

Faith-Based Health Education Project: A Case Study

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Abstract

Working with faith communities in health promotion is widely acclaimed and yet not readily practiced. This article describes a study conducted among four faith communities to determine the process required for sustainable faith-based programs. Face-to-face interviews were conducted among 12 community volunteers who participated to identify their perceptions of the project. Two staff members were also interviewed to identify the process from their perspectives. Project-related documents were also analyzed to provide details and triangulate the data from the interviews. The study followed the project for 2 ½ years. Several factors were identified as significant influences on participation and project sustainability. These included value, active pastoral support, program success, and volunteer commitment. The results of this study indicate that pastoral support and faith community ownership are critical components that should be included in faith-based community building efforts.

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Introduction

Community programs usually utilize multiple strategies for interventions. Health educators rely on collaboration because addressing community needs is most effective with active participation and input from the community (Minkler & Wallerstein, 1997). Researchers indicated that involving community members in the identification of needs, the recognition of assets, and the development of solutions leads to increased community capacity, empowerment, and critical awareness of the community members (Steuart, 1993; Wiist & Flack, 1990). The ultimate goal of all health promotion projects should be to organize communities in an effort to reduce social/physical disease risk factors and increase quality of life. The purpose of this article is to present the findings from a qualitative case study of a faith-based health education program.

Health education programs have been implemented in faith communities (churches, temples, synagogues) because of their support for meeting community health needs (Hatch & Derthick, 1992; Wiist & Flack, 1990). Jackson & Reddick (1999) described a collaborative

venture between a university and African-American churches to assess risks of chronic disease and increase participation in prevention measures. Information was exchanged, activities were coordinated, and resources were shared. It was reported that a clear understanding of each partner's abilities, strengths, and requirements was necessary to foster a good working relationship. Derose et al. (2000) reported on a randomized trial for recruiting women for mammography that utilized churches. Initial relationships for recruitment, both of churches and women, were constrained by the timeline of the grant period. Participation was good but time was a factor. A four-year project to increase consumption of fruit and vegetables among rural African-American adults was implemented through churches (Campbell et al., 2000). The intervention utilized an ecological approach, increasing fruits and vegetables served at church functions. This change was the greatest perceived benefit identified by participants. A community-based project that utilized collaboration and capacity building to target interventions aimed at reducing the incidence of stroke in the African-American population was

put into practice in three counties (Okwumabua, Martin, Clayton-Davis & Pearson, 1997). Externally driven but with input from the community and the target population, the project incorporated church volunteer teams to recruit participants. The volunteers attended workshops on teambuilding and group process, as well as spirituality and its application to health promotion. The specific emphasis of the project was on smoking cessation and weight management. Many interventions were planned and implemented. Following the project-funding period, the churches continued to promote health awareness and stroke reduction programs. Major challenges were identified as the lack of awareness of the target population about strokes, over commitment of volunteers to other programs, recruiting participants for the programs, and sustaining involvement of volunteers and participants. Church leaders in North Florida formed the Advisory Council on Health Promotion, developed a grant proposal, and created a health plan targeting hypertension and cardiovascular disease in African-Americans (Turner, Sutherland, Harris, & Barber, 1995). Assisted by the health department, the Council evaluated health statistics, created a health survey, and analyzed the results. The health department provided training for volunteers on all aspects of the program created by the Council.

Faith based programs appear to be successful in reaching marginalized and underserved people because of the perception of trust and security that many find in faith communities (Davis et al., 1990; Hatch & Derthick, 1992). Faith communities and other religious organizations represent a potentially productive avenue into American racial and ethnic minority communities. They function as social centers and educational facilities, as well as health care resource centers (Kong, 1997; Turner, Sutherland, Harris, Barber, 1995; Wiist & Flack, 1990). Indeed, public health and faith communities have a common history of community service and social change around health. Social changes, such as sanitation, disease management, immunizations, and adequate housing, which these groups initiated and sustained, have done much to increase life

expectancy and improve quality of life (Gunderson, 1999).

Steuart (1993) and others have documented the need for a program champion in community health education programs to enable the program to be successful. In faith communities, the program champion must be the pastor. Pastoral support is necessary for sustainability in faith-based programs (Haber, 1984; Turner, Sutherland, Harris, Barber, 1995). Faith based programs can affect a wide range of behaviors (Cook, 1997). Physiological problems are often related to behavior, to psychological states, and to what is happening in terms of spiritual well-being. Faith-based health education programs must understand how these factors are interrelated and account for them in planning and implementation (Sanders, 1997).

