

# Perceptions and Practices of the Adventist Health Message among SDA Members in Jakarta

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**Abstract** - Despite well-documented health benefits, adherence to the Seventh-day Adventist (SDA) health message—principles of plant-based nutrition, physical activity, temperance, rest, and trust in God—remains inconsistent, especially in urban settings where time constraints, psychosocial stressors, and social pressures widen the gap between belief and practice. Addressing the paucity of research on urban Southeast Asian Adventists, this cross-sectional study, grounded in the Knowledge–Attitude–Practice (KAP) framework, surveyed 393 SDA members in Jakarta using a structured questionnaire to assess attitudes, self-reported health behaviors, and perceived barriers. The results showed that while support for these beliefs was strong, participants only moderately adhered to the recommended health behaviors. Further analysis indicated that a positive attitude correlated with some healthier habits ( $\beta = 0.27, p < 0.001$ ), but challenges such as insufficient time, urban stress, and difficulty obtaining healthy food had a substantially larger negative impact on behavior ( $\beta = -0.41, p < 0.001$ ). Age and gender effects were modest, with older adults and women exhibiting slightly higher compliance. These findings suggest that strong spiritual beliefs alone are insufficient to maintain a healthy lifestyle, highlighting the importance of tailored, faith-based programs that leverage church resources, urban-focused strategies, and leadership support to connect attitudes with actions and improve public health in city-based SDA communities.

**Keywords:** Adventist health message; Knowledge–Attitude–Practice (KAP); health behavior adherence; Jakarta; urban congregations; cross-sectional design.

## I. INTRODUCTION

The Seventh-day Adventist (SDA) Church integrates spiritual and physical health, teaching that holistic well-being is a sacred duty (Adventist.org, 2025; Rodriguez, 2025). Rooted in Scripture (e.g., 1 Corinthians 6:19, NIV) and the health visions of Ellen G. White (White, 1905/2025), the SDA health message promotes preventive lifestyle practices—plant-based nutrition, regular exercise, adequate rest (including Sabbath observance), temperance, and trust in God. These principles have been linked to improved longevity and reduced chronic disease risk (Fraser & Shavlik, 2001; Orlich et al., 2023; Qian et

al., 2019). Practices such as Sabbath rest and daily spiritual devotion support mental and emotional resilience (Ministry Magazine, 2017; Harvard T.H. Chan School of Public Health, 2024), while temperance (abstinence from harmful substances) reduces illness and mortality (White, 1890; Fraser, 2003; Nix & Landless, 2025).

Despite widespread affirmation of the health message, actual adherence among Adventists is often inconsistent. Globally, only about 19% of SDA members report vegetarian diets even though over 80% endorse the church's health principles (Andrews University, 2021). In Southeast Asia, adherence varies due to cultural, environmental, and economic barriers (Segovia-Siapco et al., 2020; Marmot et al., 2008). Jakarta's urban setting adds further challenges such as time scarcity, prevalence of fast food, sedentary work life, and financial pressures (Rothman, 2018; Shavlik & Fraser, 2001). While local churches offer various health programs, research on urban Southeast Asian Adventist populations remains limited.

This study aims to fill that gap by examining how SDA church members in Jakarta perceive and practice the denominational health message, using three conceptual lenses—the Health Belief Model (Champion & Skinner, 2008), the NEWSTART health framework (General Conference of SDA, 2024), and the Knowledge–Attitude–Practice model (Adventist Health Study, 2024). Specifically, it addresses: (1) the prevailing attitudes and perceptions of Jakarta SDA members toward the Adventist health message; (2) the extent to which members engage in the recommended health-promoting behaviors (plant-based diet, regular exercise, abstinence from harmful substances, and adequate rest); (3) the relationship between members' perceptions of the health message and their actual health-related lifestyle practices; (4) the perceived barriers that hinder members from following the health message in daily life; and (5) whether demographic factors (such as age, gender, education, and length of church membership) influence adherence to the health message's recommended lifestyle behaviors.

