

Conceptualization of Health Among United Methodist Church Clergy in Western Kenya

by

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Thesis submitted in partial fulfillment of
the requirements for the degree of
Master of Science in the Duke Global Health Institute in the Graduate School
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ABSTRACT

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Abstract

INTRODUCTION

Clergy are a dynamic group of the population: they point people to God, navigate social and spiritual waters, provide advice and guidance, and teach and visit parishioners. Research has shown that caregivers often neglect their health to tend to the health and well-being of others. Because of their unique role in society, the health and well-being of the clergy themselves is an important subject of research. While clergy health is a growing topic of interest in the Western world, very little is known. The few studies conducted on the health of clergy have found that in some areas, this group is less healthy than the general population due to their hectic schedules, lack of social support, and job-related stressors. With the exception of literature in the United States, Canada, and Great Britain, little has been documented internationally regarding clergy health. In Africa, religion is known to play an important role in the daily life of its inhabitants; however, the overall well-being of clergy including mental, spiritual, and physical health remains under-studied. To date, nothing has been reported regarding the health of pastors in Kenya. This exploratory study sought to better understand how United Methodist Church (UMC) clergy in Western Kenya conceptualize health and how that relates to their own health-seeking behaviors.

METHODS

The author partnered with religion and public health researchers at Moi University in Eldoret, Kenya, and utilized qualitative methodology to gather information

on the conceptualization of health among UMC clergy in Western Kenya. One-hour in-depth oral interviews with seven clergy and two Associate UMC District Superintendents, and four focus group discussions were conducted with a total of 49 UMC clergy in Nyanza Province, Kenya in June and July, 2012.

ANALYSIS

All transcripts were entered and coded into QSR International's NVivo 10 qualitative data analysis software (QSR, 2011). Two members of the research team coded an in-depth oral interview and focus group transcription to ensure replicability. A combination of Grounded Theory (GT) analysis and Interpretative Phenomenological Analysis (IPA) was used to interpret the data.

RESULTS

Through data-driven analysis, the study resulted in five primary domains: Defining health, Believing God saves, Seeing illness as weakness, Intersecting cultural beliefs and health, and Seeking medical attention. Within these domains are corresponding themes that relate to conceptualization of health, religious and cultural traditions and beliefs, and when the clergy do or do not seek medical attention.

CONCLUSION

UMC clergy define health holistically as the complete well-being of a person in their mind, body, and spirit. Cultural traditions are still present within the UMC; pastors and parishioners will seek care from a magician rather than a medical doctor if they believe the disease stems from evil spirits. Religious beliefs relate to health-seeking

behavior in one of two ways: first, some clergy believe God alone heals, and thereby view medical seeking behavior as unnecessary, and second, some clergy believe God alone heals, but view the doctor as a permitted conduit of healing. This knowledge learned from this exploratory study may help inform future interventions.

Dedication

To the pastors that have influenced and shaped my life over the years, thank you. To all the clergy in Western Kenya, thank you for sharing your time with me and for opening your homes to me. I hope your joy is made more complete as a result of this paper.

To my family: Marmie, thank you for your wise guidance throughout my life and through this process and thank you for paving the way for me by getting your Masters while working full-time and raising us, you are truly an inspiration; Daddy, thank you for emphasizing the value of education to me and for sacrificially supporting and encouraging me in everything I've done, every step of the way; Scissor, thank you for taking care of details at home so that I could focus on my fieldwork and thesis—you do not know how much distraction you have saved me; and Raymond, thank you for being a constant source of praise and an emotional refuge for me in this home away from home.

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1. Introduction

The role of the church is multifaceted, providing guidance and advice for its parishioners, affirming and encouraging interpersonal relationships, teaching and valuing family life, advocating spiritual growth, and helping people know God. Many people find the church a source of emotional, spiritual, and sometimes financial refuge from the busyness and difficulties of life, consequently placing high expectation on its leaders. At the frontline of the church are clergy, responsible for the growth, maintenance, and stewardship of the church, its members, and its funds. Not only does the role of clergy have spiritual implications, it also has social implications as churches try to navigate through current political and cultural climates. Additionally, amidst a hectic schedule of church leadership and management, clergy must find the time to spend with families and loved ones. Due to their unique role in society, clergy are an important group to study.

Although the health of clerics in the United States and Great Britain is becoming a growing a topic of interest, little research exists on this subject. As research continues to evolve, recent studies regarding clergy health focus on mental health, which includes indications of burnout and stress, and difficulties with family balance and enough social support (Schaefer & Jacobsen, 2009). As most health professionals and researchers realize, mental health concerns quickly manifest into physiological and biological forms. However, aside from a few studies, no research exists on the physical health of clerics. In addition to the sparse literature regarding the physical health of clergy in resource-rich settings, the literature regarding physical health of clergy in resource-poor settings is

even more limited. To begin to address this gap in the literature, the research team explored the relationship between clergy and health in Kenya.

1.1 Why Address Clergy Health in Kenya?

Although the topic of clergy health is a matter of pressing importance, it remains understudied in the non-Western world. In Africa, as in the United States, religion is known to play an important role in the daily life of its inhabitants; however, the overall well-being of African clergy, including mental, spiritual, and physical health, remains under-researched. Realizing that as caregivers, pastors often neglect their own health to take care of their parishioners; this caregiver population requires special attention. There is no documentation about the health of clergy in Africa, not even about how they conceptualize health; therefore, this study utilized qualitative methodology to gather preliminary information on the health of United Methodist Church clergy in Kenya. With the guidance of Duke Clergy Health Initiative faculty, the author partnered with public health and religion researchers at Moi University in Eldoret, Kenya, to conduct this exploratory study. This research is a first step towards a comparative analysis between UMC clergy in North Carolina and Western Kenya. Although the two settings differ greatly (North Carolina, US and Nyanza Province, Kenya), this study seeks to examine how clergy environments, cultural traditions, and religious beliefs relate to health-seeking behavior and well-being, holding UMC denomination constant.

1.2 Aims of Thesis

The overall aim of this exploratory research project was to obtain information regarding how clergy conceptualize health in Western Kenya in order to shape future studies and possibly interventions.

Specific objectives:

1. To investigate how clergy conceptualize health in Western Kenya
2. To understand religious beliefs related to health-seeking behavior in Western Kenyan clergy
3. To understand cultural traditions related to health-seeking behavior in Western Kenyan clergy

1.3 Organization of Thesis

This thesis is organized as follows: a review of relevant literature on clergy health; a brief overview of the UMC in Kenya; a thorough description of the methods to collect data as well as the process of analysis; a relay of the main domains and corresponding themes derived from the data; an explanation and further discussion of the results; a note regarding methodological and response limitations; and finally, a summary of key findings and a look ahead at future directions.

1.4 Research Questions

Due to the lack of information on clergy health in East Africa, a hypothesis would not be feasible or appropriate for this study. Therefore, the following primary question guided the study: What are the health-related beliefs and context for UMC clergy in Western Kenya?

Secondary questions:

- How do clergy conceptualize health?
- What religious and cultural beliefs relate to health?

2. Literature Review

As discussed in Section 1, little is documented on the health of clergy in Africa. Due to the sparse nature of the literature, the following section will provide a review of literature regarding what is known about clergy health in North America and Great Britain and will provide a brief introduction to the UMC in Kenya to give the reader relevant background information.