Use of Qualitative Research Methods

This descriptive case study utilized qualitative methodology to describe in detail the Faith Based Health Education Project (the Project). The qualitative approach allows the researcher to glean thick descriptions from the participants about their experiences with the Project (DeVries, 1992; Miles & Huberman, 1994).

Purposeful sampling was used in selecting the Project and team members for the study. Purposeful sampling allows the selection of an information-rich case whose study will provide insight to the questions under investigation (Bogdan & Biklen, 1992). Because data were collected from four sites, this study was a multiple case study. The unit of analysis was the church. Selection of key informants was based on the potential for obtaining rich descriptions pertaining to participation in the Project (Bogdan & Biklen, 1992). Key informants were ten team members who were actively involved in the Project within their congregations. The pastors in each church was also interviewed where possible. Additionally, the Project staff (2) was interviewed to gain their perceptions of the Project.

Methods

Acting as a participant observer, the author worked with all phases of the project for 2 1/2

years. She began as a volunteer and was later hired as a part-time staff member. The project was implemented prior to her participation. She kept notes of all activities in which she was a participant. These were memos reflecting the atmosphere of the activity, the number of people observed and what they were doing, any feedback she was given, and any personal reflections made. Data were also collected from project documents, which included quarterly and annual reports, minutes of team meetings, and participant rosters.

Key informants were personally invited to participate in interviews. Format for the interviews was an interview guide developed with open-ended questions to document participants' experiences and perceptions about the project (available from the author). Questions revolved around why and how individuals got involved, changes they noticed in themselves and others that they ascribed to the project, and ownership and sustainability of the project in their respective churches.

An institutional review board for use of human subjects approved the methodology for this case

study. Informants were de-identified and given pseudonyms. Churches names were also changed to pseudonyms and numbers.

Interviews were done in person, audiotaped, and ranged from 30 minutes to 1 1/2 hours. The audiotapes were transcribed and then coded using the Ethnograph v5.4TM software program from Qualis Research. This program allowed the researcher to code transcribed text and created a codebook for further analysis (see Table 1 for sample). The software program provided a count of codes to aid in theme development. It also enabled the author to write memos during coding for more in-depth analysis. Initial codes were topics from the interview guide. Additional codes were needed to fully describe the data, for a total of 51 first-order codes (see Table 1 for examples). Themes were derived from the codes through analytic induction. These themes were “reason to participate”, “personal experience”, “value”, and “sustainability.” The coded interviews were peer reviewed for consensus and consistency by a research team of doctoral students and a graduate level qualitative research class.

Table 1
Sample Coding

Code Word	Definition	Count
Implement	How the project was implemented	46
Outreach	The project is available to all	40
Commitment	Personal commitment to the project	33
Pastor Support	Perceived support by the Pastor for the project	30
Personal changes	Changes of the person due to their involvement in the project	24
Resources	Resources available that teams were unaware of before the project	16
Empower	Personal feelings of empowerment	9

Themes developed were triangulated with project documents and author's memos to create a rich description of the project implementation. Informant perspectives also gave needed detail to the analysis of the project and its sustainability.

Description of Initiative

The Faith-Based Health Education Project was a primary prevention and outreach project designed to assist congregational members to develop the skills and knowledge needed to address maternal, child, and family needs. The project began in a local health department in late 1996 as an effort to respond to a growing teen pregnancy issue. The agency was located in an area whose population could be defined as underserved and marginalized. In an effort to reach members of this community, faith communities were recruited to serve as sites for health education and health promotion. The project staff chose areas of the city based on demographics, specifically incidences of teen pregnancy, low birth weight babies, low immunization rates, and chronic diseases as identified by neighborhood clinics, for program implementation. Faith communities were selected by location or willingness to participate. The faith community acted as an agent for implementation because these institutions could identify and reach members who are underserved and/or marginalized. Utilizing teams of volunteers from the congregations who acted as lay health advocates, the project was implemented based on the felt needs and interests of the faith community. The project staff, who were health department employees, assisted in identification of community resources and linkages to outside resources. The primary purpose of the case study was to understand the story of the Project from the participant's point of view. Inherent in the story was the desire to learn what motivated individuals to participate, what value they attached to their participation, what value the Project held for them and what changes occurred during their participation.

