RURAL HEALTH MINISTRY –
AN EMERGING COMMUNITY OF PRACTICE (COP)

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* Statements, views and opinions contained in this article are those expressed solely by the author as a private citizen and not as a spokesperson of any institution, organization, agency, foundation or special interest group.

Abstract
The meaning attributed to the term “rural health ministry” is very broad. Space does not allow for a comprehensive treatise of all the elements relating to it. Accordingly, the primary purpose of this article is to provide background information regarding the development of rural health ministry, the justification for HMA’s support for Rural Health Ministry Initiative (RHMI) Task Force, and the evolution of this ministry as an emerging Community of Practice (CoP).

Introduction
The Health Ministries Association is a national organization of “People of Faith Working Together for Healthier Communities”. HMA members are called, gifted and sent into a broken, wounded and hurti ng world to be God’s ambassadors caring for the needy, the ‘least of these’, in our communities.

Rural communities deserve the attention of HMA because they are home to a disproportionately high number of the ‘least’ healthy, the ‘least’ wealthy, living in the ‘least’ healthy communities with the ‘least’ support services and resources. The high number of needy residents in rural communities is the result of a multitude of factors and extenuating circumstances. The combination of depressed agricultural economy, persistent drought, summer forest fires, farm/ranch foreclosures, out migration of youth, increasing aging population, limited access to health care and support services, and increasing numbers of unemployed and uninsured has resulted in an ever increasing number of unhealthy rural communities.

Research studies show that rural residents are more likely than their urban counterparts to be older, in poorer health, uninsured, living on low-income or in poverty and to suffer from chronic illness, disability, substance abuse, domestic abuse and die prematurely from accidents, injuries, heart disease, cancer, diabetes and suicide.

Reasons for the increasing health disparities and poor health outcomes for rural residents are multiple and complex; however, a persistent common denominator is rural poverty. Poverty is frequently the underlying cause of poor individual health, unhealthy behaviors, unhealthy
relationships, disintegration of the family unit, depression, and premature death from accidents, violence, substance abuse and suicide.

The hardships permeating rural America are frequently not known for a number of reasons. First and foremost is the foundational nature of rural culture. Rural residents are known for their independence, self-reliance and stoic character – traits that frequently perpetuate suffering in solitude. Second, long travel distances, poor rural roads, inclement weather, few social gatherings and the constant demands of rural living all lend themselves to increased social isolation. For rural people of faith, hardships and adversities have long served as ‘performance-enhancing’ stimulants for personal and communal spiritual growth. Their hardships have deepened faith, strengthened character and solidified the concept of hope. Faith and hope are the foundational cornerstones for rural community living.

**Background**

The vision for developing a CoP designated as “Rural Health Ministry” grew out of experiences working in the following three separate, yet related, domains of “Rural Health”, “Rural Ministry” and “Health Ministry”. The development of each of these areas will be explained.

**Rural Health**

Rural health became a national concern when policymakers noticed the increasing costs of delivering health care services in rural communities and the decreasing numbers of physicians selecting small rural towns for practice locations. The National Health Service Corps legislation, signed into law in 1970, was designed to provide financial assistance for health care professionals who practiced in underserved areas. In 1997, Congress passed the Rural Health Clinic Services Act (Public Law 95-210) designed to improve health care in medically underserved rural areas and to improve a care delivery system that used practitioners, physician assistants and other primary care specialists.

In 1987, the federal government established the Office of Rural Health Policy (ORHP) to help promote better health care service in rural America (http://ruralhealth.hrsa.gov Accessed 11/2/07). Congress charged the new ORHP with informing and advising the Department of Health and Human Services on matters affecting rural hospitals, and health care, coordinating
activities within the department that relate to rural health care, and maintaining a national information clearinghouse. Also established in 1987 was the National Rural Health Association (NRHA) formed by the merger of the American Rural Health Association (established in 1980) and the National Rural Health Care Association (established in 1984) in order to create a “new unified voice for rural health.”

During the 1990s, the ORHP worked to establish State Offices of Rural Health (SORH) in each state as an institutional framework that would link small rural communities with state and federal resources to help develop long-term solutions to rural health problems. In addition, the ORHP funded Rural Health Research Centers (RHRCs) to help policy makers understand the problems that rural communities face in securing adequate, affordable, quality health services for their residents. The RHRCs Program is the only federal program entirely dedicated to producing policy-relevant research on health care and population health in rural areas.