2.1 Work Life and Emotional Health of Clergy

A longitudinal study conducted over an 18-year period measured job satisfaction among various professions, finding United States clergy to be generally the happiest and most satisfied overall with their jobs (Davis & Smith, 2007). Paradoxically, a study of United Church of Canada clergy showed that clergy scored higher on symptoms of stress (88th percentile) and depression (78th percentile) than the general population (Group, 2003). The job of clergy is demanding, sometimes forcing 60-80 hour work-weeks, although more frequently requiring 45-50 hour work-weeks (Carroll, 2006). The work is also constant, and intensely interpersonal in nature (Cameron & Iverson-Gilbert, 2003). This can lead to high stress, which if not dealt with, can lead to burnout. Burnout can be defined as a compilation of symptoms including “low sense of personal accomplishment, high emotional exhaustion, and a high degree of depersonalization” (Maslach & Leiter, 1996). Although burnout and depression are closely associated, burnout is directly related to one’s profession (Schaefer & Jacobsen, 2009). Upon closer examination of the literature, the following statement reoccurs, “the phenomenon of clergy burnout is

pervasive, affecting veteran and new clergy alike, cutting across all religious movements” (Schaefer & Jacobsen, 2009).

One report suggests that although many professions experience high levels of stress and/or dissatisfaction, very few professions are under the moral scrutiny that clergy members so often face (Doolittle, 2010). Literature is fairly consistent on the causes of clergy burnout and stress. This same study goes on to suggest twelve causes of clergy burnout, including the following: lack of public/private boundaries, delicate nature of leadership, financial pressures, ambiguous role in a changing society, and physical health, stress, and depression related to ministry. As stated previously, depression and emotional exhaustion are closely related to burnout. One study finds that average levels of emotional exhaustion of clergy persons exceeds those reported by other groups of “caring” professionals (Evers & Tomic, 2003). Additionally, a different study reports significantly more anxiety and depression among clergy than the general population (Knox, Virginia, Thull, & Lombardo, 2005). Because clergy members believe that they are called by God, they often find it difficult to leave their profession and can feel guilt and shame when experiencing dissatisfaction with their career choice. A study conducted in the United Kingdom reports that over 50 percent of British clergy consider leaving the ministry in their lifetime due to associated stressors and pressures (Beebe, 2007; Parker & Martin, 2011). Therefore, although the majority of clergy members are seemingly satisfied with their jobs; stress, anxiety, and depression are common experiences among them. Our study helps to bridge the gap between what is known about the health of clergy in resource-rich countries and what is known about the health of clergy in Kenya. This

paper portrays how clergy conceptualize health holistically, including an emphasis on emotional health. These results will be shown in Section 4.1. A discussion of clergy family life follows, portraying the stressors and support that clergy members experience through familial relations.

2.2 Family Life and Social Support of Clergy

Research shows that in addition to occupational stress, clergy members experience stressors surrounding family life. Some of these stressors naturally overlap with job-related stressors discussed above and include: lack of ministry (or encouragement) to clergy families, lack of personal privacy, and lack of financial stability leading to “a diminished quality of life for both the clergy person and his or her family” (Meek et al., 2003). . In the United Methodist Church specifically, clergy are re-assigned to different churches frequently, especially at the beginning of their careers. This itinerant system, where pastors move from one appointment to another, dates back to early frontier days in the UMC (*The Book of Discipline of the United Methodist Church*, 2008). This can be very difficult for spouses and children who have little decision in the move and have to re-adjust and find new jobs/new schools (Proeschold-Bell et al., 2011). The Fuller Institute of Church Growth administered a survey to pastors and reports the following significant results: 80 percent of pastors indicate that ministry negatively affects their families and 70 percent of pastors report not having a close friend (Beebe, 2007). To further investigate these data, a team of researchers from Wheaton College administered semi-structured questionnaires and interviews to a selected group of pastors. The findings reveal that many pastors live in isolation because establishing

mutually encouraging and uplifting relationships is difficult due to the position of leadership that many pastors hold in the church and in the community. Consequently, the study also states that many pastors perceive their families, specifically their spouses, as the primary source of spiritual and emotional support (Meek et al., 2003).

Because a significant number of clerics rely on their spouse for primary support, clergy marital and familial relationships must be nurtured and maintained. This can be challenging when a number of clergy spouses must seek employment outside the home in order to mitigate the financial pressures caused by decreases in clergy pay. Research shows that even though clergy spouses are often providers of emotional support, they also have unmet needs. One study indicates wives of male clergy feel as though their husbands spend too much time on church-related work, only taking one day off per week and averaging 9.3 working hours per day (Hsieh & Rugg, 1983). Additionally, wives of male clergy in seminary report feeling left behind academically and spiritually, feeling no longer needed, and having to fight for their husband's attention (Guthrie, 1961). Further, children of clergy desire to have more family cohesiveness and interconnectedness, often demonstrated by the presence of boundaries (Moy, 1987). Therefore, while a family is often seen as a unit of structural support, lack of extra-familial support has taken an emotional toll on many pastors and their wives (McMinn et al., 2005). This emotional exhaustion can lead to an immense physical burden as described in next section. The research team observed in Western Kenya how being called to pastoral ministry is viewed by the community. A discussion of this and other cultural perceptions and traditions will be described in Section 4.3.

2.3 Physical and Biological Health of Clergy

While a surplus of research examining the relationship between religion and physical health can be found, a dearth of research examining the physical health of clergy members exists. Upon surveying the literature, very few studies were found documenting the association between clergy and biological health. One exception is a report released by the Evangelical Lutheran Church (ELCA) in America in 2002 on ministerial health and wellness among Lutheran pastors. Of the total number of ELCA clergy, 25 percent were sent surveys and the response rate for all groups ranged between 43 to 49 percent. This report by Dr. Gwen Halaas indicates that high blood pressure, stress, weight, diet, and heart disease need to be addressed among lay leaders and pastors in the church (Halaas, 2002).

Another exception is the Duke Clergy Health Initiative (Duke CHI) study conducted by an interdisciplinary team at Duke University targeting the health of UMC clergy in North Carolina using qualitative and quantitative methodologies. More specifically, the Duke CHI used self-reported data from UMC clergy in North Carolina to evaluate the prevalence of obesity and chronic disease diagnoses and compare them to a comparable set of non-clergy North Carolinians. The results of the study found that the obesity rate among 35-64 year old clergy is almost 40 percent; approximately 10 percentage points higher than that of their North Carolina counterparts (of the same age range and sex). Additionally, the study reports higher rates of ever having been diagnosed with diabetes, arthritis, high blood pressure, angina, and asthma compared to North Carolina counterparts (Proeschold-Bell & LeGrand, 2010). The results of this

study are startling and are beginning to raise awareness about the unique physical concerns that clergy members are facing. Although our study did not collect quantitative data on specific health concerns, our team did gather robust information on factors influencing clergy to seek medical attention. This will be discussed in Section 4.4.

