# "We Hide Under the Scriptures"

## Conceptualization of Health Among United Methodist Church Clergy in Kenya

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## Abstract

As community leaders, clergy are well-positioned to impact the health of their congregants. Clergy's conceptualizations of health influence their own self-care and how they minister to others. Interviews and focus group discussions on health conceptualizations and health-seeking behaviors were conducted with 49 United Methodist Church clergy in Western Kenya. Data were analyzed using interpretative phenomenological methods. Participants defined health holistically using an environmental health model. Some participants reported not seeking health care so their congregants would believe that their faith kept them healthy. Participants who believed that health comes directly from God reported seeking health care less often. Participants also reported combining traditional indigenous medicine with Western medicine. This study has implications for health promotion among Kenyan clergy and offers the first study of health conceptualization among clergy in Africa.

*Keywords: clergy, Kenya, health beliefs, health-seeking behaviors, religion*

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# Autographical Note

Nicole Georggi Walther, MS, is a Counselor in the Department of Community and Family Medicine at Duke University Medical Center. Nikki focuses on nutrition and physical activity research and works closely with the Duke Global Health Institute on a micro-gardening study in Western Kenya that she coordinates. As a counselor, Nikki is interested in health education and behavior change for individuals, specifically addressing the effect of social and environmental factors.

Rae Jean Proeschold-Bell, PhD, is an Assistant Research Professor in the Duke Global Health Institute. She works closely with Duke Divinity School and is co-principal investigator of the Duke Clergy Health Initiative, which seeks to understand and improve the health of United Methodist Church clergy. As a community psychologist, Rae Jean is interested in how systems impact individuals, especially in regards to people's holistic health. She has designed and tested seven integrated health interventions for a variety of populations, including clergy, people with HIV, people with substance use, and people with hepatitis C.

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Sherine Adhiambo Adipo has a bachelor's of science degree in nursing. She is currently a master's student at Moi University School of Public Health. She is in the tract of epidemiology and disease control with her thesis focusing on barriers affecting the health of United Methodist clergy. She currently works in hospital set up and conducting field research.

Eunice Karanja Kamaara PhD, is a Professor of Religious Studies at Moi University and International Affiliate of Indiana University Purdue University, Indianapolis (IUPUI). She holds a doctorate in African Christian Ethics. Her research interest is inter-disciplinary: theological, ethical, medical-anthropological and gender approaches to contemporary challenges. She has authored and co-authored 8 books and over 60 book chapters and refereed articles. She has consulted for the World Bank, the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID), among others. She serves in the Board of Directors of Church World Service, among others.

# Introduction

The role of the Christian church is multifaceted, providing guidance for its parishioners, 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, and consequently place high expectations 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. Due to their unique role in society, clergy are an important population to study.

**Physical health of clergy**

A small but growing body of literature on the physical health of clergy in the United States (US) suggests cause for alarm. Clergy obesity rates were first found to be high among Evangelical Lutheran Church in America pastors across the US (Halaas, 2002). Later studies found that the obesity rate among United Methodist Church clergy in North Carolina was almost 40%, 10 percentage points higher than that of their non-clergy counterparts, and accompanied by higher rates of clergy ever having been diagnosed with diabetes, arthritis, hypertension, angina, and asthma compared to non-clergy (Proeschold-Bell & LeGrand, 2010). National US studies conducted in 2012 and 2013 of United Methodist Church clergy found obesity rates of 40% and 41% in both years, and high rates of hypertension, pre-diabetes, high cholesterol, and asthma (GBOPHB, 2013). The results of these studies indicate that research on the physical health of clergy populations is warranted.

There are at least two reasons to value good physical health for clergy. The first reason is a desire for all individuals, including clergy, to be healthy. The second reason is that as leaders, clergy affect the lives of their congregants and many other community members, and healthier clergy may be likely to be more effective leaders. These two reasons hold true regardless of what part of the world the clergy serve in, although to date, published studies of clergy health have been limited to the US.