Findings

Program Development

The project director began developing the project by recruiting the churches to participate and hiring staff to assist. The health department's role in the beginning of the project was that of providing direction and leadership. The project coordinator was hired in early 1997 and was responsible for project assistance within each faith community; scheduling, attending, and facilitating team meetings; locating resources to implement programs; and skills training of the team members in program processes. The project director supervised development of the project, attended a few team meetings, and assisted with locating resources for program implementation.

The project utilized four sites. Praise Temple (Church 1) was a Protestant urban church with approximately 500 primarily African-American members. Saint Anthony's (Church 2) was a Catholic urban church with approximately 350 mostly Hispanic parishioners. Santa Clara (Church 3) was a Catholic urban church, and had 20,000 primarily Hispanic parishioners. Holy Bible (Church 4) was a rural Protestant church, with approximately 100 primarily African-American members. Churches 1-3 were recruited in the first two years.

Project staff presented the project to pastors. The pastors suggested volunteers or individuals self-selected to form teams. In Church 1, several individuals heard about the project and were interested in implementing it. They recruited other members to form their team. Gina, team leader, "I think one of the ladies in the church had gotten us information and I think they were having a workshop or something at a hospital. So we just thought we would go and see what it was about." Edward, the other team member interviewed, was asked to join the team by another team member.

In Church 3, the project was presented at a church-wide ministry fair. Carlos, team leader, "I got very excited about it and I'm a member of the parish council, and all the other members

were there. So, one by one I took them over there and I introduced them to the project director and I talked to them about the project and told them what a great thing it would be here. It hadn't been started yet."

In Churches 2 and 4, the pastors recruited the teams. Consuela, leader from Church 2, "...pastor invited me and several others to a meeting, I just kind of picked up the ball and went with it. We just needed somebody to go forward." One member, Helda, joined the team after a request from the team leader. The other, Felicia, joined from contact with other church social services. Barbara, co-leader from Church 4, "... pastor said that he had been approached about having (the project) within our church and that there were some other churches that were going to be involved and he had asked me and two other ladies if we would be interested in participating. And we said 'yes' and that's how it got started." Over time, team leaders, word-of-mouth, or invitation from other team members were used to recruit other members in all churches.

These teams were responsible for project implementation. The number of volunteers on the teams varied with the site. All sites had more volunteers listed on their team rosters than actually participated. The number of active team members at each congregation ranged from three to seven.

After teams were recruited, the project coordinator and director met with them to draft covenant agreements. The covenant agreement served as a formal commitment to the Project. The team members, with the assistance of the Project staff, prepared the document. The team leaders, pastors, and project coordinator signed the final document. The covenant agreements were framed and placed in the church foyers or common room as a public statement of the commitment

Following the covenant agreements, the teams, assisted by the project coordinator and director, developed needs assessments (surveys). The development of the needs assessment instruments took several weeks. It was

important to have the documents prepared by the team members to ensure they reflected church doctrine. The staff provided examples of needs assessments or surveys used in other health programs to aid the teams in preparing their own. Although the surveys were similar, each survey was unique to each church and reflected the issues, concerns, and interests of those groups. These surveys were a means to gather information about health problems and requests for services. Questions regarding demographic information, medical problems, health care, personal safety, eating habits, and physical activity were included in the surveys. The survey also contained a list of programs or activities that church members could request as well as a space to volunteer time or talent in any activities.

Carlos, Church 3, shared the following,

"The members of the team came together, or we as Christians, came together to start. And the project coordinator and the project director were the two people from the health department that were our connection to the Project and they're the ones. Without them we would have been lost. The first thing we did was determine that we did want to do something for Santa Clara and determined that we needed their input to find out what it is that we needed to do for them. So as a team we came up with a survey that was used to canvass the parish to find out what was important to them. The project coordinator and staff were very helpful in that, they provided samples of questions that we might use. Even though we never met the other two pilot parishes we were always exchanging information through the staff. So that helped us also. Then coming up with our own questions that we thought might be of interest to our particular parish, our ethnic group, our social group, our geographic location. And in doing that we came up with our survey and we went out and canvassed the parish. So that's how we started."