2.4 United Methodist Church in Kenya

Although created in 1958 by Bishop Reuben H. Muller, the United Methodist Church has origins in both Methodist and Wesleyan bodies which originated in the 1700s by the ministries of John and Charles Wesley (*The Book of Discipline of the United Methodist Church*, 2008). In 1993, registered under “The Societies Rules, 1968,” the United Methodist Church reached four provinces in Kenya: Nairobi, Rift Valley, Nyanza, and Western. These provinces are divided into six primary UMC districts in Kenya: South Nyanza, Naivasha, Central Nyanza, Busia, Nakuru, and Nairobi, as illustrated in Figure 1. Our study collected data with participants from three districts.



Figure 1: Map of UMC districts and provinces in Kenya ("Nation's Online Project. Administrative Map of Kenya," 2011).

Each district is led by either a District Superintendent (DS) or Associate District Superintendent (Associate DS), with over 100 male and female local pastors serving as

full-time and part-time church ministers overall (Kephias, 2010). Through informational interviews, it was determined that the majority of local pastors in Kenya have little formal theological education or training and very few opportunities to receive any, although there are some who have been formally trained (Shanks, 2012).

None of the local pastors receive any formal salary and rely solely on the tithes and offerings of their congregations. These congregations vary in size and average income level, consequently affecting a pastor's monthly salary. Some pastors make as little as 300 Kenyan Shillings per month (approximately 3.50 USD) depending on the size of their congregation (Shanks, 2012). Many denominations exist in Kenya, including Africa Inland, Catholic, Pentecostal, Seventh Day Adventist, and Methodist. Some of these denominations have been established longer than the United Methodist Church in Kenya and could have an already time-honored congregation which could make new recruitment into a UMC church difficult. While the UMC is growing in Kenya, clergy may face pressure to increase congregation size out of financial necessity. The stressors of congregants, resources, and inconsistent monthly income can lead to emotional and physical stress responses for clergy.

3. Methods

3.1 Qualitative Instruments

Due to the preliminary nature of the study, qualitative methodology in the form of focus group discussions and cross-sectional in-depth oral interviews was utilized to obtain information. With permission from the Duke Clergy Health Initiative, an existing focus group discussion guide was employed as the backbone for the focus group discussion and interview guides used in this study. Two out of the five original focus group discussion questions were kept without alteration (highlighted in pinkish red below), while others were altered slightly to make them culturally relevant and new questions were added (Table 1). The open-ended focus group questions targeted definitions of health, access to healthcare, religious and cultural beliefs surrounding health, and barriers and facilitators to receiving care (Appendix A). The interview questions varied slightly from the focus group discussion questions, asking about congregational influences and what the pastor thinks may affect his or her health (Appendix B). The interview questions were pre-tested with two pastors in Eldoret, Kenya, and slight wording changes were made accordingly.

Table 1: Original Duke Clergy Health Initiative questions

1. How would you define health?
2. When do pastors think about their health?
3. How do pastors attend to their health?

4. SKIP #4 deleted after focus group 2

5. What aspects of health are hardest for pastors to attend to?

6. We would like to hear your ideas on the kinds of health promotion activities that you would be interested in being offered by the Clergy Health Initiative. What kinds of programs and resources would you like to participate in?

Table 2: Focus group discussion questions from this study

1. What is your understanding of health?

2. When do you seek healthcare?

3. When do you not seek healthcare?

4. What makes it easier for you to seek healthcare?

5. What gets in the way of you seeking healthcare?

6. What religious beliefs and practices affect your health?

7. What cultural practices affect your health?

8. How do pastors attend to their health?

9. What aspects of health are hardest for pastors to attend to?

10. What health programs are available to the clergy?

11. What do the clergy do when they fall sick?

We conducted four 90-minute focus group discussions averaging seven to ten pastors in each group. Additionally, we conducted nine 60-minute semi-structured in-depth oral interviews in order to gain more personal information that may not be obtained

in the focus group discussions. Each focus group discussion and interview was audio-recorded and occurred in a combination of English and Kiswahili. The recordings were transcribed and any Kiswahili words were translated by a transcriptionist from the research office at Moi University and verified by a bilingual member of the research team. All names were removed from the transcriptions. Eligibility of enrollment was contingent upon the following criteria: over the age of 18, working knowledge of English, active clergy appointment to the United Methodist Church in Western Kenya and availability during the study period.

3.2 Study Criteria and Recruitment

Researchers from Moi University selected a key United Methodist Church clergyman who acted as recruiter and community liaison for the study, ultimately serving as study coordinator. This study coordinator is the United Methodist Church District Superintendent for the Nyanza Province of Kenya, where the UMC is densely located (Figure 1). As coordinator, this person identified eligible United Methodist Church clergy members and invited them to a meet-and-greet event with the research team. Forty-nine pastors travelled from the four UMC provinces to attend this eight-hour meeting. At this event, the study was explained to the participants and a question and answer session was conducted to allow the participants to freely ask any question or voice any concern before participating. The participants were compensated 400 Kenyan Shillings for travel (approximately 5 USD) and refreshments were served during the discussions.

Focus group discussions were conducted with pastors from the same district or regional areas. Each interview was conducted with a pastor who had not participated in a focus group discussion to avoid biasing any answer or opinion from the focus group discussions. Interviews were conducted with assistant district superintendents (n=2), a female pastor (n=1), pastors of large congregation churches (n=2) and small congregation churches (n=4) in order to diversify the responses and attain robust data.

Table 3: Location and number of focus group discussions and interviews

Location	# of focus group discussions	# of interviews	# of participants
Migori	2	4	24
Muhuru Bay	0	4	4
Keroka	2	1	21
Total	4	9	49

3.3 Data Analysis

We used a combination of Grounded Theory (GT) analysis and Interpretative Phenomenological Analysis (IPA) to thoroughly explore the data. Grounded Theory analysis aims to go beyond mere data description in order to generate a theory that explains a pattern of behavior or way of thinking. This method of analysis studies the lived experiences of the participants through examination of their beliefs, assumptions, values, ideologies, and feelings (Charmaz & Bryant, 2008). Interpretative

Phenomenological Analysis has been traditionally used in the psychology discipline to explore how study participants are making sense of the physical and social world around them (Drummond, Hendry, McLafferty, & Pringle, 2011). The study team found it best to use both forms of analysis to shed light on these extensive, abstract data.

All data transcripts were coded using QSR International's NVivo 10 qualitative data analysis software. Since this thesis is a first step in a larger comparative study between United Methodist Church clergy in North Carolina and Western Kenya, the existing codebook for the Duke Clergy Health Initiative focus group discussions was utilized. Because we had no a priori hypothesis, irrelevant codes were removed and new codes were derived based on the data (Appendix C). While code derivation was iterative throughout the data analysis process, two members of the research team engaged in line-by-line coding of the first focus group discussion and first oral interview transcripts in order to generate data-driven codes (Charmaz, 2012). We also double-coded the first focus group discussion and the first oral interview and reconciled any differences in the coding and clarified the codebook to promote consistent future coding in those areas.

The next step in the analysis process was to continue coding the data, adding codes as necessary and pausing to memo-write, a "crucial method in grounded theory because it prompts you to analyze your data and codes early in the research process" (Charmaz, 2012). Upon memo-writing and coding completion, codes and corresponding quotes relevant to this paper were chosen. Themes were generated from each set of codes and quotes to ensure that the themes were derived from the data.

