faith community nurses INTERNATIONAL

International Journal of Faith Community Nursing

Volume 6
Issue 1 *Fall*

Article 5

October 2021

Spiritually Influenced Health: Results of a Health Promotion Initiative in Houses of Worship

Crystal C. Shannon
Indiana University Northwest

Follow this and additional works at: https://digitalcommons.wku.edu/ijfcn

Part of the Other Nursing Commons

Recommended Citation

Shannon, Crystal C. (2021) "Spiritually Influenced Health: Results of a Health Promotion Initiative in Houses of Worship," *International Journal of Faith Community Nursing*: Vol. 6 : Iss. 1 , Article 5.
Available at: https://digitalcommons.wku.edu/ijfcn/vol6/iss1/5

This Article is brought to you for free and open access by TopSCHOLAR®. It has been accepted for inclusion in International Journal of Faith Community Nursing by an authorized administrator of TopSCHOLAR®. For more information, please contact topscholar@wku.edu.

Introduction

Integration of faith-based approaches to health are commonly referenced in healthcare regimens. However, the actual process occurs less frequently than many health providers might admit, thus reducing the overall effectiveness of care delivery (Cone & Giske, 2017). Individuals and families in minority communities, African Americans, for example, often seek health related answers from spiritual and faith-based sources (Goode, 2018). In fact, some minority populations are often more likely to incorporate spirituality, religion, and faith into every day health practices than their White counterparts (Pew Research Center, 2021). Although faith-based organizations within these communities provide a cultural, spiritual and social support system to the populations, they may not effectively provide for the health needs of the congregant.

Existing Literature

The influence of faith is ever present in many minority neighborhoods, but the rates of conditions, such as heart disease, obesity, and respiratory disease remain higher for these groups than the national average (National Center for Health Statistics, 2021). The integration of health promotion and prevention activities provides an opportunity for health providers to partner with faith and spiritual leaders to address major determinants for health and potentially reduce risk factors (Callaghan, 2015). The collaboration between health professionals and faith-based organizations (FBOs) with the goal of improving community health, is not new and is frequently employed by a variety of health care professionals (Shillam et al., 2012; Zahnd et al., 2018; Pappas-Rogich, 2012; Callaghan, 2015). However, given the continued concerns about the health of at-risk communities, additional calls for intervention and action remain.

Many communities fail to have consistent access to preventative care, thus impacting the health outcomes of the congregant. Additionally, healthcare professionals recognize that available care providers are often culturally different than the population served (Goode & Landefeld, 2018). This potentially creates a disparity in health support and treatment. Community-based collaborations performed with FBOs provide opportunities for targeted partnerships with trusted entities (Timmons, 2015). Horton et al. (2014) acknowledged the benefit of such partnerships by specifically exploring the efforts of a university team and FBO to address the health benefits of increasing physical activity and promotion of nutritionally valuable meals. The authors acknowledge that in spite of a challenge of limited trust, the collaboration demonstrated improved health as evidenced by weight and blood pressure reductions and increases in nutritional intake for the congregant. Chase- Ziolek (2015) acknowledged the positive impact of health delivery within a faith-based setting and suggested the church as a routine site for delivery of health services. Furthermore, all collaborations do not require the direct involvement of traditional healthcare providers when delivering health information and several studies demonstrate equally effective health outcomes with the use of lay health educators and subject matter experts (SMEs) (Tetty et al., 2016; Johnston et al., 2017; Sharpe et al., 2018).

Purpose

Despite existing examples of faith and healthcare collaborations, research continues to demonstrate the need for additional measures to improve health education. This paper describes the results of a health promotion initiative with four faith organizations, explores the impact of educational sessions on health habits of the FBO participants, and discusses lessons learned. Future opportunities for collaboration between nurses and FBOs are discussed.

Methodology

The Health Promotion and Education Program

A health promotion initiative was developed with undergraduate nursing students and course faculty in connection with a service-learning health promotion class. Students and faculty collaborated with regional faith organizations between fall 2015 and fall 2018. IRB approval was received from the involved university. The initiative was designed with members of locally based faith organizations to explore important concepts related to health literacy, navigation of the healthcare system, nutrition, and heart health. Potential topics were identified based on current healthcare data on morbidity and mortality rates, gender, age, and ethnicity applicable to the selected area.

Setting and Sample

The Midwestern region of focus exhibits higher than national average rates of cardiovascular disease, obesity, and respiratory conditions and is ranked as one of the least healthy counties in the state (National Center for Health Statistics, 2021; County Health Rankings and Roadmaps, 2021). Additionally, the area is widely diverse in terms of racial, ethnic, faith, and socio-economic status. The county has a total of 485,493 residents of which 53.8% are White and 46.2% are minorities (African American, Hispanic, Asian,). The median household income is $56,128 (US Census Bureau, 2019).