The reasons why US clergy experience poorer physical health outcomes than non-clergy is not known. One qualitative study found that clergy reported placing the needs of others before their own in an effort to live out their calling to serve God (Proeschold-Bell et al., 2009). Simultaneously, the study found that congregants underestimate the full range of clergy responsibilities, and had high expectations of clergy to meet the diverse needs of congregants. In addition, clergy reported that they believed that excessive work would be rewarded by congregants and denominational leaders alike. Other US studies focused on clergy health report similar barriers to clergy caring for their mental well-being (Cameron & Iverson-Gilbert, 2003; Carroll, 2006; Doolittle, 2010; Evers & Tomic, 2003; Schaefer & Jacobsen, 2009).

**Conceptualizations of health**

The conceptualization that clergy have of health may play an important role in whether and how they take care of their own health, and what messages they send to their congregants. United Methodist Church clergy have been found to define health holistically, as including the mind, body, and spirit (Proeschold-Bell et al., 2009). The authors of a clergy health intervention study reported that they hypothesized that clergy interpret their call to ministry to be all-encompassing, and as such in their busyness, find it acceptable or even desirable to sacrifice their own health in service to God (Proeschold-Bell et al., 2013). Thus, in order to create health promotion interventions targeting clergy who appear to be at risk for negative health outcomes, it is necessary to understand their conceptualization of health.

There are many ways to define health. Larson (1999) reviewed conceptual models of health, starting with the medical model, which defines health as the absence of disease or disability. A second model of health is that of the World Health Organization: health is "a complete state of physical, mental, and social well-being and not merely the absence of disease or infirmity." A third model is the wellness model, which is one of "health promotion and progress toward higher functioning, energy, comfort, and integration of mind, body, and spirit (Armentrout)." A fourth model is the environmental model of health, defined as "adaptation to physical and social surroundings—a balance free from undue pain, discomfort, or disability." According to this model, health is related to stressors and interactions with the environment, and "exists when an organism works with its environment successfully and is able to grow, function, and thrive" (Larson, 1999). Of course, conceptualizations of health may differ by culture. In a qualitative study on the meaning of health and healing in Nyanza Province, Kenya, researchers found that respondents from both traditional health and biomedical health ideologies identified health as "a multi-dimensional state of well-being (physical, social, spiritual, psychological) associated with happiness, hygiene, and good diet" (Kamaara, 2014). Differences in these models of health have important implications for the design of health interventions, such that it is critical to understand a population's conceptualization of health.

**United Methodist Church in Kenya**

Clergy health is understudied in the non-Western world. In Africa, as in the US, religion is known to play an important role in the daily life of its inhabitants. However, there is no documentation about the health of clergy in Africa, not even about how clergy conceptualize health and how their religious and cultural beliefs relate to health. We chose Kenya because of the considerable number of United Methodist Church clergy in Kenya.

Although created in 1958 by Bishop Reuben H. Muller, the United Methodist Church (UMC) 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*, 2008). In 1993, registered under "The Societies Rules, 1968," the UMC 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. Each district is led by either a District Superintendent or Assistant District Superintendent, with over 100 male and female pastors serving as full-time and part-time church ministers (Kephas, 2010). Through informational interviews, it was determined that the majority of 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 UMC pastors in Kenya receive a formal salary. Instead, they rely solely on the tithes and offerings of their congregations. These congregations vary in size and income, consequently affecting a pastor's monthly salary. Some pastors make as little as 300 Kenya Shillings per month (approximately 3.50 USD), depending on the size of their congregation (Shanks, 2012). Many faiths and denominations exist in Kenya, including Africa Inland, Roman Catholic, Pentecostal, Seventh Day Adventist, and Methodist. Some of these faiths and denominations have been established longer than the UMC in Kenya and could have an already time-honored congregation, making 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.

In this study, we sought to understand the conceptualization of health of UMC clergy in Western Kenya. Because, to our knowledge, no studies on clergy conceptualization of health in Africa exist, we utilized qualitative methods without a priori hypothesis. Determining the conceptualization of health of UMC Kenyan clergy is the first step to understanding health messages that clergy send their congregants and how Kenyan clergy may be encouraged to care for their own health.