Rural Ministry

The concept of “Rural Ministry” dates back to the founding of America with the itinerant preacher, or circuit rider on horseback, serving some of the most remote rural settlements. With the opening of the frontier and migration west, one of the first buildings erected by settlers was the church. Throughout history, the local church has been a cornerstone advocating for justice and equity for rural and frontier residents.

In December of 1915, the Commission on Church and Country Life, under the authority of The Federal Council of Churches in America, held a national conference in Columbus, Ohio, entitled “The Church and Country Life”. One of the speakers at the conference was President Woodrow Wilson. His presentation, “The Rural Church as a Vitalizing Agent” underscored the importance of the church in the vitality of a rural community (Wilson, 1916). During the Great Depression and other periods of crisis, small rural churches were instruments of hope that played a key role in maintaining the stability of rural communities.

In 1971, Dr. Rockwell Smith, Professor of Sociology of Religion at Garrett Theological Seminary, published his study of more than 200 rural sociologists and over 300 town and country Methodist pastors in a book entitled “Rural Ministry & the Changing Community”(Smith, 1971). His findings provided compelling evidence to support his thesis that the rural church is a key change agent in the rural community.
During the 1970s, the Rural Church Network (RCN) of the US and Canada grew out of several organizations associated with the Joint Strategy and Action Council (JSAC), Rural North American Task Force (Ruesink, 2007). Today, the RCN is an international organization with the purpose “to be a forum for sharing among denominational leaders and other town and rural strategic partners working for wholeness and health of rural communities.” The RCN works to be a strong advocate and prophetic voice for rural ministry in church and public arenas and also cultivates dialogue and partnerships with theological institutions and other leadership training organizations.

The farm crisis of the early 1980s resulted in foreclosures of approximately 650,000 American farms and for every seven foreclosures, one rural town business folded. The Rural Chaplains Association (RCA) emerged during this critical period from work accomplished by the Center for Town and Rural Ministry resulting in a recommendation from the United Methodist Rural Fellowship that an association of Rural Chaplains be organized. From its beginning in 1987, the RCA has functioned from an ecumenical perspective certifying clergy and lay leaders as Rural Chaplains from many different denominations and faith persuasions. A variety of resources and programs that developed during the 1990’s served to support the continued growth of rural health ministries.

Some selected examples are:

- In 1991, the National Institute for Healthcare Research (NIHR) was founded with a mission to advance the understanding of spirituality and health.
- In 1993, the Interfaith Health Program (IHP) was established at the Carter Center in Atlanta to encourage faith groups to improve the individual and collective health of their members and the local and global communities they serve.
- In 1996, the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) contained provisions for charitable choice, opening the door to federal funding of charitable, religious and private organizations that helped those in need.
– In 1997, the American Nurses Association recognized Parish Nursing as a specialty of the nursing profession.
– In 1999, the federal government established the “Faith Partnership Initiative” under the Bureau of Primary Health Care, HRSA, DHHS, to foster and build partnerships between federally funded community health centers and faith-based organizations.
– In 1999, Rev Abigail Rian Evans published *The Healing Church - Practical Programs for Health Ministries* (Evans, 1999a) and *Redeeming Marketplace Medicine - A Theology of Health Care* (Evans, 1999b) both of which challenged the church to reclaim its ministry of health and healing.

The focus of a ministry of health to disenfranchised and depressed rural communities came to the forefront in 1998, with the publication of a book entitled *Rural Ministry: The Shape of the Renewal to Come* (Jung, et al, 1998). This book raised a sense of urgency and importance to the many crises occurring in rural communities, including closing of schools and hospitals, corporate buyout of farms and ranches, the graying of rural communities, and the changing face of rural poverty. The authors presented an impressive history of the rural church and a compelling vision of how the church must work for justice and change in and beyond rural communities. The ray of hope in the book is based on the potential for cooperative and collaborative partnerships geared to the solution of rural problems.