3.4 Ethical Approval

This study was approved by the Duke University Institutional Review Board and the Moi University Institutional Review and Ethical Committee. Written informed consent was obtained from the study participants for both the in-depth oral interviews and the focus group discussions.

4. Results

The following figure portrays the five domains and related codes that were chosen for this thesis. This section will summarize the domains that arose from the data along with corresponding themes, Figure 2.

Table 4: Domains and related codes

Domain	Related Codes and number of times this code was referenced (in parenthesis)	Number of times code referenced	Total times referenced
Defining Health	Conceptualization of health	54	175
	Mental health	20	
	Physical health	38	
	Holistic—Mind, body, spirit	33	
	Spiritual health	30	
Believing God Saves	Believing God saves	91	299
	Religious traditions or beliefs	41	
	Differing levels of faith	41	
	Financial strain	83	
	Identifying as victims of poverty	43	
Seeing Illness as Weakness	Seeing illness as weakness	43	265
	Barriers to health	95	
	Congregations	57	
	Support	30	
	Stress	40	
Intersecting Cultural Beliefs and Health	Cultural traditions and beliefs	84	264
	Environmental conditions	83	
	Health problems	70	

	Food and nutrition	27	
Seeking Medical Attention	Seeking medical attention	143	207
	Self-care	16	
	Program-positive	11	
	Programs-negative	37	

The domains chosen were pervasive ideas through the text, with all of them being coded at least 175 times. Interestingly, Believing God saves, Barriers to health, and Seeking medical attention were coded with the most frequency. Positive programs had the least frequency, mainly due to the lack of clergy-specific programmatic activities in the area.

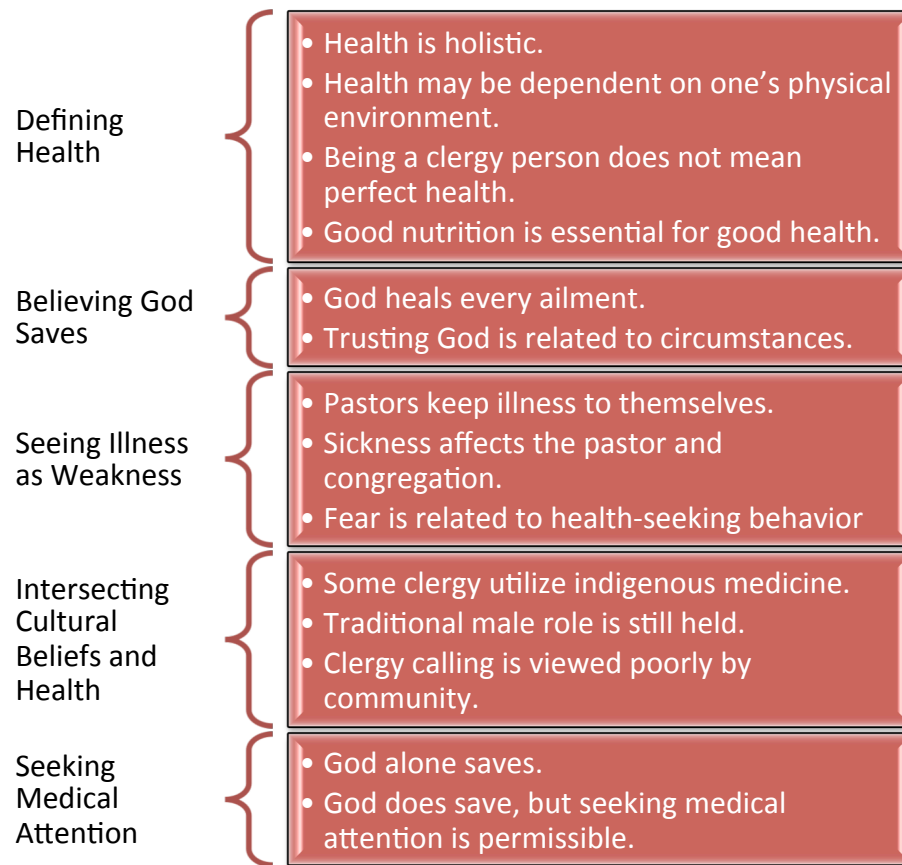


Figure 2: Domains and corresponding themes.

4.1 Defining Health

The first domain to be discussed is Defining Health. Within this domain we see the theme of conceptualizing health holistically. The majority of the clergy defined health in a holistic fashion. Holistic health, defined as more than just physical health, was referred to in each focus group discussion and in-depth oral interview. They stated that health is holistic; it is the complete well-being of a person in their mind, body, and spirit. Participants indicated that it is not just the absence of physical disease, but the presence

of mental and spiritual well-being, as well. The following are an understanding of health as indicated by participants:

Health touches on all those diverse aspects of human life style, the physical life, spiritual life, social life etc.

I can say it is the complete well-being of a person mentally, physically and spiritually, socially.

I think health according to my understanding is wholeness in the system the way your system operates, that is body wise and mentally even spiritually.

I think health is a physical, emotional, spiritual, and intellectual normal way of living. You are right wholly in your whole body both mentally, spiritually, physically.

Another theme under the Defining Health domain is that of an understanding or conceptualization of health dependent on one's physical environment. Participants indicated that a clean and sanitary environment is necessary for good health.

But because we don't have clean water to clean those crops before we use them, we just take in with all that chemicals and it affects our health so much.

Health, if you are living in bad conditions then your health is bad.

What is required is your living conditions should be good, it should start from your home then go out. Your living environment must be clean and all times be a person that loves cleanliness. We should see that our health is clean. There are many diseases describing cleanliness e.g. cholera because of poor living environment.

Health is one must be clean that makes one to start from cleaning for the body, living environment, it begins from there.

4.2 Believing God Saves

The pastors had varying religious beliefs that influenced their conceptualization of health and health-seeking behavior. One domain that arose at the intersection of religion and health is Believing God Saves. A theme that arose under this category is the belief that God heals every ailment. Participants stated that every so often, sickness will come and the solution is to trust that God will heal.

But when the sickness comes, I always give me to seeking God in prayer and taking up my fate by reading and studying the word of God and me always myself getting healed. Recovered all these years and that faith has kept me to today.

There comes decisions which they always believe that their God is able to an extent that even if somebody is almost dying is still believes God saves.

The absolute truth that exists and will still remain, it is that the bible speaks of Christ having healed us. I may look sick now and bear symptoms of sickness but number one fact and truth according to the holy scriptures is that by his stripes I was healed so that if am even sick now according to my level of faith, I want to go to the hospital, I want to seek medical attention, access medical service but it does not reveal the fact that Christ has healed us.

Another theme that arose is trusting God due to surrounding circumstances. Participants stated that trusting God for healing may be the result of poverty or other impediments to seeking care.

Positive side actually in western Kenya as they have told you concerning poverty it is because of this reason that most pastors faith have been built to an extent that they cannot access health care based on the fact that we have believed.

Okay when am just walking sometimes one is just expensive first I say God can you heal me because I go there they tell me pay 5k or 4k (5000 or 4000 Kenyan

Shillings) and I don't have that money and if I go to public hospital I get many queues so many people there, God I just take faith and go that is it.