# Methods

**Data collection**

This study is part of a larger study of United Methodist Church (UMC) clergy, and for that reason, we sought to recruit UMC clergy specifically. A UMC clergy person in the Nyanza Province of Kenya served as study coordinator. He used public access rolls to identify eligible UMC clergy members. To be eligible, clergy had to be age 18 or older, possess working knowledge of English, have an active clergy appointment to the UMC in one of the four UMC provinces located within the Nyanza Province of Western Kenya, and be available during the study period. The study coordinator invited eligible clergy to a meet-and-greet event with the research team. At this event, the study was explained and clergy were encouraged to ask questions. Those who chose to participate could do so that same day. We compensated participants 400 Kenyan Shillings for travel (approximately 5 USD) and served refreshments.

We conducted a mix of individual interviews and focus groups discussions. For the interviews, we invited assistant district superintendents, female pastors, pastors of large congregation churches, and pastors of small congregation churches, in order to ensure diverse respondents and allow clergy of these particular groups to speak without fearing the reactions of focus group members. Everyone who was approached for an interview consented to participate. All others were invited to participate in focus group discussions, which also received a 100% acceptance rate. All focus group discussions were conducted with clergy from the same district or regional areas.

The interview and focus group guides were adapted from an ongoing study of US clergy (author citation, 2011), and additional questions were added. The open-ended focus group questions targeted definitions of health ("What is your understanding of health?"), access to healthcare ("How do pastors attend to their health? When do you seek healthcare? When do you not seek healthcare?"), religious and cultural beliefs surrounding health ("What religious beliefs and practices affect your health? What cultural practices affect your health?"), and barriers and facilitators to receiving care ("What aspects of health are hardest for pastors to attend to? What health programs are available to the clergy? What makes it easier for you to seek healthcare? What gets in the way of you seeking healthcare?"). The interview questions additionally included the questions: "What affects your health? How does being a pastor of a congregation influence your health-seeking behavior?"

Focus groups discussions lasted approximately 90 minutes and interviews lasted 60 minutes. Each was audio-recorded and occurred using a combination of English and Kiswahili. The recordings were transcribed and any Kiswahili words were translated by a transcriptionist from Moi University and verified by a bilingual member of the research team. All names were removed from the transcriptions.

**Data analysis**

We used an interpretative phenomenological approach to analyze the data. Interpretative phenomenological analysis is traditionally used in psychology to explore how study participants make sense of the physical and social world around them (Drummond, Hendry, McLafferty, & Pringle, 2011). All data transcripts were coded using QSR International's NVivo 10 qualitative data analysis software (QSR International, 2012). Codes were data-driven. Two members of the research team engaged in line-by-line coding of the first focus group discussion and first interview transcripts in order to generate data-driven codes (Charmaz, 2012). Additional codes were added during the iterative data analysis process. To promote consistent coding across transcripts, two authors

double-coded the first focus group discussion and the first interview, reconciled differences in the coding, and clarified definitions in the codebook.

In addition to coding, we engaged in memo-writing, which is taking preliminary analytic notes about codes and comparisons and using writing to articulate testable hypotheses while mid-stream in the process of data analysis (Charmaz, 2012). Upon memo-writing and coding completion, we examined the coded data for similarities and constructed themes, which were complete sentences conveying patterns in the data (Miles & Huberman, 1984). Themes were double-checked by searching the data for supporting quotes. We also grouped similar themes into larger domains.

This study was approved by the Duke University Institutional Review Board and the Moi University/Moi Teaching and Referral Hospital Institutional Review and Ethics Committee. Written informed consent was obtained from all study participants.

# Results

**Participants**

Forty-nine pastors travelled from the four UMC provinces to attend the meet-and-greet event. Forty clergy participated in a total of four focus group discussions, with seven to eleven participants per group. Individual interviews were conducted with two assistant district superintendents, one female pastor, two pastors of large congregation churches, and four pastors of small congregation churches.