Once the final document was completed, the team members, facilitated by project staff,

selected times and dates to survey their congregations. The needs assessment surveys were distributed to the congregations over several weeks. Carlos, Church 3, best described the actual process of surveying the congregations.

“We did it two-fold. After every (service) there are announcements. A member of the team went up after each (service) and said 'we are taking this survey'. We explained what we were trying to do and we asked for people to stay for a few moments to fill out the survey. We were also giving out T-shirts, (project) T-shirts, to anyone who filled out the survey. We assured them that it was not only confidential but it was anonymous because their names were not on there. So we did that after the (services). Then secondly, we were in the Hall. After the (services), we have a breakfast in our Hall so there are a lot of people who go in there and we had people fill out surveys and we gave out a T-shirt to everybody who did fill out a survey. So those are the two methods that we used. After we received those back, the project staff had someone tabulate them, we had all the results down, and using that we were able to put together a plan to say 'ok, these are the different projects that we are going to do.' And we went from there.”

The other churches reported similar experiences, utilizing incentives to assist with participation, and administering the surveys at a time and place most likely to ensure participation. Project staff analyzed the completed surveys and returned the results to the teams. They assisted the teams in creating a health plan by linking the most frequent requests for programs and most cited health issues from the data analysis.

In addition to the needs assessments done in the churches, the health department held community focus groups to ascertain if there were similar issues in the larger community that could be addressed through programs at the churches. The focus groups were also used to pilot a media campaign the health department used to advertise the project. The focus groups revealed

concerns that were not easily or readily addressed within the scope of the project so referrals to other agencies were made. It was anticipated that as programs were successfully implemented regarding churches' felt needs that other community issues would present themselves and could be addressed.

In working with the faith communities, project staff quickly learned that their original agenda (teen pregnancy, low birth weight babies, and immunizations) were not issues in the faith communities. The project staff followed the felt needs of the faith communities instead of the original focus of the project proposal. Following the felt needs of the faith communities enabled the project to “start where the people are” and to include them in intervention development and implementation. The literature indicated that there are often different agendas between health educators and the community (Hatch & Derthick, 1992; Steuart, 1993.). The project focused on increasing awareness about health issues and available resources in the community and changing individual behavior, which were found to be effective by others (Preston et al., 1988; Van Assema et al., 1997).

The teams then developed programs and timelines to address their communities' concerns. The teams selected which goal to address first, and members volunteered to take responsibility for the planning, implementation, and evaluation of the programs. One condition that all teams had to meet was the inclusion of the surrounding neighborhoods in any activities planned. This was an attempt to build or strengthen community ties and enlist additional resources.

The teams met monthly (at least) to plan activities for their faith communities. The project staff prepared the agendas, took the minutes, and attended the meetings. They aided in procuring resources for activities and developing evaluation tools for programs. They also supplied funding for printing and material costs associated with any program implementation.

Programs implemented. The following is a synopsis of the programs implemented by the teams in their respective churches.

Newsletters. The first activity begun by each team was the development of a newsletter. The newsletter was used to communicate the project activities to the congregation. The staff assisted in writing articles, formatting, and translation of the newsletters, and the health department absorbed the cost of printing. The teams were responsible for distribution to their congregations. As the teams gained skill and knowledge, they assumed the writing of the articles. Timelines were determined for the newsletters so that formatting, translation, and printing were done in a timely fashion, and distribution was coordinated with the church office.

The project took a step toward accounting for cultural differences by publishing newsletters in both Spanish and English to better include those who had bilingual congregations. Steuart (1993) noted that accounting for cultural differences in community health programs was necessary for their success. There was an assumption made, however, that individuals who were Spanish speaking were also literate in their primary language. Having the newsletter already translated did increase the possibility of increasing awareness in both the Spanish-speaking and English-speaking individuals who received them.

Activities. A wide variety of activities were offered at each site. Most of the programs were focused on increasing awareness and education (health fairs, newsletters). The cooking classes, exercise programs, walking groups, and support groups also focused on increasing skills and changing behaviors. These programs were popular with participants and capable of influencing the entire family, not just the individual. Activities with low participation were not repeated and others were tried. Others found that programs most often offered by faith communities are educational and skills-based (Kong, 1997; Sutherland et al., 1995; Turner et al., 1995; Wiist & Flack, 1990) and program comprehensiveness is important to increase the

opportunities for participation (Preston et al., 1988; Van Assema et al., 1997).

