regular exercise, and maintaining an ideal weight clearly play a role in the prevention of chronic diseases (Kahn, Phillips, Snowdon, & Chol, 1984; O'Neil & Nicklas, 2007). Because these health challenges decrease human productivity and wellness as well as human longevity, nations are constantly looking for ways to improve health.

The World Health Organization has adopted resolutions to tackle the challenges. In May 2004 (Resolution 57.17), the Global Strategy on Diet, Physical Activity, and

Health (DPAH) was adopted by the World Health Assembly. In 2007, Resolution WHA60.23 “Prevention and control of non-communicable diseases, implementation of the global strategy,” was taken; and in May 2008, Resolution WHA61.14 “2008-2013 Action Plan for the Prevention and Control of Non-communicable Diseases” was approved. Implementing the resolutions and involving different government and non-government organizations into action plans are very challenging (Tukuitonga & Keller, 2005).

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 worked to establish hospitals and clinics and to raise community awareness on health. Their lifestyle may represent a solution to the health problems of modern society. A special report by *National Geographic* magazine (Buettner, 2005) noted Adventists among the population groups with the longest 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). However, most Adventist organizations run health programs individually and independently, and collaboration among organizations or institutions is not common.

The Chinese Union Mission (CHUM) of the Seventh-day Adventist Church in Taiwan, Hong Kong, and China has been running a series of rather successful healthful lifestyle programs, particularly the NEWSTART lifestyle program, for the past 10 years. The programs have received recognition from the local government health bureaus and support from different communities and even the WHO. Evidence-based research on

these programs and the follow-up monitoring on the participants' health indicators provide scientific evidence that the Adventist health lifestyle can be a promising solution to the global health problems, as underpinned by the WHO resolutions to combat against NCDs.

The CHUM Adventist health lifestyle programs are unique in that they function within an organizational structure that includes several different institutions that work together to deliver a collaborative health program model. The collaboration based its model on biblical Christian values and developed into a series of programs that the leaders and institutions of CHUM are involved in to improve health. There are four important components in the collaborative model: (a) The NEWSTART Health Centers, (b) The Adventist Foundation; (c) The NEWSTART Wellness Expo; and (d) The Management Committees. The NEWSTART Health Center at the Taiwan Adventist College, for example, being one of the important components in the collaborative model, is funded by the union for the Center's construction; however, it is managed by the Taiwan Adventist Hospital to run NEWSTART for 1-week and 2-week live-in lifestyle programs, but at the same time the Health Center is the teaching center and laboratory for the College health major degree program to train health workers to serve in the field. The three Adventist health lifestyle centers located in Taiwan and Hong Kong Adventist College campuses, and the one at Xiamen in the Fujian Province of China, are the result of the collaborative leadership of the colleges, the hospitals, the local conferences, the union health department, and the Chinese government participating in the programs to promote and to sustain the Adventist health lifestyle.

How do the CHUM institutional leaders involved in the collaborative model

implement the Adventist health lifestyle programs, such as the health centers, tackle the challenges of lifestyle-related NCDs; and what role does leadership play in the process of collaboration? The answers to these questions are the basis for this study.

Statement of the Problem

Adventist health lifestyle programs can play a positive role in alleviating the challenging health issues identified by the WHO Global Strategy on Diet, Physical Activity, and Health (DPAH). Their work can help to combat non-communicable diseases (NCDs). Research on Adventist health and lifestyle has been extensive; however, research on the role of the leaders in implementing the health and lifestyle programs is limited. Adventists have a functioning collaborative model of health lifestyle programs led by the institutional leaders that could provide insight and understanding on collaboration on health education and services if we understood their role better.

Purpose of Study

The purpose of this qualitative case study is to describe the roles and functions of the institution leaders when they are involved in the collaborative model within the Chinese Union Mission organizational structure to implement Adventist health lifestyle programs in the Chinese community.

The Central Research Question

This research is designed to address one central question: How do the Adventist institutional leaders function and collaborate within the Chinese Union Mission structure to implement Adventist health lifestyle programs?

Research Design

This study used a qualitative case study to describe the activities of the Chinese Union Mission institutional leaders involved in Adventist health lifestyle programs. A qualitative research approach is most appropriate to explore the central question of this study. According to Stake (1995) case study researchers study on a program, an event, or activity that involves individuals rather than a group of people or events. It has the characteristics of strong narratives, and uses the cooperative inquiry method as described by Reason (1999) and Creswell (2008).

A case study is an in-depth exploration of “a bounded system” (e.g., an activity, event, process, or individuals) based on extensive data collection (Creswell, 2007, p. 73). Bounded system means that the case is separated out for research in terms of time, place, or some physical boundaries. The bounded system in this study is the study of Chinese Union Mission between the years 2001 and 2010, and its institutional leaders in the process of implementing the Adventist health lifestyle programs in Taiwan, Hong Kong, and Xiamen, China.

Theoretical Conceptual Framework

This research is framed by a few related concepts and fields of knowledge. They provide guiding ideas into the research problem and the emerging perspectives. The foremost one is the WHO research on global prevalence and challenges of NCDs (Tukuitonga & Keller, 2005), the China Study (Campbell & Campbell, 2006), and the Adventist studies with the Adventist lifestyle in relation to NCDs and longevity (Kahn et al., 1984). Lifestyle management practices and services are becoming central to health reform and health improvement for the modern society (Rippe, Angelopoulos, & Rippe,

2009). The section of the literature review gives rich resources that helped to frame this study on the Adventist leader's role in the implementation of Adventist health lifestyle programs.

The second field of knowledge focuses on organizational behavior and leadership collaboration. The framework helps the researcher to understand why and how the Adventist institutional leaders collaborate in the Adventist health lifestyle programs. Four perspectives were used to describe the collaboration: the trend of collaboration (Cross, Dickmann, Newman-Gonchar, & Fagan, 2009), what motivates collaboration (Sowa, 2009), how the collaborative process works (Yoo et al., 2004), and the outcomes of collaboration (Pinto, 2009).

The third area of knowledge was health communication. According to Schiavo (2007), health communication is a comprehensive and theoretical field of knowledge that requires leadership competency for health promotion. It helps one to understand how our institutional leaders communicate their collaboration of implementing Adventist lifestyle programs to the community, for collaboration cannot function well without communication (Jackson & Reddick, 1999).

The fourth field of knowledge is the Adventist organizational structure. In this field of literature review, it helps to understand that Adventist institutional leaders are prompt to work together in the context of the Adventist organizational structure (B. Oliver, 1989), particularly at the union level.

Significance of Study

This study seeks to understand and describe collaborative leadership roles in the Adventist union organization structure to provide health services, through the

institutional leader collaborative effort with the Adventist health lifestyle programs. This focus on collaboration could inform other Seventh-day Adventist organizations as well as other religious, non-profit, and profit organizations working towards improving world health.

This research will be able to contribute and support the resolutions and action plans that the WHO and the Adventist world church have been promoting to prevent and control NCDs. This study may provide principles that Adventist leaders, through collaboration in implementing the Adventist health lifestyle programs, become leaders in the communities around the world, influencing changes in their communities' health and quality of life.

Delimitations

This research study is delimited to the leaders and organizations of the Chinese Union Mission of the Seventh-day Adventist Church, which is a small sample of 12 leaders of hospitals, colleges, a publishing house, health centers, and the local churches. This study also focuses on issues only related to implementing the Adventist health lifestyle programs. The research outcomes are designed to inform cultural context when referred by other unions of different cultures.

Definitions

The following definitions apply to terms as they are used in this study:

Adventist Health Lifestyle: According to Buettner (2005), Adventists are among the people groups that enjoy longevity mainly due to their lifestyle that practices a plant-based diet, regular exercise, no smoking and no alcohol, and a faith-based family life that keeps a weekly day of rest on the Sabbath (Saturday).

Adventist Health Lifestyle Programs (AdHeLP): There are a number of lifestyle programs that help the participants to practice the principles of Adventist health lifestyle. Acronyms like the NEWSTART program, the CELEBRATIONS program, and the HARTLAND program, for example, are copyrighted by various organizations that promote the Adventist health lifestyle in the formats of educational seminars or live-in programs.

Collaboration: According to Kreuter, Lezin, and Young (2000), the terms *consortium*, *collaborative*, and *coalition* are used interchangeably by some practitioners and researchers, yet some distinctions are still made in the literature. The terms *consortia* and *collaborative* are typically used to describe similar organizations that join together to benefit more from their collective actions than they could as individual players. In contrast to *consortia*, in which participating organizations are linked because they offer similar services or share patients, the term *coalition* tends to refer to groups of varied organizations whose interests converge or overlap to varying degrees but whose member organizations have separate agendas and interests of their own. (p. 61)

Constituency Relations (CR): According to Schiavo (2007), in health communication, constituency relations can be defined as the process of convening, exchanging information, and establishing and maintaining strategic relationships with key stakeholders and organizations with the intent of identifying common goals that can contribute to the outcomes of a specific communication program or health-related mission. (pp. 199-200)

NEWSTART Program: The Weimar Institute coined and copyrighted the acronym that spells out the eight principles of health as it was first described by Ellen White in her book, *Ministry of Healing* (1905). The acronym stands for N: a plant-based nutritive balanced diet; E: regular exercise; W: ample use of water; S: adequate sunshine; T: temperance and abstinence from harmful substances; A: use of fresh air; R: adequate rest; and T: trust in the creator God.

The Seventh-day Adventist Church Structure: There are four tiers in the organizational structure of the Adventist Church. The General Conference and its 13

Divisions around the world are the top tier, while the second tier is the union, the third tier is the local conference that leads the local churches, and the basic level is the local churches that make up the world church.

The Chinese Union Mission (CHUM): The territories of this union include China, Hong Kong, Macao, and Taiwan (when restructured in 2012, Taiwan was placed directly under the NSD), with a population of approximately 1.5 billion. There were approximately 460,000 church members, and 4,000 local churches and congregations, according to the 2009 world statistics of the General Conference (General Conference of Seventh-day Adventists, 2009).

Summary of the Study

This study is organized and deliberated in five chapters. Chapter 1 discusses the background of the problems of NCDs and lifestyle health improvement, the purpose of the research study, the central research question, the research method used, the theoretical conceptual frameworks that guide the study, and the importance of the study. The chapter also gives a list of definition of terms, the delimitations of the study, and the organization of the study.

Chapter 2 is the literature review. The introduction discusses the purpose of the literature review. There are three main sections in this chapter with the first section being a review of the relationship of lifestyle and NCDs with special attention on the Adventist health lifestyle. The second section focuses on leadership and collaboration forming the underlying leadership framework for collaboration in the implementation of Adventist health lifestyle programs. The third section deals with the Adventist Church's organizational structure related to collaboration.

Chapter 3 deliberates on the methodology, which is qualitative research using case study, showing how it is suitable for this study. The chapter describes the sources and analysis of data collected from interviews, focus groups, artifacts, and historical documents to create a holistic view of the roles of the institutional leaders collaborating in the implementation of Adventist health lifestyle programs. My personal experience is intertwined in this chapter showing how I practice and implement the principles of an Adventist health lifestyle.

Chapter 4 contains the results of the data analysis. The focus is upon the key categories and the major themes that are related to leadership collaboration exhibits in the roles of the institutional leaders.

Chapter 5 concludes the study with a discussion of the lessons learned in this case study with recommendations and applications made that will provide references to improve the effectiveness of leadership in the implementation of the Adventist health lifestyle programs aiming at improving health with respect to the WHO 2004 and 2008 resolutions to prevent and control NCDs. The chapter also develops recommendations for other unions of the Seventh-day Adventist Church around the world to consider a collaborative approach to the implementation of lifestyle programs based on a better understanding of the roles of the union institutional leaders.

CHAPTER 2

LITERATURE REVIEW

Introduction

The purpose of this study was to investigate the collaborative roles of the leaders of the institutions in the Chinese Union Mission when implementing the Adventist health lifestyle programs, in the context of the union structure of the Seventh-day Adventist church to improve health. This study looked at the institutional leaders in the Chinese Union Mission who believe that an unhealthy lifestyle is closely related to many chronic diseases. The leaders are working in the union organizational structure to collaborate and to communicate, among many other things, to better implement the Adventist health lifestyle programs. This literature review helped to guide this study.

The literature review provided the conceptual framework for the study, and focused on four facets. They provide guiding ideas into the research problem and the emerging perspectives. First, I review lifestyle and health, the correlation between lifestyle and NCDs. Second, I review materials related to leadership and organizational behavior, particularly from the perspectives of collaboration. Third, I discuss leadership and health improvement deliberating on health communication. Lastly, I look at Adventist health reform and the organizational structure of the Seventh-day Adventist Church and its relationship to leadership and health improvement.

Perspectives on Lifestyle and Health

Lifestyle and NCDs

I looked at the literature that discusses the relationship between lifestyle and NCDs. The WHO's (2011a)

2010 Global status report on non-communicable diseases shows that NCDs are the biggest cause of death worldwide. More than 36 million people died from NCDs in 2008, mainly from cardiovascular diseases (48%), cancers (21%), chronic respiratory diseases (12%) and diabetes (3%). More than 9 million of these preventable deaths were of individuals less than 60 years old, 22% of whom were men, and 35% women in low-income countries; and of whom 8% were men, and 10% women in high-income countries. (p. 3)

The WHO has adopted three resolutions to address the challenge of NCDs, namely; Resolution 57.17 of May 2004 titled “Global Strategy on Diet, Physical Activity and Health (DPAH)”; Resolution WHA60.23 of 2007, titled “Prevention and Control of Non-communicable Diseases: Implementation of the Global Strategy”; and Resolution WHA61.14 of May 2008 titled the “2008-2013 Action Plan for the Prevention and Control of Non-communicable Diseases.” As observed by Tukuitonga and Keller (2005), “implementing DPAH is challenging because current investment in non-communicable disease prevention and control at national and international levels, seriously lags behind what is required, and varying levels of political commitment lead to a limited capacity to respond effectively” (p. 122).

WHO compiled and published on its website the “Non-communicable Diseases Country Profiles 2011” (WHO, 2011b) global report to inform member countries of the prevalence and status of these diseases based on 2008 estimates. The report reviews each country, organizes the data in figures, pie charts, and line charts, shows causes of death as a proportion of total deaths (proportional mortality) for NCDs, communicable diseases, and injuries. The Country Profiles also categorize the NCD mortality, behavioral risk

factors for NCDs, and metabolic risk factors for NCDs for both males and females. There are four line charts that show metabolic risk factor trends, over the past 28 years for (a) Mean systolic blood pressure, (b) Mean body mass index, (c) Mean fasting blood glucose, and (d) Mean total cholesterol. The Country Profiles reveal 17 indicators that address the countries' capacity to respond to NCDs, for example, the responsible government unit or department taking care of the challenge, or whether there is funding available to tackle NCDs, whether the reporting system is functioning, and whether action plans are being implemented.

In the two most populated countries in the world, India and China, the percentage of total deaths (all ages) due to NCDs are 53% and 83% respectively (WHO, 2011b). The metabolic risk factor trends are on the rise, particularly in China. A study done in India reported by Yadav and Krishnan (2008) shows that

rapid urbanization and accompanying lifestyle changes in India, have led to an increase in non-communicable disease risk factors. A survey was done in Haryana state in northern India, to study the changing patterns of diet, physical activity and obesity among urban, rural and slum populations. Using the WHO STEPS questionnaire, on a sample of 4,129 men and 3,852 women, the survey showed that urbanization increases the prevalence of the studied non-communicable disease risk factors, more so in women than men. NCDs control strategy needs to address urbanization and pay attention to gender sensitive strategies that specifically target women. (p. 13)

The China Study

The correlation between lifestyle and NCDs is described in the China Study and it shows the need for implementing primary healthcare and health education (Campbell & Campbell, 2006). The China Study is an influencing study, according to Redwood and Shealy (2005) who say,

The massive study by T. Colin Campbell on the relationship between diet and disease, conducted in China in the 1980s with Jun-shi Chen of the Institute of

Nutrition and Food Safety of the Chinese Center for Disease Control and Prevention and epidemiologist Richard Peto of Oxford University, has been widely acclaimed for its unprecedented scale, scope, and rigor. This is the project that the *New York Times* Science section called “The Grand Prix of Epidemiology.” (p. 1117)

The China Study shows that a plant-based diet can prevent cancer, and that China’s modernization has resulted in a change in diet to a high protein animal-based diet, which has increased cancer rates among the Chinese.

China's fast economic growth, “modernization and urbanization has changed the diet of its population, resulting in the morbidity of lifestyle diseases increasing. Physical activity and sedentary behavior among rural populations, areas are undergoing rapid transitions, needs to be better understood,” according to Ding et al. (2011, p. 37). “Prevalence of obesity and associated diseases in adult women—overweight (22.7%), obese (7.6%), hypertension (18.0%), dyslipidemia (15.9%), diabetes (2.66%), and metabolic syndrome (11.4%)” (Liubai & Yan, 2009, p. 201)—has increased rapidly in Mainland China making it critical to identify nutrition risk factors of obesity prevention and control. The implementation of the WHO strategy on diet, physical activity, and health is essential for a China undergoing such rapid economic growth, in order to improve and maintain health.

Critics of the China Study findings argue that, although the morbidity of lifestyle diseases is significantly lower in China because of its plant-based diet, the longevity of the Chinese as of 2005 was 7 years shorter than that of North America (Redwood & Shealy, 2005). The Adventist Health Studies (AHS), though, seems to support the China Study in that the Adventist sample was from North America; the plant-based diet of the Adventists, together with their lifestyle, gave Adventists a longevity 7 years longer than that of average Americans (Kahn et al., 1984). The Adventist health lifestyle programs

support the findings of the China Study, which should encourage the Chinese to stay on their original plant-based diet to keep healthy.

Campbell and Jacobson (2013) published a second book called *WHOLE: Rethinking the Science of Nutrition*, 7 years after his first book, *The China Study*. In the introduction chapter, Campbell shares the main reason for writing his new book. He compares his first book and the second by saying:

The China Study focused on the evidence that tells us the whole food, plant-based diet is the healthiest human diet. *Whole* focuses on why it's been so hard to bring that evidence to light—and on what still needs to happen for real change to take place. (p. xiv)

Campbell and Jacobson (2013) underscore the dilemma between evidence-based scientific truth about health and that of practicing the health lifestyle. He says:

Also, since 2005, many of my colleagues have conducted varied studies that show even more powerfully the effects of good eating on the various systems of the human body. At this point, any scientist, doctor, journalist, or policy maker who denies or minimizes the importance of a whole food, plant-based diet for individual and societal well-being simply isn't looking clearly at the facts. There's just too much good evidence to ignore anymore. (p. xiii)

Yet Campbell and Jacobson (2013) further describe why practicing the health lifestyle in diet is not prominent by saying:

And yet, in some ways, very little has changed. Most people still don't know that the key to health and longevity is in their hands. Whether maliciously or, as is more often the case, due to ignorance, the mainstream of Western culture is hell-bent on ignoring, disbelieving, and, in some cases, actively twisting the truth about what we should be eating—so much so that it can be hard for us to believe that we've been lied to all these years. It's often easier to simply accept what we've been told, rather than consider the possibility of a conspiracy of control, silence, and misinformation. And the only way to combat this perception is to show you how and why it happened. (p. xiii)

The implementation of Adventist health lifestyle programs faces the same challenge that Campbell and Jacobson (2013) underpinned in his second book.

Collaborative leadership and the role of the leaders, that this study tries to understand, are

intended to enhance the effectiveness of implementing and practicing a healthful lifestyle.

Adventist Health Studies

Extensive research studies on the Adventist health lifestyle have been undertaken and are still ongoing. One such study,

the Adventist Health Studies (AHS) is a series of long-term medical research projects of Loma Linda University (LLU) with the intent of ascertaining the link between lifestyle, diet, disease and mortality of Seventh-day Adventists. Due to their unique dietary habits, Seventh-day Adventists have a lower risk than other Americans of succumbing to certain diseases. This provides a special opportunity to answer scientific questions about how diet and other health habits affect the risk of suffering from many chronic diseases. (“Adventist Health Study-2,” 2008)

“Certain lifestyle characteristics, such as heavy cigarette smoking, consumption of alcohol, and diets heavy in fats may confound or change the effects of other factors, making it difficult to study members of the general population” (LLU, 2014). The Seventh-day Adventists (Adventists) tend to be “far more homogeneous in many lifestyle choices, and they are more heterogeneous in nutritional habits than the general population.” Furthermore, “the wide range of dietary habits of the Adventists, from strict vegetarianism to a normal American diet, greatly enhances the ability of investigators” to make observations (LLU, 2014).

According to the Loma Linda University School of Public Health Adventist Health Studies reports (LLU, 2014), the first major study of Adventists was carried out between 1958 and 1966. It has become known as “the Adventist Mortality Study.” It was “a prospective study of 22,940 California Adventists. The study was conducted at the same time as the large American Cancer Society study of non-Adventists, and comparisons were made for many causes of death between the two populations.” The second major study, namely the Adventist Health Study-1 (AHS-1), was conducted

between 1974 and 1988. It was “designed to determine which components of the Adventist lifestyle give protection against disease. Several questionnaires were mailed to 34,198 California Adventists in the study. AHS-1 was primarily a cancer investigation, and a cardiovascular component was added later” (LLU, 2014). The most recent Adventist Health Study-2 (AHS-2) started in 2002 and is still proceeding. As of May 2006 it had an enrollment of 96,741 where the study goal was 125,000 enrollments. In July 2011, National Institutes of Health awarded AHS-2 a \$5.5 million 5-year grant to continue the study (“Adventist Health Study-2,” 2008, 2011; LLU, 2014; “Loma Linda University Given \$5.5 Million,” 2011). AHS-2 is “one of the largest and most comprehensive studies on diet and cancer in the world” (LLU, 2014).

The benefits of Adventist health lifestyle are revealed in the studies of five simple habits among the thousands of Adventists. The habits are (a) regular exercise, (b) eating a plant-based diet, (c) eating small amounts of nuts regularly, (d) maintaining normal body weight, and (e) not smoking. The study results show the Adventist health lifestyle is significant in many health related findings. For example, in life expectancy, Adventist males and females live 9.4 and 6.2 years longer than Californian males and females respectively (Kahn et al., 1984). Adventist health lifestyle is holistic. It includes the body, mind, spirit, and social relationship and is a faith-based lifestyle (Nedley, 1998). The research outcomes of the Adventist health lifestyle seem to provide positive reference to the challenge of NCDs that WHO has initiated in 2004 with the Global Strategy on Diet, Physical Activity, and Health. The Adventist lifestyle model can be considered the theoretical framework to meet the challenge of the high prevalence of NCDs, and provide the methods of prevention and control of the risk factors (Willett, 2003).