**Current Status of Rural Churches**

Much has been published regarding the plight of small town and rural churches (Jung & May, 2000; Lumis, Part B, accessed 11/4/07; Poling-Goldenne & Jung, 2001; Snow, 1989; Stephen, 2000). Many small rural churches are faced with aging congregations, dwindling memberships, shrinking budgets, limited resources and vacant pulpits. Just over half of the estimated 325,000 churches in the US are located in small town and rural settings. Reports show that half of the congregations in the US have fewer than 100 regularly participating adults and 25% have fewer than 50 (Dudley & Roozen, 2001). It is not surprising that small rural congregations have difficulties attracting full-time pastors because of the very modest salary packages they can offer. Many of these small membership churches are served by bi-vocational pastors filling a part-time pastoral position.
The low starting salary for rural pastoral positions is compounded by the fact that many seminary graduates are older second-career individuals with families to support. In addition, few seminary-educated clergy are familiar with small town rural culture and find it difficult to relate to, and communicate with, rural congregants. With the aforementioned problems in mind, regional leaders have offered the following possible solutions for vacant pulpits in rural churches:

(1) Merge with another congregation close by;
(2) “Yoke” congregations of a judicatory under one pastor or clergy team;
(3) Establish the circuit-rider model of a seminary-educated pastor-visiting monthly with each congregation in a regional cluster;
(4) Identify a judicatory that would offer financial incentives to pastors willing to serve in rural areas;
(5) Encourage retired clergy living in the local area to serve;
(6) Facilitate “union congregations” where cooperative congregations are supported by several denominations; and,
(7) Ordain lay leaders to less than full clergy status for limited ministry (Lumis, Part B, accessed 11/4/07).

A central theme woven through these proposed solutions is interfaith activity, which according to surveys, has more than tripled since 2000. A recent survey sponsored by the Cooperative Congregational Studies Partnership found that 22.3% of congregations reported participating in interfaith worship services and 37.5% of congregations reported joining in interfaith community service activities (Interfaith Worship-Hartford Institute for Religion Research, 2006).

**Health Ministry**

The “Health Ministry” movement, dating back to the time of Christ and before, is based on the interrelationship between two healing traditions – medicine and religion. The HMA was born out of the health, healing and wholeness discussions at the first Westberg Symposium in 1989. Dr. Granger Westberg and Rev. David Carlson presented the idea of a Health Ministry Association to 29 faithful symposium attendees who later became the charter group of the
Rural Health Ministry and the Health Ministries Association (HMA)

At the 2004 HMA 15th Annual National Conference & Exhibition, a workshop was offered entitled “Rural Health Ministry: An Emerging Diversity of Practice” (Young, 2004). This presentation provided a snapshot of rural America with respect to barriers to health care and support services, documentation of inequities and disparities, and the role of the church in building healthier rural communities (Baker et al, 2007).

The potential role for the HMA in the ‘rural’ mission field was first brought to the attention of the HMA Board of Directors during their meeting in July of 2004. Discussions concerning HMA’s potential role in “Rural Health Ministry” continued during 2005. In January 2006, HMA President Peggy Matteson authorized the appointment of a Rural Health Ministry Initiative (RHMI) Task Force.

The overall mission of the RHMI is to raise the level of awareness of the broad range of unmet health-related needs of rural residents and to help equip and empower rural churches in creating healthier communities. The RHMI is working to identify and develop evidence-based best practices/programs, training workshops, CDs, CD-Roms, DVDs, webinars, guides, toolkits and other resources and services that will help build the capacity of rural churches to promote health, healing and wholeness in rural communities.

A call for HMA members interested in joining the RHMI Task Force appeared in the Spring 2006 issue of the HMA Today in an article entitled “Developing a Rural Health Ministry Initiative for the HMA”. After several months of e-mail exchanges and recruitment, a total of twelve individuals agreed to serve on the RHMI Task Force. The first ‘task’ of the Task Force was to define Rural Health Ministry which was accomplished as follows: “Rural Health Ministry is a ministry that seeks to nurture the holistic health and well-being of people in rural communities. Built on traditional rural values of hopefulness, resilience, and cooperation, it involves people of faith who desire to promote the full integration of faith and health based on the belief that God wants all people to flourish in mind, body and spirit.”