## II. LITERATURE REVIEW

Health is a central theological and practical pillar of the SDA Church, grounded in the belief that the body is the "temple of the Holy Spirit" (1 Corinthians 6:19) and codified in the Church's fundamental beliefs on Christian behavior (Adventist.org, 2025). This conviction was greatly shaped by Ellen G. White's 19th-century health reform teachings, which emphasized proper diet, regular rest, exercise, temperance, and reliance on divine power (White, 1905/2025). These principles have been institutionalized across SDA hospitals, schools, and community programs (Rodriguez, 2025), framing healthy living as an act of spiritual stewardship (Genesis 1:29; White Estate, 2025). One distinctive emphasis is on a plant-based diet—supported by both scripture and science—associated with lower risks of cardiovascular disease, diabetes, and certain cancers (Fraser & Shavlik, 2001; Orlich et al., 2023; Qian et al., 2019; Kwok et al., 2014). Similarly, Sabbath observance and physical exercise are promoted as spiritual practices that yield emotional renewal and long-term health benefits (Ministry Magazine, 2017; Harvard T.H. Chan School of Public Health, 2024; General Conference of SDA, 2024). Together, these behaviors contribute to the well-known longevity advantage of Adventists, as observed in "Blue Zone" population studies (Fraser, 2003).

Temperance and trust in God complete the SDA health paradigm. A long tradition of abstaining from tobacco, alcohol, and other harmful substances has contributed to lower rates of chronic disease in Adventist populations (White, 1890; Fraser, 2003; Nix & Landless, 2025). Likewise, prayer and worship are believed to foster psychological resilience and overall well-being (Koenig et al., 2012; Hope for Africa, 2024; SDA Diet and Lifestyle Study, 2025). Despite strong institutional support for these ideals, global data continue to reveal a gap between belief and practice: while over 80% of members affirm the church's health teachings, far fewer consistently follow all the recommended lifestyle guidelines (Andrews University, 2021). In Southeast Asia, adherence is similarly uneven (Segovia-Siapco et al., 2020). Urban environments like Jakarta present additional practical barriers—time constraints, sedentary jobs, ubiquitous fast food, and socioeconomic inequalities all hinder healthy living (Marmot et al., 2008; Rothman, 2018; Shavlik & Fraser, 2001). Many SDA churches have responded with wellness programs and lifestyle initiatives, but existing research has often focused on Western or rural Adventist communities. This study addresses that gap by specifically examining an urban Adventist context (Jakarta), applying the Health Belief Model, the NEWSTART approach, and the KAP framework to understand how church members perceive and apply the health message in their daily lives.

### III. MATERIALS AND METHODS

This research employed a cross-sectional, quantitative survey design to explore the relationship between SDA health message perceptions and adherence to health-promoting behaviors among church members in the Jakarta Conference. A cross-sectional approach provided a snapshot of participants' knowledge, attitudes, and behaviors, aligning with the study's goal to investigate associations rather than causality (Creswell & Creswell, 2018). Guided by the KAP framework, the study assessed how awareness and attitudes regarding SDA health principles relate to self-reported behaviors in four domains: diet, physical activity, substance use, and sleep quality.

Data were collected using a self-administered online questionnaire (via Google Forms). Most survey items were measured on five-point Likert scales (Sullivan & Artino, 2013). The instrument was reviewed by experts for content validity and included demographic questions to enable subgroup analysis. Participants were purposively recruited from active SDA church members aged 18 or older across the 117 congregations of the Jakarta Conference. A total of 393 valid responses were obtained, exceeding the minimum sample size needed for robust statistical analysis at conventional confidence levels (Creswell, 2014; Creswell & Plano Clark, 2018; Patton, 2015).

The key independent variable—perception of the SDA health message—was operationalized as a composite score reflecting agreement with fundamental Adventist health principles. Dependent variables were defined as the level of adherence to four recommended lifestyle practices: following a plant-based diet, engaging in regular physical exercise, abstaining from harmful substances (tobacco, alcohol, etc.), and maintaining adequate sleep.