**Findings**

Five domains were identified in the data based on their pervasiveness: Defining Health, Believing God Saves, Seeing Illness as Weakness, Intersecting Cultural Beliefs and Health, and Seeking Medical Attention. Table 1 depicts the codes with the number of times each code was referenced; the most references were made to Seeking Medical Attention and Believing God Saves. In addition, the table depicts the themes with corresponding domains.

Table 1. Domains and themes as related to codes, with their frequencies noted

| Domains and Themes | Codes |
|---|---|
| **Defining Health**<br>• Health may be dependent on one's physical environment.<br>• Good nutrition is essential for good health.<br>• Health is holistic. | Conceptualization of health (54)<br>Mental health (20)<br>Physical health (38)<br>Holistic—Mind, body, spirit (33)<br>Spiritual health (30) |
| **Believing God Saves**<br>• God heals every ailment.<br>• Trusting God is related to lacking other resources. | Believing God saves (91)<br>Religious traditions or beliefs (41)<br>Differing levels of faith (41)<br>Financial strain (83)<br>Identifying as victims of poverty (43) |
| **Seeing Illness as Weakness**<br>• Pastors keep illness to themselves.<br>• Fear is related to health-seeking behavior<br>• Sickness affects the pastor and congregation. | Seeing illness as weakness (43)<br>Barriers to health (95)<br>Congregations (57)<br>Support (30)<br>Stress (40) |
| **Intersecting Cultural Beliefs and Health**<br>• Some clergy utilize indigenous medicine.<br>• Traditional male role is still held.<br>• Clergy calling is viewed poorly by the community. | Cultural traditions and beliefs (84)<br>Environmental conditions (83)<br>Health problems (70)<br>Food and nutrition (27) |
| **Seeking Medical Attention**<br>• God alone saves.<br>• God does save, but seeking medical attention is permissible. | Seeking medical attention (143)<br>Self-care (16)<br>Program-positive (11)<br>Programs-negative (37) |

**Defining Health**

The first domain is Defining Health, which includes the theme, *health is holistic*. The participants in each focus group discussion and interview defined health as more than just physical health. Participants indicated:

> Health touches on all those diverse aspects of human lifestyle, the physical life, spiritual life, social life, etc.
>
> 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 *health may be 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.
>
> 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.

A third theme in this domain is *good nutrition is essential for good health*.

> 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(s) 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.
>
> So food, enough food and different kinds of food, is needed for a person to become healthy [and] to maintain health.

**Believing God Saves**

The pastors reported varying religious beliefs that influenced their conceptualization of health and health-seeking behavior, including 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 topping up my fate by reading and studying the word of God and me always find myself getting healed. Recovered all these years and that faith has kept me to today.
>
> There come decisions which they always believe that … even if somebody is almost dying, 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 is related to lacking other resources*. Participants stated that trusting God for healing may be the result of poverty and 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 Kenya 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."

**Seeing Illness as Weakness**

The third domain is Seeing Illness as Weakness, which is also at the intersection of religion and health. Participants stated that they worried the congregation would lose their faith if they found out the pastor was sick, and so *pastors keep illness to themselves*.

> 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 the flock will lose their faith in what we 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, [and] I will not get sick. And yet that pastor is very sick. Most of the pastors have got ulcers, but they don't want to disclose it. Just study the way [they] are eating and 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 and they don't want to let the flock to know.

A second theme under this domain is that *fear is related to health-seeking behavior for clergy*. Some pastors stated they are afraid to seek care because it may seem as though they are without faith or are immoral.

> 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 drink 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 I am pastor so-and-so and am [HIV] positive, how will I go and preach to the people while [I] am suffering?

The final theme for this domain is, *sickness affects the pastor and the congregation*. 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.

**Intersecting Cultural Beliefs and Health**

The fourth domain is Intersecting Cultural Beliefs and Health, which includes the theme, *some pastors use indigenous 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 … [do] 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, [and] 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, [but] 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.

Another theme that emerged in this domain is *the traditional male role is held*. 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…, so the African tradition--the mentality of a man is … don't seek for advice.