NCDs pose a huge challenge to many developed countries' healthcare budget, such as that of the United States of America, and such that lifestyle change is being promoted as a mainstream health reform to reduce healthcare expense (Rippe et al., 2009). Wagner (2008) reports on the recommendations for public officials to allocate resources efficiently to fight NCDs such as chronic respiratory and cardiovascular diseases. It is important to "reorient health systems," "mitigate health impacts of poverty and urbanization," "engage businesses and community in promoting healthy lifestyles," and "modify risk factors" (p. 9). Adventist health lifestyle programs can be a positive solution to both developed and developing countries.

Perspectives on Leadership and Health Improvement

Leadership and Organizational Behavior

The second area of literature review pertains to leadership and organizational behavior, which this study uses as the theoretical and conceptual framework, particularly in the organizational process of leadership collaboration. Leadership is not a position but a process (Hughes, Ginnett, & Curphy, 2008) that involves many elements interacting and influencing one another. Leadership is about influence and change (Kotter, 1990). Researches show that leadership is a complex process that involves the leaders, the followers and the situations interacting together (Hughes et al., 2008). Leadership inspires a common vision with a set of values that pulls the group or community together for the accomplishment of objectives, which need both the knowledge and skills of leader-managers (Kotter, 1990). These leadership ingredients are all described in collaboration and collaboration research. This framework will help to shed light on why

and how the Adventist institutional leaders collaborate on the Adventist lifestyle programs.

Collaboration and Collaborative Research

The table in Appendix E gives a summary of the research articles used to describe the four main perspectives of organizational behavior in collaboration and collaborative research. Each perspective will be elaborated on accordingly.

A review of the literature shows that “in recent years there has been increasing attention to the importance of interagency collaboration for improving community well-being, environmental and public health, and educational outcomes” (Cross et al., 2009, p. 310). This phenomenon is also seen in the field of science technology (Chompalov & Schrum, 1999), in the arena of social enterprise and political-economic collaboration (Di Domenico, Tracey, & Haugh, 2009), in the delivery of public services in the United States (Sowa, 2008; Takahashi & Smutny, 2002). The same trends are also visible in international business and research efforts (Adler, 1991). There are many reasons and motivators that encourage interagency collaboration, which will be discussed in the next section. The trend is that collaboration has become an important process in organizational behavior and development (Babchuk, Keith, & Peters, 1999).

The Perspective of What Motivates Partners to Collaborate

Sowa (2009) did a thorough study describing why nonprofit organizations collaborate. “As interagency collaborations are undertaken for different reasons across various policy areas, it would be difficult to surface a single theory as to why agencies engage in collaborations (C. Oliver, 1990)” (Sowa, 2009, p. 1005). Three perspectives that scholars adopted to understand the motivation to collaborate among organizations are

(a) the resource dependence perspective, (b) the network perspective, and (c) the institutional theories perspective.

From a “resource dependence perspective, researchers maintain that environmental constraints and the need to secure resources, are driving factors for engaging in collaborative endeavors in order to reduce the uncertainty that may exist in one’s environment” (Sowa, 2009, p. 1005). Network perspective factors include “a willingness to cooperate with others, previous history of collaboration, the need to share expertise, and the need to develop the organization’s ability to adapt to changing circumstances” (p. 1005). For the institutional theories perspective, scholars specify “such motivations as the need to develop a shared response to some common problems in the field,” and “the need to achieve legitimacy as an individual organization” (p. 1005).

Combining different theories to explain the motivation to collaborate are seen in the studies of Di Domenico et al. (2009) which merged “social exchange theory and dialectical theory to build a framework to examine corporate-social enterprise collaborations” (p. 887). Hill and Lynn (2003) used rational choice theories that focus on exchange of organizational goals, and socialized choice theories that focus on relationships to enhance shared values; while Guo and Acar (2005) “combine multiple theoretical perspectives of resource dependence, institutional, and network theories” (p. 340). Foster and Meinhard (2002) used “a sample of 645 nonprofit organizations in Canada, constructing and validating a regression model to explain the predisposition to collaborate. It investigated the influence of a combination of factors on collaborative behavior” (p. 549). In summary, the reasons and what motivates organizations to collaborate is a complex and diverse field of study.

The Perspective of How Collaboration Works and Processes

Imperial (2005) “utilizes a comparative cross-case analysis of six watershed programs as a conceptual framework that illustrates how collaboration is a process occurring at the operational, policy-making, and institutional levels” (p. 281). A four-stage model is used to show how organizations achieve collaborative partnerships by Jackson and Reddick (1999).

The four-stage model allows partners to involve (a) networking to exchange information; (b) coordinating to exchange information and alter activities and schedules; (c) cooperating to exchange information, alter activities and schedules, and share resources (i.e., merging operations); and (d) collaborating to exchange information, alter activities and schedules, share resources, share risks, and enhance the capabilities of each participating partner. (p. 666)

In order for collaboration to occur, a “collaboration window must open, this could be a problem, a policy, an organizational or social/political/economic issue. A collaborative entrepreneur must act upon the opportunity presented by the open window” (Takahashi & Smutny, 2002, p. 145). Other scholars emphasize the process evaluation aspect of collaboration, underscoring the importance of the balanced approach by which collaborators do their work, and evidence that the collaboration is making a difference (Cross et al., 2009; Lachance et al., 2006; Roe & Roe, 2004; Tolma, Cheney, Troup, & Hann, 2009). A process evaluation tool called “the dialogue boxes, has proved extremely useful in diverse health promotion program and planning efforts” as described by Roe and Roe (2004, p. 138). Tolma et al. (2009) explore the evaluation process during collaboration. These involve “(a) the development of an evaluation plan, (b) development of evaluation instruments (i.e., survey, interview guides, observation forms), and (c) development of evaluation questions and process objectives” (p. 537). One evaluation research indicates that “intra-project collaboration peaked in the middle of a grant and

started to decline during the last year” (Cross et al., 2009, p. 310).

Partnership principles are a powerful mechanism to assure ethical relations between collaborators. The partnership principles are used in a descriptive analysis of the development, functions, and benefits of such an inter-institutional academic partnership that was formed to reduce and ultimately eliminate health disparities in rural South Carolina. (Levy, Baldyga, & Jurkowski, 2003, p. 314)

“Elements that are important for building and sustaining collaboration and partnerships are mutual respect and trust, open and clear communication, and shared decision and problem solving” (Logan, Davis, & Parker, 2010, p. 580).

A six-step process was used to show the participation between universities and communities in New Orleans. This “community empowerment project showed how community members and university facilitators collaborated to increase the capacity of the community” (Yoo et al., 2004, p. 256). “The six-step process is (a) entrée into the community, (b) issue identification, (c) prioritization, (d) strategy development, (e) implementation, and (f) transition. Using a social ecological model as a conceptual framework was helpful for the community to assess their status and develop action plans” (Yoo et al., 2004, p. 260).

A conceptual model of “sustainability in community health partnerships” suggests that there are five primary attributes or activities of partnership leading to consequential value and eventually to sustainability of collaborative capacity. They “include (a) outcomes-based advocacy, (b) vision-focus balance, (c) systems orientation, (d) infrastructure development, and (e) community linkages” (Alexander et al., 2003, p. 130).

Studies show “that corporate and social enterprise collaborations are shaped by (a) the value that each member of the collaboration attributes to their partner’s input, (b) competing practices and priorities intrinsic to the corporation and the social enterprise, and (c) expected benefits of the collaboration to each partner” (Di Domenico et al., 2009,

p. 887). In another words, the two main benefits that motivate organizations to collaborate are the enhancement of the services provided by each of the organizations and the betterment of the organizations as a whole because of the collaboration (Sowa, 2009).

The Perspective on Collaboration Making a Difference

The Pinto (2009) study has shown that “community collaboration in research can lead to better methods, results, and dissemination of interventions” (p. 930). Lachance et al.’s (2006) study on evaluation designs for assessing community collaborations emphasizes that evaluation must be well prepared for collaboration to make a difference. In order to show the relation between collaboration and program success, “a study of a multisite program, a nurse home visitation program, was adopting, it involved varying degrees of collaboration in the 16 communities. A theory of commitment transfer is offered as an explanation of the relationship” (Hicks, Larson, Nelson, Olds, & Johnston, 2008, p. 453). These were researches designed “to study the collaborations between academic institutions to improve health outcomes in medically underserved populations” (Logan et al., 2010, p. 580). A study on “how well collaboration works in practice for small community-based organizations suggests that small community-based organizations, because of their informal organizational structures and adaptability, can develop highly effective partnerships.” The study illustrates “that even with high degrees of interagency conflict, collaboration can result in highly effective program outcomes” (Takahashi & Smutny, 2002, p. 145).

Collaboration has been observed in changes to the strategic behavior of participating organizations’ decision-making, “amplifying and rippling effects on the collaborators’ strategic direction, and changed, and the perceptions of managerial roles”

(Stone, 2000, p. 98). Cummings and Kiesler (2005) “investigated scientific collaboration across disciplinary and university boundaries to understand the need for coordination in these collaborations and how different levels of coordination predicted success” (p. 703).

Some community-based collaborations offer only

marginal evidence that such approaches lead to health status/health systems change. Three possible explanations are proposed: (a) collaborative mechanisms are inefficient and/or insufficient mechanisms for carrying out critical planning and implementation tasks, (b) expectations of health status/health systems change outcomes are unrealistic, and/or (c) health status/health systems changes may occur but may go undetected because it is difficult to evaluate and demonstrate a cause-and-effect relationship. It is important to ask the right questions when evaluating collaborative activity. (Kreuter et al., 2000, p. 49)

One prominent barrier to prevent collaboration is limited healthcare resources (Shaibu, 2006; Snaveley & Tracy, 2002; Sowa, 2009). Human relationship and leadership issues, such as mistrust, lack of communication, and errors in decision and problem solving, are also barriers for collaboration and collaboration research (Logan et al., 2010).

Leadership and Health Communication

The third area of literature review that provided the theoretical framework for this study is on leadership and health communication. Health collaboration is linked to health communication; it is “a multifaceted and multidisciplinary approach to reach different audiences.” In health communication, it “shares health-related information with the goal of influencing, engaging, and supporting individuals, communities, health professionals, special groups, policymakers and the public to champion, introduce, adopt, or sustain a behavior, practice, or policy that will ultimately improve health outcomes” (Schiavo, 2007, p. 7). Health communication is more than health education because it involves different stakeholders and constituencies for the development of health.

This field of knowledge enriches this study. The model of Constituency Relations

(CR) is one of the theoretical conceptual frameworks in this study. According to Schiavo (2007),

In health communication, constituency relations can be defined as the process of convening, exchanging information, and establishing and maintaining strategic relationships with key stakeholders and organizations with the intent of identifying common goals that can contribute to the outcomes of a specific communication program or health-related mission. (pp. 199-200)

The Wellness Expo described in this study, as well as the community health project implemented in Hong Kong and Taiwan, closely relates to the model of Constituency Relations. Such an instance would be when our institutions involved in “the process of convening, exchanging information, and establishing and maintaining strategic relationships with many district stakeholders and organizations” (Schiavo, 2007, p. 199) communicate to the public the Adventist health lifestyle programs.

Health Communication

Constituency relations is an effective and structured approach, according to Schiavo (2007). Attention to four key components is needed in order to encourage constituency relations and partnership-oriented mind-set among stakeholders. These are (a) establishing a department or an office dedicated to CR; (b) “to emphasize the importance of teamwork, listening, and negotiation skills, as well as balancing different needs and sharing credit for success with other organizations or institutions; (c) training staff members; (d) sharing results with other organizational departments” (pp. 203-204). A list of do’s and don’ts in undertaking CR (see Table 1) is very helpful to give “guidelines for establishing and preserving long-term relationships” (Schiavo, 2007, p. 205).

This health communication theoretical framework, Constituency Relation (CR), is

used as reference when considering the working relationship of all the institution leaders of CHUM in the implementation of the AdHeLP.

Adventist Health Perspectives

The fourth area of literature review relates to the Adventist health and church structure that gives the theoretical and conceptual framework for this study in the collaborative leadership roles in the implementation of AdHeLP. The Seventh-day Adventist Church was established in 1863. In the same year the health reform message was promoted by one of the Advent Movement pioneers, Ellen White. There was a close relationship between the Adventist movement and the health reform movement. The principles of healthful living and medical missionary works are described in many of White's writings and compilations, including *Healthful Living* (1897, 1898), *Ministry of Healing* (1905), *Counsels on Health* (1923), *Medical Ministry* (1932), *Counsels on Diet and Foods* (1938), and *The Health Food Ministry* (1970).

Different areas of study were done on Adventist health and institutions. Robinson (1965) describes the story of the Adventist health message, giving its origin, character, and development of health education in the Seventh-day Adventist Church. While Numbers and Larson (1986) deliberate on the Adventist tradition on health and medicine in the context of Western religious traditions, more recent studies were done on the development of Adventist lifestyle and healthcare service in institutions based upon Adventist values (Covrig, 2003, 2005) and the core convictions of Adventist healthcare and the leadership alignment with the convictions (Haffner, 2006).

The Adventist health institution leadership role can be traced back to its origin. It was June 5, 1863, when the first vision related to health reform was shown to Ellen

Table 1

Do's and Don'ts

Do's	Don'ts
Understand the mission, strategic priorities, and focus of key constituency groups.	Look down at constituency groups if they are smaller in size or in favor of a different approach to a 'health' issue.
Reach out to these groups at the program's onset.	Assume they will support every aspect of your health cause or communication program.
Keep an open mind in exchanging relevant information.	Give the impression they are not accountable for their responsibilities if a partnership is established or do their share of the work.
Consider their worries and concerns.	Try to control or micromanage them.
Recognize and respect cultural, ethnic, or other kinds of differences.	
Look for shared goals and priorities.	
Act to establish long-term relationships based on trust and mutual respect.	
When of interest, address barriers to potential partnerships.	
If a partnership is established, honor deadlines, financial commitments, and mutually agreed-on procedures and roles.	
Encourage and maximize participation by all partners in program design, implementation, and evaluation.	

Note. From Table 8.1 "Guidelines for Establishing and Preserving Long-Term Relationships," *Health Communications: From Theory to Practice* (p. 205), by R. Schiavo, 2007, San Francisco, CA: Jossey-Bass. Reprinted with permission.

White, one of the pioneers of Adventist health lifestyle. The first institution, the Western Health Reform Institute, opened its doors on the fifth of September 1866 with a 10-room facility. By 1876 it was 100-bed facility. The following 3 decades witnessed the growth, success, and tumult of the Adventist health message and lifestyle practices. A report on health in *United for Mission 150 Years (1863-2013)* recounts the following (General

Conference of Seventh-day Adventists, 2013):

1. Harry (1879-1977) and Maude Miller (1880-1905) were missionary physicians in China. When Maude died tragically from illness at 25, Miller continued saving lives in China, and later throughout Asia, Africa, and the Caribbean. Miller invented myriad food products, including soy milk.

2. Law Keem (1867-1919) was a medical missionary and the first Chinese Seventh-day Adventist medical doctor.

3. John Harvey Kellogg (1852-1943) was a physician, inventor, administrator, and author. Vital in the establishment of the Battle Creek Sanitarium and College and the American Medical Missionary College, Kellogg was a gifted medical doctor, a visionary and innovator of Adventist missions and lifestyle practices. However, the falling away of Dr. Kellogg could be traced to two primary causes, according to Fiedler (1996): (a) the Doctor's inordinate desire to control everything with which he was connected, and (b) his involvement with the deceptive teachings of theosophy. A power struggle ensued; leadership was opposed to the practice of collaboration.

The Adventist Church Organizational Structure

At the turn of the 20th century, the rapidly developing organization of the Seventh-day Adventist Church had become too large for its administrative structure since its formation in 1863. Some basic administrative principles were not practiced before 1901. Top-level administrators had too many divisions directly responsible to them. Not all parts of the organization were represented in the governing body and not directly responsible to it. The responsibility for making decisions on routine administrative

matters rested on a few people who were not close to the problems. According to Dart (1956):

The work of the denomination was being conducted on just two administrative levels—the local conference and the General Conference. All problems not handled in the local conferences in different parts of the world must be referred to the General Conference Committee of thirteen men in Battle Creek, Michigan. (p. 250)

From 1897 to 1901 the church organization was operating under the plan of strong departmental organizations and institutions, each one seeking world-wide control.

We had our General Conference; we had our International Tract Society, our International Sabbath School Association, our International Medical Missionary Association, and various departments, each one seeking world-wide control in its branch of the work, and there was no ample provision made for union. This is where the complication largely came in. It was through this world-wide departmental work. (Crisler, 1938, p. 164)

Crisler (1938) used the words of W. C. White in 1903 to describe what was done in the reorganization of the church organizational structure in 1901:

Then we go to the union conference, and we have the same condition. Every branch of the work is represented on the union conference committee. When the union conference committee comes together for counsel, every branch is represented—publishing, educational, medical, Sabbath school, religious liberty; these are all branches. What is the head? What is the Body? You may say, the heart? Why, the evangelical work is the work of the conferences, and all these branches are auxiliary to the evangelical work; so far they are parts of the body. (Crisler, 1938, p. 165)

The 1901 General Conference had made several substantial structural changes in an effort to ensure two major reforms: (a) the decentralization of decision-making, responsibility, and direction of church work through the establishment of union conferences and (b) the integration of a growing variety of church activities through the establishment of departments represented on the conference executive committees at all levels. The union conferences and divisions of the General Conference, which became basic administrative units of the world church of the Seventh-day Adventists, were to

provide opportunity for more decentralized decision-making, and the implementation of church policies and programs (Schwarz, 1979). Schwarz further described the reorganization of the church structure by saying:

Ellen White thoroughly approved the organization of these union conferences. She believed that it would be 'for the health of the different conferences to have it thus.' It was not, as some feared, to have a disintegrating effect on the church. 'The Lord God of Israel will link us all together,' Mrs. White affirmed. 'The organizing of new conferences is not to separate us. It is to bind us together.' (p. 277)

The Seventh-day Adventist Church, with its global organizational structure, is committed to world mission and evangelism (B. Oliver, 1989). Health reform is often called the right arm of the gospel ministry. With the Adventist health lifestyle and the world-wide organizational structure, Adventists may be able to share their lifestyle globally.

In summary, major steps were taken in the original organizing process of the Seventh-day Adventist Church, first in the United States of America, and then to all the other parts of the world. This process started in the 1850s, congregations organizing themselves and electing their own leadership. Then, in the early 1860s, state conferences were established to integrate the congregations within their respective territories. By May 1863, the General Conference of Seventh-day Adventists was organized. The members of the church, under a representative ecclesiastic model, had member delegates from their churches elected to state conference officers or leadership positions, then these delegates elected the General Conference officers. The General Conference experienced 40 years of significant growth and expansion from the 1850s to the late 1890s; then a reorganization took place in the 1900s and 1910s. With the establishment of union conferences and union missions (1901) and divisions (1913, revised in 1918), the organizational structure

ended up consisting of (a) local churches/companies, (b) local conferences/mission, (c) union conferences and union missions, (d) divisions, and (e) the General Conference (Olson, 1966; Timm, 2013).

There are four tiers in the organizational structure of the Adventist Church (General Conference of Seventh-day Adventists, 2010a). The General Conference and its 13 Divisions around the world are the top tier. It provides vision, mission, values, and leadership, and redistributes resources to the world church of 16,000,000 members, established in 208 countries and regions around the world. The second tier is the union level, which by 2010 statistics numbered 150. The union level provides leadership and management to all the institutions within a specific territory. The third tier is the local conferences that lead the local churches. The fourth tier is the local churches that make up the world church at the grass-roots level.

The Chinese Union Mission (CHUM) of the Seventh-day Adventist Church is one of the unions among the 150 unions. The territories of CHUM include China, Taiwan, Hong Kong, and Macao. There are 370,000 church members, 3,000 local churches, two local conferences and one un-organized territory (The People's Republic of China), three hospitals, five secondary schools, six social service institutions, two colleges, 10 health centers, a health food company, and a publishing house. This study considers the union structure as a model and conceptual framework for leadership collaboration for the implementation of Adventist health lifestyle programs to improve health.

Attention needs to be drawn away from studies of the benefits of the Adventist health lifestyle to the implementation of an Adventist health lifestyle. If living a quality and longer life is what the Adventists are doing, how can the lifestyle be shared and

enjoyed by the general public? Why is the Adventist health lifestyle, after 150 years of its origin, not commonly practiced by the majority of the urban residents? Why is there an increased consumption of processed food and a decreased tendency by the urban dwellers to exercise? What are the Adventists doing to enhance the practice of a healthful lifestyle? This study looked for the answers particularly in the leadership role and function of the Adventist global church structure that is supposed to have the platform to implement the Adventist health lifestyle.

Adventist Church Organization and Health Improvement

Adventist health lifestyle has its advantages and challenges. A special report by Buettner, in the *National Geographic* November 2005 issue on a longevity research study funded by the U.S. National Institute on Aging, listed Adventists among the people groups that live longer. After the report, Buettner conducted further research on the same topic and his book, *The Blue Zones* (2008), describes fully the Adventists' lifestyle. Longevity studies relating to lifestyle were done with ample evidence-based reports (Belloc & Breslow, 1972; Breslow & Enstrom, 1980; Fraser, 2003). The Adventist Church is facing the challenge to improve the health of its membership. China represents that challenge, in that many opportunities exist to serve its vast population through the implementation of Adventist health lifestyle programs.

After the Global Conference on Healthcare and Lifestyle of 2009, convened by the World Health Organization in Geneva, the General Conference of the Seventh-day Adventist Church took a very important committee action to promote the Adventist health lifestyle at all levels of the world church. In the closing remarks of the Global Conference, a commitment was made that the Adventist Church and WHO continue to

communicate and collaborate for community lifestyle change. The content of the committee action reads:

09-138—SEVENTH-DAY ADVENTIST CALL TO COMMITMENT TO HEALTH AND HEALING

VOTED To adopt the statement, Seventh-day Adventist Call to Commitment to Health and Healing, which reads as follows:

The Seventh-day Adventist Church affirms the commitment and objectives of its Health Ministry aiming to achieve the well-being of its members and the communities it serves, and improving global health.*

The General Conference of Seventh-day Adventists reiterates its commitment to the principles of human dignity and equity, social justice, freedom, self-determination, access to clean food and water, and non-discriminatory universal access to available health care. Through its ministry of preaching, teaching, healing, and discipling the Church seeks to represent the mission of Jesus Christ in such a way as to be:

1. Regarded globally as teaching a wholistic model of evidence based healthful living in primary health care.
2. Seen at all times as a trusted, transparent organization with compatible goals and vision, in alleviating suffering and addressing basic health and well-being.
3. Recognized for the unconditional scope of its embrace of all persons seeking this basic health and well-being.
4. Involved not only administratively but also functionally at every level including each congregation and church member in this ministry of health and healing.