One of the successful activities was the cooking class. These cooking classes were developed and presented by a local non-profit agency whose focus was improving nutrition and eating behaviors, especially of low-income individuals. The program consisted of a 6-week course where participants were taught basic nutrition and the components of a healthy diet. They prepared a meal at each meeting and then received the ingredients and recipes for that meal to take home and try. The participant feedback from the cooking classes was always positive and in some cases profound. Helda (Church 2) stated, "And I've taken the cooking classes and I really have learned to eat vegetables. I'm not afraid to cook them anymore, throw them in foods, I mean it's just, all the different aspects." Felicia (Church 2) shared, "the cooking classes I thought those were great! I participated in one and I learned a lot! And I was able to take it straight home because my mother's a diabetic and all this other, so I've implemented it in her home as well as mine. And I see that big change."

Walking and exercise groups were also popular. Helda (Church 2) shared, "it's made me see that I do need to exercise and its made me go out there and just do it. Its challenged me but I you know I may slack off a week and during the hot weather we all kind of slack off but it keeps me going and getting back in there and doing it." There were several in each church who were consistent in attendance and looked forward to the activity. Another agency in the local health department hosted walking leader training workshops. Many of the team members attended these training sessions and were provided with information and incentives to use with their walking groups.

The staff explained the importance of evaluation with each activity. The churches kept a log or sign-in sheet for activities. Church 1 offered raffle prizes to those who visited the most booths in their health fairs. They and the staff designed a "ribbon" for participants to wear and receive stickers at each booth. The participants

then turned these in as they were leaving. Drawings were held throughout the fair for the raffle prizes. In Church 2, the staff and team designed the cards for participants to carry to each booth. Stickers were given out as participants visited the booths. As the participants left the cards were turned in for raffle prize drawings. Both churches 1 and 2 procured their raffle prizes on their own. They visited neighboring retail establishments and also made requests for products from church members. Finding vendors for the booths was a joint effort between the staff and the teams. As teams made their own connections with vendors, they assumed the responsibility for contacting them for future service. The teams increasingly found contacts within their church communities for services as well. Team members from the walking groups and exercise classes kept log sheets of participants. The teams hosting the activities maintained these log sheets and copies were sent to the project office. Review of these log sheets revealed that turnout was sporadic as far as actual participation went. The cooking classes were evaluated by the agency providing them. They had a questionnaire that covered the usefulness of the information provided and determined behavior change because of participation in the classes. In addition, the project staff kept a log of phone calls requesting these classes for future use.

As time passed, the staff focused on teams taking full responsibility for the Project. The

teams began setting meeting agendas and writing the minutes. They became more confident in procuring resources for activities and began a dialogue about fund-raising for project continuation.

As of September 1999, only one church remained active in the project. Church 1 hosted one health fair each year and was involved in one community-based program as well. However, the team disbanded and was no longer actively involved with the project. They cited internal problems within their team and said that they would temporarily disband and then reconvene once these conflicts were resolved. Church 1 had many volunteers but lacked the commitment of the pastor to institutionalize the project. The team tried many times to get the project before the church budget committee for funding and acknowledgement of it as a worthy church program. These attempts met with failure. Church 2 was the most active and also assumed full responsibility of their project. Church 3 initially had a large number of activities, but only successfully implemented one program in 1999. Church 3 struggled throughout the time period with little volunteer support within their faith community. As of September 1999, the team disbanded but the leader took on the responsibility of publishing the newsletter. Church 4 had three successful activities in 1999 but did not remain active with the project (see Table 2).

Table 2
Longitudinal View of Project by Year and Participants

Year & Quarter Activities	Church 1 Protestant 500 members	Church 2 Catholic 350 members	Church 3 Catholic 20,000 members	Church 4 Protestant 100 members	Staff
Y1q1 Sept-Nov 1996					RFP 5/96. Letters to faith communities 9/96. Funded 10/96.
Y1q2 Dec-Feb 1997	Joined 1/97.	Joined 2/97.			Coordinator hired 1/97.
Y1q3 Mar-May 1997	Covenant agreement 3/97.	Leader changed.	Joined 4/97.		Staff hired 3/97. Community focus groups 4/97.
Y1q4 Jun-Aug	Needs assessment 6/97.	Covenant agreement 8/97.	Covenant agreement 8/97.		