A final theme within the domain Intersecting Cultural Beliefs and Health is *the clergy calling is viewed poorly by the community*. Specifically, 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 … is perceived by the public, is very wearied in one way. They believe that if you come one 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 somebody who is an outcast, somebody who is challenged mentally, somebody who is a failure, a loser in life.
>
> 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.

**Seeking Medical Attention**

Clergy perceptions regarding seeking medical attention fell into two themes: first, those who believe that *God alone heals* and believe that going to the doctor is unnecessary and second, those who believe that *God heals but seeking medical attention is permissible*, because physicians and others are conduits of God's healing. Participants who indicated that God is enough for physical healing made statements such as:

> 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. … 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 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 in God's hands.

Participants who indicated that physicians are a conduit of God's healing made statements such as:

> 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 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.

# Discussion

This study sought to understand the conceptualization of health among UMC clergy in Western Kenya and how that conceptualization relates to their health-seeking behaviors. The results can be conceptualized within the domains of defining health, believing God saves, seeing illness as weakness, intersecting cultural beliefs and health, and seeking medical attention.

The clergy defined health holistically, not merely an absence of disease or physical illness, but rather including physical health and spiritual and emotional well-being. Traditionally, Africans do not compartmentalize 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). In the previously mentioned study conceptualizing health among key caregivers in Kenya, a healthy person was defined as someone happy, clean, right with God, and morally upright. In contrast, a sick person was not right with God, was lonely, isolated, and tired, and also experienced physical symptoms (Kamaara, 2014). Thus, God is central to health, as are one's relationships with others. 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 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). A study carried out in Western Kenya on use of complementary and alternative medicine observes: "… health is a multi-dimensional state of wellbeing (physical, social, spiritual, psychological) associated with happiness, hygiene, and good diet… Good health is also associated with physical aspects of the individuals as well as with religiousness, and positive relationships with supernatural beings were said to positively contribute to good health" Kamaara et al, (2012). In a study of UMC clergy in North Carolina, clergy defined health in a similar way to clergy in Kenya by using phrases such as "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.

The Kenyan clergy in this study conceptualized health as relating to 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 discussed the importance of nutrition, sanitation, and surroundings in regard to health outcomes. Scholars have also posited environmental models of health, in which health occurs when people can successfully interact with their environment to grow and prosper (Larson, 1999). This model is consistent with what the clergy said about their health: that it is related and somewhat dependent on the environment in which they live. Over the last two decades, Western Kenya has been altered significantly by HIV disease, malaria, tuberculosis, post-election violence, drought and revolution (Odhiambo et al., 2012) Understanding that these clergy are facing incredible, ever-changing circumstances reinforces the idea that their health embodies the interactions with the world around them.

The clergy participants indicated that they utilize both indigenous and Western medicine. In practice, traditional African cultural beliefs are mixed with Christian ideology in Kenya (Kamaara, 2009). Traditionally, religious experts practiced magic, and some religious rituals contained magical elements (Ocholla-Ayayo, 1976).

The majority of this study's participants were part of the Luo and Kisii tribes of Kenya who believe that spirits of nature live in every being. Additionally, both Luo and Kisii hold magic in high regard. They believe that the magician has vibrant power, is able to set these spirits in motion, and often holds the power to cure and cast out things such as S*ihoho* (evil eye). The clergy commented that although they are saved by Jesus, they are still Luo and their culture cannot be taken out of them. In some cases, they trusted local doctors and witches in matters related to evil spirits instead of trusting a medical doctor, consistent with Kamaara's claim that African traditional beliefs are integrated into many Christian denominations (Kamaara, 2009).

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, Pecchioni, & Grant, 2000). The clergy participants believed 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% of 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 UMC is not included under the Conservative Protestant denominations in Ellison and Musick's study, the more conservative UMC clergy in Western Kenya may share similar conservative ideologies.