*This statement follows the deliberations and recommendations of the Global Conference on Health and Lifestyle held in Geneva July 2009 in collaboration with the World Health Organization, and calls for cooperation with similar credible bodies aiming to improve global health. (General Conference Executive Committee Minutes, 2009, #138)

The Adventist world church that covers over 200 countries and regions is an important organizational model that can provide the framework for global strategy for health improvement. At the union level there are different institutions that are organized to collaborate together through the union executive committee to facilitate the hospitals, the colleges, publishing houses, health centers, local conferences and local churches to

accomplish the church mission, which is a holistic gospel of a healing ministry (B. Oliver, 1989).

The Adventist Chinese Union Mission and Health Improvement

The Chinese Union Mission (CHUM) of the Seventh-day Adventist Church in Taiwan, Hong Kong, and China has been running a series of rather successful Adventist health lifestyle programs, particularly for the past 10 years. This program, the NEWSTART Lifestyle Program, has received recognition from the local government health bureaus, the support from the community, and the WHO. The collaborative approach to lifestyle programs in CHUM has gone through a rather long journey. It started out with a vision and a core value that a healing ministry of Adventist lifestyle would bring change and health, starting from our Adventist healthcare institutions, and collaborating with other Adventist institutions and local churches, and then to the communities around the churches, and finally to the whole country.

CHUM has developed a vision to become a leader that provides a collaborative approach among all the stakeholders in the community to implement the Adventist health lifestyle programs. CHUM has endeavored to achieve its health vision since 2001. It has cohered its institutional leaders, local church leaders and members to capture the vision, that it is essential to expand the influence of AdHeLP in the community, which would promote health through lifestyle change. It is a challenging leadership process to achieve this vision.

Three Adventist health centers were set up with the collaboration of the union, the hospitals, the colleges, and the local churches on the campus of the Taiwan Adventist College, the Hong Kong Adventist College, and one in Xiamen, China. These health

centers have become platforms of collaboration for health behavior change of NCD patients of the hospitals, for training of health major degree students, and for the interests of the local churches involved in health evangelism.

The demand is there for health and lifestyle change in Hong Kong, Taiwan, and China. How influential is the Adventist health lifestyle message in these territories? Can it become a brand for the general public? Can it be a movement, like the fast-food chain restaurants which are proliferating in China and are changing the lifestyle of the new generation? This study plans to better understand the collaborative leadership roles in the implementation of Adventist health lifestyle programs, with the hope to give a wider supply of health solutions to counter the increasing prevalence of NCDs in China and many developed and developing countries around the world.

CHAPTER 3

RESEARCH METHODOLOGY

Introduction

Studies show that collaboration brings better service outcomes and enhances the development of participating organizations (Lachance et al., 2006; Pinto, 2009). The Seventh-day Adventist Church has a world-wide organizational structure that encourages inter-institutional cooperation to serve the community in gospel ministry, education, healthcare, and social welfare, amidst others. The institutions within certain union territories are structured to collaborate on projects and to complement one another in leadership and administration.

The purpose of this case study was to describe the roles and functions of the leaders of the institutions in the collaborative approach of Adventist health lifestyle programs. This study endeavored to understand leadership effectiveness in the implementation of the Adventist health lifestyle programs in the context of the union structure of the Seventh-day Adventist Church. This study was designed to address one central question: How do the Adventist institutional leaders function and collaborate within the Chinese Union Mission structure to implement Adventist health lifestyle programs?

General Research Design

To address the central research question of this study, a qualitative case study

design was chosen to describe how the Adventist institutional leaders function and collaborate within the Chinese Union Mission to implement Adventist health lifestyle programs. A qualitative research approach is most appropriate to explore the central question of this study. According to Stake (1995) case-study researchers study a program, an event, or activity that involves individuals rather than a group of people or events. It has the characteristics of strong narratives, and the cooperative inquiry method as described by Reason (1999) and Creswell (2008). A case study is an in-depth exploration of “a bounded system” (e.g., an activity, event, process, or individuals) based on extensive data collection (Creswell, 2007).

A qualitative case study serves the purpose of illuminating a particular issue, in this case it was the collaborative leadership roles. In their *Handbook of Qualitative Research*, Denzin and Lincoln (1984) acknowledge that qualitative research can have different meanings to different people. They offer what they called a “generic definition” by saying,

Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. 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. Qualitative research involves the studied use and collection of a variety of empirical materials—case study, personal experience, introspective, life story, interview, observational, historical, interactions, and visual texts—the described routine and problematic moments and meanings in individuals’ lives. (p. 2)

“Case study research has a long, distinguished history across many disciplines” (Creswell, 2007, p. 73). According to Flyvbjerg (2006), there were common misunderstandings about case-study research. However, many recent prominent researchers have helped to correct these misunderstandings and explained that “social

science may be strengthened by the execution of a greater number of good case studies” (p. 219).

Qualitative data are defined as “detailed descriptions of situations, events, people, interactions, observed behaviors, direct quotations from people about their experiences, attitudes, beliefs, and thoughts and excerpts or entire passages from documents, correspondence, records, and case histories” (Patton, 1990, p. 22). The central emphasis in case study is to reveal the meaning of phenomena for the participants. Stake (1981) supports this assumption, and suggests that case-study knowledge is real and contextual through the perspectives of the reader’s experience. Stake (1981) prefers case-study methods because the reader’s experience can be compared to the research methods. He prefers case-study methods because of their epistemological similarity to a reader’s experience (Newman & Benz, 1998).

This research design had three phases and each phase provided significant insights into the leadership issue of collaboration in the implementation of the Adventist health lifestyle programs. The first phase included a series of face-to-face interviews with the institutional leaders. Each interview focused around the central research question. The second phase included two focus groups, one in Taiwan and one in Hong Kong. The purpose of the focus group was to review emerging themes from the initial interview phase and to enrich the findings of the central research question through dialogue among the institutional leaders. The third phase included communication via telephone call, Skype, and email to confirm and to clarify the individual narrations and group inputs, with the support of artifacts and documentations.

Self as Research Instrument

Throughout the study I interacted with the participants individually and in focus group discussions to better describe the leadership role and function of the institutional leaders. Discussions with open-ended questions were asked, and responses were carefully noted. The process of interview and data collection was important. I presented myself to the participants as a fellow seeker of Adventist health lifestyle and leadership effectiveness (Creswell, 2007). The conceptual frameworks that this study is based upon was referred to for the implementation of the Adventist health lifestyle programs.

Although I could not fully replicate the views of the participants, I tried to enter their settings and situations to the extent possible. Qualitative researchers seem to have more room or advantage than quantitative researchers, according to Charmaz (2006), that in the process of gathering data, qualitative researchers can add new building blocks to the entire research structure.

I am presently the vice president for lifestyle and spiritual affairs of the two Adventist hospitals in Hong Kong. Although I am practicing the Adventist health lifestyle and am involved in the implementation of the programs, I have no direct line of administrative authority over the institution leaders, nor do I chair any of the management committees of the institutions like the health centers in the Chinese Union Mission. This avoided bias and pressure on the interviewees in this research study.

Data Collection

In this section, the important aspects of data collection, which include the sources of data, data collection procedures, and data management, and the issue of developing a purposive sample are discussed.

Purposive Sample

Creswell (2007) describes the concept of purposeful sampling as used in qualitative research and the importance of the sampling strategy. The selected locations and individuals for the study can provide better understanding that aims at the research problem and the central research question (Bloomberg & Volpe, 2008).

Institutional leaders within the Chinese Union Mission administrative structure in Taiwan and Hong Kong were selected. Only two local church pastors, one from Taiwan and one from Hong Kong, were selected. The local churches are not directly under union supervision, but under the local conferences, and the two selected respondents had been involved in the implementation of Adventist health lifestyle programs. Only two health centers in Taiwan and Hong Kong were selected; of the 20 health centers in China, none have been involved in the collaboration thus far. Thus, the purposive sample for this case study included the union president, the presidents of the two colleges and two hospitals in Hong Kong and Taiwan, two local conference presidents, the publishing house manager, the managers of two health centers, and two local church pastors. Altogether 12 institutional leaders were selected for the study.

Sources of Data

Data were collected from the following four sources: interviews, focus groups, artifacts, and field notes and journals.

Interviews

One pilot interview was conducted with one of the participants. The preliminary Interview Guide with questions and format is shown in Appendix A. Appointments were scheduled individually with each of the institutional heads, each interviewee receiving a

Consent Form (see Appendix C) and the Interview Guide prior to the face-to-face, 1½-hour interview. Besides taking note during the interviews, audio recordings were made for later transcription.

Focus Groups and Dialogue

Two focus group discussions, one in Hong Kong and the other in Taiwan, were convened to allow all the institutional leaders to interact with one another and with me on the emerging themes gleaned from the preliminary data analysis after the individual interviews were completed. The purpose of the focus group was to verify the themes, and to encourage the individuals to share more ideas and perspectives through dialog. Both focus groups went for about 2 hours, and they were recorded for verbatim transcription.

Artifacts

Each participant was asked to provide materials that reflect the role and function of each individual job and institution in the process of implementing Adventist health lifestyle programs. These artifacts included program brochures, planning-meeting minutes, newsletters, annual reports, trophies, and certificates. Some of these were incorporated as references in the research.

Field Notes and Journal

Notes were taken during each interview and focus group discussion and then entered into Word documents to be used in coding. A personal journal was kept to record the chronological order of research activities, emerging themes, reflections, observations, and personal learning experience throughout the study.

Collection Procedures

Emails were sent and telephone calls made to secure appointments with the leaders through their secretaries on dates, timings, and venues of the interviews and focus group meetings, double checking and confirming the appointments 1 week before each appointment. The respective office secretaries assisted in providing artifacts and documents related to the study. The notes were written with coding during the interviews and focus group discussions. The interview questions were in sequence for the interviews. All comments from participants, together with my observations and reflections, were recorded in a personal journal as research raw data. I transcribed the notes, recorded digital tapes, and journal into Word documents.

Data Management

The procedure used to manage data included a back-up of written documents every time the files were updated. Two separate digital back-up copies of the research files were made on two hard drives, one located at home, the other at the office, with an additional back-up through iCloud.

Data Analysis

The materials collected through interviews, focus groups, and artifacts were reviewed many times in order to identify emerging themes that this study was trying to find. Reference was made to the template for coding a case study, the Multiple and Collective Case Approach, as suggested by Creswell (2007). The institutional leaders and the researcher were involved in the process of generating themes, interpretation and analysis of the categorization of data, development of mega themes, and the tracking of

frequent articulated topics or themes. During the focus groups, some major themes were mentioned and discussed.

The coding of the data collected went through three stages. First was the basic coding of all comments made by the leaders during the individual interviews and the two focus group discussions. Then the coded comments from the first stage were reviewed and grouped into categories. Finally the categories were reviewed and analyzed from the perspectives of the theories and conceptual frameworks of this study into themes.

Validity and Reliability and Trustworthiness

According to Newman and Benz (1998) because multiple data-collection techniques are used in case study (e.g., interview, focus group discussion, observation, and document study), they have the potential for increased validity. Case studies in general collect data from different data sources. There should be a relationship between these data sources. If there is a consistency within the case, validity is enhanced. The “critique checklist” provided by Stake (1995) for a case-study report was used to check the observations and interpretations for triangulation. Reference was also made to Creswell's (2007) six criteria for evaluating a case study for validity and reliability.

Generalization

Many researchers suggest that generalization is the purpose of quantitative, but not qualitative research (Newman & Benz, 1998; Polkinghorne, 1991). In addition, researchers (Christensen, 1987; Cragg, 1940) also believe that in social science, qualitative research, as in case study, contributes depth and the expertise of “context-dependent knowledge and experience” (Flyvbjerg, 2006, p. 222). Flyvbjerg explains that from the basis of a single case, it is possible that one can generalize and use what one

learns for further scientific development and as an addition to or a substitute for other research methods. As suggested by Eisner (1991), it is usually the readers, in this case, the union institutional leaders, who will consider whether the research findings can be generalized or be referred to the conditions or situations of their respective unions and institutions.

This study described in detail the roles of all the institutional heads under the Adventist union organizational structure when they participated in the implementation of Adventist health lifestyle programs. Phenomena, processes, and outcomes of the collaboration were presented to allow other global Adventist union leaders to consider, to reflect, or to generalize.

Institutional Review Board (IRB) Approval and Ethics

The Institutional Review Board (IRB) Approval was received October 18, 2011. The approval was given to complete the study over a 1-year period (see Appendix D). An extension to complete the data collection by the end of 2012 was later approved. An approval from the CHUM Administrative Committee was obtained to conduct the research interviews with all the institutional heads in Hong Kong and Taiwan (see Appendix B) and to view the minutes of the CHUM ADCOM. Consent forms were read and signed by the individual respondents to conduct the personal interviews. Verbal consent was obtained from the respondents to record the interviews for the purpose of transcription. Names of the individuals were not used in the research.

Summary

Looking from the perspective of collaborative leadership issues for the implementation of Adventist health lifestyle for health improvement, I have described in

this qualitative case study the roles of the institutional leaders who were supposed to communicate, to collaborate, and to implement projects within the union structure of the Seventh-day Adventist Church, and to fulfill the vision, mission, and value of the Seventh-day Adventist Church. This case study provided significant findings that would contribute to the effectiveness of leadership to implement Adventist health lifestyle programs at the union structural level of the Adventist church to combat NCDs to improve health.

CHAPTER 4

FINDINGS AND ANALYSIS

Introduction

This chapter describes the results of the data analysis. The focus is on the major themes that are related to leadership collaboration to enhance health for the Chinese community. The individual interviews and focus group discussions with 11 of the institutional leaders had one central purpose. It was to gather data for the research central question: “How do the leaders of the institutions of Chinese Union Mission understand their leadership roles and functions that encourage the collaborative approach of Adventist health lifestyle programs to improve health for the Chinese community in the context of the union structure of the Seventh-day Adventist Church?”

There were all together 12 interview questions divided into three categories. The first two questions related to the leaders’ personal experience and belief in the Adventist health lifestyle. The following three questions were the core interview questions for this study. These three questions tried to elicit information regarding what were the collaborative activities the leaders and their institutions participated in over the past few years in the union, and the most important question was to ask: “How would you (the institutional leaders) describe your role and function as president/general manager/pastor as they relate to the effectiveness of the collaborative approach of Adventist health lifestyle program implementation?” The third part of the remaining 12 questions was to

triangulate the information gathered from different perspectives, such as, “What worked well and what did not? If someone else is implementing this, what suggestions would you give to them? What other approaches could be used for health improvement in China?” During the two focus group discussions which were conducted after the individual interviews, the leaders were asked to discuss a few themes that became apparent in the interviews. These themes were again related to the research question of this study: (a) The theme on the personal experience in Adventist lifestyle of the leaders, (b) Other themes related to collaboration, like the foundational collaborative activities and actual collaborative service activities, and (c) Themes about the institutional leaders’ role as finders, supporters, builders, and owners of the collaboration in Adventist lifestyle programs.

In the data analysis process, some of the themes discussed are related to some of the theoretical and conceptual frameworks in this study as described in Chapter 2. In order to keep the smoothness of story narration, references to authors and the literature review of the theoretic and conceptual frameworks are given in Chapter 5 under the heading of Discussion. In Chapter 4, the results of data analysis in major themes in the form of narrative using direct quotes, stories, and examples of the institutional leaders are deliberated.

Leaders and Lifestyle

This section of the data analysis provides the stories of the leaders in their service years and personal experiences in the Adventist health lifestyle. It is important to know the “being” of the leaders before understanding their “doing” in Adventist health lifestyle programs.

Years of Service of Leaders

The majority, six out of 11, have served in their present leadership positions for more than 5 years. They knew what had happened in the past 5 years or more regarding the Adventist health lifestyle programs and the activities of collaboration. Regarding five of the other leaders, one served 3 to 4 years, and four of them served less than 3 years. For this group, one leader came from the division and knew very little about the union activities before assuming the leader position. The remaining four are working in the same union territory in different positions; they participated in the Adventist health lifestyle activities in different roles.

Leaders' Personal Experience in Adventist Lifestyle

During the interviews I found the institutional leaders were glad to share their personal experience in the Adventist health lifestyle. The union president pinpointed the year 2000, that while a pastor of a church, he was first serious about the Adventist health message. He went through a process of health reform, practiced ample sleep, regular exercise, and a diet change. From his personal experience he realized the importance of Adventist health lifestyle. Besides sharing his spiritual and religious beliefs, he also started sharing his experience of the health message to his church members and friends. Two years after he became the union president, he said with a smile, "I would not be able to handle the stressful job, if not because of the Adventist health principles that I practice."

One of the college presidents was brought up in an Adventist home. He is well aware of the importance of the Adventist health lifestyle. He believes in the lifestyle and tries to practice it, but frankly admitted that he still has a way to go. He stressed the

importance of personal example—living to the standard of a good healthful lifestyle has strong influence on students, staff, and faculty. Another college president shared her story that she started her career as a health promoter and educator at the local conference. She is a strong believer in Adventist health lifestyle, particularly the NEWSTART eight principles of health. The college president has developed a strong health department under her leadership. Personally she practices a healthful lifestyle which she believes is good for tackling the stress of administrative work and responsibilities. She enjoys exercise on the college campus. The challenge is, she said with a gesture of frustration, “I tend to gain weight when on business itinerary with heavy schedule of meetings.”

The two pastors interviewed strongly believed in the Adventist health lifestyle programs that they are able to minister to the needs of the people they serve. Both conducted health evangelism and interest classes, like vegetarian cooking class and health seminars. The “Right Arm of the Gospel” refers to the health message and is emphasized by both pastors. The pastors’ personal experiences are more job oriented than personal experiences of practicing the Adventist health lifestyle. The pastors’ stories echo those shared by the two local conference presidents. They both are strong believers that the Adventist health message is good for evangelism and is needed by the general public. The challenge is in the matter of practicing the lifestyle. This seems to be the general situation in the pastoral workforce. Health programs are tools for outreach evangelism, but the principles of healthful living are not generally practiced in the personal experience of the pastors in Hong Kong, Taiwan, and China.

The two health center managers have many good personal experiences in the NEWSTART lifestyle programs because they both participated in many live-in lifestyle

programs conducted in the two health centers in Taiwan and Hong Kong. I have seen them exercising with their clients and enjoying a nutritive plant-based diet with them. One of the managers encouraged her father to join a 13-day live-in lifestyle program to improve her father's health. She shared her personal journey of going through a weight-management program. The Taiwan health center manager narrated his college years at the Taiwan Adventist College at which he did not appreciate the healthful lifestyle on the campus. However, when he later took up a managerial career after obtaining his MBA, he learned to practice and appreciate the Adventist health lifestyle. 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, and menus, and has supported many health Expo booth graphic designs. What he appreciates most is the core value of the Adventist health message.

From the interviews I observed that the strongest believers and promoters of Adventist health lifestyle were the two hospital presidents. As a practicing medical doctor himself, one hospital president explained how Adventist health lifestyle is a complete healthcare model much more than just medicine. It takes care of the whole person—body, mind and spirit. "When we promote a healthy diet," the hospital doctor/president passionately explained, "we provide more than just plant-based diet but a therapeutic diet for people with the '3-highs'—high blood pressure, high cholesterol, and high blood sugar." This hospital president witnessed the process of starting the NEWSTART program in 1997 by inviting the professionals from Weimar Institute in California to implement the lifestyle program in Taiwan. And he led the process to obtain from the

WHO to become the first two hospitals accredited with “The Health Promoting Hospital.” Healthful lifestyle, under the leadership of the president, has become a “working policy in this hospital,” said the well-experienced leader. As for the president in the other hospital in Hong Kong, keen emphasis was on resource allocation for Adventist lifestyle. Setting aside a 5% hospital net profit for health mission and appointing a vice-president for lifestyle and spiritual affairs were innovative. As for his personal story in healthful lifestyle, the hospital president is successful in doing his weight control program. Sharing with a smile the president said, “I am just a few pounds from my ideal weight.” The hospital president has a strong opinion about Adventist health lifestyle—he believes in progressive change and in providing room for those who are less rigid in practicing the principles of health.

In summary, the personal experiences of the 11 institutional leaders provided strong support of the Adventist health lifestyle, some of them practicing it in their job and personal lives as well. They believe that the Adventist health principles and the lifestyle programs provide positive evidence to better serve the needs of the people and to improve health for the Chinese community.

Leaders Involved in Collaborative Activities

This study identified the collaborative activities that the institution leaders have been involved with in the union organizational structure. The data collected through interviews, focus groups, and observations were analyzed, and activity themes were listed as collaborative activities as shown in Table 2. In the implementation of Adventist health lifestyle programs, there are nine major activities that the institutional leaders described that involved collaboration. These activities required collaborative efforts to find

Table 2

Collaborative Activities Described by Leaders

Leaders Involved in Collaborative Activities	Leader Input Codes	Remarks
Shared Resources	P _{c1} Q ₃ 2; P _{c2} Q ₃ 3 F _{hk} Q ₃ 4; F _{hk} Q ₃ 5 F _{hk} Q ₄ 1; F _{hk} Q ₄ 2 F _{hk} Q ₄ 4; F _{hk} Q ₄ 5	HKAC renovated men's dormitory to become health center; Taiwan Adventist College provided land in campus for health center; hospitals shared net profits 10% for health services and 5% for Mission Fund; concerns raised by leaders for involvement and collaboration more than just shared resources
Health Training	P _{h2} Q ₃ 1; P _{c1} Q ₃ 5 P _{c2} Q ₃ 2; P _{c2} Q ₃ 4 M ₂ Q ₃ 5; P _{r1} Q ₃ 4 F _{hk} Q ₃ 3; F _{hk} Q ₄	Health major students placement training at hospitals; college health department trains local church leaders; union and local conference health directors trainings; collaborated training to set up local health centers in the community
Health Center Operation	P _u Q ₃ 5; P _{c1} Q ₃ 1 P _{c1} Q ₃ 4; P _{c2} Q ₃ 1 F _{hk} Q ₃ 2; F _{hk} Q ₄ 8	Union president supporting the operation; college presidents and hospital presidents involved in different models of operation; the challenge of self-interest; the need for win-win collaboration and common agenda
Union Structure Support	M _p Q ₃ 1; M ₂ Q ₃ 2 F _{tw} Q ₃ 4	Structural support needed for collaboration within organization; union structure enhances collaboration through committee and board meetings; the challenge of self-interest and clear role function
Lifestyle Programs Participation	P _u Q ₃ 2; P _{h2} Q ₃ 3 P _{c2} Q ₃ 8; M _p Q ₃ 4 M ₂ Q ₃ 5; P _{r1} Q ₃ 1 F _{hk} Q ₄ 15	Service-oriented activities involved by institutional leaders; union president supported; hospital and college presidents encouraged staff and faculty to participate; local pastors actively involved
Wellness Health Expo	P _u Q ₃ 1; P _{h2} Q ₃ 8 P _{c2} Q ₃ 8; M ₂ Q ₃ 1 P _{r1} Q ₃ 2; F _{tw} Q ₃ 6 F _{hk} Q ₃ 1	Strong union leadership in Expo that involved all institutions; hospital strong support in booth display; college involvement in health Expo; local pastor participated in Expo; promote awareness of health concept; institutional collaboration through health Expo
Health and Gospel Evangelism	P _u Q ₃ 3; P _{h2} Q ₃ 1 M _p Q ₃ 5; P _{r1} Q ₃ 3 P _{r2} Q ₃ 1	Union encourages health evangelism; hospital president believes health is gospel; publishing house supports local church health evangelism; local church believes the importance of ownership of health evangelism by participating institutions
Mass Media	P _u Q ₃ 4; P _{h2} Q ₃ 1 P _{c1} Q ₃ 3; M _p Q ₄ 5 F _{hk} Q ₄ 8	Union supports vegetarian menu publications; hospital dietitians involved in vegetarian menus; college faculty involved in Hope TV recording; publishing house facilitates health mass media materials

Table 2. *Continued.*

Leaders Involved in Collaborative Activities	Leader Input Codes	Remarks
Hospital Staff with Community and NGOs	P _{h2} Q ₃₃ ; M ₂ Q ₃₃ F _{hk} Q ₄₉	Hospital president involves staff to reach out into the community for services; health center manager believes in collaborative platform for health solution; leaders working with schools and non-government organizations to promote healthful lifestyle

resources in planning and implementing, to do evaluation in searching for outcomes, and to aim in sustaining the programs. The institutional leaders participated in most of the activities but in different levels of involvement. From the individual interviews and focus group discussions, I coded the inputs from the leaders, and then distributed them into categories. The distribution came up with nine categories. The codes were given as, for example, P for presidents, M for managers, Q for question, H for hospitals, C for colleges, R for pastors, etc. The remarks' column lists the inputs from the leaders under the same categories.