4.3 Seeing Illness as Weakness

The third domain we see is Seeing Illness as Weakness, which is also at the intersection of religion and health. Within this category, we see the theme that clergy hide under the Scriptures so that the flock can continue to believe in the Word of God. Participants stated that they worried the congregation would lose their faith if they found out the pastor was sick.

When it comes to talking of our health, we pastors we are very poor on that side. Pastors we are the worst pretenders why, because we don't want to let our flocks to know that we are sick. It means that they flock will lose their faith in what are preaching to them that God is able. And therefore we want to hide under the scripture that we are not sick so that the flock can continue to believe in the word that actually our pastor I have never seen him sick because he believes in the scripture, so I believe in the scripture fully I will not get sick and yet that pastor is very sick.

We don't want to disclose ourselves to the flock, we shall be rendered redundant so we want to hide under the scripture but actually we also as pastors need to seek for medical health but we fear going there because our flock will lose their faith in the word of God.

Most of the pastors have got ulcers, but they don't want to disclose it. Just study the way are eating you will discover this person is having a health problem somehow, the pastors have got problems of even the teeth because they don't eat enough calcium but they don't want to let the flock to know, they have eyesight problem they don't want to let the flock to know.

Many pastors stated that illness is a weakness to them and their congregants. They noted:

Being sick is a weakness in us and you will find that most of us we don't perform well in our areas of ministry because we are unhealthy, it is true, yes.

And also the kind of some that may be as my colleague has said, even when he has all the symptoms and the signs of sickness, and as my the other colleague has said, he will see it as a weakness when the congregation happens to know may be he is sick as he said.

Sometimes you may be weak and people will wonder, ‘Is this preacher for real? You are only a preacher because you have not enough things that is why you are weak without good health.’

One theme under this domain is that clergy may not want to seek health out of fear.

Some pastors stated they are afraid to seek care because it might seem as though he is without faith or is immoral.

And again, in my experience as a pastor, is that some pastors they even fear going to the pharmacy to buy drugs that if they see a pastor going to buy drugs it is your faithless person, you are supposed to be bringing us the healing so you cannot preach of water and drinking wine.

They say, ‘Why is pastor so and so is sick?’ and then they start demonizing your sickness and this makes many pastors keep it to themselves they don’t want to open up. They say that what is this taking place in me and even you realize some pastor is HIV positive and a pastor will fear going for that test, that if they find that am pastor so and so and am positive and how will I go and preach to the people while am suffering so they fear going for that test.

4.4 Intersecting Cultural Beliefs and Health

Another domain to be discussed is Intersecting Cultural Beliefs and Health. A theme within this domain is the utilization of traditional medicine. Participants stated that some cultural practices encourage people to seek medical health from ancestral spirits and local herbs instead of clinical medicine.

The culture the traditions and the customs in western Kenya has also roots in our churches and you find that in some culture and customs or traditions in some communities, does not believe in seeking health from medical facilities but they would rather seek medical health from their ancestral spirits some in the church

they seek their health from the word of God, some seek their health from local herbs rather than going to the medical facility.

We pastors at the same time, we can also seek from the spirits intervention not the spirit of God spirits, traditional spirits intervention in our situation of health.

A cultural practice like my colleague has said because even us the Luo we believe that there are other things that one should not go to hospital but be treated at home if one should use herbal medicine because they believe the spirit kills.

There were those beliefs which they believed in and because there were no medical practitioners, biological medicine or faculties or doctors/nurses there were not many in this region that time, so people relied on their cultural beliefs, relied mostly on herbs but because right now people have been educated and they know what is going in the world, those now are going away because people have been educated so people have changed these days.

Cultural practices that depend on herbs one gets sick but because the cultural practice say that certain type of sickness you cannot go to the hospital so they get you herbal medicine and you are in pain and continue to be in pain so that is a barrier to a person.

Another theme that emerged in this domain is about the mentality of men in Kenya.

Participants stated that most Kenyan men are not used to getting advice and do not seek out medical advice.

Want to say as Africans, we are not used to being advised especially in Africa, and most pastors are men.

Here most pastors are men I think you can even look around, so the African tradition the mentality of a man is a man who cannot be don't seek for advise so as we know health is not only the physical well-being but it is both spiritual, mental and even social.

A third theme in this domain is that of viewing food and nutrition as an important aspect of health. Participants reported that good health requires good nutrition.

We can't discuss health without touching on nutrition. Some of us have problems because like it is always said that, good food good health long life. But if you

don't eat well of which some of us are victims because of poverty, poverty levels don't allow us to eat the way white eat, so this is also a factor that we have to consider when we are doing this our discussion. Nutrition is part and parcel of health; we also have to touch about it.

So food, enough food and different kinds of food is needed for a person to become healthy to maintain health and just comparing a person to become healthy.

I understand the word of health, I know the name health is to care for our bodies, to take clean water, eat clean food that is how I understand the word health.

A final theme within the domain Intersecting Cultural Beliefs and Health is in relation to the community's perception of clergy work. Participants indicated that being called into Christian ministry is poorly received in Western Kenya.

And so much in the western region of Kenya the work of the ministry the work the pastoral work the way it is perceived by the public is very wearied in one way, they believe that if you come one day evening home and say that I feel a call to serve in the ministry I feel to serve as a pastor then you are from the point to go seen as seen somebody who is an outcast, somebody who is challenged mentally, somebody who is a failure, a loser in life.

Such that pastors are perceived majorly as failures when they are majorly perceived as failures and then the traditional belief and lifestyle of the western religious people, the people who go to church, who belief in Christ savior even who are born again their aspect and lifestyle of giving is poor in churches.

The society sees you as an outcast I want to take an example with me, I went to school but when I told my dad that I had a calling of serving god, I was literally beaten, thoroughly because he felt that I was becoming a disgrace to the family I am choosing a profession where I will only be feeding on offering.

4.5 Seeking Medical Attention

This final domain also serves as the outcome of interest. In other words, the previous four domains relate to pastors seeking medical attention. In addition to how indigenous cultural beliefs relate to health, generally, clergy perceptions regarding seeking medical attention fall into two themes: first, those who believe that God alone heals and believe going to the doctor to be unnecessary and second, those who believe that God heals and view physicians as a conduit of healing. Regarding the first theme within this domain, participants indicated that God is enough for physical healing.

When there are parts in your body, first we inform God, you tell God I am feeling unwell in my body and am asking you to listen to me and help me. God will help you and then issues to do with the doctor will not apply but if you believe in God, let me tell you my sister since 1969 up to now, I have never gone to any doctor, if it is flu, my work is to ask my wife to give me hot water and then I raise my hands and ask God to help me and then I get strength to go and preach, that's all, if we put God before everything else, and ask we ask him to inspire us with holy spirit that will act as our doctor, that will help us in the United Methodist.

Like for me of Methodist church, I pray to God and He helps me. Other times I feel that feel I can't move a little bit ... but when I pray, God helps me, I get healed. Even if I go anywhere, when am walking, I ask God to strengthen me because God is able, you might be weak and you fall then people will wonder was this an epileptic? I pray to God to help me in everything.