The RHMI Task Force held its first formal workshop at the HMA 18th Annual National Conference & Exhibition in San Antonio, TX on June 24, 2007 (Young, 2007) entitled “Living
Waters to Heal and Revitalize Rural America - ‘Rural Health Ministry’”. Attendees learned about the evolution of the RHMI, the broad range of health-related needs and disparities in rural areas and discussed various action steps that could be beneficial to rural communities. The concept of a Community of Practice (CoP) was discussed at the workshop as a potential avenue for development of Rural Health Ministry.

Understanding the Phrase Community of Practice (CoP)

The term CoP was first used about 15 years ago in reference to the process of collective social learning that occurs when people who have a common interest, concern or passion collaborate over a period of time sharing experiences, ideas, and innovative solutions. According to Etienne Wenger (Wenger, 1998; Wenger, McDermott & Snyder, 2002), the following three characteristics of CoPs are crucial: (a) the domain - a commitment to a shared domain of interest and a shared level of collective competence whereby members learn from each other; (b) the community - within the domain of shared interest, members engage in a community of joint activities and discussions building relationships that enable them to learn from each other; and, (c) the practice - members are practitioners who invest time and effort in sharing a repertoire of experiences, stories, tools and resources in addressing problems that is sustained over an extended period of time.

CoPs are associated with organizational knowledge management and viewed as a method to enhance social capital, nurture new knowledge and stimulate innovation and creativity within an organization. Currently CoPs are becoming more and more a useful approach to knowing and learning as an integral part of organizational development, as well as, a key to improving an organization’s performance (Wenger, 2007).

The next ‘task’ for the RHMI Task Force will be to engage members in strategic planning – developing a mission, vision, guiding principles, core values, strategic objectives, and expected outcomes for this new CoP. Successful ministry development requires critical ground work by passionate individuals who share a common vision and are committed to intentional practices of communal prayer, study, discernment and investment of time and effort. Ministry development is unique because it involves cultivation of people of faith – called, gifted, empowered and sent – to fulfill God’s purposes. Efforts to improve health and reduce the impact of illness, disease, disabilities and disparities in rural settings will require a comprehensive collaborative effort that
brings communities and institutions together sharing assets, resources, strengths, capacities, ideas and solutions.

**The Challenge of Healthy People 2010**

The increase in health-related disparities and premature deaths in rural settings runs counter to the national health agenda, *Healthy People 2010*, which is designed to eliminate health disparities and to increase the quality and years of healthy life (*Healthy People 2010*, 2000). One of the major goals of *Healthy People 2010* is to achieve health equity, regardless of geographic location, stated as follows:

“*Healthy People 2010 is firmly dedicated to the principle that—regardless of age, gender, race or ethnicity, income, education, geographic location, disability, and sexual orientation—every person in every community across the Nation deserves equal access to comprehensive, culturally competent, community-based health care systems that are committed to serving the needs of the individual and promoting community health.*” (*Healthy People 2010*, 2000) (bolding emphasis added).

Unfortunately, children are at the forefront of the disparity wave across rural America (*The Health and Well-Being of Children in Rural Areas, Maternal and Child Health Bureau, 2006; Petit, 2006*). Rural children are more likely than their urban counterparts to be victims of child abuse, to suffer from low self-esteem, emotional problems, depression and to experience more frequent suicide attempts and successes, to be absent from school, to be substance abusers, to be more involved in crime, to repeat a grade in school, to drop out of school, to have lower educational attainment, and to have higher mortality rates. Compounding this dismal picture are limited opportunities for educational advancement and vocational improvement for rural youth.

Inequalities in income and educational attainment are key co-occurring etiologic factors in the epidemic of poor health outcomes and premature deaths across rural America. A disproportionate number of rural residents and families are living in poverty or on low-income. The direct association between wealth and health has been well documented for over forty years. In 1967, British epidemiologist Michael Marmot began studying the relationship between poverty and health and showed that with each step up or down the socio-economic ladder there was a corresponding increase or decrease in health status (Marmot, 1998). More recently,
Marmot has reported that just the experience of inequality in society, i.e., a person’s personal perception of their place in the social hierarchy, is in fact an important health determinant (Marmot, 2001; Marmot, 2004). Experiencing such negative social forces such as divorce, poverty, low-income, low-educational attainment, discrimination, violence, social isolation, lack of social support networks, unemployment, job stress, substandard housing and other untoward events can actually cause people to become ill. Wealth inequality is becoming a serious public health problem in rural areas, such that economic and political health remedies are being proposed by public health researchers. America has not seen such a gap in income inequality since just before the onset of the Great Depression in the late 1920s.