The collaborative leadership roles of the institutional leaders aim to lead people and institutions to implement the Adventist health lifestyle programs. There are two main groups of programs or activities with which the institutions in CHUM have been involved. The first group concerns some foundational collaborative activities which are basic requirements for the implementation of Adventist health lifestyle programs. They include the sharing of resources, health training for staff and participants, and the establishment and operation of lifestyle health centers. The second group of collaborative activities concerns mainly service activities, which include various health seminars, interest classes, health screening, and live-in camps for healthful lifestyle experience and

behavior change. The Wellness Health Expo has been a major service activity that gathered resources and institutions together for collaboration. Health and gospel evangelistic series at the local churches and mass media program productions at the institutional level are good service programs that are welcomed by the communities.

Foundational Collaborative Activities

In the analysis of the collaborative activities that the institutional leaders described, four collaborative activities were grouped together that are fundamental of all other activities. They laid the foundation for collaboration. First and foremost is the sharing of resources which includes financial budget sharing, human resource sharing, and the sharing of expertise. Training is another basic collaborative activity that the leaders articulated, for training allows the implementation of many collaborative lifestyle program activities in different locations and settings. The third foundational activity that allowed the institutional leaders to work together is the operation of the health centers in the union territories. This is the fundamental infrastructure needed for the promotion and implementation of lifestyle programs. The fourth basic activity was the union organizational structure that allowed the institutional leaders to communicate and to work together in executive committees, board of directors, and annual meetings. Each of these four foundational collaborative activities is described separately below, narrating some of the personal experiences of the leaders.

Sharing of Resources

Almost all of the leaders expressed that sharing of resources was the most extensive activity that happened in the process of collaboration. The need to secure resources is the driving factor for engaging in collaborative endeavors. The sharing of

resources is clearly practiced in the Chinese Union Mission among the institutions. During the focus group discussion, this aspect of collaboration was freely shared among the leaders. Both college presidents indicated that their college campuses and facilities are used for lifestyle programs and training, for example, the Hong Kong Adventist College former men's dormitory 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 also allocated both human and financial resources to support the health center in design and equipment, program running, and client referral to the health center for health lifestyle change.

The two Adventist hospitals have been paying institutional tithe (10%) from their net profits to the union for many years, supporting the ministerial and health ministries. Further, both hospitals have set aside another 5% of their net profits specifically for medical missionary and lifestyle programs since the years 2000 and 2005. A vivid picture of collaboration in the sharing of resources was described in the focus group discussion by the Hong Kong college and hospital presidents—the college allowed the use of the men's dormitory to convert it into a lifestyle health center. The hospital and the union (using the hospital institutional tithe) allocated around 10 million Hong Kong dollars (around 1.3 million US\$) to fund the collaboration. A similar situation exists in Taiwan between the Adventist college and hospital as well. The Taiwan Adventist College contributed a very good piece of land for the hospital and the union to build a well-furnished and equipped health center on the college campus.

However, one college president raised a concern. She pointed out that it was not just the sharing of resources that counted, but involvement, collaboration, and long-term

participation of all institutions even down to the local church level; these were the real issues. This concern was seconded by the other college president. “Participating in the distribution of literature or running a booth in the Food Fair,” said the college president, “is this collaboration in the sharing of resources? Not really. These are only supports in response to the invitations given by other institutions.” The leaders were trying to underscore the importance of collaboration in sharing of resources.

Training of Health Workers

Many of the institutional leaders shared the same experience on collaborative training programs. Activities were coordinated among our hospitals, colleges, health centers, and local churches. Among some of the activities shared by the leaders were (a) college health major students’ placement at the hospitals, (b) college health department faculty conducted health seminars to train local church health officers, (c) union and conference health directors held certificate courses at local churches to train volunteer health workers, and (d) the union, hospital, college, and conference all worked together to help any interested local churches to become health education centers.

Collaboration in training involved planning and need assessments. The Taiwan Adventist College president was very keen on this aspect of collaboration. She explained how she and her faculty worked through the local conference and the local churches when they conducted a series of community health outreach training programs. The key element was to “stay long enough” and to work closely with the local church leaders until they owned the programs. “The training and learning process with the local church leaders and members was vital to the sustainability of the implementation of the health lifestyle programs especially in the community,” expressed the college president. “We

have collaborated with the local church leaders until even the government officials in that district realized our good influence to the health of the community.”

The Chinese Union Mission led out in the training of health and ministerial workers in China through online courses by affiliating with Griggs University. College faculty, together with experienced and qualified pastors, were involved in the production of online video courses. Due to government restrictions there is no formal Adventist training institution in China. Distance learning becomes vital for the preparation of trained workers. One- and 2-year certificate courses and a 4-year major in health are the results of the collaboration in training among the union institutions.

Operating Lifestyle Health Centers

The leaders shared the theme of collaborative leadership and management in the operation of the three lifestyle health centers in Hong Kong, Taiwan, and Xiamen, China. The union appointed two management committees to govern the two centers in Hong Kong and Taiwan that consisted of members from the union, hospitals, colleges, and local conferences. They worked together to set goals and objectives, marketing plans, human resources, and budget to operate the centers. The hospital and college presidents were most involved in this activity. The lifestyle health center in Xiamen was similar but without a direct management line of authority with the union. A local management committee, with mainly the collaboration of the Taiwan college, the union health department, and the local church, was involved.

Both the college and hospital presidents of Taiwan and Hong Kong described in detail how they have tried from one model to another to manage the two lifestyle health centers. In Taiwan, after the union appointed a joint-management committee with the

union director of health ministry chairing the committee, the hospital worked with the college to share the responsibilities to operate the lifestyle health center. A few years later the college fully took over the management with the hospital only sending clients and a health service team to use the facilities of the lifestyle health center, while the college staff operated the center. This model was changed again after 2 years to allow the hospital to fully operate the center. The last model was the best among the three. The three models used to operate the lifestyle health center have shed light on the challenge and complexity of collaboration. The challenges of self-interest, win-win outcomes, and a common agenda were mentioned in the discussion among the leaders during the focus groups. These issues will be discussed in Chapter 5 of this study under the section of Discussion and Recommendation.

Supporting the Union Organization Structure

Another theme of collaborative activities described by the institutional leaders laying the foundation for collaboration was the organizational structure. Two aspects of structure were mentioned by some of the leaders who were involved in collaboration. One hospital president and health center manager described the coordination among the departments within the hospital, including the out-patient doctors, the health assessment department, and the dietetic and lifestyle departments. The hospital in Taiwan organized a lifestyle steering committee, chaired by the hospital president, to allow the inter-departmental structure to work smoothly. The Hong Kong hospital board appointed a vice-president to lead the newly re-structured organization that combined the lifestyle management center and the chaplaincy to form the lifestyle and spiritual affairs (LSA) of the hospital. The vice-president of LSA is directly under the supervision of the hospital

president/CEO. Organizational structure reengineering involved collaborative leadership led by the hospital president. The second aspect of structure clearly pointed out by the union president and the publishing house manager was the union structure of the Adventist church organization that all the institutional leaders were able to sit in annual and mid-year meetings, the executive committee of the union, and the board of directors of the various institutions. These meetings, if used properly, would 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 mostly collaboration 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.”

The four foundational collaborative activities described above were themes that the institutional leaders had in common. Laying the foundation further allowed them to participate in service-oriented activities to be described in the following paragraphs. These service-based activities are the core activities of Adventist health lifestyle programs. The next five themes were grouped together under the title Collaborative Service Activities.

Collaborative Service Activities

Since the purpose of the implementation of Adventist health lifestyle programs was 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, the local churches and communities. Five common

themes appeared in the analysis of the data collected during the institutional leader personal interviews and focus group discussions, as well as my observations of the past activities carried out in the union. They were grouped together under collaborative service activities.

Conducting Healthy Lifestyle Programs

Common lifestyle program activities that our leaders collaborated to serve were vegetarian cooking and baking classes, fitness and exercise classes, stress management seminar, nature and mountain hiking, and lectures on major lifestyle-related diseases given by some of the hospital physicians. Day camp, weekend, 1-week, and 2-week live-in camps are some major health behavior change lifestyle activities that involve the institutions. The NEWSTART eight health principles are the core values for health behavior change. These activities need coordination and support among the health leaders and their subordinates, between institutions like the hospitals, the colleges, the local conferences and the local churches within the union.

The pastors were particularly involved in this collaboration. They surveyed the needs of their church members and the target people they wanted to reach in the community. Then they involved the experts from the hospitals and the colleges to provide services to the target people. The procedures usually begin from the pastor presenting the proposal to the local church board. The proposal then goes to the conference administrative committee for approval, to be passed on to the college or hospital administrative committees. The key elements involved in the collaboration of health lifestyle service activities were human resources and financial budget. The local churches shared general implementation and administrative human resources while the hospital

provided the professional health personnel. As for financial resources, a percentage of net profit shared between all the participating institutions was practiced in this union.

Sometimes it was the hospitals or the colleges that initiated and extended their services to the communities. The hospitals in Hong Kong, for example, collaborated with the community district councils to organize lifestyle programs for different target groups. The CEO/President of the hospitals empowered his staff and provided ample financial support to serve the communities with different lifestyle programs to meet the needs of the target people groups.

The hospital president in Hong Kong described how at the local conference pastoral workers' meeting, the hospital health experts were invited to present to the pastors what health lifestyle programs were ready to be implemented at the local churches. Among some of the health lifestyle programs offered by the hospital to the local churches were health screening for the general public, vegetarian cooking and nutrition classes, and programs addressing chronic diseases for the middle aged and the elderly.

Involvement in Wellness Health Expo

A major activity conducted that needed collaboration was the Wellness Health Expos conducted in Taiwan, Hong Kong, and China. Many hours of planning and preparation were spent in these events. All the union institutions were involved and contributed to make the event successful. In 2009, for example, more than 4,000 participants took part in the Wellness Health Expo 2009 that year. The emphasis on “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

seen in the process of conducting the Wellness Health Expo among the union institutions.

The Adventist Institution Wellness Health Expos conducted in 2006, 2007, and 2009 had two main purposes. First, the Expo 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 Expo the institutions were to share with the community of Hong Kong the wellness concept and principles of the Adventist health lifestyle.

The idea of organizing an Adventist Institution Wellness Health Expo came during a meeting when all the institutional heads met in early 2006 as they began a new term in office. The leaders reviewed the function of the union structure of the Seventh-day Adventist Church. They reflected upon the 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 base 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 the important role of 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 theme was shared. 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. In the interviews and focus group discussion, some leaders stressed the importance of not only participation but ownership of the program. The pastor in Taipei shared his experience working with the hospital in 2 consecutive years. “Previously we only invited the hospital to help out in our evangelistic meetings by asking our doctors to give health talks,” said the senior pastor. “However, in our recent evangelism, we collaborated with the hospital. From the very beginning I got the permission from the union and the hospital presidents to organize a steering committee consisting of the hospital chaplains, the publishing house manager, and our church elders. We all owned the evangelistic program this time!” According to the hospital president and the senior pastor, the 1-week meetings were conducted Monday to Thursday in the hospital auditorium and then transferred to the local church from Friday to Saturday of the same week. Many of the institutional staff from the hospital and publishing house worked closely with the church members.

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 were working together to share the Adventist health lifestyle. A public

exhibition hall with 700 seating capacity was rented for the first two evening meetings followed by three consecutive weekend meetings at the local church with 300 seating capacity. 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.

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 doctors, dieticians, and health educators were involved in the program production to promote healthful lifestyle and healthcare. The Taiwan Adventist College president shared the same story. The union also remodeled two of the college classrooms into a recording studio to produce programs for Adventist Hope TV. Spiritual as well as health lifestyle programs were produced with collaborative efforts between the union and the college.

Mass media health service activities through the internet were especially strong and well established in China. The union contracted with an Adventist media company in China as an agent to enhance the collaboration. Special websites for health were established. Training through the Griggs University health courses was done through the internet distance learning. Institutional leaders were involved in the activities and allowed the faculty from the college, health educators and dieticians from the hospitals, and pastors from the union and local churches to share messages through the internet.

The publishing house involved the institutional leaders to publish health books and magazines. The head office in Taiwan and a new branch office in China were

actively involving the leaders to collaborate in resource sharing and promotion activities. Institutional leaders were asked to contribute chapter contents and forewords of vegetarian menu books and health-related books. Hospital presidents supported their dieticians to be involved in the 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. “It is our hospital policy to involve our staff,” 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 vegetarian promotion, and collaborated with the Diabetic Association, other charity foundations, and the community vocational colleges for healthful lifestyle promotions that reached out into the community.

Role and Function of Leaders in Collaboration

I spent the most discussion time during the individual interviews and focus group discussions with the institutional leaders on the interview question “How would you describe your role and function as president/general manager/pastor as it relates to the effectiveness of the collaborative approach of Adventist health lifestyle programs?” After the data analysis I categorized the narrations of the leaders into themes based upon some of the key action verbs our leaders used to describe their stories as shown in Table 3.

Table 3

Institutional Leaders' Role and Function

No:	Key Word Theme	Leader Input Code	Remarks
1.	To find	M _p Q ₄ 3;P _{r1} Q ₄ 1 P _{c1} Q ₄ 4;P _{r1} Q ₄ 2 F _{hk} Q ₄ 18;P _{r1} Q ₄ 3 P _{h2} Q ₄ 1	Find people needs; find resources; find community needs; find out staff motivation (bottom up)
2.	To encourage To convince To support To empower	P _u Q ₄ 2;P _u Q ₄ 3 P _u Q ₄ 4;P _{h2} Q ₄ 2 P _{c1} Q ₄ 6;F _{hk} Q ₄ 13 F _{hk} Q ₄ 21;P _u Q ₄ 6 P _u Q ₅ 5;P _{c1} Q ₄ 1 P _{r2} Q ₄ 2;P _{c2} Q ₄ 1 P _u Q ₄ 1;P _{r2} Q ₄ 3 P _{h2} Q ₄ 5;M _p Q ₄ 3 P _{r2} Q ₄ 6	Institution leaders to promote; health director to push; institution leaders to share resources; Union staff join NEWSTART; as chair of hospital board to run health center; convince leaders to support; support for health major students; make use of others' strengths; give credit to others; collaborate for strength finder
3.	To create To build To form To evaluate To achieve To initiate To pioneer	P _u Q ₄ 7;P _{c1} Q ₄ 6 F _{hk} Q ₄ 17;F _{hk} Q ₄ 24 P _{c1} Q ₄ 7;M ₂ Q ₄ 3 P _{r2} Q ₄ 5;M _p Q ₄ 6 P _{c2} Q ₄ 5;F _{tw} Q ₄ 2 F _{hk} Q ₄ 11;P _{h2} Q ₄ 1 P _{h2} Q ₄ 4;P _{c1} Q ₄ 3 M _p Q ₄ 4;F _{hk} Q ₄ 12 P _{h2} Q ₄ 4;F _{tw} Q ₄ 4	Make model health centers; build facilities to get people involved; committee for health center management; collaborate for achievement; regular evaluation for efficiency; Build value not just price; create vision to face challenges; create collaboration & culture of health (top down); should initiate from union; initiate from hospital; hospital pioneer on lifestyle; union research initiative for broad view;
4.	To use To own To participate To facilitate To coordinate	P _u Q ₄ 5;F _{tw} Q ₃ 5 P _u Q ₅ 6;P _{r2} Q ₄ 4 F _{tw} Q ₃ 8;F _{hk} Q ₄ 11 P _{h2} Q ₃ 3;M _p Q ₅ 1 M _p Q ₅ 2;M _p Q ₁₁ 1 P _{c1} Q ₄ 2;P _{c1} Q ₄ 5 P _{c2} Q ₄ 3;P _{c2} Q ₄ 4 M _p Q ₄ 5;M ₂ Q ₄ 2 M _p Q ₄ 1;M _p Q ₄ 2 M _p Q ₁₂ 1;P _u Q ₅ 3 P _{h2} Q ₄ 4;P _{c2} Q ₄ 2 M ₂ Q ₄ 1;P _{r2} Q ₄ 1 F _{tw} Q ₄ 1;F _{tw} Q ₄ 4	Use union structure to promote sharing; to own common agenda; in community outreach programs; as invitee or collaborator? connect community via health; facilitator to participate with institution in mass media; in marketing; social marketing; coordinator with institution leaders

Leaders' Role as Finders

The most common expression used by the institutional leaders was “to find resources.” “Implementing healthy lifestyle programs, we are to find resources to meet the needs of the target clients we served” was clearly expressed by the leaders, particularly by the frontline local church pastors. One of the pastors was very active in playing the role of finding shared resources among the Adventist institutions. But first and foremost, the pastor emphasized, “Working in the front line, my job is to first find out the needs of my people and the community I am serving, and then go look for resources to meet the needs.”

The leader's role as a finder has different perspectives. One of the hospital presidents suggested that to find out the motivation of his staff involved in lifestyle program collaboration is important. He wanted “bottom-up” motivation rather than top-down administrative pressure for his staff to be involved in lifestyle programs. The need for meaning in life, for fulfillment and self-actualization, is one of the basic intrinsic human needs. Working through a healthful lifestyle program to serve others is meaningful and fulfilling, and it should come from those who experienced the goodness of healthful living. Human resource is important in collaboration. If the collaboration is just another program without the intrinsic bottom-up motivation of the frontline staff or participants, it would not be genuine and able to sustain the collaboration.

A common perspective that leaders are finders is to seek the allocation of funds. Both hospital presidents were glad to share their stories as to how their hospital boards were able to approve the allocation of 5% of the net profit of the hospitals for health mission. This fund has been used as a shared resource among the institutions. It is not

without obstacles in the process of funding allocation. One resistance is self-interest. The need for institutional resources for expansion and development competes with the need for sharing and cause many administrators and board members to look inwardly rather than embracing the sharing of resources with other institutions in collaboration.

Leaders' Role as Supporters

Institution leaders understood their role as supporters as they narrated their stories. Some of the key verbs they used when sharing their experiences were: to encourage, to convince, to empower, and to support in the contexts of wanting to see others involved in lifestyle program collaboration. Institutional leaders emphasized the importance of getting people to participate. Leaders without followers are like generals without soldiers. The leaders believed in the collaboration of lifestyle programs; however, many of them understood that the challenge was to convince their college faculty, their hospital staff, and their church members to willingly practice the lifestyle and to participate in the lifestyle promotion programs.

The union president said he encouraged all the union staff to join the NEWSTART program by requesting the health ministry director to “push” the office staff to participate. He fully supported the health director. Further, as chair of the hospital board, the union president said he supported the hospitals to operate the two health centers in Taiwan and Hong Kong. He used the word “support” rather than *force* or *demand* to describe the role of the union president and chair of the board of directors. This is an important leadership role, emphasized the president.

The presidents of the colleges and hospitals shared the story of how they played the supportive role in helping the health major students. Senior students were given the

opportunity to participate in the lifestyle programs and activities of the hospital lifestyle management department. Both student placement and internship were supported by the hospitals for students to learn skills outside the classrooms. Hospital clinical experience and health center customer service skills were arranged for the students. Further, the college president of Taiwan was excited when she shared the experience about how the local church pastors supported the student placement program.

Our students were able to work with the local church at Ping Tong for community health development. Even the district government health officials were impressed with the Adventist health lifestyle NEWSTART program that our students used to serve the people for better health. We are very thankful for the support of our pastors and faculty.

The leaders shared a common concept in leaders as supporters—to make best use of others' strength and to give credit to others in the collaboration. The idea was described by one of the leaders that collaboration was a means for finding strength. Through collaboration leaders were able to develop their followers' potentials and skills. They supported the health lifestyle programs to provide opportunities for involvement, and thus for staff and faculty development—supporting others to achieve better health, supporting others to serve, supporting others to succeed, and to give them the credits.

Leaders' Role as Builders

The institutional leaders being interviewed did realize that leaders were not just finders and supporters but they should be builders as well. This theme gives the concept that the leader's role is to be an activist and a starter. His role is to create both the environment and to allow people to collaborate. The leaders used similar key words like initiate, pioneer, create, and achieve to describe their role in this theme.

Who should be the initiator was a question raised by a number of the leaders. The

hospital and college presidents indicated that the union president should be the initiator for collaboration. The publishing house manager specifically stressed that the union has the responsibility to initiate research on the macro-environment and collaborate all the institutions under the governance of the union to face the challenges together and to accomplish the mission of the church organization. However, on the aspect of health and lifestyle, the union president said, “Our hospitals should be the pioneers and initiators of the Adventist health lifestyle programs.” The consensus of the institutional leaders seemed to be that creating the vision to develop the Adventist lifestyle programs functioning as “the right arm” of the church ministry should still be the leadership role of the union.

The story narrated by the leaders and through my observation depicted the following picture. First, as described by the hospital president, the Taiwan Adventist Hospital initiated the NEWSTART lifestyle program in 1997 by inviting the president of Weimar Institute, Dr. Milton Crane, from California to Taiwan to hold a lifestyle seminar for the hospital administrators and physicians. The hospital leaders collaborated with the college and then started a live-in lifestyle program at the college campus. After a few years, the program proved successful; then the union allocated funds to build a well-designed new health center, with the college providing the land at the college campus, and the hospital providing all the necessary furnishings and equipment. The union then appointed a managing committee to oversee the collaborative management of the health center with committee members representing the union, the hospital, college, local conference, and the center manager.