Year & Quarter Activities	Church 1 Protestant 500 members	Church 2 Catholic 350 members	Church 3 Catholic 20,000 members	Church 4 Protestant 100 members	Staff
1997		Needs assessment 8/97.	Needs assessment 8/97. Leader changed.		
Y2q1 Sept-Nov 1997	Goals and strategies developed. Health fair 11/97.	Goals and strategies developed. Newsletter begins 11/97.	Goals and strategies developed. Health fair 11/97. Newsletter begins 11/97.		Graduate student volunteers (GJ) 11/97. Project director and coordinator attended national conference.
Y2q2 Dec-Feb 1998	Newsletter 12/97	Diabetes support group 2/98	Cooking classes 1/98		
Y2q3 Mar-May 1998	Leader changed. Exercise classes 4/98. Walking group 4/98.	Walking group 3/98. Cooking classes 4/98. Safety workshop 5/98.	Walking group 4/98.	Joined 3/98.	Project director resigns 4/98.
Y2q4 Jun-Aug 1998	Exercise classes ends. Walking group ends.	Health fair 8/98. Cooking classes 8/98.	Violence workshop 6/98. Walking group ends 7/98.	Covenant agreement 7/98.	Graduate student (GJ) hired 7/98.
Y3q1 Sept-Nov 1998	Health fair 9/98.	Hispanic health fair 10/98.	Hispanic health fair 10/98. Leader changed.	Needs assessment 10/98. Goals and strategies developed.	Staff attended health conference 10/98.
Y3q2 Dec-Feb 1999	Community health fair 2/99	Singles group began			Staff attended health conference 12/98
Y3q3 Mar-May 1999		Cooking classes 3/99. Safety workshop 5/99.	Cooking classes 3/99. Newsletter falters 3/99.	Marriage workshop 3/99.	Booth at state conference 4/99. Presented at state conference 5/99.
Y3q4 Jun-Aug 1999	Sent 6 to national conference 6/99. Published 4 newsletters to date.	Sent 3 to national conference 6/99. Cooking classes 7/99. Published 12 newsletters to date.	Sent 3 to national conference 6/99. Team disbanded 8/99. Published 10 newsletters to date.	Walking group 5/99. Sent 3 to national conference 6/99.	Did not attend same national conference 6/99. Graduate student (GJ) presents at national conference 6/99. Graduate student (GJ) resigns 8/99.
Y4q1 Sept-Nov 1999	Team disbanded 9/99.	Health fair 9/99.	Newsletter taken on by team leader 10/99.	Health fair 9/99. No activity with project 10/99	Staff reassigned 10/99.

Discussion

Interviews revealed that team members and pastors found an intrinsic value in the project and saw it as a viable means to impact the health of the community. Abigail, Church 4 shared,

“This you can do a little bit more, provide more services.” Carlos, Church 3, remarked, “My spirit just told me ‘this is important’ and I don’t know why but I feel that it is. I think there are a lot of health needs in our parish.” Felicia,

Church 2 stated, "I thought I could make a difference." Gina, Church 1 acknowledged, "I thought there was a need in our church and in our community and I thought a lot of people would be helped by it." Personal health reasons for participation, a desire to help others, to serve the community, to answer a spiritual call, or personal reasons were cited most often.

The value of this project was important to discern, because if no value is associated then people are less likely to remain involved. The underlying theme from participation was value. Interviews revealed that all participants found an intrinsic value in the project and saw it as a viable means to impact the health of the community. Value was determined through the interviewee's statements and their involvement in the project. Each of the teams interviewed (Churches 1 – 3) had at least one member who had personal health reasons for participation, such as diabetes or a desire to quit smoking. Those interviewed from Church 4, who were health professionals, did not cite any personal reasons for participation. Other reasons for participation included a desire to help others, to serve the community, to answer a spiritual call, or for personal reasons.

The most important experience reported was awareness of needs within the community. All team leaders believed that to be their most important experience. Barbara, church 4, shared that this Project "gives us an opportunity to work in the community and to see some of the issues that are in the community that I never would have thought existed. I think it's a very healthy project for any area to be involved in."

Team leaders and members alike also cited the increased awareness in resources. These resources provided the teams with the ability to help those in their communities. All noted that the assistance of the project staff was necessary for their participation and their successes.