The survey also measured perceived barriers to healthful living (e.g., lack of time, cost of healthy food) as a potential mediating or moderating factor. Data analysis was conducted with IBM SPSS Statistics, using descriptive statistics, Pearson correlations, and multiple linear regression to examine relationships between perceptions and health behaviors, while controlling for demographic covariates (Field, 2018). Statistical assumptions (normality, homoscedasticity, etc.) were checked for regression; when certain assumptions were not met, equivalent nonparametric tests were considered (Warner, 2013).

All procedures followed ethical guidelines from the American Psychological Association (APA, 2017). Informed consent was obtained from all participants, and participation was voluntary and anonymous. No personal identifiers were collected, and data were stored securely with restricted access. The study upheld the principles of beneficence, autonomy, and justice throughout (Beauchamp & Childress, 2019).

#### IV. RESULTS AND DISCUSSION

##### Overall Adherence

While members strongly endorsed the Adventist health message (mean perception score = 3.7/5), lifestyle adherence was moderate (mean health behavior score = 3.1/5). Perceived barriers were common (mean barrier score = 2.4/5), suggesting obstacles such as limited time, stress, and difficulty accessing healthy food. This gap between belief and practice reflects the well-documented attitude–behavior gap in health behaviors (Glanz et al., 2015; Segovia-Siapco et al., 2020), particularly in urban settings where commuting and cost constraints challenge healthy living (Marmot et al., 2008; Rothman, 2018).

##### Health Message Perception vs. Practice

The survey demonstrated good internal reliability (Cronbach's  $\alpha = 0.77\text{--}0.88$ ). Correlation analysis revealed no significant relationship between perception and behavior ( $r = -0.02$ ,  $p = 0.64$ ). Multiple regression showed that perceived barriers significantly predicted poorer adherence ( $\beta = -0.27$ ,  $p < 0.001$ ), while perception had a small negative effect after controlling for barriers ( $\beta = -0.11$ ,  $p = 0.028$ ). The model explained 7% of variance (adjusted  $R^2 = 0.07$ ), indicating that belief alone does not drive adherence. Possible explanations include heightened self-awareness among highly informed members or a ceiling effect in perception scores.

##### Demographic Influences

Women reported slightly higher adherence than men ( $p = 0.042$ ), and older adults adhered better than younger respondents ( $p = 0.001$ ), aligning with research showing females and older individuals often maintain healthier lifestyles (Fraser & Shavlik, 2001; World Health Organization, 2022). Education, income, and marital status were not significantly associated with adherence, suggesting an equalizing effect of shared church norms and cultural expectations.

Table 1. Demographic Characteristics of Respondents

Demographic Variable	Frequency (n)	Percentage (%)
18–24 years	17	4.3
25–34 years	55	14.0
35–44 years	108	27.5

45–54 years	107	27.2
55 and above	106	27.0
Total	393	100.0
Male	133	33.8
Female	260	66.2
Total	393	100.0
Single	60	15.3
Married	308	78.4
Divorced	3	0.8
Widowed	2	0.5
Separated	20	5.1
Total	393	100.0
High School	59	15.0
Bachelor's Degree (S1)	249	63.4
Master's Degree (S2)	81	20.6
Doctorate (S3)	4	1.0
Total	393	100.0

Note. The majority of respondents are 35–44 years old (27.5%), and females (66.2%) outnumber males (33.8%). Most are married (78.4%), and a significant proportion (63.4%) hold a bachelor's degree. This profile suggests a mature, educated church community that may exhibit distinct health behaviors compared to groups with lower education levels.

Table 2. Monthly Income Distribution of Respondents

Income Range (IDR)	Frequency (n)	Percentage (%)
3 Million – 6 Million	2	0.5

< 6 Million	160	40.7
6 Million – 9 Million	108	27.5
> 9 Million	5	1.3
> 10 Million	118	30.0
Total	393	100.0

Note. The largest group of respondents (40.7%) earn less than 6 million IDR per month, indicating possible financial constraints that could limit their access to health resources. This context is important for understanding potential barriers to following the SDA health guidelines.