A similar story happened in Hong Kong. This picture shows that the hospital was

the builder laying the foundation of the lifestyle programs, while the college and the union were contractors raising the “lifestyle program mansion” upon its foundation to reach its appropriate height with full functions.

Building the lifestyle health center was not the total picture, but the operation and management team of the health center completed it. Creating a well-balanced and experienced managerial and service team of workers was a challenge. The presidents of the union, the hospital and the college have gone through the transition of managing the health center between the union, the hospital, and the college within the past 10 years. Building an atmosphere of trust, respect, and collaboration needed leadership. The leaders expressed the frustration that agreement among the senior leaders was not difficult to achieve; however, diffusing the collaborative agreement down to the middle and frontline staff was another matter. Skilled workers were easier to prepare but building a team of workers who were willing to trust and to collaborate with other institutional workers was difficult. Self-interest was the main obstacle. When the hospital staff worked with the college staff and faculty, the leader’s role of building a team spirit among the two institutions became vital.

Therefore, constant evaluation of the collaboration between the union, the hospital, and the college was important, explained the leaders. “We must build value, not just price,” delineated the Taiwan health center manager, “because price and profit caused more conflicts among our two institutional staff. Unless we build the value of mission in our collaboration we would not be successful in working together.” The leaders suggested the following solutions: building a vision—with a common agenda; creating a win-win situation; building a culture and value of collaboration; and

emphasizing “owning” the programs by the staff of both the college and the hospital.

This leads us to the next leader’s role of lifestyle programs’ ownership discussed among the leaders.

Leaders’ Role as Owners

This theme describes how the institutional leaders played the role of owners and were able to become users, participants, facilitators, and coordinators in the lifestyle programs. The institutional leaders explained that unless the leaders are good models in practicing lifestyle program collaboration, the program could not be sustained. This theme was discussed enthusiastically among the leaders in the Taiwan focus group. The essence of collaboration, stressed by the leaders, was that all institutions really play the role of owners. “Invitee is different from an owner of the program,” said the local pastor in Taiwan. “When you are invited to participate in a health program, you completed your assigned task and left. If you are a stakeholder or owner of the program, you want to see the outcomes of the program. You participated and stayed.” The pastor described in detail how one year he invited the hospital to take part in his church health and gospel evangelistic series and how for the following year he changed his strategy. Instead of inviting the hospital to just take part in the program, from the very beginning he invited the hospital leaders to sit with the local church leaders to brainstorm, to plan, and to come up with a common agenda. The evangelistic series in the following year became a collaborative event owned by the local church and the hospital as well. With the spirit of ownership, the pastor expressed with a sense of accomplishment that the participants showed interest and commitment, which was different from the previous year, and the

owners were interested in running the evangelistic series again the next year; thus, the program was sustained.

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 in different administrative levels, from the General Conference, the division, the union, the institution, the local conference, and down to the local church. Leaders are committee or board members sitting in one another's committees. Institutional leaders have the assignment to sit in different organizational committees or boards. They would perform the role of owners. They were able to become participants, users, facilitators and coordinators of the program. The challenge was that very often each institution focused only on its own interests and needs. This was pointed out by the publishing house manager, saying that a "more common agenda should be discussed in the union executive committee, and then to be passed on to the college board, the hospital board, the publishing house board, and the local conference executive committee." A few examples were mentioned in the interviews and focus group discussions as a common agenda that the institutional leaders owned. The Wellness Expo was a community outreach program that involved collaborative planning in different levels of committees and boards among the institutions. Gospel and health evangelistic series occupied many hours of discussions and planning in different institutional boards. The mass media project in producing Chinese Hope TV as relating to Adventist lifestyle programs was among the common agenda, too.

In summary, the institutional leaders' collaborative roles in the implementation of

the Adventist health lifestyle had four major themes as narrated in the stories of the leaders. They were the roles of finders, the roles of supporters, the roles of builders, and the roles of owners. These roles were related to the beliefs and the leadership skills of the institutional leaders. The following section describes the stories that motivated the leaders to function in the roles.

Beliefs and Skills to Fulfill Leaders' Roles

During the personal interviews and focus group discussions, many of the leaders shared the beliefs that motivated them to fulfill their leaders' roles as collaborators in the implementation of the Adventist health lifestyle programs. Two general belief themes came out from the data analysis. And there were three themes that describe the skills of the leaders' roles. Table 4 shows the themes of general beliefs and leadership skills that underpinned the motivation and ability of the leaders to execute their roles.

God's Message of Health Reform

The two pastors were particularly strong in the emphasis that the Adventist health message was sent from God. The message is for the end-time just before the second coming of Jesus. The health message that Adventists practice and share is to extend the healing ministry of Christ. "Extending the healing ministry of Christ is the motto of our hospitals," reported the hospital president in the focus group discussion. This theme was also supported by the college president as well as the health center manager. They believed that the gospel of Jesus should go together with the health message to meet the need of the contemporary world, especially in the large cities.

The leaders believed that prevention is better than cure. Adventists lived longer and better than the general population because they practice preventive medicine with a

Table 4

Leaders' Beliefs and Skills

No:	Category Key Word	Leader Input Code	Remarks
1.	God's Message	P _{r1} Q ₅ 1;P _{r1} Q ₅ 2 P _u Q ₅ 7;F _{hk} Q ₄ 19 P _{c2} Q ₅ 1;M ₂ Q ₅ 1	Prevention; God's Word together with health message; local church health evangelism active participant; God's given message for end-time
2.	Self-Practice and Example	P _u Q ₅ 1;P _{c1} Q ₅ 2 P _{c2} Q ₅ 2;M _p Q ₆ 1 P _u Q ₅ 2;F _{tw} Q ₄ 12 F _{hk} Q ₄ 16;P _u Q ₅ 4 M ₂ Q ₅ 1	Self-practice then promote; become a good example to others; promote as a local church leader; truthfulness
3.	Leadership Skills	P _{r1} Q ₅ 7;P _{r2} Q ₅ 1 P _{r1} Q ₅ 8;M ₂ Q ₅ 2 P _{h2} Q ₅ 5;P _{h2} Q ₅ 6 P _{h2} Q ₅ 7;F _{tw} Q ₅ 9 P _{h2} Q ₅ 3	Job assignment for collaboration; evaluation and review experience; recognize the large direction with others; involvement as union; union leadership through ACHA; union leadership skills; evidence-based education for physicians on lifestyle; tackle the health reform
4.	People Skills	P _{c1} Q ₅ 1;P _{r1} Q ₅ 4 P _{r1} Q ₅ 5;P _{r1} Q ₅ 6 P _u Q ₅ 2;P _{c2} Q ₅ 3 P _{h2} Q ₅ 2	Making friends; seek out the people; group prayer; dining with non-Adventists; team building sustaining; getting physicians agree and involve in lifestyle
5.	Communication Skills	P _{h2} Q ₅ 4;P _{c2} Q ₅ 4 M ₂ Q ₅ 3;P _{r2} Q ₅ 2 P _{h2} Q ₅ 8;F _{tw} Q ₄ 4 F _{tw} Q ₄ 8;F _{hk} Q ₄ 14 P _{h2} Q ₅ 1	Communicate well; common agenda for collaboration; need benchmarks and indicators

healthful lifestyle. Prevention is a holistic approach to health. The leaders believed that education, training, and promotion of the Adventist health lifestyle could help people to enjoy longevity with quality of life. Further, together with the gospel message, helping people to prevent the diseases of the world is to prepare a people ready to meet the Lord soon to come. This belief gave the true value that the leaders practiced their roles in the implementation of the Adventist health lifestyle. This message was very clear in the

evangelistic series conducted in the local churches.

Example and Truthfulness

“We must be true to ourselves, if we do not practice the lifestyle ourselves how can we expect others to practice it?” deliberated the college president, when he shared his endeavor to encourage the college faculty and staff to live healthfully. The same experience was narrated by the union president who enjoyed practicing the Adventist health lifestyle from his youth. Being good examples as leaders to others introduced a stronger message than promotion by talks, agreed the leaders during the focus group discussion. “Good living examples of the institutional leaders, especially in their local churches, would give a genuine truthfulness to the promotion of Adventist health lifestyle,” said the union president. “It was not by positional power or authority per se, it was a personal choice,” explained the president.

I observed among the leaders a common agreement on the theme of being examples and truthfulness. The leaders enjoyed the Adventist health lifestyle themselves. The enjoyment in the process of practicing the lifestyle and the outcomes of the goodness of the lifestyle motivated the leaders to collaborate in the implementation of the Adventist health lifestyle programs.

Leadership Skills

In the process of fulfilling the leadership roles as described previously, the leaders practiced many skills. In the roles of supporters and builders, job assignments for staff and faculty were decided by careful deliberation by the leaders. Many leaders expressed that they supported the Adventist health lifestyle programs by assigning their department heads and staff to participate in the activities. These assignments were not forced on

individuals but were delegated in ways that considered the maturity level of the staff. Some of the staff had no previous experience in working in lifestyle programs, others came with some experience, and some had extensive experience and were ready to be given full responsibility for their job assignment in those programs.

The leaders shared the importance of keeping evaluation and review in the process of collaboration. The college president in Taiwan shared the details of evaluating the project on which the faculty and student collaborated with the local churches in the Ping Tong district. In the beginning of the collaboration, the college team of faculty and students went to church after church to implement the lifestyle programs. However, explained the college president, after evaluation, the college team changed tactics. Instead of going to church after church in that region, the team stayed and focused on a chosen church to do in-depth programming. The outcome was that even the local official was involved and appreciated the effort of health promotion in that region because health improvements were seen in that particular church. “Evaluation in the process helped us to improve the collaboration,” said the president.

In the interviews and focus group discussions, a repeated theme of leadership skill was the casting of vision and direction of collaboration. This is basic for leadership. Beginning from the union and to the institutions, leaders fulfilled their roles as builders because they looked forward and projected a vision of collaboration in the implementation of the Adventist health lifestyle. Transformative leadership skill was observed. Since the leaders were willing to tackle the obstacles of health reform and were able to paint a large picture, people were inspired to become involved. The leaders practiced the skill of empowering leadership. They recognized and supported the grand

visionary direction with other leaders. Making use of the Adventist Hospital Association, described the union president, hospital leaders supported the direction of collaboration. Evidence-based education and a symposium for the physicians on lifestyle to empower the doctors were implemented. The union leadership in this theme was prominent.

People Skills

The institutional leaders described the importance of working with people in their leadership roles. The ability to make friends with different stakeholders—community representatives or other institutional staff—enables the leaders to collaborate well in the implementation of the Adventist health lifestyle programs. The pastor in Hong Kong stressed the skill needed in making friends with people in order to find out the needs of the people in the church and in the community. The union president narrated his experience in making friends when visiting in China with government officials. “I used to dine with government officials and I promoted a vegetarian diet and our health message. Through our health message we show our care for their health and we made friends. Friendship enhances our collaboration with the government in running the health center in Xiamen, China.”

Teamwork and team building are important skills in collaborative leadership. The stories of 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 work together first in prayers.” The college president emphasized that team building sustained the collaborative effort in the implementation of Adventist health lifestyle programs. When working with the local

church in Ping Tung, Southern Taiwan, they build service teams made up of faculty, students, and local church members, according to the college president. “Forming service teams is important to sustain the lifestyle program. When our faculty and students leave the local church, the service teams of the local church continue the health program.” The hospital president in Taiwan tackled the challenge of teamwork. “It was difficult to get our doctors to work with our lifestyle staff and to support the Adventist health lifestyle programs. The doctors are so busy working on acute patient care, and could not find the time and energy to get involved in lifestyle medicine.” However, a better story played out at the Hong Kong hospital. A recently retired doctor volunteered to team up with the lifestyle program team to be the consultant doctor, and the team opened a lifestyle medical clinic. Teamwork in acute and lifestyle patient care provided a holistic approach service that fulfilled the mission of the hospitals—to minister to the physical, mental, and spiritual needs of the patients.

Communication Skills

Leadership communication skills were mentioned many times by the leaders in the interviews and focus group discussions. To collaborate well is to communicate well was the central theme. The lack of professional and leadership skill in communication barricaded the process of collaboration, indicated the leaders. The most important issue in the process of communication is the need of a common agenda for collaboration. The presidents of the hospital and the college and the publishing house manager emphasized this issue. They strongly believed that it is the responsibility of the union leadership to initiate a common agenda. It should be communicated throughout the committees and boards of all the union institutions. The union leaders must set the direction, the vision,

benchmarks, and indicators for all the institutions to work together. “I suggest a 80/20 principle in our committees,” said the Taiwan college president, “that 80% of our resources be spent within each individual institution, and 20% of our resources to be used for collaboration, for common agenda, and for our common mission.”

Communication is the nervous system of all the roles and functions of collaborative leadership in the implementation of the Adventist health lifestyle. Effective communication was the backbone and the framework that supported the leaders’ roles. The Adventist church union structure outlined the framework for networking and communication through the different committees and boards at various levels of the church structure. If the union structure were properly used, said the publishing manager, the roles of the leaders could be more effective in the collaboration. Some of the leaders identified the challenge as institutional self-interest that hindered true collaboration as long as there was no strong initiative from the union leadership.

Leaders’ Roles in the Context of the Adventist Church Structure

The second tier of the Adventist church structure—the union level, as described in this study—allows the institutional leaders to meet in formal committee meetings at least 10 to 15 times annually. The collaborative leadership roles of the institutional leaders, to perform as finders, supporters, builders, and owners in the implementation of Adventist health lifestyle programs, can be facilitated easily. According to the *General Conference Working Policy* (General Conference of Seventh-day Adventists, 2010b), the members of the union executive committee as well as the members of the managing board of the institutions (for example, the hospital, the college, and the conference), all the union officers and the heads of the institutions are by position the members of one another’s

committees or boards. In other words, each head of the institution will sit in the managing committee of other institutions and vice versa. This working policy aims to facilitate all the institutions under the leadership of the union to share resources, to communicate, and to collaborate for the mission of the church in the union territories. The structure enhances unity and builds trust among the institutions, similar to the members of the body with different roles and functions. The union acts as the platform for all the specialties of the church—in healthcare, in education, in mass media, and in gospel ministry to work in unity, as a “union.” The “machine” that should really carry out the mission of the global Adventist church is the union because it has most of the important functions and specialties of the church. The collaborative leadership roles of the institutional leaders, if properly facilitated and empowered, could make a real impact to influence the world because of this global coverage with the 120 unions around the world, and in the context of this study—the impact of health and lifestyle change to combat NCDs.

Complaints were expressed by some of the institutional leaders that there were too many meetings within the union organizational structure even though such meetings were stipulated at the different tiers of the Adventist church organization structure in the working policy. Complaints would be valid only when meetings were not providing development or growth to the participating institutions. A possible reason would be the lack of collaboration.

Challenges and Obstacles of Collaborative Leadership Roles

The four collaborative leadership roles of the institutional leaders discovered in this study, when compared with the conceptual frameworks of collaborative theories and

models, provided a few insights that are analyzed in Table 5. The table uses five columns to describe first the collaborative theory, the second column on the underlying value of the theory, the third column describes the issue addressed, the fourth column shows the collaborative leadership roles, and the final column indicates the obstacle encountered.

For example, the collaborative theories of rational choice and the socialized choice theories by Hill and Lynn (2003) give the underlying value to share organizational goals and values. The challenge addressed in this study was getting the CHUM institutions to share and plan together. The leadership role is a builder. One obstacle encountered was that shared goals and vision required efforts to communicate.

The four-stage model proposed by Jackson and Reddick (1999) seeks to strengthen the process of collaboration in order to address the challenge of the lack of information sharing and communication. In this study leaders had to act as supporters and builders as they encountered local church leaders afraid to reach out to their communities.

One of the most important obstacles encountered in this study was that collaborative leadership took time to build trust. The six-step process community empowerment model of Yoo et al. (2004) has the underlying value of showing the how of doing collaboration, and the issue addressed was the institutions in CHUM were doing health programs independently in the past. The leadership roles that related to this model are supporter and owner as well. Collaborative leadership roles discovered in this study were theory-based. They are functional to address challenges, and to overcome obstacles when implementing the Adventist health lifestyle programs to improve health.

Resource allocation was a frequently discussed challenge in this study. Many institutional leaders had to convince their administrative teams to set aside budgets to

Table 5

Collaborative Leadership Roles and Obstacles Encountered

Collaborative Theory Used	Underlying Value	Issue Addressed	Leadership Roles	Obstacle Encountered
The Three Perspective Theory of Resource Dependence, The Networking, and Institutional Perspectives by Sowa (2009)	To enhance and motivate collaboration among organizations	Lack of resources and the motivation to collaborate among CHUM institutions	The leadership role as Finder and Supporter that allows the CHUM institutions to run the health centers in Taiwan and Hong Kong	To overcome the barrier of self-interest and self-protection
The Rational Choice and The Socialized Choice Theories by Hill and Lynn (2003)	To share organizational goals and values	Getting the CHUM institutions to share and plan together	The leadership role as Builder	Shared goals and vision took efforts to communicate
The Six-step Process Community Empowerment Model by Yoo et al. (2004)	The how of doing collaboration	Institutions in CHUM were doing health programs independently	The leadership role as Supporter and Owner	It took time to build trust and vision for the collaboration
The Conceptual Model of Sustainability in Community Health Partnerships by Alexander et al. (2003)	To enhance better outcomes through collaboration	The lack of joint-venturing project and program by our health-related institutions	The leadership role as Supporter and Owner	Collaborative leadership and networking power
The Four-stage Model by Jackson and Reddick (1999)	To strengthen the process of collaboration	The lack of information sharing and communication	The leadership role as Supporter and Builder	Local church leaders were afraid to reach out to the communities

work with other institutions. The question asked by some administrators was, “Why do we need to put 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 that felt that the union should shoulder the bigger share of the needed resources. However, the union felt that the hospitals, being the more affluent institutions, should contribute the greater share. Coming up with an agreed-upon 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?

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. Lifestyle programs should not drain the resources from the institutions but should create revenue and sustain the programs themselves. The concept of medical missionary outreach programs was not appreciated enough.

The drifting apart of healthcare medicine focusing on acute care from preventive lifestyle health services has been a challenge. The collaborative leadership roles in the implementation of lifestyle programs need to consider the strategy to integrate lifestyle medicine with acute care mainstream medicine. Lifestyle medicine is not alternative medicine as some called it. It should be integrated holistic patient care that acute care, rehabilitation, prevention, lifestyle, screening, diagnosis, and treatment should all work together for patient-centered healthcare services. Today medicine should not be just acute care disease-centered medical services.

Rippe et al. (2009) wrote in an editorial of the *American Journal of Lifestyle Medicine* saying:

Let us restate and underscore our central premise of this editorial: 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. (Rippe et al., 2009, pp. 423-424)

Chinese food culture was observed as a huge obstacle when implementing the Adventist lifestyle programs in the Chinese community. Chinese food is famous with many delicacies from different parts of China. Feasts with 12 entrées during dinner in the restaurant 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 Adventist health lifestyle. Adventist health reform is far from common in the Chinese Adventist community. Some of the institutional leaders saw the challenge as too enormous to tackle. Their roles in the implementation of Adventist health lifestyle programs were not welcomed and appreciated. To support and to build a valued principle and culture of Adventist health lifestyle in the local churches, especially among the pastors, faculty of the educational institutions, and the staff working in the

healthcare institutions, has been a challenging obstacle that needed vision, persistence, and leadership competency.

From the perspective of an obstacle, the problem of mistrust, due to the lack of communication and the poor decision-making process, was reported from the frontline level rather than the leadership level. This 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. Top-down communication was weak. Leaders were asked to share more, to explain and to communicate more, and to give a few more incentives. Strengthening the human relationship of the frontline staff among and between the staff of the institutions participating in the collaboration was a challenge.

The institutional leaders in Chinese Union Mission believe they have practiced collaboration in the implementation of Adventist health lifestyle programs. The leaders also perceived their roles and the importance of their influence to the success of the implementation. However, there is much room for growth and improvement, both in the roles and collaboration. Conversations among the leaders about what worked well and what did not work well in the leadership roles for collaboration revealed important dynamics, which are listed in more detail in Appendix F.

Summary

This chapter has presented the results of the data analysis. The data came from the stories and experience of the institutional leaders of Chinese Union Mission. The leaders shared their collaborative leadership roles in the implementation of Adventist health lifestyle programs to gain health in the community of Hong Kong and Taiwan. They first

narrated their personal experience in practicing the Adventist health lifestyle, followed by their active involvements of collaborative activities, described from the perspective of being the heads of the institutions in the same union. There were two main categories of activities--the foundational collaborative activities that laid the base of collaboration, and the collaborative service activities that ran services to improve health. In all these collaborative program activities, the institutional leaders described their four main roles as finders, supporters, builders, and owners. These leadership roles were underpinned by the leaders' beliefs and skills. The four institutional leader roles were executed in the context of the global organizational three-tiered structure of the Seventh-day Adventist Church. The final analysis in this chapter narrated the challenges and some obstacles that collaborative leadership roles had to confront.

After identifying the collaborative leadership roles of the institutional leaders in the implementation of the Adventist health lifestyle programs in the Chinese Union Mission, the next chapter gives a summary of this study, followed by a discussion and recommendations from the perspectives of implementing Adventist health lifestyle programs to improve health in the setting of the union structure of the Seventh-day Adventist Church.

CHAPTER 5

DISCUSSION AND RECOMMENDATIONS

Summary of the Study

After antibiotics were discovered and widely used in the 1940s, the war against bacteria and infectious communicable diseases, such as syphilis and tuberculosis, had gained ground. Human mortality rate, caused mainly by communicable diseases, was on the downward trend. Modern medicine seemed to be able to control diseases caused by parasites, bacteria, and viruses. However, at the turn of the 21st century, the war shifted. According to the WHO *Non-communicable Diseases: Country Profiles 2011* (2011b), most developed countries and many developing countries were facing the same problematic health challenge, in that 60% to 80% of the mortality rate was from NCDs—mainly cardiovascular diseases, cancers, pulmonary diseases, and diabetes, totaling about 36 million deaths globally in 2008. The trends are not encouraging for the future. WHO projected that by 2015 and 2030 the global NCDs mortality would be 39 million and 52 million deaths respectively. Sixty percent of these deaths in 2008 were individuals under the age of 60, which is considered a premature death (WHO, 2011a). Most of the risk factors that correlated to the prevalence of NCDs were lifestyle related, such as unhealthy diet, physical inactivity, the use of tobacco, and excessive alcohol consumption.