I think there is no pastor who wants to go to hospital to seek for medical checkup because they are saved; they are on God's hands.

The other primary theme under this domain is the idea that seeking medical attention is permissible. Some participants stated that they believe God saves, but also see the value in modern medicine.

In fact we as the United Methodist Church, we believe that first of all Christ can cure and afterwards now we can take our patient to where, to a hospital to get treatment. Because you know in this world where we are, there is Satan and Satan is the one who brings diseases.

If your child or you are the one who is sick, pray first then you go to the hospital. Don't say let me just observe I will get well, you pray yes then you go to the hospital.

You can also see a doctor when you want to see some preventive measures on your health.

When one is sick, we seek, we go to medical doctor for treatment because they are sick of diseases.

5. Discussion

The key research question of this thesis was to explore and begin to understand the conceptualization of health among UMC clergy in Western Kenya and how that relates to their health-seeking behaviors. From focus group discussions and in-depth oral interviews, participant responses indicate that to understand how UMC clergy in Western Kenya conceptualize health, one would benefit from understanding defining health, believing God saves, seeing illness as weakness, intersecting cultural beliefs and health, and seeking medical attention.

5.1 Conceptualization of Health

Traditionally, Africans do not compartmentalize religion and health as Westerners tend to do, but see the human being as one person made up of many parts; the essential elements of human nature are merged into a harmonious united whole (Chalmers, 1996). Therefore, as far as defining health, we expected the participants to define health holistically as they did, meaning not merely an absence of disease or physical illness, but including spiritual and emotional well-being as well. Even in non-African societies, the paradigm shift from the medical model of defining health as solely the “absence of disease or disability”, to the World Health Organization (holistic) model of health as a “state of complete physical, mental, and social well-being” is not a new concept, but one that has transitioned over the last few decades (Larson, 1999). In their study of UMC clergy, Proeschold-Bell et al. (2011) found that the UMC clergy in North Carolina defined health in a similar way to clergy in Kenya by using phrases such as “whole of the

spirit. Mind, body, and spirit”, “a general sense of well-being,” and “spiritual, emotional, physical, mental well-being,” (Proeschold-Bell et al., 2011). Consequently, the fact that the participants, as Africans and as United Methodist Church pastors, viewed health as holistic is not surprising, but is still informative.

Another way clergy conceptualize health has to do with their environment. Repeatedly, participants stated that good health is dependent on a good environment, and that poor health is a result of a poor environment. They discuss the importance of nutrition, sanitation, and surroundings in regard to health outcomes. In his paper on conceptualization of health, James Larson (1999) discusses the wellness and environmental models in addition to the more known medical model and WHO model (Table 4).

Table 5: Models for defining health

Model	Definition
Medical Model	The absence of disease or disability.
World Health Organization Model	State of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
Wellness Model	Health promotion and progress toward higher functioning, energy, comfort, and integration of mind, body, and spirit.
Environmental Model	Adaptation to physical and social surroundings--a balance free from undue pain, discomfort, or disability.

The environmental model could be useful in better understanding this idea that both physical and social surroundings influence health. According to this model, health is defined elastically; that is, health is related to stressors and interactions with the environment. Additionally, “health is related to the ability of an organism to maintain a balance with its environment, with relative freedom from pain, disability, or limitations, including social abilities. Health exists when an organism works with its environment successfully and is able to grow, function, and thrive” (Larson, 1999). This model provides an explanation for what the clergy said about their health: that it is related and somewhat dependent on the environment in which they live. Over the last ten to twenty years, this region of Western Kenya has been altered significantly by HIV disease, malaria, tuberculosis, post-election violence, drought and revolution. Understanding that these clergy have faced and are facing incredible, ever-changing circumstances reinforces the idea that their health embodies the stressors and interactions with the world around them.

5.2 Health-Seeking Behavior

How a person conceptualizes health is related to their decision to seek medical attention (McAuley, Pecchioni, & Grant, 2000). Because Africans do not tend to compartmentalize cultural traditions, religious beliefs, and health-related behavior, we expected that cultural and religious practices could relate to health-seeking behavior in this population. Moi University religion professor, Eunice Kamaara, observes that African Traditional Religions are still seen widely in Kenya. In practice, traditional

cultural beliefs are mixed with Christian ideology in Kenya (Kamaara, 2009). The majority of the participants interviewed are part of the Luo and Kisii tribes of Kenya who believe that spirits of nature live in every being. Additionally, Luo hold magic in high regard and believe that the magician has vibrant power able to set these spirits in motion, often holding the power to cure and cast out things such as *Sihoho* (evil eye). Traditionally, religious experts practiced magic and some religious rituals contained magical elements (Ocholla-Ayayo, 1976).

Upon analyzing the data, it appeared that participants in rural settings like Keroka and Muhuru Bay more thoroughly discussed the influence of cultural tradition on health-seeking behavior. Participants conversed regarding the accepted view (held by themselves and their parishioners) of ancestral spirits, witch doctors, and magicians in health-related matters. A few of the clergy commented that even though they are saved by Jesus, they are still Luo and their culture cannot be taken out of them. This signifies the natural tendency to trust local doctors and witches in matters related to evil spirits instead of trusting a medical doctor, and further confirms Kamaara's claim that African traditional beliefs are integrated into many Christian denominations.

Research suggests that religious beliefs may influence health-seeking behavior directly or indirectly through banning negative activities, such as drinking or smoking, or through providing social networks and coping strategies (McAuley et al., 2000). As briefly stated in Section 4.2.1., the majority of UMC pastors in Western Kenya believe strongly that God is the one who saves them from physical, spiritual, and emotional disturbances. This is interesting, although not surprising, as the Bible contains many

references of God providing physical and spiritual healing and restoration. For example, the Bible states, “LORD my God, I called to you for help, and you healed me” (Psalm 41:3 New International Version), “The LORD sustains them on their sickbed and restores them from their bed of illness” (Psalm 147:3 NIV), and “‘For I will restore health to you and heal you of your wounds,’ says the Lord” (Jeremiah 30:17 NIV). While the majority of the clergy agreed that only God has the power to heal, some of them disagreed on the appropriateness and usefulness of seeking medical care.

Many of the participants interpreted the Bible in a conservative manner, taking the Scriptures literally to mean that God alone will be the one to save them from any infirmity. The idea of Biblical literalism is not new. A study on conservative Protestantism and public opinion toward science in the US found that 34 percent of the 1988 respondents agreed that the “Bible is the actual word of God and is to be taken literally, word for word”(Ellison & Musick, 1995). Although the United Methodist Church is not included under the Conservative Protestant denominations in this study, the more conservative UMC clergy in Western Kenya may share similar ideologies to some of this study’s respondents. Under some circumstances, it seems as though this firm belief in God alone for healing is associated with poverty and a lack of resources. Participants mentioned that poverty was a blessing in disguise because it helps build a person’s faith. Inadequate finances could act as a deterrent in seeking medical attention, thereby encouraging people to rely on God for all provision, including medical. Another reason clergy rely on God alone for healing is to exercise their faith. Participants said that there are differing levels of faith that each person possesses and that people with

lower levels of faith may have to rely on physicians or other medical providers for healing instead of relying on God.