Frustrations cited by team members included lack of participation by the congregations and not enough people involved in the planning, implementing and evaluating of programs. All wanted more participation from their faith and

neighborhood communities in activities. All leaders commented on the difficulty of keeping the teams motivated to continue the project especially during busy times at the church and during the summer. Time was also a critical component, as all participants were active in other church activities and in their personal lives. Finding time to work with the project affected all participants at one point or another. Those with the most commitment appeared to make the time to work on the project. As with most community programs, sufficient time is required to develop and implement the program, and in this instance, more time was needed to actually impact health outcomes.

Team members reported increases in self-esteem and self-confidence, as well as knowledge and awareness about health issues. They attributed these to their participation in the project. Two reported increases in self-efficacy and self-esteem that had carried over into their personal and professional lives. Consuela, Church 2, "I always wanted to do something like this but was afraid I wouldn't be able to cope. And the harder it is, the more involved, the more I like it!" Helda, Church 2, "It has given me confidence in myself and my abilities that has helped me in my day job. I'm not afraid to speak up anymore."

The health impacts or behavioral changes that had occurred because of their participation in the project were seen as important. Each team had one member who had experienced personal changes they believed were important. Delores, Church 3, acknowledged, "There have been subtle changes, I'm more aware of nutrition and how it affects the population." Carlos, Church 3, reported, "a change in knowledge of personal health and being more aware of the control that we do have over trying to be healthy." Edward, Church 1, commented, "being [involved in the project] made me realize I should take care of my own body and take care of other people as well."

Impact or changes outside of self were also reported as the congregational members became aware of the services through the newsletter or programs. For example, Edward, Church 1

reported, “one of the elderly ladies at the church, I guess she got overheated, the health ministry team was there to help her out, too. And that was a great accomplishment and that got a lot of people aware of what the [project] is doing.” Helda, Church 2, shared, “I think the functions that we’ve had, I think they know that the [project] does exist.”

Several instances were cited where the project assisted a church member with a health issue. The teams reported that more congregation members asked to be involved in various programs and attendance increased at their activities. Henry, Church 2’s pastor said, “A lady called me and told me the project had saved her life!” It was also reported that the surrounding neighborhood participated in several of the programs. Team members reported increases in attendance at their health fairs and increased awareness and participation in activities.

Pastoral support was an integral part of the project success. Church 2 had the most felt support and involvement of the pastor of all the churches in this study. The pastors found value in the project but only two of the three interviewed felt ownership (Churches 2 and 4). As stated in the literature, pastoral support is necessary for church members’ participation in programs offered. Their support of programs that address physical needs or health issues increases members’ awareness and participation (Haber, 1984; Turner et al., 1995). It is believed that the lack of pastoral involvement in the project in Churches 1 and 3 led to its failure. Church 1’s team disbanded in part due to the lack of pastoral support for the project. The pastor from Church 3 revealed in his interview that a newsletter was probably the “most appropriate method for increasing health awareness in this parish.” The newsletter continued to be published by the former team leader.

For the project to be sustainable within the faith community, ownership of the program was necessary. Data indicated that all teams believed they had ownership of the project but also recognized their dependence on the project

staff. All stated that good communication among all team members and the pastors was essential. All team members believed there was pastoral support for the project even if their pastors didn’t take an active role. The teams most successful in project implementation had more pastoral involvement and felt more pastoral support than the other two teams.

The project was not sustained in all faith communities. Project sustainability seemed most affected by the commitment and participation of the team members as well as pastoral involvement. Pastoral support of the project appears essential for its success. Church 2 is the only one that sustained the project and continued even without the involvement of the project staff. They also reported the most support of the pastor. Church 4 was involved in implementing programs but not involved with this project. Church 3’s large size and difficulty in procuring a large volunteer base was problematic.

This study strongly indicates that the use of volunteers increased the credibility of the project and helped ensure that programs offered would be appropriate for the population. Team membership also aided in ownership and commitment of the volunteers in all faith communities. The team members were volunteers who were active in many other church programs as well. Others found that volunteers from the community increased the compatibility of programs implemented with local culture as well as increased community participation (Delgado et al., 1995; Marín et al., 1995; Neighbors et al., 1995; Paradis et al., 1995; Pulley et al., 1996; Thompson & Kinne, 1990; Wells et al., 1990; Wiist & Flack, 1990).