Most NCDs are preventable by the adoption of a healthful lifestyle, that is, adopting a proper diet and plenty of physical activities, and removing known risk factors

like smoking and alcoholic beverages. Two well-known research studies provided evidence that a healthful lifestyle correlates to significant lower risk of NCDs were the China Study (Campbell & Campbell, 2006) and the Adventist Health Studies (Beeson, Phillips, Andress, & Fraser, 1989; Fraser, 2003; Kahn et al., 1984). The Adventist health lifestyle emphasizes the natural way of life that has its basis in the teachings of the Bible, the writings of Ellen G. White, and is supported by evidence-based research. The Chinese Union Mission leadership responded to the global health challenge of NCDs by practicing the collaborative leadership approach over the past decade, in the implementation of Adventist health lifestyle programs. It has produced positive outcomes and received recognition from healthcare officials and the healthcare industry. Little was known about the roles of the institutional leaders who were actively involved in the implementation of Adventist lifestyle programs to meet the challenge of NCDs.

This descriptive qualitative case study discovered that there are four major roles of the institutional leaders—leaders as finders, as supporters, as builders, and as owners. This understanding provided clues to the process and outcomes of collaborative leadership in the implementation of Adventist lifestyle programs to meet the challenge of NCDs. Twelve institutional leaders participated in this study. Individual interviews and focus groups were conducted with this purposive sample.

This study identified not only the four institutional leaders' roles but four complex underlying elements that interact together in the implementation of Adventist health lifestyle programs. Like the four wheels of a vehicle, or the four legs of a chair metaphor, or better still—a four-stranded cord with each strand of its own strength, when woven together, the combined strength will accomplish the task that an individual strand could

not. The four strands or elements are: (a) The leader's four roles as finders, supporters, builders, and owners, (b) the global Adventist church three-tiered structure, (c) the Adventist health lifestyle programs in foundational activities and service activities, and (d) the collaborative leadership skills in personal, interpersonal, and organizational collaboration. Figure 1 illustrates the interacting and weaving action of the four strands or elements to empower the central common agenda of combating NCDs.

The findings of this case study at the Chinese Union Mission of the Seventh-day Adventist Church suggested that all 124 unions (General Conference, 2014) around the world could reference this collaboration model to implement the Adventist health lifestyle programs in combating the global challenges of NCDs. It would make a strong and global Adventist health service army in collaboration with WHO and many other nations, with the goal of improved health and better quality of life.

Discussions and Recommendations

To make the findings of this study more practical and an easy reference for the other unions, there are 10 recommendations given under the four elements or strands. The format of these 10 recommendations is similar to the minutes of the Union Executive Committee or Board of Directors of the Adventist institutions and is used here to emphasize the need for administration action. The discussions are given in the format of a number of "WHEREAS" clauses that lead to the "IT IS RECOMMENDED" clause.

The First Strand—The Four Collaborative Leaders' Roles

Under this first strand there are two recommendations suggested. The first recommendation has to do with resource funding, and the second calls for training to make sure the leaders' roles are enhanced.

Figure 1. Four-strand collaboration model of Adventist health lifestyle programs.

First Recommendation: To Form a Resource Fund

WHEREAS the institutional leaders of the Chinese Union Mission described four main collaborative leadership roles when they implemented the Adventist health lifestyle programs—the roles of finders, supporters, builders, and owners—they deserve greater attention. The most fundamental was the finder role—aiming at finding collaborative resources to meet the needs of the target people groups. The leaders were looking for the means to serve their target groups with the health programs as well as looking for resources that could sustain program operation. This collaborative leadership role is supported by the studies of Shaibu (2006), Snavelly and Tracy (2002), and Sowa (2009) who found that “environmental constraints and the need to secure resources are driving

factors for engaging in collaborative endeavors in order to reduce the uncertainty that may exist in one's environment" (Sowa, 2009, p. 1005). The frontline leaders in this study, for example the pastors were keen finders for supportive resources.

WHEREAS networking is a means to find resources and an important collaborative behavior that the institutional leaders need to perform (Sowa, 2009), it should be used more extensively. Finding ways and opportunities to cooperate with others, building a social network, and sharing resources with others are roles that the finders have to fulfill. This study observed that Adventist institutional leaders tended to socialize and network only within the Adventist circle. Only the hospital leaders were more proactive in networking and finding resources in the community, for example, organizing fund-raising activities. Through community networking and securing support from the community, leaders may be able to find more resources for the Adventist health lifestyle programs.

WHEREAS one of the reasons why collaborative leadership roles worked well in the implementation of the Adventist health lifestyle programs was that the NEWSTART program is a well-branded product that is well known especially in Hong Kong and Taiwan, more resources to do marketing and promotion for the band NEWSTART should be used to enhance the success of the Adventist health lifestyle programs. Institutions participated in the programs because NEWSTART programs were well known and well accepted by the communities. The brand has a halo effect, and institutional leaders and staff are willing to be involved.

IT IS RECOMMENDED to approve in the union executive committee and pass on to the managing boards of all institutions within the union a resolution to allocate a

certain percentage of revenue to form an Adventist Health and Lifestyle Resource Fund. The Resource Fund is to be managed by the union executive committee. The purpose of this Resource Fund is for the implementation of Adventist health lifestyle programs according to the common agendas as discussed, recommended, and approved by the union executive committee. The percentage of revenue set aside for the Resource Fund can begin with 1% and should be reviewed regularly. Application for the Resource Fund for the implementation of Adventist health lifestyle programs can be initiated from the local churches or the institutions. However, in the process of reviewing applications for the Resource Fund, it is not for activities and programs run by isolated churches or institutions. Collaborative projects, as initiated by the process of common agendas, should mainly be entertained. Thus, the finder role of the leaders can easily be actualized because of this Resource Fund.

Second Recommendation: To Train Leaders

WHEREAS some of the institutional leaders expressed the need for the preparation of standardization of protocols for the roles of the institutional leaders, these roles should be included in the job description of the leaders. Newly appointed leaders of an institution were not given any orientation to the knowledge and skill of collaboration. As a written description of the meaning and competency of leadership collaboration among institutions in a union setting should be part of the job of each institutional leader, the standardized protocol should also include the preparation of a common agenda for the committee, the procedures for creating a common vision, and the process of sharing resources.

WHEREAS the studies of Sowa (2009) and Stone (2000) show that collaboration

helps organizations in decision-making to change strategic direction, collaboration also influences their perceptions of the roles of the leader, training for this discipline is vital for organizational effectiveness and growth. This perspective is supported by Cummings and Kiesler (2005), “who investigated scientific collaboration across disciplinary and university boundaries to understand the need for coordination in these collaborations and how different levels of coordination predicted success” (p. 703). Studies show that collaboration is important for the leaders and the organizations, proper orientation and training should be part of the in-service program of every institution, and that job performance and evaluation of the institutional leaders should be a standard procedure in the organization.

WHEREAS this study discovered that the union institutional leaders strongly supported and felt the need for collaboration among the institutions within the Chinese Union Mission, the suggestion was made that the union officers should take the lead. Because studies show the positive outcomes of collaboration that can bring improvements and changes to the participating institutions (Hicks et al., 2008; Logan et al., 2010; Pinto, 2009; Sowa, 2009; Takahashi & Smuty, 2002), the need to empower the newly appointed union and its subsidiary institution leaders for collaboration is important and needed.

IT IS THEREFORE RECOMMENDED to conduct a union-wide “Leadership Conference on Collaborative Leadership,” and that this conference should be organized by the union administration and that the participants include all the union officers and institutional leaders, together with a few selected local church pastors. The contents of the conference should include topics on the importance of collaboration, the motivation

for collaboration, the process, the outcomes, and the roles of collaborative leadership. This conference should be held right after the new quinquennial session of the Chinese Union Mission, in order to prepare the union and institutional leadership for effective collaborative leadership roles among the union institutions. Workshops and discussions should be conducted during the conference to allow all the newly appointed institutional leaders to understand the roles of the institutional leaders, and some of the contributing factors on collaborative leadership roles in the perspectives of standardization of roles, protocol for the preparation of common agendas, education and training of the collaborative leadership roles.

The Second Strand—The Global Adventist Church Structure

This study revealed that institutional leaders worked within the context of the Adventist church structure in order to exercise their roles to implement the Adventist health lifestyle programs. The third and the fourth recommendations among the 10 recommendations given in this study are related to this strand.

Third Recommendation: To Prepare a Common Agenda

WHEREAS the institutional leaders worked within the context of the union structure, they realized the importance of the church structure. It was the platform to facilitate collaborative leadership through executive committees, institutional board of directors, management committees, and the distribution of resources. The Chinese Union Mission belongs to the organizational structure of the global Seventh-day Adventist Church. The roles of the institutional leaders functioned within the context of the organizational structure of the church. The global church structure facilitated the roles of

the leaders to implement the Adventist health lifestyle programs.

WHEREAS this study discovered that although the union structure exists to provide the platform for collaboration, observation showed that institutional leaders did not have a common agenda that allowed the leaders to participate in order to bring positive outcomes to each participating institution. This concept is deliberated by Hicks et al. (2008) as the theory of commitment transfer. This is an important guide in the study of collaborative leadership roles, that collaboration would bring a difference, improvement or benefit to the stakeholders (Lachance et al., 2006; Pinto, 2009; Takahashi & Smutny, 2002).

WHEREAS it was observed that some of the institutional leaders were just voting members at the various committees and boards with minimum execution of the collaborative leadership roles of finders, supporters, builders, and owners as suggested, the institutional leaders, starting from the union president, need to work together on some common agenda that is related to most or all institutions, constantly keeping in mind that the institutional leaders present at one another's committees or boards need to realize and fulfill their roles from the perspectives of their respective institutions, contributing to the benefit of the other institutions.

WHEREAS the studies of Sowa (2009) and Stone (2000) indicated that if there were collaboration among the participants, there should be changes occurring to the strategic behavior of the participating organizations in decision-making, and there should be “amplifying and rippling effects on the collaborators’ strategic direction, and changed, to some degree, the perceptions of managerial roles” (Stone, 2000, p. 98).

WHEREAS the problem of “waiting” on the union president to initiate the

common agenda was observed in this study, the subsidiary institutions of the union organization tend to “wait” for the union president to make the first move—to lead out in the aspiration of a common vision; and being the chair of the union executive committee, the institutional leaders were expecting the union president to initiate some common agenda, both short-term and long-term agenda for collaboration. Takahashi and Smutny (2002) called this the Open Window for collaboration. The authors pointed out that in order for collaboration to occur that a “collaboration window must open which involves the problem, policy, organizational, and social/political/economic issues, and a collaborative entrepreneur must act accordingly to the opened window” (p. 145). It is proper to expect the union president or the chair of the union executive committee to open the collaborative window.

IT IS THEREFORE RECOMMENDED to delegate to the Chinese Union Mission Executive Committee the responsibility to prepare common agendas for collaboration, and that a standing committee, namely the Collaborative Common Agenda Steering Committee, should be appointed to monitor and to evaluate the process and the outcomes of the common agendas. The chair of the Steering Committee should be the union executive secretary, together with four other members of the union executive committee, representing the major institutions of the union. The Terms of Reference of the Steering Committee are: (a) To remind the union executive committee to propose collaborative common agendas; (b) To pass on the initiated common agendas to all the union institution committees or boards for discussion and action; (c) To monitor the process of making inputs and implementing action plans among all the union institutions; (d) To evaluate the outcomes and measurable objectives of the collaborative common agendas

for improvements and developments; (e) To make recommendation of a common agenda and report to the union executive committee. This recommended protocol, and the forming of the Steering Committee for the common agenda, should be implemented from the union and the union institution level, and down to the local conferences, and the local churches.

IT IS FURTHER RECOMMENDED that the common agendas observed in CHUM in the implementation of Adventist health lifestyle programs, for example, the discussion on the sharing of resources, the Wellness Health Expo, the operation of the health centers, and health evangelistic series be expanded to include also strategic plans to run health programs in the cities to meet the needs of the postmodern people, to organize programs that would allow all institutions to contribute their expertise to build a momentum of Adventist health culture in the community, and to consider putting more resources from all institutions to do joint marketing to establish the Adventist brand name that together they are here to serve the community.

Fourth Recommendation: To Call for Commitment

WHEREAS the study by Tukuitonga and Keller (2005) observed that it was a challenge for the leaders to implement lifestyle behavior change programs, the importance of these programs is growing. The WHO has adopted resolutions to tackle the problem of noncommunicable diseases, which have been renewed every 4 years with increasing urgency.

WHEREAS the General Conference of the Seventh-day Adventist Church has taken action to support the strategy of WHO to combat against NCD, and after the Geneva 2009 Global Conference on Healthcare and Lifestyle, an action was passed by

the executive committee (GC EC 09-138) entitled “Seventh-day Adventist Call to Commitment to Health and Healing,” two factors in the action particularly gave weight to this study—one of them was that the Church should be “regarded globally as teaching a holistic model of evidence-based healthful living in primary health care,” and the other factor was that the Church should be “involved not only administratively but also functionally at every level including each congregation and church member in this ministry of health and healing” (GC EC 09-138).

WHEREAS the mission statements of the Chinese Union Mission and its subsidiary institutions all depict the concept of caring for the whole person with the gospel and healing ministry of Jesus Christ; and

WHEREAS the global Adventist church continued to commit itself to combat NCDs and to improve global health, the second Global Conference on Health and Lifestyle was held in July 2014 in Geneva, again with the theme “Non-communicable Diseases: Lifelong Lifestyle Prevention and Accessible to All,” the union executive committee should take action to support the world church and to recommit itself to the action of the world church.

IT IS THEREFORE RECOMMENDED to reaffirm that the Chinese Union Mission’s commitment is to join the global Adventist church through the health ministry to achieve the well-being of its members and the Chinese communities it serves, and to contribute to improve global health. This call to commitment should be carried out in all levels of the church organization from the union, its institutions, and to the local churches and communities. Goals, measurable objectives, and action plans should be prepared by each entity at all levels during annual meetings. The annual plans should be reported to

the higher level and monitored by the executive committees or boards of the higher level within the union organizational structure. The collaborative leadership roles of the union and institutional leaders should be effectively performed in the implementation of the GC commitments after the 2009 and 2014 Geneva Global Conference on Health and Lifestyle.

The Third Strand—The Adventist Health Lifestyle Programs

This study found that the institutional leaders have been involved mainly in two groups of collaborative activities. One group of activities was foundational in that the leaders were involved in the sharing of resources, training of health workers, and the operating of the lifestyle health centers. The second group of activities centered on collaborative services to improve health that included conducting lifestyle interest seminars and classes on cooking, fitness exercises, stress management, and trust enhancement, organizing NEWSTART live-in camps, and community services like the Wellness Health Expo, conducting health and gospel evangelistic series, and promoting health via mass media and the internet. The following four recommendations are related to both foundational and collaborative services.

Fifth Recommendation: To Rotate Operation of Health Centers

WHEREAS the institutional leaders experienced different operation models and rotation of operation of the Adventist Lifestyle Health Centers, this allowed leaders from different institutions to collaborate and to participate in the activities.

WHEREAS three different models of operation and management were used in the past, it took almost 15 years to gain the experience of operating the health centers as

described in this study. The institutional leaders exercised their roles to find resources, to support the operation of the lifestyle health center, and helped to build the new center in Taiwan, and renovated the men's dormitory into a lifestyle health center in Hong Kong. The leaders had tried to own the operation in different periods, trying out the different models of operation.

IT IS THEREFORE RECOMMENDED to use a Rotation Operation Model for the management of the Adventist Health Lifestyle Centers between the hospital, the college, and the local conference towards a win-win management outcome. Each rotating operation term could be 2 years. A standing Lifestyle Center Management Committee should be appointed by the union executive committee with the president of the institution or his/her designated person to be the chair when the term was rotated, while the Committee executive secretary should always be the manager of the lifestyle center. The annual operation budget should be shared between the participating institutions. This Rotation Operation Model would allow each of the participating institutions to contribute expertise to specific needs. The hospital would be able to serve clients for lifestyle change to improve health. The college would be able to train its health major students using the health center as a laboratory for clinical experience. Local churches would be able to send interests with chronic diseases to the live-in lifestyle programs at the lifestyle health center where they learn not only about health but also about the gospel. The lifestyle health center could be an important platform for institutions within the union to collaborate and take turns to own the health center. They have a common agenda.

Sixth Recommendation: To Hold a Wellness Expo

WHEREAS the most participated in, collaborative Adventist health lifestyle

programs among the institutions was the Adventist Wellness Health Expo conducted three times in Hong Kong, one time in Taiwan, and four times in China (although not included in this study), the Wellness Health Expo allowed the institutional leaders to exercise all four leaders' roles as finders, supporters, builders, and owners.

WHEREAS the Wellness Health Expo was clearly defined and easy to participate in, it allowed all the institutions to look forward to a clear vision, and it provided the platform for staff of different institutions to plan and work together during the process of preparation, and the outcomes were measurable—the number of participants, and the volume of promotional materials distributed by all participating institutions. It was highly supported by the institutional leaders that this union-wide Wellness Health Expo should be conducted at least bi-annually in different areas of the union territories.

WHEREAS the Constituency Relations Model (Schiavo, 2007) emphasizes effective communication and the identification of common goals, it underscores “the process of convening, exchanging information, establishing and maintaining strategic relationships with key stakeholders and organizations with the intent of identifying common goals that can contribute to the outcomes of a specific health-related mission” (pp. 199-200), the concept of stakeholder should be an important consideration for the institutional leaders acting as owners in the implementation of Adventist health lifestyle programs—the Wellness Health Expo has been one of the best programs in terms of successfully collaborating to serve the community.

IT IS THEREFORE RECOMMENDED to conduct biennially the Adventist Health Expo among all the union institutions, and to use the Constituency Relations Model that there must be (a) a designated office to look after the event, (b) emphasis

must be put on teamwork and negotiation skills, (c) training must be given to staff on job assignments, and (d) outcomes must be shared with all participating institutions. A Steering Committee made up of all representatives from all institutions should be appointed. The budget would be divided up and shared among all the participating institutions. Measurable and expected outcomes should be approved by various committees with evaluation and continuous improvement plans.

Seventh Recommendation: To Join a Lifestyle Club and Team 20

WHEREAS the purpose of the global Seventh-day Adventist Church's organizational structure is to fulfill her commitment for world mission (B. Oliver, 1989), health reform, the practice of a holistic healthful lifestyle, is one of the principle teachings to accomplish the mission of the Adventist church. This alignment of the mission of the Adventist church and the health outreach has been described by a number of researchers (Covrig, 2005; Haffner, 2006; Numbers & Larson, 1986; Robinson, 1965).

WHEREAS this study observed that the institutional leaders paid more attention to the statistics of collaborative health program activities than to the positive health change or outcomes of the participants who participated in the activities, such reports fail to capture the solid results achieved by the programs. Too often statistical reports were given to the leaders regarding how many participants attended the lifestyle programs, and/or how many programs were conducted in a certain period of time. Not too often did leaders receive reports regarding how many diabetic patients had reverted their blood sugar level to normal, or how many clients with high blood pressure, since participating in the lifestyle programs, had kept their blood pressure under control without medication at the normal range for certain periods of time.

WHEREAS the Adventist Lifestyle Club and the Healthy Team 20 teams operated by the hospitals allow lifestyle change to happen in a progressive manner, this change has proven sustainable. The Adventist Lifestyle Club and the Health Team 20 both help to monitor and document the ongoing lifestyle change of the participants. They are based on the evidence-based concept that behavior change is difficult. Progressive change begins with the 5% of the target objective or population of the normal distribution curve or Gaussian distribution, and it takes time to influence the next 15% of the normal curve to reach a 20%, the law of the vital few 20/80 Pareto principle, to become a movement for change in the institution or a community.

IT IS THEREFORE RECOMMENDED that the union executive committee and all union institutional managing boards support the promotion of Adventist Lifestyle Club and Healthy Team 20, and encourage their staff to become members of the Adventist Lifestyle Club and Healthy Team 20. Each institution should set measurable objectives for membership enrollment and team formation. All the Adventist Lifestyle Club members and Healthy Team 20 teams formed in various institutions should be networked with the community to increase the momentum and influence of the Adventist health lifestyle. Adventist Lifestyle Club and Healthy Team 20 members are the focus for sustainable lifestyle behavior changes, and measurable indicators for health improvement. Being the right arm of the union, the Adventist hospitals in the union and the union health ministry department could be assigned as the coordinating agents for the network. The implementation of this network could become a common agenda for the union and institutions.

Eighth Recommendation: To Use the Four-Level Lifestyle Behavior Change Model

WHEREAS studies show that despite the fact that a healthful lifestyle could either detain or eliminate many chronic diseases, “a distressingly low percentage of people in the United States follow the cluster of practices known to lower the risk” of many NCDs (Rippe et al., 2009, p. 422). “The Nurse Health Study reveals that only 4% of this population of health care workers followed all the practices that would lower the risk of heart disease and diabetes (Stampfer et al., 2000)” (Rippe et al., 2009, p. 424). The practices of healthy diet, regular physical activities, and refraining from the use of tobacco and alcohol are the cluster of practices known to many people that are good for their health and yet difficult to practice.

WHEREAS the process of health behavior changes can be slow since it involves breaking habits that were established over many years, the Four-Level Lifestyle Behavior Change Model has proven helpful to assist participants, with the support of a coach, in this process of progressive behavior change. As Figure 2 shows, the model has two parts or models within itself: the upper part, or Model 1, shows the many activities helping participants to become aware of the need for lifestyle change. While the lower part, or Model 2, illustrates a process, it is the evolutionary or transformational coaching that program activities are geared to coach the participants to go through the process of lifestyle changes.

IT IS THEREFORE RECOMMENDED that the union executive committee assign the hospitals to involve all union institutions to support the Four-Level Lifestyle Behavior Change Model. All lifestyle programs are to be structured in such a way that the participating institutional staff and the clients they serve be coached through the four

Wellness Management Program Lifestyle Behavior Change Conceptual Framework

Model 1: Functional Mentoring

Model 2: Evolutionary or Transformational Mentoring or Life Coaching

Figure 2. Four-level lifestyle behavior change model.

levels of behavior changes. Health improvement outcomes of the participants would be the focus of attention. The hospitals would be responsible to train coaches recruited from all the union institutions. This initiative should involve the Healthy Team 20 from all institutions. The hospitals should gather regular reports from all institutions regarding the number of participants in the Healthy Team 20 progress and their progress on the four levels of health behavior change. The number of coaches from each institution would be an important measurable objective that all institutions would work with.

This lifestyle behavior change model provides a long-term perspective that

emphasizes that change toward a healthful lifestyle is a process. The collaborative leadership roles are needed to improve the interaction among institutions in the implementation of lifestyle programs to measure realistic outcomes. Currently we are inviting people to become members of the Adventist Health Lifestyle Club. The idea behind this membership is to support those who are going through the progressive four levels of behavior change. They are called Newstarters or Adventist Lifestyle Club members—they are members of a community that shares a common culture of diet practices, exercise habits, and supportive interest groups like cooking classes, diabetic groups, Weight Watchers, and others.