With respect to opportunities for reducing health disparities, Healthy People 2010 states that “the greatest opportunities for reducing health disparities are in empowering individuals to make informed health care decisions and in promoting community wide safety, education, and access to health care” (Healthy People 2010, 2000).

What are the Rural Health Issues?

The confluence of a multiplicity of negative forces has resulted in a broad spectrum of disparities, inequities and injustices in rural settings. For this article, the term ‘equity’, in regards to health, refers to a concept of fairness in distribution and access such that all individuals have ‘fair and equal’ opportunity to achieve their full health potential through access to the known pre-requisites for good health and disease prevention (Starfield, 2006).

Factors affecting the health, well-being and quality of life of rural residents are complex and multidimensional and cannot be discussed apart from knowledge of the changing dynamics of the US health care system. The US health care system was designed originally as an acute care system with a focus on emergency care and extended hospital stays. Today, the greatest demands on the health care system are for health promotion, disease prevention, early intervention, improved self-care management, and long-term care for those with chronic health conditions.

What is Rural America?

Rural America comprises 75-80% of the nation’s land area and is home to 20-25% of the US population (50-60 million residents). Of the total 3,141 counties in the US, 2,000 counties
(64%) are designated non-metro or rural by the US Census Bureau. With respect to health care facilities, rural areas are home to 3,300 Rural Health Clinics, 2,009 Rural Community Hospitals and a growing number of Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Primary Care Public Housing Health Centers (http://bphc.hrsa.gov accessed 11/4/07).

Between 2000-2005, rural America added 1.1 million residents, representing a 2.2% increase in population, compared to a 6.0% growth rate for urban areas during the same period. Rural areas are experiencing a decline in population of individuals under 20 years of age and a corresponding increase (7.8%) of individuals in the 40-59-year-old age group.

The way people earn their living is shifting from farming to manufacturing. In 2000, only one in five rural counties was classified as farming-dependent – that is to say, 15% or more of its earnings or employment came from farming. Currently the rural economy is more dependent on manufacturing compared to urban areas (Ghelfi & McGranahan, 2004).

Transportation costs are disproportionately higher in rural areas because people are more dependent on personal vehicles and must travel longer distances. In 2001, rural households with vehicles used 40% more gasoline and drove a third more vehicle miles than urban households with vehicles.

**Community Health in Rural America**

Research shows that individual health is closely linked to community health and community health is influenced by collective beliefs, attitudes and behavior. Community health is contingent upon justice and equal access to jobs, health care, adequate housing, and education, as well as collective beliefs, attitudes and behaviors. Public health researchers are now focusing more on community health because they realize that changes at the community level foster and sustain individual behavioral change.

Faith and health are foundationally interdependent and similar in the fact that both are personal (private) and community (public) driven. Health surveillance systems now include community health indicators and social health determinants. The National Expert Panel on Community Health Promotion now recommends community-based participatory research and surveillance, training and capacity building, new approaches for health and wellness, and changes in federal investments (Navarro et al, 2007).
Chronic Health Conditions

Chronic conditions are currently the most prevalent, costly and preventable of all health problems accounting for 75% of the nation’s $2 trillion plus health care expenditures. The transition of focus of care from acute care to chronic care, parallels the transition of the leading causes of death from infectious diseases to chronic illnesses (Navarro et al, 2007). Virtually all of the growth in Medicare spending since 1987 can be traced to an increase in patients being treated for five or more chronic health conditions. The growing prevalence of chronic health conditions necessitates implementation of a continuous care model that empowers patients to engage in improved self-care management, prevention and early interventions.