Findings from this descriptive case study are not representative of all community programs. This is an example of one community’s efforts to address health problems of the marginalized and underserved. Answers to the research question, ‘why did people get involved’ ranged from a desire to reach those in the community to personal health problems. With respect to impact within the community, the participants, pastors, and staff believed they began an

important program and process for addressing needs and utilizing resources. The potential for sustainable programs in faith communities is great. Health educators and funding agencies must recognize that the building of such a program requires time. All who were interviewed believed that the project offered an important opportunity and a viable method to address health issues and impact health. The increased awareness and skills that individuals gained in developing their own programs and incorporating their strengths became the components for improving the health of all participants.

Suggestions for Practice

In an attempt to improve the implementation and the success of this project in future settings, I asked several participants for their suggestions. There was some concern voiced regarding future funding of the Project and an overall consensus that the time line of the original grant period was too short. Henry, the pastor from Church 2, shared the following:

“The health department generally has a tendency to do some things that are so broad that they don't really touch reality. This program was cut down, it was started in three parishes and it has done some very concrete and good work in the three parishes. And I think if the health department especially would learn that you can't do massive things, it's better to do small things and do them well, then I think we would have a better health program going in the country.”

It was very clear that the support of the community, spiritual or otherwise, was imperative for any program initiation or implementation.

Additionally, having a greater commitment from the church, through active team members or willingness to assume some financial responsibility for program activities, was considered a benefit. At least one participant from each church stated that if the faith community wasn't ready to support the project that it was best not implemented at that time.

Based upon observations and participation in this project and from interviews with project staff, some changes should be considered in future project implementation. First of all, faith communities that choose to participate must be willing to take on the responsibility of project implementation and ownership. Having congregations involved from the very beginning or facilitating the initiation of the project themselves should increase their ownership and accountability and help with sustainability.

For increasing the awareness of faith communities regarding this project, an introductory meeting is warranted. Its purpose would be to introduce the project, describe possible program components, and discuss the responsibilities of the faith communities as well as the project staff. Those interested in implementing the project could register for a training workshop at that time. A requirement of project implementation would be that the spiritual leader be involved initially and be supportive of the project within his or her faith community.

The workshop would consist of increasing awareness of health issues; developing leadership and program management skills; opportunities for modeling behavior related to skill development; and introduction of potential community partners. Workshop participants would gain experience in small group facilitation, surveying skills, and methods to determine strengths and resources present in their communities as well as the importance of program evaluation. Agencies that provide resources would be available not only for their specific presentations but to provide personal contacts for the faith community participants. Future training sessions would be held to draft documents such as surveys or needs assessments. By providing the participants with the opportunities to develop the project and learn skills prior to actual implementation, ownership of the project, motivation for continued participation, and successful implementation are more likely to occur. Upon completion of the workshop, participants should be able to assess their faith community for strengths and needs, develop a health plan with goals and strategies

to meet them, plan and evaluate program activities, and develop collaboration within the faith community and the greater community.

As the participants begin the implementation of the project, staff should be available to provide further technical assistance. Having the participants implement their projects based on their own identified needs and evaluating their own programs should increase their ownership of the project and help ensure project sustainability. As stated previously, time is necessary for sustainability. Staff may need to be involved for several years before the faith communities are capable of assuming full responsibility for their projects. As the project remains visible in the communities, members may show an increased awareness of its presence and more individuals may participate. Funding agencies and health department staff must also be committed to the ongoing presence of the project and supportive of the time necessary for building sustainable programs.

Conclusion

Commitment to the project and pastoral support and involvement were found to be critical for

successful implementation and sustainability of the project. Staff support was also important. The faith communities were all unique. Adequate training of the volunteers enabling them to find the resources and strengths they need to address the issues they encounter was necessary. Community-focused programs take time to build awareness of the activities offered. Time is also required for community members to ascertain possible benefits of participation. Building trust through the continued presence in the community also requires time. Respect must be given not only to starting where people are, but also recognizing that new programs such as this require ample amounts of time and interaction between the staff and the volunteers.

Further research is warranted in creating healthy communities and development of other community health education programs that emphasize building capacity, community competence, and critical awareness through faith communities. Increasing opportunities for participant-driven programs and collaborations may help reduce health disparities and increase years of quality life. Such programs can lead to healthy, productive communities.

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