Participants reported that this firm belief in God alone for healing is associated with poverty and a lack of resources. Participants stated that poverty was a blessing in disguise because it helps build a person's faith. Inadequate finances can act as a deterrent in seeking medical attention, thereby encouraging people to rely on God for all provision, including medical care. Another reason clergy reported relying 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 indicated that although they believe God alone heals, there is necessity in seeking medical care. This mentality, while slightly different, is held by many Christians throughout the world. In a study on African-Americans and Whites living in rural Oklahoma, McAuley and colleagues (2000) found that respondents viewed God as healer and miracle worker in relation to disease and finances. African-American participants, especially, believed that prayer was a conduit for receiving God's healing. These respondents went on to say that oftentimes God works with physicians to provide healing, and God's healing powers are superior to that of physicians (McAuley et al., 2000). In that study, 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, consistent with the results of this study—that the Kenyan is a holistic person who does not compartmentalize faith and health.

Participants spontaneously spoke to the stigma attached with being clergy in Western Kenya, and used strong words such as "outcast" and "loser." This view may be based on the traditional mentality that men should be providers, and because the clergy profession is not a lucrative one, it seems a poor choice. This societal opinion of clergy is quite different than that in the US, where a 2013 survey found that Americans rank clergy sixth in

contributing “a lot” to society’s well-being, such that clergy were ranked below the military, teachers, and doctors, but above journalists, business executives, and lawyers (Pew Research Center, 2013). The derogatory opinion of their vocation that United Methodist clergy in Kenya experience may decrease their social support and negatively impact their emotional well-being.

The strengths of this study include the collection of data from an under-studied population and in-depth analysis of those data by both Kenyan and US researchers. The limitations of this study include data collection from just one Christian denomination, such that the generalizability of these findings outside of the UMC in Western Kenya is unknown. It is important to note that people of other faiths and denominations may have different perceptions of health. In addition, people of other geographic locations may hold different attitudes toward the clergy profession, for example, by highly respecting rather than disparaging clergy. This paper does not serve as a theological discourse on clergy or health in Kenya, but rather allows the reader to understand how UMC clergy in Western Kenya view their own health and well-being. While the findings of this study are limited to this single denomination and location, they prompt additional research questions. What kinds of clergy believe that health comes directly from God as opposed to through medical care, and how does this affect their health? Is it common for clergy in other faiths and denominations fear seeking medical care due to public perception? Are there clergy in Africa of certain denominations and faiths who have greater financial resources, and if so, and what are the institutional supports for them? Do greater financial resources relate to seeking medical care, as opposed to leaving health in God’s hands, as was suggested by some participants in the current study? In addition to this study’s limited generalizability, it should also be noted that we did not measure any health indicators of the clergy, so we were unable to interpret the findings with the context of the participants’ health status. Finally, it is possible that some participants did not feel able to talk openly in focus groups composed of their peers, although for this reason we used a combination of interview and focus group data collection.

In sum, this study found that clergy define health holistically, emphasizing the mind, body, spirit, and environment, and that indigenous cultural tradition is very much alive in Kenya and relates to whether or not clergy will seek Western medical care. The study also found that believing that God heals is common among clergy and can affect whether or not they choose to seek medical care. By shedding light on the current health conceptualization of pastors in Western Kenya, this exploratory study may serve as a stepping stone for future research on clergy. Researchers may consider conducting future qualitative studies with clergy of other Christian denominations and religious faiths in Kenya and throughout Africa to determine whether differences based on theology or regional location exist. They may consider collecting data from clergy spouses and congregants in order to provide more robust data on the clergy reports. In addition, researchers may consider collecting data on health indicators on nutrition and infectious disease status to shed light on clergy responses. Finally, additional research is needed to inform whether and what kinds of health interventions may be needed for clergy. This study’s finding that clergy are reluctant to seek health care for fear of appearing unfaithful to their congregants suggests reason for concern for the health of UMC clergy in Western Kenya. This study fills an important gap in the literature; the UMC is growing in Kenya, meaning that there will be more clergy in Kenya serving more congregants. The understanding of the health conceptualization can aid in the design of future health interventions targeting UMC clergy in Western Kenya.

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