Family Caregiving

According to the National Family Caregivers Association, more than 50 million Americans care for loved ones with a chronic illness or disability or the frailties of old age. A recent article in The Washington Post (August 25, 2007) reported that a growing number of children and teenagers are taking on the responsibility of caring for family members with debilitating illnesses. According to a 2005 survey by the United Hospital Fund and the National Alliance for Caregiving as many as 1.4 million young people ages eight to 18 in the U.S. care for a chronically ill or disabled relative. Within this population, mood swings and antisocial behavior are more common among these teenage caregivers than their peers. They also have increased rates of missing school and/or after-school activities. There are few public services to aid young caregivers, who often do not receive recognition for their adult-level responsibilities.

Differential in Access to Information

Since the development of the Internet, rural areas have lagged far behind urban areas in both Internet access and use; however, the gap is closing. For instance, in 2003 only 9% of rural Americans had broadband at home compared to 22% for suburban and urban Americans. By the end of 2005, overall Internet use for adult rural Americans was 62% compared to 70% for non-rural residents. In addition, by the end of 2005, 24% of rural Americans had high-speed Internet connections at home compared to 39% of adult Americans living in non-rural areas (Rural Broadband Internet Use, 2006). A recent study found that some disparities are narrowing as the elderly and poor in need of access to public health insurance are searching for it online (Shields,
The authors reported that people without Internet access and experience (perhaps the oldest and poorest) remain disadvantaged with respect to accessing critical information that can link them to needed health care services.

Internet access is a significant health education factor. Recent polls show that Americans use the Internet as a primary source for medical and health information. Eighty-four percent of on-line adults are learning about medical conditions, symptoms and treatments and then making appointments with their family health care provider to discuss possible treatments. Of more than 3,300 US adults polled regarding their primary source of health information, 40% reported using friends and family, 30% used newspapers and magazines, 26% relied on television, 70% used the Internet and 72% asked their local physician (Health Literacy, 2004).

Opportunities for the Rural Church

In these times of widening disparities, there is a compelling need to enlist the faith community in partnership with health-related and community-based organizations to help make our rural communities healthier (Young, 2003). The faith community has the moral authority and moral imperative to promote healthy behaviors and healthy relationships – an activity that government cannot legislate nor public or private agencies/organizations easily accomplish. As people of faith we are directed to make the most of every opportunity. Creating healthier rural communities offers a unique opportunity for the church to collaborate, partner, network and enhance the sense of community through shared visioning and leveraging resources. The church is a key stakeholder in the health and well-being of rural communities and has a pivotal intentional role to play in fully integrating faith and health at the community level.

Rural churches need to become fully engaged in the health-enhancing movement of their communities. Productive collaboration between rural churches and other organizations interested in creating healthier rural communities will result in improved access to health care, depletion of barriers to care, reduced disparities and inequities, improved continuum-of-care and increased home care support services.

Increase Health Literacy

It has been reported that individual behaviors and environmental factors are responsible for approximately 70% of all premature deaths in the U.S. (Healthy People 2010, 2000). More
recently, studies have revealed that health literacy, low socio-economic status, low educational attainment, negative social factors, lack of social support networks and the experience of inequality are significant social health determinants predicting poor health outcomes and premature deaths (Ragan, 2007). In rural areas, the impact of these social health determinants is magnified because of the disproportionate numbers of poor, unemployed, minority, elderly, disabled and special needs populations.

Of all the social health determinants impacting health outcomes and premature death, ‘health literacy’ is becoming a top predictor (Health Literacy, 2004). An estimated 90 million American adults read at a level no higher than the fifth grade. Unfortunately, much of the health literature is written for reading at a higher grade level. According to an Institute of Medicine report on health literacy, roughly 50% of US adults lack the literacy skills to manage their own personal health care. Low health literacy can lead to problems following health provider instructions, prescription medications, understanding health insurance forms, advanced directives and informed consent instructions. A recent study of 3,260 Medicare managed-care enrollees found that participants with inadequate health literacy had higher risk-adjusted rates of cardiovascular deaths among community-dwelling elderly persons (Baker et al, 2007).

The Use of the Internet by Faith Communities

Members of most faith traditions use of the Internet at a similar frequency as the general population; with some surveys reporting use by clergy as high as 80-90%. Other research reveals that the strongest correlation to church growth is establishing a website that is then visited by an online community. The possibilities for use of online services for faith communities are endless. Churches are finding out that listservs for prayer requests, notification of meetings, newsletters, announcements, committee reports, bulletins, etc are very cost effective.