Sustainable outcomes are thus used to build a movement to draw more people to join this culture by word of mouth and positive experience sharing. Some of the services provided for the Newstarters who are members of the Adventist Lifestyle Club, are personal websites, a newsletter, volunteer officers elected to manage the Club, regular activities for members and families, and special discounts for health products and rewards like cookbooks, health foods, and seminars.

The Fourth Strand: Collaborative Leader Skills

Two recommendations are given under the fourth and final strand of the collaboration model that this study discovered.

Ninth Recommendation: To Apply Health Communication

WHEREAS this study shows that the operation of the lifestyle health centers was affected by issues of self-interest among the staff of different institutions and the problem of mistrust, they must be addressed by collaborative leaders. The barriers of mistrust, lack

of communication, and the defect in decision making and problem solving, as described by Logan et al. (2010), happened in the process of operation.

WHEREAS the study of Schiavo (2007) underscores that leaders should not assume that the stakeholders of a collaborative endeavor would support every aspect of the health cause or communication program, leaders need to strive for multi-level communication. In this study it was discovered that the institutional leaders agreed on the administrative level with committee actions or minutes. But when the decision went down to the frontline operational staff, due to self-interest and mistrust, problems arose. Problems observed included a lack of accountability, irresponsibly allowing tasks to remain undone, and staff manifesting a reactive instead of a proactive work behavior with the staff of other institutions.

WHEREAS this study discovered that many institutional leaders felt the need of more communication and better skills in order to fulfill the collaborative leadership roles, there is a need for conceptual structure to support the overall collaboration effort. The Constituency Relations Model (Schiavo, 2007) for health communication described in this study can be used as a guiding framework for collaborative communication. The model underpinned many important elements that enhance the collaborative leadership roles of the institutional leaders; health communication is defined as “the process of convening, exchanging information, and establishing and maintaining strategic relationships with key stakeholders and organizations with the intent of identifying common goals that can contribute to the outcomes of a specific program or mission” (pp. 199-200).

IT IS THEREFORE RECOMMENDED to use the union’s official website to

provide a platform for health communication based on the Constituency Relations Model. A task force should be appointed to implement this recommendation. The head of the Information Technology (IT) Department of the union should be the chair of the task force, and members should include a representative from each institution's IT staff. The Term of Reference for this task force would be to facilitate the union website to allow the union officers and all institutional leaders to use it for better communication, to better “convening, exchanging information, and establishing and maintaining strategic relationships with” (Schiavo, 2007, p. 199) one another, especially among the frontline staff of all the institutions involved.

Tenth Recommendation: To Value the Four-Strand Model

WHEREAS the history of the Seventh-day Adventist Church shows that there was a close relationship between the Adventist church organization and the health reform movement, this relationship needs to be strengthened today. Robinson (1965) describes the story of the Adventist health message with its origin and the development of its health education. The development of the Adventist health lifestyle and healthcare institutions was studied by Covrig (2003, 2005), Haffner (2006), and Numbers and Larson (1986). The first Adventist institution, the Western Health Reform Institute, was organized in 1866, just 3 years after the official formation of the Seventh-day Adventist Church, and the following 30 years witnessed the rapid growth of the Church through its strong “right arm”—its health message and healthcare institutions.

WHEREAS the restructuring of the Adventist church organizational structure was initiated in 1901-1903, a new emphasis on cooperation between church institutions and structures is needed today. The Adventist church underwent a structural reengineering

when the three-tiered global church structure was formed with the union conference structure as the core for development and growth. Institutional theories explain that Adventist leaders operate the church functions out of concern for legitimacy and loyalty (Covrig, 2003). Covrig's study on the development of Loma Linda University suggests that institutional theories gave a better explanation of Loma Linda University than the contingency theories. The same phenomenon is seen in other parts of the world. For example, in Hong Kong and Taiwan, the healthcare institutions were developed under the guiding values of the Adventist church organization. The growth of some church institutions, either in the field of healthcare, education, publishing, or in local churches, reveals the development was based on the concepts of both institutional theories and contingency theories. Thus, close consideration given to the relationship between collaborative leadership roles, the implementation of Adventist lifestyle programs, and the Adventist organizational structure is appropriate.

WHEREAS the collaborative leadership roles of the institutional leaders, under the church union organizational structure, have the same mission to share the Three Angels' Messages and the teachings of Jesus Christ to all nations and to prepare people for the soon second coming of Jesus, in this study context the Adventist health lifestyle programs are part of the Three Angels' Messages of Revelation 14.

WHEREAS that collaboration may bring change and improvement, that collaboration is a complex interactive process. Collaborative leadership roles and outcomes of Adventist health lifestyle programs are closely related. Thus, it is important that the leaders' roles are not only to find resources, to support, to build, and to own the

health programs, but that the leaders' efforts bring results and outcomes in sustainable lifestyle changes as well.

IT IS THEREFORE RECOMMENDED to seek the understanding and commitment of all unions and their institutional leaders to the importance of the Four-Strand Collaboration Model. Leaders would benefit by paying close attention to this model that the four strands or elements are woven together to give stronger strength for mission and service. The four strands are: (a) the collaborative leadership roles performed in the context of (b) the Global Adventist church structure, (c) the implementation of Adventist lifestyle programs, and (d) the collaborative leadership skills.

IT IS FURTHER RECOMMENDED that the union officers and institutional leaders have confidence in the Four-Strand Collaboration Model since the Adventist health lifestyle is an evidence-based model supported by research like the China Study by Campbell and Campbell (2006) and the Adventist Health Studies by other researchers. Participants of Adventist health lifestyle programs are experiencing health improvement and many have become members of the Adventist Lifestyle Club, and some of them have become coaches to support health behavior change. Further, teams were formed to continue the new lifestyle and to create a new culture of healthful living in the community. This model could be proposed as a means to combat noncommunicable diseases as called for by the WHO and as supported by the General Conference of the Seventh-day Adventist Church.

Unexpected Findings

The purpose of this qualitative case study was to describe the roles of the institution leaders when they are involved in the collaborative Adventist health lifestyle

programs within the Chinese Union Mission's organizational structure. The findings isolated four distinct roles of the institution leaders. However, there were two unexpected findings that are closely related to the roles of the leaders. First is the initiation of common agendas for collaboration. This is important for the executive committees and boards of management of the institutions to discuss, to approve, and to implement activities and programs. The institutional leader suggestion for the concept of common agenda initiation has not been performed by the leaders but was strongly needed.

The second unexpected finding was the inter-related-influencing relationship, like a weaving of a four-strand cord, between the institutional leadership roles, the Adventist church union organizational structure, the implementation of Adventist health lifestyle programs, and the collaborative skills of the leaders. This finding showed that the roles of the institution leaders were a complex leadership process. The central research question of this study was designed to address one central question: How do the Adventist institutional leaders function and collaborate within the Chinese Union Mission structure to implement Adventist health lifestyle programs? The unexpected finding was that the leaders did not function by themselves, but they function in a complex inter-related-influencing process.

Recommendations for Further Study

This research case study focused on the collaborative leadership roles of the institutional leaders. It would be interesting to know from the perspectives of the frontline workers, the middle managers, and the executive committee members, what the roles are for each level of participants or stakeholders in the implementation of the Adventist health lifestyle programs within the union structure of the Seventh-day Adventist Church.

Understanding the roles of each level of participants, and finding the weight of their roles, would give a more complete picture of the collaboration. Therefore, the following two suggestions are made for further research studies.

First, further study should be considered for collaborative leadership in the committee setting. What are the roles of the administrative committee or board members in the collaborative implementation of the Adventist health lifestyle programs within the union organizational structure? Second, further research should be considered to understand the collaborative roles from the perspectives of the frontline staff who implemented the Adventist health lifestyle programs. During the personal interviews and focus group discussions with the institutional leaders, they were asked to share ideas and suggestions for better collaboration. Many good ideas were given. These ideas are listed in Appendix G. Some of the ideas could be areas for further study. For example, it was suggested to conduct a union-wide survey on the demands of Adventist health lifestyle programs.

Concluding Summary

This qualitative case study sought to understand the roles of the Chinese Union Mission institutional leaders in the collaborative leadership approach in the implementation of Adventist health lifestyle programs within the Seventh-day Adventist church organizational union structure. The findings provide a better understanding that the institution leaders recognized themselves to have four roles: (a) they are resource finders for program needs and implementation, (b) they are the supporters of Adventist health lifestyle values, programs, and the frontline staff in the collaboration, (c) they are builders of the program infrastructures and initiatives, and (d) they are the owners of the

collaborative programs within the union organizational structure.

Before the findings of this case study, I observed that there were joint ventures and cooperation of programs among the union institutions. I saw many activities and programs that involved two or more institutions. Invitations were extended among and between union institutions for support and participation. I was not sure about the roles of the institutional leaders and the process involved. This study revealed that there was a complex process of leadership in collaboration. There were a number of factors that were inter-related and influencing one another in the process of performing the collaborative leadership roles of the institution leaders. This understanding allows us to pay attention to the factors, the roles of the leaders, and to get better outcomes and changes for collaborative leadership among institutions, not necessarily only for the implementation of Adventist health lifestyle programs, but in many other aspects of organizational operation and management for development.

The assumptions of this study were that there was collaboration among the institutions of the Chinese Union Mission institutions in the implementation of the Adventist health lifestyle programs. Through interviews and focus group discussions, these assumptions were clarified and the guiding frameworks were relevantly referred to and used.

This study, as described in the introductory chapter, suggested that a better understanding of the collaborative leadership roles of the institutional leaders is significant because it could inform not only the Seventh-day Adventist global church, but also other religious, non-profit, and for-profit organizations working towards improving world health. It is hoped that the findings of this study will contribute to greater

effectiveness as the importance of the interplay between the different leadership roles and skills, organizational synergy, and the power of Adventist health lifestyle programs to improve global health is considered. These research findings should be able to support the resolutions and action plans that the WHO and the Adventist World Church have been promoting to prevent and to control NCDs. Finally, this study also provides recommendations that Adventist leaders at different organizational levels can refer to and implement.

Five years after the first Global Conference on Health and Lifestyle in 2009, the second Global Conference on Health and Lifestyle was held in Geneva in July 2014. The theme was “Non-Communicable Diseases: Lifelong Lifestyle Prevention, Accessible to All.” This conference provided an additional opportunity for the global Seventh-day Adventist Church to unite with the world nations to face the challenge of NCDs. The General Conference President, Pastor Ted Wilson, explained the importance of the conference:

This conference, sponsored by the Health Ministries Department of the General Conference of the Seventh-day Adventists and many others, will be focusing on the way in which to live a healthy life and to combat non-communicable diseases—diseases that come about because of lifestyle, and how intervention with simple health practices can make a big difference to the health of the people. This is all part of comprehensive health ministries, every church being a health center. (Wilson, 2014)

Adventists believe they have a mission similar to John the Baptist who prepared a people ready for the first coming of the Son of God, Jesus. Adventists are modern John the Baptists. They are being counseled to live a healthful and simple lifestyle similar to John the Baptist—to be ready as a people for the second coming of Jesus!

APPENDIX A

GUIDE FOR INITIAL INTERVIEWS

APPENDIX A

GUIDE FOR INITIAL INTERVIEWS

Questions and Field Notes

面談指引：問題及註釋

Interviewee: _____

接受訪問者：

Organization: _____

所屬機構名稱：

Time: _____

受訪日期：

Setting for interview and observations:

受訪時的情況與觀察：

The research central question: How do the leaders of the institutions of Chinese Union Mission understand their leadership roles and functions that encourage the collaborative approach of Adventist Health Lifestyle Programs (AdHeLP) to improve health for the Chinese community in the context of the union structure of the Seventh-day Adventist Church?

核心研究問題：華安聯合會各機構主管如何認知他(她)們的領導角色和功

能，在基督復臨安息日會聯合會之組織架構下，促進實行整合式復臨信徒健康生活方式去改善華人社區的健康？

Interview questions:

1. How long have you served in your current role?

請問您任職目前崗位多少？

2. How important is the Adventist health lifestyle programs for health improvement?

請問對改善健康來□，復臨信徒健康生活方式項目有多重要？

3. How are you collaborate with other CHUM leaders to help implement AdHeLP programming, and what are some of the collaborative activities you and your institution participating?

您如何與聯合會其他機構負責人整合執行本會健康生活項目，您及貴機構參與那些整合活動？

4. How would you describe your role and function as president/general manager/pastor as it relates to the effectiveness of the collaborative approach of AdHeLP implementation?

請問，作為貴機構的院長／經理／堂主任，您如何描述您在有效率地實行整合式復臨信徒健康生活方式項目時，您的角色與功能？

5. How do you describe your belief and skills in the role as president/general manager/pastor that functions as a leader in the implementation of the collaborate approach of Adventist health lifestyle programs (AdHeLP)?

請問，您作為貴機構的院長／經理／堂主任，在實行整合式復臨信徒健康生

活方式項目時，您如何描述您角色和功能的信念和技巧？

6. What is working well?

那一些方面運作得好的？

7. What is not working well?

那一些方面運作得不好的？

8. What challenges are you experiencing?

您經歷甚麼挑戰？

9. What written materials; posters, programs, notes, reports, speeches, etc., do you have that might offer additional insights into how your work as president/general manager/pastor relates to implementing AdHeLP programming?

請問您有沒有一些材料，如海報、節目表、記錄、報告、演講稿等，可以幫助了解您作為貴機構的院長／經理／堂主任與此項目的關係？

10. What questions, ideas, and perspectives do you have that might enrich our study on this matter of the president/general manager/pastor's role and function influencing the effectiveness of the collaborative approach of AdHeLP?

請問您有沒有一些問題、意見、和觀點，可以加強我們這次的研究，有關作為貴機構的院長／經理／堂主任，在有效實行整合式復臨信徒健康生活方式項目時，您的領導角色和功能所帶來的影響？

11. If someone else implementing this, what suggestions would you give them?

假如由另一位來實行此項目，您會向他們提出甚麼意見？

12. What other approaches could be used for health improvement in China?

有甚麼其他方案可在中國用作改善健康？

APPENDIX B

CHUM ADMINISTRATIVE COMMITTEE MINUTES

APPENDIX B

CHUM ADMINISTRATIVE COMMITTEE MINUTES

Please be informed that on August 9, 2011, the Chinese Union CHUM Administrative Committee approved the following action(s):

AC 11-362 DOCTORAL RESEARCH INTERVIEW PERMISSION - JAMES WU (胡子輝)

Whereas, the doctoral dissertation research at Andrews University of James Wu is entitled: “Leadership Issues in the Implementation of Adventist Health Lifestyle: A Case Study of the Chinese Union Mission’s Collaborative Approach,” and

Whereas, written permission from CHUM ADCOM is needed to proceed with the interview of the presidents of the two hospitals (AHHK, TAH), two colleges (HKAC, TAC), union president, general managers of the three health centers and STPA, and four local pastors, it is

VOTED To approve to give permission to James Wu for his doctoral dissertation research to interview, individually and in focus groups, the 14 individuals of CHUM institutional presidents, general managers and four local pastors between the months of September, 2011 to March, 2012.

Note:

1. Consent forms will be provided for all participants to sign before the interview and focus group interview to protect their rights;
2. No expenses will be incurred.

Thank you very much for your attention.

Winnie Cheung (張詠恩),

Administrative Secretary for

Executive Secretary / Administration / HR Chinese Union Mission

Tel: (852) 2838-3991

Fax: (852) 2834-6119

APPENDIX C

PARTICIPANT CONSENT FORM

APPENDIX C

PARTICIPANT CONSENT FORM

Leadership Department

安德烈大學 領導學部門

Informed Consent Form

受訪同意書

Title: Leadership Issues in the Implementation of Adventist Health Lifestyle: A Case Study of the Chinese Union Mission's Collaborative Approach.

主題：實行復臨信徒健康生活方式的領導議題：華安聯合會整合式方案之個案研究

Purpose of Study: I understand that the purpose of this study is to understand the roles and functions of the leaders of the institutions in the collaborative approach of Adventist health lifestyle programs, in order to enhance the leadership effectiveness in the implementation of the health programs in the context of the union structure of the Seventh-day Adventist church, and thus for the better health improvement in the Chinese community.

研究宗旨：我明白本研究的宗旨是去了解機構領袖，在實行整合式復臨信徒健康生活方式項目時的角色與功能，藉此強化領導人在基督復臨安息日會聯合會

的架構下，執行健康項目的效率，以至改善華人社區的健康。

Inclusion Criteria: In order to participate, I recognize that I must be an adult at least 18 years old and of sound mind, and must be the head of an Adventist institution of Chinese Union Mission.

準則：參與此研究時我知道我必須是一位滿 18 歲的成人，並且頭腦清醒和必須是華安聯合會的機構負責人。

Risks and Discomforts: I have been informed that there are no physical risks to my involvement in this study. I understand that there will be audio recording during the individual and focus group interviews for the purpose of transcription.

風險與不安：我被告知在參與此研究是沒有人身風險的。我知道個別受訪及小組討論時將會進行錄音以作轉錄之須。

Benefits/Results: I accept that I will receive no remuneration for my participation, but that by participating, I will help the researcher and the Seventh-day Adventist Church in the on-going quest to prepare competent leaders for service in the church or in society.

利益／成果：我接受此為無酬參與，但因我的參與，可協助研究者和基督復臨安息日會繼續為預備有能力的領袖而努力，為教會或社會服務。

Voluntary Participation: I understand that my involvement in this research is voluntary and that I may withdraw my participation at any time without any pressure, embarrassment, or negative impact on me.

志願參與：我知道我參與此研究乃自願並可以隨時退出參與而對本人沒有任何壓力、困窘或不良影響。

Confidentiality: I have been informed and understand that the individual and

focus group interviews will be audio recorded, and that the data collected will also be made available to the dissertation committee, heads of participating institution, and union officers as deemed necessary.

保密：我被告知並了解，在有需要時，個人受訪和小組討論的錄音和資料收集，將供論文委員會、參與此研究的機構負責人、和聯合會行政人員參考。

Procedures: Individual interview will be conducted at the institution head office (For examples, the HK and Taiwan Adventist Hospital CEO Offices, the HK and Taiwan Adventist College President Offices, etc.) between November, 2011 and February, 2012 upon appointments confirmed by the interviewees and interviewer, and each individual interview will be less than two hours; while the focus group interviews will be conducted in Hong Kong and Taiwan Seventh-day Adventist Union Offices located in Hong Kong and Taipei, upon appointments made with appropriate interviewees between the same dates with each interview session no more than two hours.

程序：個人受訪將於機構負責人的辦公室舉行(例如：港安和臺安醫院院長室，香港三育書院院長室等)，日期由 2011 年 11 月至 2012 年 2 月期間，由訪問者與受訪者約訂合適日期和時間，每次訪問少於兩小時；而小組討論則會安排在聯合會香港及台北會議室，於同一期間進行，日期和時間將會與各受訪組員約訂，每次小組討論不超過兩小時。

Contact Information: In the event that I have any questions or concerns with regard to my participation in this research project, I understand that I may contact researchers, Dr. Erich Baumgartner, Professor in Leadership at baumgart@andrews.edu [Tel: (269) 471-6580], or Dr. Shirley Freed, Professor in Leadership at freed@andrews.edu [Tel: (269) 471-6580], or Dr. Duane Covrig, Professor in Leadership

at covrig@andrews.edu [Tel: (269) 471-6580].

查詢：若我對參與此研究的問題或關注，本人可以接洽有關研究者教授如

下：Dr. Erich Baumgartner, Professor in Leadership at baumgart@andrews.edu [Tel: (269) 471-6580], or Dr. Shirley Freed, Professor in Leadership at freed@andrews.edu [Tel: (269) 471-6580], or Dr. Duane Covrig, Professor in Leadership at covrig@andrews.edu [Tel: (269) 471-6580].

Signature of Subject 受訪者簽名

Date 日期 _____

Signature of Witness 見證人簽名

Date 日期 _____

Signed at:

簽署地點：

APPENDIX D

IRB APPROVAL LETTER FOR RESEARCH

APPENDIX D

IRB APPROVAL LETTER FOR RESEARCH

RE: APPLICATION FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS

IRB Protocol #: 11-134 Application Type: Original Dept.: Leadership

Review Category: Expedited Action Taken: Approved Advisor: Erich Baumgartner

Title: Leadership Issues in the Implementation of Adventist Health Lifestyle: A Case Study of the Chinese Union Mission's Collaborative Approach

This letter is to advise you that the Institutional Review Board (IRB) has reviewed and approved your proposal for research involving human subjects entitled: "Leadership Issues in the Implementation of Adventist Health Lifestyle: A Case Study of the Chinese Union Mission's Collaborative Approach" IRB protocol number 11-134 under Expedited category. We ask that you reference this protocol number in any future correspondence regarding this study. This approval is valid until October 17, 2012. If your research is not completed by the end of this period you must apply for an extension at least two weeks prior to the expiration date. We also ask that you inform the IRB Office whenever you complete your research.

Any future changes made to the study design and/or consent form require prior approval from the IRB before such changes can be implemented.

While there appears to be no more than minimum risks with your study, should an incidence occur that results in a research-related adverse reaction and/or physical injury, this must be reported immediately in writing to the IRB. Any project-related physical injury must also be reported immediately to the University physician, Dr. Hamel, by calling (269) 473-2222.

Please feel free to contact our office if you have questions.

We wish you success in your research project.