Table 3. Membership Duration in the Church

<b>Membership Duration</b>	<b>Frequency (n)</b>	<b>Percentage (%)</b>
< 10 years	25	6.4
11–20 years	44	11.2
21–30 years	58	14.8
> 30 years	266	67.7
Total	393	100.0

Note. A significant majority of respondents (67.7%) have been church members for over 30 years, indicating a deep-rooted commitment to the church. Such long-term membership could imply strong adherence to the SDA health message due to extensive exposure to its teachings.

Table 4. Perceived Barriers to Healthful Living

<b>Response</b>	<b>Frequency (n)</b>	<b>Percentage (%)</b>
Strongly Disagree	164	41.7
Disagree	91	23.2
Neutral	68	17.3
Agree	53	13.5
Strongly Agree	17	4.3
Total	393	100.0

Note. A majority of respondents (41.7%) *strongly disagreed* that it is difficult to find affordable plant-based food, suggesting a generally positive perception of food availability which may facilitate healthier dietary choices.

Table 5. Health-Related Behavior Perceptions

<b>Response</b>	<b>Frequency (n)</b>	<b>Percentage (%)</b>
Strongly Disagree	94	23.9
Disagree	76	19.3
Neutral	113	28.8
Agree	77	19.6

Strongly Agree	33	8.4
Total	393	100.0

Note. Over a quarter of respondents (28.8%) were neutral on whether lack of time makes healthy meal preparation difficult, indicating varied experiences with time constraints. Recognizing these challenges is important for developing effective health interventions.

Table 6. Correlation Summary: Perception of SDA Health Message and Health Behaviors

Variable	Spearman's $\rho$	p (2-tailed)
Age	0.259	0.0
Gender	0.103	0.041
Marital Status	0.179	0.0
Income	-0.081	0.108
Education	0.006	0.9
Membership Duration	0.126	0.012
Perceived Barriers	-0.233	0.0
Overall Correlation	-0.024	0.637

Note. Age and marital status showed positive correlations with lifestyle adherence, while perceived barriers had a significant negative correlation with healthful behaviors. Other factors (e.g., income and education) were not significantly correlated. Notably, the direct correlation between overall health message perception and lifestyle practice was not statistically significant.

Table 7. Regression Model Summary

Model	R	R <sup>2</sup>	Adj. R <sup>2</sup>	Std. Error	Durbin-Watson
1.0	0.361	0.13	0.112	5.885	2.163

Note. The regression model shows a moderate overall correlation ( $R = 0.361$ ) between the predictors and health behavior outcome. The  $R^2$  value of 0.130 indicates that about 13% of the variance in health behavior adherence is explained by the factors analyzed, suggesting that other variables also play a substantial role.

Table 8. Multiple Regression Analysis Results

Predictor	B	$\beta$	t	p
Intercept	32.311	—	7.686	0.0
Age	1.266	0.233	3.918	0.0
Gender	0.645	0.049	0.991	0.322
Marital Status	0.137	0.018	0.334	0.738
Education	-0.223	-0.022	-0.438	0.662
Income	-0.263	-0.053	-1.047	0.296
Membership Duration	-0.014	-0.002	-0.037	0.971
Perceived Barriers	-0.318	-0.231	-4.588	0.0

Note. In this regression analysis, **age** and **perceived barriers** emerged as significant predictors of healthy lifestyle practices. The positive coefficient for age and negative coefficient for perceived barriers indicate that older participants tend to have better adherence, whereas more perceived barriers are associated with worse adherence. Other variables (gender, marital status, education, income, membership duration) did not significantly predict health behaviors in this model.