Improved Internet connectivity, ready access and use in rural areas would help to create healthier rural communities by making distances transparent, countering social isolation, engaging rural residents in teleconferences, web conferences and tele-health services. In addition, computer-based Internet access would provide opportunities for: (a) development of electronic home-based businesses; (b) online education programs, degrees, scholarships and job opportunities; (c) improved health literacy, health decision-making and self-care management of
personal health issues; (d) establishing tele-home health monitoring systems; (e) establishing computer-based social support chat rooms and information systems for homebound chronically ill; and, (f) online social networking and e-ministry for the church (Shields, 2007).

Partner in Writing Grants that Assist the Community

In this day and age of increasing charitable giving and grant making, few small town rural churches have the capacity to write grant applications and manage the programmatic and fiscal responsibilities. In the US, there are 71,000 foundations granting over $40 billion and 26 federal grant making agencies awarding over $500 billion in grant funds through some 900 programs.

A study in 2005 of ten rural states revealed that foundation grant-making amounted to $35 per resident compared to the national average of $104 per resident. The study compared the top ten and bottom ten states relative to numbers of foundations and foundation assets. The ten bottom rural states averaged $0.6 billion in foundation assets compared to $35 billion in the top ten states with the most foundations. This disparity in rural giving has attracted the attention and ire of Senator Max Baucus (D-MT), Chair of the Senate Finance Committee, who has challenged grant making foundations to double their grants to rural areas within five years (Perry, 2006). More recently, Senator Baucus hosted a Rural Philanthropy Conference in his home state of Montana attracting approximately 180 foundation leaders to discuss solutions to help resolve the situation of gross under-funding of programs for rural residents (Perry, 2007).

The Role of the Rural Health Ministry Initiative of HMA

We cannot aspire to have healthy rural communities without healthy individuals, healthy families and healthy organizations. We cannot continue to deny the broad range of unmet needs nor the disproportionate numbers of needy people in rural America – the homeless, poor, marginalized, disenfranchised, abused, addicted, abandoned, incarcerated, elderly, diseased, disabled, sick and dying.

We cannot deny the sacredness of God’s plan for each and every individual. We cannot deny that the rural church is a sleeping giant, a storehouse filled with untapped social and spiritual capital. The church, through education, advocacy and direct services, is called to partner with other community-based organizations, agencies and interest groups to promote healthy
lifestyles, reduce and eliminate disparities, and reduce the impact of illness, disease and disability. The rural church needs to be recognized, better utilized and included as an active member of healthy community initiatives in an effort to improve the health and well being of rural residents.

The Rural Health Ministry Initiative of the HMA will help rural health ministries not only survive but possibly thrive. Through development and implementation of the Rural Health Ministry CoP, the HMA will be challenged to be a missional organization. That is to say, an organization that aligns its programs, functions and activities around the mission of God in the world. [The word ‘missional’ in use for about 100 years, is an adjective used to describe the way in which an organization does all of its activities. A missional organization is one that focuses on discerning how it is called and sent in alignment with God’s mission in the world.] The HMA, a membership organization of people working in arenas that combine ministry and health, is in a pivotal position to share member resources that equip, empower and enable rural churches to create healthier, safer, thriving, vibrant rural communities.

Faith communities are the instrument of hope, healing and wholeness for struggling rural communities. In this time of rural crisis, faith communities need to become fully engaged in partnership with local community organizations, interest groups and residents in addressing the broad range of unmet health and social needs.

Health equity for rural residents is not just a medical issue, but a social, economic, ethical and moral imperative. Rural residents should be afforded access to the necessary tools of technology and the supportive interventions to make informed choices and decisions that enhance self-care, to live as independently as possible, to be a contributing member of a family and a community, and to pursue a meaningful vocation of their choice.

In conclusion, HMA provides a most appropriate birthing and incubating chamber for the RHMI because it is an organization of people of faith dedicated to fulfilling the good works that God has prepared in advance for them to do (Ephesians 2:10). The RHMI Task Force of HMA envisions a future of enhanced engagement of small rural churches in creating healthier rural communities, one church at a time.

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Office of Rural Health Policy. HRSA. http://ruralhealth.hrsa.gov/