Sincerely,

Sarah Kimakwa

APPENDIX E

SUMMARY OF COLLABORATION THEORIES AND MODELS

APPENDIX E

SUMMARY OF COLLABORATION THEORIES AND MODELS

Evidence of more collaboration	What motivates partners to collaborate	How does collaboration work, the process, and the barriers	Making a difference because of collaboration
1. Adler (1991) 2. Cross et al. (2009) 3. Babchuk et al. (1999) 4. Chompalov and Schrum (1999) 5. Di Domenico et al. (2009) 6. Sowa (2008) 7. Takahashi and Smutny (2002)	1. Acar (2005) 2. Di Domenica and Tracey (2009) 3. Foster and Meinhard (2002) 4. Gray and Wood (1991) 5. Hill and Lynn (2003) 6. C. Oliver (1990) 7. Shaibu (2006) 8. Snarely and Tracy (2002) 9. Sowa (2009)	1. Alexander et al. (2003) 2. Cross et al. (2009) 3. Di Domenico et al. (2009) 4. Imperial (2005) 5. John-Steiner et al. (1998) 6. Jackson and Reddick (1999) 7. Lachance et al. (2006) 8. Levy et al. (2003) 9. Logan et al. (2010) 10. Roe and Roe (2004) 11. Takahashi and Smutny (2002) 12. Thomas et al. (2009) 13. Tolma et al. (2009) 14. Yoo et al. (2004)	1. Foster and Meinhard (2002) 2. Hicks et al. (2008) 3. Kreuter et al. (2000) 4. Lachance et al. (2006) 5. Logan et al. (2010) 6. Pinto (2009) 7. Stone (2000) 8. Takahashi and Smutny (2002)

APPENDIX F

WHAT WORKED WELL AND WHAT DID NOT WORK WELL IN COLLABORATION

APPENDIX F

WHAT WORKED WELL AND WHAT DID NOT WORK WELL IN COLLABORATION

No.	Interview Question	Category	Leader Input Code	Description
Q6	Working Well	What?	P _{r1} Q ₆ 1;P _u Q ₆ 2;P _u Q ₆ 3	Health Expo; hospital canteen good vegi food & bakery; Health Mgt Center; Appointment of VPLSA
		Why?	P _u Q ₆ 1;P _{r2} Q ₆ 1	NEWSTART program well known; all institutions involved
		How?	P _{c2} Q ₆ 1;P _{r1} Q ₆ 2;P _{h2} Q ₆ 1 M ₂ Q ₆ 1	People invited to church through lifestyle programs; health centers collaborate with hospitals
Q7	Not Working Well	What?	P _{c2} Q ₇ 2;P _{r1} Q ₇ 2;P _{c1} Q ₇ 3 P _{r1} Q ₇ 3;P _u Q ₇ 1;P _u Q ₇ 3 M _p Q ₇ 1	Limited resources; more union leadership; local churches not practicing healthful living; not enough health food products; establish stronger foundation
		Why?	P _{r1} Q ₇ 1;P _{r2} Q ₇ 2P _u Q ₇ 2 P _{h2} Q ₇ 1;M ₂ Q ₇ 1;M _p Q ₇ 2 P _{r2} Q ₇ 1;P _{c2} Q ₃ 5;M _p Q ₇ 1 F _{tw} Q ₃ 7;P _{c2} Q ₇ 1;P _{c2} Q ₇ 3 M _p Q ₃ 3;F _{tw} Q ₃ 3;F _{tw} Q ₄ 5 P _{c1} Q ₃ 6;M _p Q ₃ 2;F _{tw} Q ₃ 1 M _p Q ₄ 6	Need more teamwork; hospital emphasizes more on health; local church pastors not participating; local church members not involving; only outward activities; solitary performing; weak collaboration; lack of trust
		How?	P _{c1} Q ₇ 01;P _{c1} Q ₇ 02; P _{c1} Q ₇ 04 F _{tw} Q ₇ 01;F _{hk} Q ₇ 01; F _{hk} Q ₇ 02	Increase activities at health centers; more communication; more facilities; better follow through and sustaining
Q8	Challenge	What?	P _u Q ₈ 2;P _u Q ₈ 3;F _{hk} Q ₄ 6 F _{hk} Q ₈ 1;P _{c1} Q ₈ 1;M ₂ Q ₃ 4 F _{tw} Q ₄ 2;P _{c2} Q ₈ 2	Limited financial resources; need real practical experience; need practicing promoters; need organization leadership and management; need strong union leadership

Table—*Continued.*

No.	Interview Question	Category	Leader Input Code	Description
		Why?	M ₂ Q ₈ 1;P _{r2} Q ₈ 1;P _{c2} Q ₈ 1 F _{tw} Q ₃ 2;F _{tw} Q ₄ 5;F _{hk} Q ₈ 2	Evidence-based outcomes; self-sufficient culture; top leaders agreed but difficult to push to frontline workers; social world fast changing but our institutions slow; no market for profits
		How?	P _{r1} Q ₈ 1;P _{r1} Q ₈ 2;P _u Q ₈ 1; M ₂ Q ₈ 3;M ₂ Q ₈ 2;P _{r2} Q ₈ 2 M _p Q ₈ 1;P _{h2} Q ₈ 1	Share information on resources; compile list of resources; united belief and value; emphasize mission leadership; communication on collaboration; involve higher levels; education on human resource with value and collaboration; build a lifestyle culture in institutions

APPENDIX G

IDEAS AND SUGGESTIONS FOR BETTER COLLABORATION

APPENDIX G

IDEAS AND SUGGESTIONS FOR BETTER COLLABORATION

No.	Category	Leader Input code	Description
1.	How	P _{r1} Q ₁₀ 1;F _{tw} Q ₄ 13;P _{r1} Q ₁₁ 1 P _u Q ₁₀ 1;M ₂ Q ₁₁ 1;P _{r2} Q ₁₁ 1 P _u Q ₁₀ 3;P _{c2} Q ₁₁ 1;P _{r2} Q ₁₂ 1 F _{tw} Q ₁₂ 1;F _{tw} Q ₁₂ 2;F _{hk} Q ₄ 10 F _{hk} Q ₄ 2	Hold regular meeting to share resources; make record of activities to share; communicate purpose of collaboration; regular review and evaluate; improve health practical lifestyle outcomes; every Executive Committee has common agenda to serve others; need a representative steering committee to plan together
2.	What	P _{r1} Q ₁₂ 1;P _u Q ₁₂ 1;P _{c1} Q ₁₂ 1 M ₂ Q ₁₂ 1;P _{h2} Q ₁₁ 1;F _{hk} Q ₄ 7 M _p Q ₁₀ 1;P _{r2} Q ₁₀ 1;P _{h2} Q ₁₂ 1	Promote emotional and spiritual health; insomnia problems; Chinese is still at the materials need level, collaborate with outside corporations and celebrity; combine ministerial and health trainings; share Taiwan and HK experience with China
3.	Who	P _{c2} Q ₁₂ 2;M _p Q ₁₀ 1;P _{r1} Q ₁₁ 2 F _{hk} Q ₄ 23;P _u Q ₁₀ 2;P _u Q ₁₀ 4 P _u Q ₁₀ 5;F _{tw} Q ₄ 13;P _{c1} Q ₁₀ 1 P _{c1} Q ₁₁ 1;P _{c2} Q ₁₀ 1;F _{tw} Q ₄ 14 P _{h2} Q ₁₀ 1;P _{c2} Q ₁₁ 3;F _{tw} Q ₄ 11 F _{tw} Q ₄ 10	Be proactive to collaborate with others; share responsibilities; let others know the progress of collaboration; listen to others' difficulties; conduct a union wide survey on practicing ideas; to determine the demand level; clarify union role and function; all institution leaders need training to fulfill role of collaboration; need followership to support the union
4.	Why	P _u Q ₁₁ 1;P _u Q ₁₂ 2;P _{c2} Q ₁₁ 2 P _{r2} Q ₁₁ 2;P _{c2} Q ₁₂ 1;F _{hk} Q ₄ 20	Sustain the health ministry because believe to be the last ministry on earth before the coming of Jesus; Adventist lifestyle is tool in Bible studies; strengthen our core beliefs on health message; aging world population opportunity to collaborate

REFERENCE LIST

- Adler, N. J. (1991). *International dimensions of organizational behavior*. Boston, MA: PWS-KENT.
- Adventist Health Study-2. (2008). In *Wikipedia, the free encyclopedia*. Retrieved from http://en.wikipedia.org/wiki/Adventist_Health_Studies#Adventist_Health_Study_2_.28AHS-2.29
- Adventist Health Study-2 awarded \$5.5 million from National Institutes of Health. (2011, August 4). *Highland Community News*, Retrieved from http://www.highlandnews.net/news/article_7bbe10f5-d297-52c9-9558-9869974055ac.html?TNNoMobile
- Alexander, J. A., Weiner, B. J., Metzger, M. E., Shortell, S. M., Bazzoli, G. J., Hasnain-Wynia, R., et al. (2003). Sustainability of collaborative capacity in community health partnerships. *Medical Care Research & Review*, 60(4 suppl), 130S-160S.
- Babchuk, N., Keith, B., & Peters, G. (1999). Collaboration in sociology and other scientific disciplines: A comparative trend analysis of scholarship in the social, physical, and mathematical sciences. *American Sociologist*, 30(3), 5-21.
- Beeson, W. L., Phillips, R. L., Andress, M., & Fraser, G. E. (1989). Chronic disease among Seventh-day Adventists, a low-risk group: Rationale, methodology, and description of the population. *Cancer*, 64(3), 570-581.
- Belloc, N. B., & Breslow, L. (1972). Relationship of physical health status and health practices. *Preventive Medicine*, 1(3), 409-421.
- Bloomberg, L. D., & Volpe, M. (2008). *Completing your qualitative dissertation: A roadmap from beginning to end*. Los Angeles, CA: Sage.
- 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 Books.

- Campbell, T. C., & Jacobson, H. (2013). *WHOLE: Rethinking the science of nutrition*. Dallas, TX: BenBella Books.
- Charmaz, K. (2006). *Constructing grounded theory*. London: Sage.
- Chompalov, I., & Shrum, W. (1999). Institutional collaboration in science: A typology of technological practice. *Science, Technology, & Human Values*, 24(3), 338-372.
- Christensen, C. R. (1987). *Teaching and the case method*. Boston, MA: Harvard Business School Press.
- Covrig, D. M. (2003). Institutional integrity through periods of significant change: Loma Linda University's 100 year struggle with organizational identity. In A. S. Iltis (Ed.), *Institutional integrity of health care organizations* (pp. 139-174). New York, NY: Kluwer Academic.
- Covrig, D. M. (2005). Mountains, flatlands, and tenuous meaning: Organizational sociology in administrative sensemaking. *Journal of Educational Administration*, 43(1), 102-120.
- Cragg, C. I. (1940). Because wisdom can't be told. *Harvard Alumni Bulletin* (Harvard Business School Reprint 451-005), pp. 1-6.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: Sage.
- Creswell, J. W. (2008). *Educational research planning, conducting, and evaluating quantitative and qualitative research* (International ed.). Upper Saddle River, NJ: Pearson Education.
- Crisler, C. C. (1938). *Organization: Its character, purpose, development in the Seventh-day Adventist church*. Washington, DC: Review & Herald.
- Cross, J. E., & Dickmann, E., Newman-Gonchar, R., & Fagan, J. M. (2009). Using mixed-method design and network analysis to measure development of interagency collaboration. *American Journal of Evaluation*, 30(3), 310-329.
- Cummings, J. N., & Kiesler, S. (2005). Collaborative research across disciplinary and organizational boundaries. *Social Studies of Science*, 35(5), 703-722.
- Dart, A. O. (1956). *The story of our church*. Mountain View, CA: Pacific Press.
- Denzin, N. K., & Lincoln, Y.S. (Eds.). (1984). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Di Domenico, M., Tracey, P., & Haugh, H. (2009). The dialectic of social exchange: Theorizing corporate—social enterprise collaboration. *Organization Studies*, 30(8), 887-907.

- Ding, D., Sallis, J. F., Hovell, M. F., Jianzhong, D., Miao, Z., Haiying, H., & Owen, N. (2011). Physical activity and sedentary behaviours among rural adults in Suixi, China: A cross-sectional study. *International Journal of Behavioral Nutrition & Physical Activity*, 8(1), 37-44. doi:10.1186/1479-5868-8-37
- Doblmeier, M. (Director/Producer) & Juday, D. (Producer). (2010). *The Adventists* [Documentary]. Alexandria, VA: Journey Films.
- Eisner, E. W. (1991). *The enlightened eye: Qualitative inquiry and the enhancement of educational practice*. New York, NY: Macmillan.
- Fiedler, D. (1996). *Hindsight: Seventh-day Adventist history in essays and extracts*. Harrah, OK: Academy Enterprises.
- Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, 12(2), 219-245.
- Foster, M. K., & Meinhard, A. G. (2002). A regression model explaining predisposition to collaborate. *Nonprofit & Voluntary Sector Quarterly*, 31(4), 549-564.
- Fraser, G. E. (2003). *Diet, life expectancy, and chronic disease: Studies of Seventh-day Adventists and other vegetarians*. New York, NY: Oxford University Press.
- General Conference Executive Committee Minutes. (2009). Hagerstown, MD: Author.
- General Conference of Seventh-day Adventists. (2009). *147th Annual Statistical Report—2009*. Retrieved from <http://documents.adventistarchives.org/Statistics/ASR/ASR2009.pdf>
- General Conference of Seventh-day Adventists. (2010a). *Seventh-day Adventist Church Manual* (18th ed.). Hagerstown, MD: Review & Herald.
- General Conference of Seventh-day Adventists. (2010b). *Working policy*. Hagerstown, MD: Review & Herald.
- General Conference of Seventh-day Adventists. (2013). *United for mission: 150 years (1863-2013)*. Silver Spring, MD: Author.
- General Conference of Seventh-day Adventists. (2014). *Seventh-day Adventist world church statistics—2012: Summary of statistics as of December 31, 2012 (Except where indicated as June 30, 2013)*. Hagerstown, MD: Author.
- Gray, B., & Wood, D. J. (1991). Collaborative alliances: Moving from practice to theory. *Journal of Applied Behavioral Science*, 27(1), 3-21.
- Guo, C., & Acar, M. (2005). Understanding collaboration among nonprofit organizations: Combining resource dependency, institutional, and network perspectives. *Nonprofit & Voluntary Sector Quarterly*, 34(3), 340-361.

- Haffner, R. L. (2006). *Identification of Seventh-day Adventist health core convictions: Alignment with current healthcare practice* (Unpublished doctoral dissertation). Andrews University, Berrien Springs, MI.
- Hicks, D., Larson, C., Nelson, C., Olds, D. L., & Johnston, E. (2008). The influence of collaboration on program outcomes: The Colorado-Nurse Partnership. *Evaluation Review*, 32(5), 453-477.
- Hill, C. J., & Lynn, L. E., Jr. (2003). Producing human services: Why do agencies collaborate? *Public Management Review*, 5(1), 63-81.
- Hughes, R. L., Ginnett, R., & Curphy, G. (2008). *Leadership: Enhancing the lessons of experience* (6th ed.). New York, NY: McGraw-Hill/Irwin.
- Imperial, M. T. (2005). Using collaboration as a governance strategy. *Administration & Society*, 37(3), 281-320.
- Jackson, R. S., & Reddick, B. (1999). The African American church and university partnerships: Establishing lasting collaborations. *Health Education & Behavior*, 26(5), 663-674.
- John-Steiner, V., Weber, R. J., & Minnis, M. (1998). The challenge of studying collaboration. *American Educational Research Journal*, 35(4), 773-783.
- Kahn, R. H., Phillips, R. L., Snowdon, D. A., & Chou, W. (1984). Association between reported diet and all causes of mortality: Twenty-one year follow up on 27,530 adult Seventh-day Adventists. *American Journal of Epidemiology*, 119(5), 775-787.
- Kjellstrom, T., & Mercado, S. (2008). Towards action on social determinants for health equity in urban settings. *Environment & Urbanization*, 20(2), 551-574.
- Kotter, J. P. (1990). *Leading change*. Boston, MA: Harvard Business School Press.
- Kreuter, M. W., Lezin, N. A., & Young, L. A. (2000). Evaluating community-based collaborative mechanisms: Implications for practitioners. *Health Promotion Practice*, 1(1), 49-63.
- Lachance, L. L., Houle, C. R., Cassidy, E. F., Bourcier, E., Cohn, J. H., Orians, C. E., et al. (2006). Collaborative design and implementation of a multisite community coalition evaluation. *Health Promotion Practice*, 7(2 Suppl), 44S-55S.
- Levy, S. R., Baldyga, W., & Jurkowski, J. M. (2003). Developing community health promotion interventions: Selecting partners and fostering collaboration. *Health Promotion Practice*, 4(3), 314-322.
- Liubai, L., & Yan, H. (2009). Nutrition status and weight management in Chinese women. *Current Women's Health Reviews*, 5(4), 201-211.

- Logan, B. N., Davis, L., & Parker, V. G. (2010). An interinstitutional academic collaborative partnership to end health disparities. *Health Education & Behavior*, 37(4), 580-592.
- Loma Linda University. (2014). *History of Adventist health studies*. Loma Linda, CA: Author. Retrieved from <http://www.llu.edu/public-health/health/history.page>
- Loma Linda University given \$5.5 million for health study. (2011, August 7). *Press-Enterprise*. Retrieved from <http://www.pe.com/articles/study-598525-cancer-health.html>
- Mitlin, D. (2005). Chronic poverty in urban areas. *Environment & Urbanization*, 17(2), 3-10.
- Nedley, N. (1998). *Proof positive: How to reliably combat disease and achieve optimal health through nutrition and lifestyle*. Ardmore, OK: Author.
- Newman, I., & Benz, C. R. (1998). *Qualitative-quantitative research methodology: Exploring the interactive continuum*. Carbondale, IL: Southern Illinois University Press.
- Numbers, R. L., & Larson, D. R. (1986). The Adventist tradition. In R. L. Numbers & D. W. Amundsen (Eds.), *Caring and curing: Health and medicine in the Western religious traditions* (pp. 447-467). New York, NY: Macmillan.
- Oliver, B. D. (1989). *Principles for reorganization of the Seventh-day Adventist administrative structure, 1888-1903: Implications for an international church* (Unpublished doctoral dissertation). Andrews University, Berrien Springs, MI. Retrieved from <http://proquest.umi.com/pqdweb?did=743976251&Fmt=7&clientId=1898&RQT=309&VName=PQD>
- Oliver, C. (1990). Determinants of inter-organizational relationships: Integration and future directions. *Academy of Management Review*, 15, 241-265.
- Olson, A. V. (1966). *Through crisis to victory 1888-1901*. Washington, DC: Review & Herald.
- O'Neil, C. E., & Nicklas, T. A. (2007). State of the art reviews: Relationship between diet, physical activity, and health. *American Journal of Lifestyle Medicine*, 1(6), 457-481.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.
- Pettee, K. K., & Ainsworth, B. E. (2009). The building healthy lifestyles conference: Modifying lifestyles to enhance physical activity and diet and reduce cardiovascular disease. *American Journal of Lifestyle Medicine*, 3(1 Suppl), 6S-10S.

- Pinto, R. M. (2009). Community perspectives on factors that influence collaboration in public health research. *Health Education & Behavior*, 36(5), 930-947.
- Polkinghorne, D. E. (1991). Narrative and self-concept. *Journal of Narrative & Life History*, 1(2 & 3), 135-153.
- Reason, P. (1999). Integrating action and reflection through cooperative inquiry. *Management Learning*, 30(2), 207-226.
- Redwood, D., & Shealy, C. N. (2005). The China study: The most comprehensive study of nutrition ever conducted and the startling implications for diet, weight loss, and long-term health: Two reviews. *Journal of Alternative & Complementary Medicine*, 11(6), 1117-1119.
- 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.
- Robinson, D. E. (1965). *The story of our health message: The origin, character, and development of health education in the Seventh-day Adventist Church*. Nashville, TN: Southern.
- Roe, K., & Roe, K. (2004). Dialogue boxes: A tool for collaborative process evaluation. *Health Promotion Practice*, 5(2), 138-150.
- Schiavo, R. (2007). *Health communication: From theory to practice*. San Francisco, CA: Jossey-Bass.
- Schwarz, R. W. (1979). *Light bearers to the remnant*. Oshawa, Ontario, Canada: Pacific Press.
- Shaibu, S. (2006). Community home-based care in a rural village: Challenges and strategies. *Journal of Transcultural Nursing*, 17(1), 89-94.
- Snaveley, K., & Tracy, M. B. (2002). *The new nonprofit almanac and desk reference*. San Francisco, CA: Jossey-Bass.
- Sodjinou, R., Agueh, V., Fayomi, B., & Delisle, H. (2008). Obesity and cardio-metabolic risk factors in urban adults of Benin: Relationship with socio-economic status, urbanisation, and lifestyle patterns. *BMC Public Health*, 8, 84-96.
- 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.
- Stake, R. E. (1981). *Case study methodology: An epistemological advocacy*. Minneapolis, MN: Minnesota Research & Evaluation Center.

- Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.
- Stampfer, M. J., Hu, F. B., Manson, J. E., Rimm, E. B., & Willett, W. C. (2000). Primary prevention of coronary heart disease in women through diet and lifestyle. *New England Journal of Medicine*, 343(1), 16-22.
- Stone, M. M. (2000). Case study: Exploring the effects of collaborations on member organizations: Washington County's welfare-to-work partnership. *Nonprofit & Voluntary Sector Quarterly*, 29(Suppl 1), 98-119.
- Takahashi, L. M., & Smutny, G. (2002). Case study: Collaboration among small, community-based organizations. *Nonprofit & Voluntary Sector Quarterly*, 31(1), 145-157.
- Timm, A. R. (2013). 150 years of church organization. *Elder's Digest*, 19(1), 4-5.
- Tolma, E. L., Cheney, M. K., Troup, P., & Hann, N. (2009). Designing the process evaluation for the collaborative planning of a local turning point partnership. *Health Promotion Practice*, 10(4), 537-548.
- Tukuitonga, C., & Keller, I. (2005). Implementing the World Health Organization global strategy on diet, physical activity, and health. *Scandinavian Journal of Nutrition*, 49(3), 122-126.
- Wagner, C. G. (2008). Fighting noncommunicable diseases. *Futurist*, 42(2), 9-9.
- White, E. G. (1897, 1898). *Healthful living*. Battle Creek, MI: Medical Missionary Board.
- White, E. G. (1905). *Ministry of healing*. Mountain View, CA: Pacific Press.
- White, E. G. (1923). *Counsels on health*. Mountain View, CA: Pacific Press.
- White, E. G. (1932). *Medical ministry*. Mountain View, CA: Pacific Press.
- White, E. G. (1938). *Counsels on diet and foods*. Washington, DC: Review & Herald.
- White, E. G. (1970). *The health food ministry*. Washington, DC: Ellen G. White Estate.
- Willett, W. (2003). Lessons from dietary studies in Adventists and questions for the future. *American Journal of Clinical Nutrition*, 78(3), 539S-543.
- Wilson, T. (2014). *Welcome video*. Retrieved from <http://vimeo.com/album/2759748/video/88676547>
- World Health Organization. (2004). *Global strategy on diet, physical activity and health*. Geneva, Switzerland: Author.
- World Health Organization. (2007). *Prevention and control of noncommunicable diseases: Implementation of the global strategy*. Geneva, Switzerland: Author.

- World Health Organization. (2008). *2008-2013: Action plan for the global strategy for the prevention and control of noncommunicable diseases*. Geneva, Switzerland: Author.
- World Health Organization. (2011a). *Global status report on noncommunicable diseases 2010: Description of the global burden of NCDs, their risk factors, and determinants*. Geneva, Switzerland: Author.
- World Health Organization. (2011b). *Non-communicable diseases: Country profiles 2011*. Geneva, Switzerland: Author.
- Yadav, K., & Krishnan, A. (2008). Changing patterns of diet, physical activity, and obesity among urban, rural, and slum populations in north India. *Obesity Reviews*, 9(5), 400-408. doi:10.1111/j.1467-789X.2008.00505.x
- 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.
- Zimmer, Z., & Kwong, J. (2004). Socioeconomic status and health among older adults in rural and urban China. *Journal of Aging & Health*, 16(1), 44-70.

VITA

VITA

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