Other participants believe God alone heals, but also saw the necessity of seeking medical care. This mentality, while slightly different, is also not surprising as this view is held by many Christians throughout the world. In a study on African Americans and Whites living in rural Oklahoma, McAuley et al. found that respondents viewed God as healer and miracle worker in relation to disease and finances. African Americans especially believed that prayer is a conduit for receiving God's healing. These respondents went on to say that oftentimes God works with the physicians to provide healing and God's healing powers are superior to that of physicians (McAuley et al., 2000). African Americans were more likely than Whites to respond strongly about God's role in their lives and the authors traced it back to their roots in Africa, confirming the results of this study: that the Kenyan is a holistic person who does not compartmentalize faith and health.

6. Limitations

One limitation of the study is that it did not collect quantitative data. While qualitative data is useful for hypothesis-gathering information about subjects for which little is known, we did not measure any health indicators of the clergy. Another limitation to this study is that it was limited to UMC clergy. Given the resources, timeframe, and the hope to draw future comparisons to UMC clergy in North Carolina, the research team decided it best to limit the scope of the project to UMC clergy in Western Kenya.

One primary limitation of the study was a misunderstanding of international research and international foreign aid on the part of participants. Nyanza Province, where all the focus group discussions and in-depth oral interviews took place, has the highest HIV and malaria rates in all of Kenya (N, 2007). Because of this, many non-governmental organizations and foreign aid organizations are in Nyanza Province providing support and resources. It became clear after having conversations with some participants that they were misinformed about the idea of a voluntary research study. This could have been due to what was told to them by the District Superintendent during recruitment, or could have been a result of the familiar work of the NGOs. Regardless of the reason, some of the participants believed they were entitled to a post-study intervention or opportunity. While the research team does not believe this to have heavily biased any answers, it may have led participants to focus their responses on possible interventions or resources to receive in the future.

The focus group discussions were generally formed by region of service to the UMC. While the research team saw this as a benefit so that participants from similar backgrounds who knew each other well would feel at ease, it could have led people to be less open. A final limitation is self-report bias. While this study only gathered responses from the clergy members themselves, it opens the door for conversation with clergy spouses and congregants in the future.

7. Conclusion

In order to better understand how UMC clergy conceptualize health in Western Kenya, it is important to understand the following main ideas:

1. In general, Africans do not compartmentalize religion and health, but integrate these to form a harmonious, united whole;
2. Clergy define health holistically, emphasizing the mind, spirit, and soul as well as the body;
3. Indigenous cultural tradition is very much alive in Kenya and relates to whether or not clergy will seek medical care; and
4. Believing that God heals is a common theme among clergy that can affect whether or not they choose to seek medical care.

This is important because understanding how clergy think about health could be informative for future interventions and programming. Therefore, this exploratory study sheds light on the current health conceptualization of pastors in Western Kenya and may serve as a stepping stone for future research on clergy elsewhere.

The results of this study could act as a link for future research and interventions. One next step could be to conduct similar qualitative research with other denominations in Kenya and throughout Africa to see if any significant differences exist based on theology or regional location. Another possible study could be conducted with the wives and congregants of the UMC clergy participants in this study in order to confirm their reports and provide more robust data. Quantitative methodology on specific health indicators surrounding nutrition and infectious disease status could also be a possible way

to shed light on the situation in Western Kenya to see if a future intervention would be helpful in this population.

Appendix A: Focus Group Discussion Guide

Make sure each participant has been read the informed consent form and agrees to participate, knowing their participation implies consent.

Name of interviewer:

Place of interview:

Date of interview:

Group identification

Preliminaries

Welcome and thank you for sparing time to come and participate in this discussion. Your participation definitely contributes a lot to this research. My name is Nicole Georggi and I am a graduate student global health student. This is my colleague, Sherine Adipo, who is obtaining her Master of Public Health and Moi University in Eldoret. We are carrying out this study to investigate the health-seeking behaviors of the clergy in United Methodist Church in Western Kenya. The purpose of our discussion today is to share and learn from you because I think you have the knowledge and opinions necessary to best inform this research. This information will be useful in guiding religion and biomedical researchers to better understand the health of the clergy. Before we begin, I would like to go over the informed consent paper. (*Do this now*).

This discussion will last for 2 hours at most. I will be asking questions and any one of you can freely respond or not. I will be taping the questions but if anyone objects to taping of any section do not hesitate to let me know and we will switch off the tape-recorder for the session. It is necessary for me to tape the information so that I will have an accurate record of what we said in the discussion and can then effectively transcribe it. Any one of you can speak when he/she wishes but let us be sensitive to listen to the ideas of others.

There is no right or wrong answer today. Everyone here has an important perspective to share and you all have expertise on this subject. I would like to hear as many different ideas as possible today, so I may ask you to be brief to give others a chance to share. I hope you'll understand and be OK with this request.

We will share experiences, knowledge, and opinions amongst ourselves, and agree or disagree with one another on certain issues. Please remember that you are not obliged to discuss all questions that I ask you. If you are not comfortable with any question simply do respond so that only those of you who are comfortable discuss. If none of you feel comfortable to discuss any issue, we will proceed to the next question. Remember also that you have a right to opt out of this discussion at any point.

Do you have any questions on this study before we proceed? *If there are any questions or comments, the researcher should respond to them honestly and as informatively as*

possible to the satisfaction of the group.

I will begin by sharing my favorite Bible verse. Please feel free to share your favorite Bible verse.

At this point I would like to remind all of us that everything that we discuss here will remain confidential and will be reported without specific reference to any of us. *(Note: The researcher should also introduce herself to be seen as a member of the group)*

Focus Group Discussion Questions

Actual FGD Question	Study Objective addressed by the questions	Check list for responses
<u>Understanding of health</u> 1. What is your understanding of health? 2. When do you seek healthcare? 3. When do you not seek healthcare? 4. What makes it easier for you to seek healthcare? 5. What gets in the way of you seeking healthcare?	To investigate reasons for clergy engaging in cultural, religious and biomedical practices.	<ul style="list-style-type: none"> ➤ Pick a few answers from individuals in the group ➤ Probe here to get more reasons ➤ Observe non- verbal communication ➤ Focus on Biomedical and religious practices effect on clergy health.
<u>Cultural, Religious and Contextual Factors</u> 6. What religious beliefs and practices affect your health? 7. What cultural practices affect your health? 8. How do pastors attend to their health? 9. What aspects of health are hardest for pastors to attend to?	To identify contextual factors that affect health-seeking behavior in Western Kenya.	<ul style="list-style-type: none"> ➤ Explain and give illustrations and examples where necessary. ➤ Probe to get explanations on factors where necessary
<u>Health programs</u> 10. What health programs are available to the clergy? 11. What do the clergy do when they fall sick?	To investigate how best health programs can be implemented and sustained for benefit of clergy.	<ul style="list-style-type: none"> ➤ Assure participants on importance of health care programs for the clergy. ➤ Probe for details

Appendix B: Oral Interview Schedule

By the interview time of each group discussion, the subjects of study should have read (or have informed and made to understand) the content of the informed consent form, agreed to participate in the study and acknowledge that their participation implies consent in the study. This should be confirmed at the beginning of every discussion.