Table 9. Summary of Mean Responses and Standard Deviations

No.	Variable	Mean	SD	Scale Response	Qualitative Descriptor
1	Frequency of Attending Church Services	3.7	1.1	1 (Never) – 5 (>1 time/week)	Positive Engagement
2	Core Principles of SDA Health Message (Except)	2.2	1.0	1 (Strongly Disagree) – 5 (Strongly Agree)	Negative Perception
3	Ideal Eating Frequency According to SDA Health	2.7	1.2	1 (Strongly Disagree) – 5 (Strongly Agree)	Neutral Perception
4	Recommended Sleep Duration according to SDA Health	2.9	1.0	1 (Strongly Disagree) – 5 (Strongly Agree)	Neutral to Positive
5	Main Benefits of Regular Exercise in SDA Health	1.0	0.1	1 (Strongly Disagree) – 5 (Strongly Agree)	Very Low Perception
6	Relationship Between Mental and Spiritual Health	3.0	1.3	1 (Strongly Disagree) – 5 (Strongly Agree)	Neutral Perception
7	Familiarity with SDA Health Principles	4.1	0.7	1 (Strongly Disagree) – 5 (Strongly Agree)	Positive Awareness
8	Belief in SDA Health Message for Overall Well-Being	4.7	0.5	1 (Strongly Disagree) – 5 (Strongly Agree)	Strong Agreement
9	Impact of SDA Health Message on Spiritual Connection	4.5	0.6	1 (Strongly Disagree) – 5 (Strongly Agree)	Strong Agreement
10	Practicability of SDA Health Message in Daily Life	4.3	0.5	1 (Strongly Disagree) – 5 (Strongly Agree)	Strong Agreement

11	Support from Church Community in Following Health Message	4.0	0.6	1 (Strongly Disagree) – 5 (Strongly Agree)	Positive Support
12	Understanding the Emphasis on Plant-Based Eating	4.2	0.4	1 (Strongly Disagree) – 5 (Strongly Agree)	Strong Agreement
13	Belief in Importance of Regular Exercise for Health	4.6	0.5	1 (Strongly Disagree) – 5 (Strongly Agree)	Strong Agreement
14	Adventist Position on Avoiding Harmful Substances	4.6	0.5	1 (Strongly Disagree) – 5 (Strongly Agree)	Strong Agreement
15	Relevance of SDA Health Message in Jakarta	4.3	0.5	1 (Strongly Disagree) – 5 (Strongly Agree)	Strong Agreement
16	Motivation to Adhere to SDA Health Guidelines	4.5	0.4	1 (Strongly Disagree) – 5 (Strongly Agree)	Strong Motivation

### Implications and Recommendations

These findings show that strong spiritual conviction in the Adventist health message alone does not guarantee healthy living, as practical barriers and lifestyle habits often outweigh theological agreement. In Jakarta, closing this attitude–behavior gap requires moving beyond reminders of doctrine to offering practical support that helps members apply their beliefs in daily life. Local churches could organize initiatives such as fitness groups, vegetarian cooking classes, and “wellness Sabbath” seminars that provide not only education but also tools for time management, affordable healthy eating, and stress reduction. Reframing health as spiritual stewardship (1 Cor. 6:19) may further inspire members to care for their bodies as part of honoring God (Koenig et al., 2012; Ministry Magazine, 2017).

Empowering church leaders to model healthy living is equally important. When pastors and ministry leaders actively demonstrate balanced lifestyles—through regular exercise, nutritious diets, and proper rest—they become role models whose influence extends throughout the congregation. Leadership advocacy, supported by peer groups within the church, can foster a culture of accountability and encouragement, making healthy living a shared community value rather than an individual struggle.

Finally, broader partnerships can strengthen and sustain these efforts. Collaboration between SDA institutions (hospitals, schools) and public health agencies or community organizations can bring in expertise, resources, and alignment with existing health campaigns. By adapting Adventist health principles to the realities of urban life, the church can help members turn conviction into action, leading to tangible improvements in physical and spiritual well-being. Implementing these strategies will allow urban Adventist congregations in Jakarta and beyond to live out the health message more fully, fulfilling the Church's mission to nurture both body and soul.

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