Name of interviewer:
Date of interview:

Place of interview:
Group identification

Preliminaries

Welcome and thank you for sparing time to participate in this discussion. Your participation definitely contributes a lot to this research. My name is Nicole Georggi and I am a graduate global health student at Duke University in the United States. My colleague, Sherine Adipo, is a graduate public health student at Moi University in Eldoret. I am carrying out this study to better understand the health of United Methodist Church clergy in Western Kenya. The purpose of this interview is to learn from your experience, knowledge, and expertise. This information will be useful in guiding religion and biomedical researchers to improve clergy health in the future. We will now review the informed consent document. *Let the interviewee know that their participation in the interview implies their consent.*

This discussion will last for at most one and half hours. I will be asking questions and you can choose to respond or not. I will be taping the discussion but if you object to taping of any section do not hesitate to let me know and we can switch off the tape recorder. It is necessary for me to tape the information so that I will have an accurate record of what we said in the discussion and can then effectively transcribe it.

Please remember that you are not obliged to discuss all questions that I ask you. If you are not comfortable with any question simply keep quiet or freely say you do not wish to respond. If you are not comfortable to respond to any question, we will proceed to the next question. Remember also that you have a right to opt out of this discussion at any point. We will not record or report with our study results any information that would identify you.

Do you have any questions before we proceed? *If there are any questions or comments, the interview should respond to them honestly and as informatively as possible to the satisfaction of the participant.*

At this point I would like to remind you that everything that we discuss here will remain confidential and will be reported without specific reference to you.

Appendix C: Oral Interview Questions

Date _____ Gender _____

1. What is your understanding of health?
2. What do you think causes ill health?
3. How do you know that you are sick?
4. When do you seek health care?
5. Where do you seek health care from?
6. What gets in the way of you taking care of your health?
7. What affects your health?
8. How does being a pastor of a congregation influence your health-seeking behavior?
9. What health programs do you know of that are available to clergy in Western Kenya? Have you used any of these programs?

Thank you!

Appendix C: Codebook “Suggested Set of Limited Codes for Clergy Health Focus Groups”

Emotions

Any comments that include emotional content, with or without a direct reference to the actual emotion being experienced.

Holistic– Mind/Body/Spirit

References to a definition of health that is more than just physical health, or references to the intention of wanting holistic health for oneself. Does not have to reference all three of mind, body, and spirit to be coded Holistic.

Mental Health

Comments on one’s emotional or mental health, including challenges to mental health, solutions to maintaining mental health (i.e., mental health practices), and references to maintaining a balance in life.

Spiritual Health

Comments on one’s spiritual health, including challenges to spiritual health, solutions to maintaining spiritual health (i.e., spiritual health practices), and references to prayer life, keeping Sabbath, and rejuvenating spiritually.

Physical Health

Comments on one’s physical health, including challenges to physical health and solutions to maintaining physical health (i.e., physical health practices).

Role Models

References to Biblical, clergy, and peer role models in terms of modeling healthy or unhealthy behavior for clergy, and references to clergy being healthy or unhealthy role models for congregants or congregations. Quotes coded as Role Models may also receive a code of Peers.

Challenges

Challenges to maintaining any kind of health, including challenges to your family’s or spouse’s health. An example of a challenge is boundaries. There is no need to code Stress or Workload or Life Unpredictability issues as Challenges if you have already coded them as Stress or Workload or Life Unpredictability, because these are basically codes for more specific kinds of Challenges.

Cues

Cues that one needs to take better care of one’s health or maintain one’s health.

Self-care

Ways that clergy care for themselves. These may be concrete ways (eating a healthy diet, praying) or less concrete, like being accountable to oneself. Quotes coded as Self-care may also receive a code of Mental Health or Spiritual Health or Physical Health.

Programs- positive

Ideas for programs that would **benefit** clergy health, with health being broadly defined. These program ideas may be either individual-oriented programs or system-level changes. May include mention of current activities or programs that the respondent perceives is good for clergy health. If the program refers to a peer group, just code it as “peer group” positive or negative but there is no need to also code it as Programs.

Programs – negative

Negative comments about current or potential programs for clergy health or any aspects of these programs that are viewed negatively. If the program refers to a peer group, just code it as “peer group” positive or negative but there is no need to also code it as Programs.

Spouses

Any references to spouses. Quotes coded as Spouses may also receive a code of Challenges, Self-care, Support, System Impacts, etc.

Additional Codes using Grounded Theory

[Not] Seeking Medical Attention/Care

Any comment regarding seeking medical care, seeing a doctor, going to the hospital, etc. Can include comments about NOT seeking medical attention.

Identifying as Victims of Poverty

Any comment referencing how poverty may affect the life of the pastor, his health, his environment, his ability to access care, etc.

Believing/Trusting God Saves/Heals

Any comment about God having the power to heal, trusting Him to save, relying on Him to provide healing, sustenance, provision, etc.

Differing Levels of Faith/Working by faith

Any comment on levels of faith being different, how faith levels affect health, role of faith, etc.

Practicing what is Preached

Any comment on being a hypocrite if illness is exposed, of having to keep illness a secret for the sake of parishioners.

Family

Any references to family or individual family members with the exception of spouses, which should be coded under Spouses. Quotes coded as Family may also receive a code of Challenges, Self-care, Support, System Impacts, etc.

Privacy

Comments on the need for privacy, the lack of privacy, ways to maintain privacy, or the flip side of privacy which is public life.

System Impacts

Comments on how the United Methodist system or clergy ordination/education systems impact health. Examples of System Impacts include references to itinerancy, pastor-parish relation committees (PPRCs), the appointment/charges process, and supervision arrangements.

Congregations

Any references to congregations, whether or not the reference bears directly on health. Examples of Congregations include toxic climate, unappreciative congregations/congregants, congregations that are dominated by a small number of families, congregations resistant to change, and congregations supportive of health (which may also receive a code of Support). References to a single congregant should not be coded Congregations.

Peer Group-Positive

Comments on the positive aspects of peer groups, positive experiences with peer groups, or ideas that would make peer groups better.

Peer Group-Negative

Comments on the negative aspects of peer groups, negative experiences with peer groups, or barriers to participating in peer groups.

Support

Comments on sources of support for clergy health. For examples, clergy may find support in relationships with other clergy, with spouses, with friends, the bishop, the DS, church members, or God. This should not be a category in which strategies to improve health are coded; so although God may be a source of support, prayer would be coded as Self-Care. Support instead is more a code of Connectedness. Include comments on lack of support.

Stress

Reports of experiencing stress or attempts to avoid stress or the aspects of clergy life that are stressful. Include comments on lack of stress.

Workload

Comments on the amount of work clergy have to do or the level of expectations experienced by clergy.

Life unpredictability

Comments on lack of control over one's own life, attributable to one's role as clergy.

Health problems

Health concerns or problems that the respondent has or that the respondent is reporting about other clergy or clergy family members

District Superintendents

Any comments on interaction with DSs, the role of DSs, the expectations of DSs, or hopes for DSs

Bishops

Any comments on interaction with bishops, the role of bishops, the expectations of bishops or hopes for bishops

Trust

Any comments related to trust, including hesitance to disclose problems or personal information for fear of consequences. Also include comments related to confidentiality issues. Include comments on the presence of trust as well.

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