All FBOs within the county (N=516) were contacted by nursing student program assistants via phone for possible participation in the health sessions. Churches were identified from local resources such as yellow pages, internet databases and windshield surveys. A total of 30 FBOs (6% of the faith group database) indicated they were interested in health education

sessions. A convenience sample of 10 FBOs from the interested group were contacted via mail to determine willingness to participate in the health education sessions. A total of four churches (*n*) responded, confirmed interest in participating and were included in the health education training between fall 2015 and fall 2018.

Prior to the initiation of any educational sessions, pastoral leadership was consulted at all organizations to determine perceived importance of potential educational topics. Additionally, pastors or designated church leaders shared feedback on specially requested areas of interest such as medication education and health programming logistics. After approval, program participants were recruited by flyers shared by church leadership.

Instrument

All participating members received an initial health literacy assessment using a modified existing tool (REALM-R©; Bass et al., 2003) and completed a survey identifying current health habits and risk factors. The REALM-R© is a validated assessment tool acknowledged by the Agency for Healthcare Research and Quality (AHRQ) as an effective method for determining basic health literacy ability. The tool is a screening instrument for assessment of an adult patient's ability to read common medical terms. The tool is a word recognition test and not an evaluation of reading comprehension. Adults are asked to pronounce the words they are shown and a point is given to their score. The tool was modified for use in this study to include scoring for the ability to define the words. This approach was taken in recognition of the fact that many patients receive discharge instructions with medical terminology and verbiage in which they may be unfamiliar. A total score of 16 could be achieved with the modified tool. The health

assessment survey was designed to explore nutritional habits, tobacco and alcohol use, physical activity, and personal perceptions of current health status.

Procedure

Upon completion of the initial health habits survey, a series of health promotion educational sessions were delivered over the course of four to six consecutive weeks as determined by FBO leadership. A different topic was presented at each session that lasted 60 to 90 minutes. The majority of the events were delivered as health education seminars with SMEs leading the program. Workshop topics included navigating the healthcare system, diet and nutrition, stress management, and exercise. The seminars were taught by dieticians and nutritionists, physical therapists and exercise physiologists, or Registered Nurses. Following the presentation, participants joined in interactive Q&A sessions and active demonstrations of meal prep, yoga, or exercise often involving audience participation. Visual aids, such as PowerPoints, hand-outs, and videos were used. Extra copies of all visual aids were provided to church leadership upon completion in support of continued efforts to promote follow-up engagement in health promoting behaviors. The sessions were delivered at the time of day, day of the week, and physical location as determined by the faith leaders or Pastor. The following describes the timing and location of the health education events for each of the faith groups participating in the sessions:

- FBO1 met during the course of regular Sunday service inside the main sanctuary.
- FBO2 met immediately after regular Sunday service inside the main sanctuary.
- FBO3 met immediately after Sunday service in a designated classroom in a building located adjacent to the main sanctuary.

- FBO4 met on a weeknight after Bible class in the rear of the main sanctuary.

A gift card was provided to participants for enrolling in the health promotion initiative. Congregants were reassessed by the health habits survey at the end of the four to six week workshop to evaluate changes to their health habits and to receive feedback on programming delivery. Additionally, participants were followed up and reassessed at three months, six months, and twelve months after completion of the educational programming to determine sustainable impact of the education on health habits. Finally, upon completion of the last health education session, faith leaders were anonymously and electronically surveyed on perceived effectiveness of the programming and likelihood of the congregation to implement health education. Additionally, faith leaders provided feedback on any prior delivery of health education as a part of the church ministry, the likelihood of continued delivery of the health education provided by the SMEs, and the existence of a faith community nursing/ parish nursing program.

Data Collection and Analysis

A one-group pre-test-posttest quasi-experimental design was utilized to explore the effects of faith-based health sessions on health habits. Data were collected in the aggregate via a paper survey delivered by nursing student program assistants and entered into an electronic survey tool (Qualtrics ©) for analysis. Survey results are reported as mean ± SD with qualitative analysis of textual comments performed using a general inductive approach for categorization and thematic coding.

Results

Between 2015 and 2018, four faith organizations participated in a total of 23 health education sessions with each FBO receiving a series of three to six sessions. The participants

provided initial insight into their current health status and provided feedback on the impact of the session on their health after completion. Additionally, participants were followed post program delivery at three, six, and twelve months to identify sustained changes and perceived impact on health. All participating FBOs were located in a Midwestern city with a large minority population (85%) and an annual household income of $32,000 (US Census Bureau, 2019).

The self-reported faith denomination of all of the host FBOs was Baptist with an average church membership between 50 and 75 members. Direct and indirect Faith leader involvement was present in all four organizations. Church leaders were consulted on the health education protocol, delivery schedule, and implementation site. Attendance varied from five to fifteen members at each health session event. A total of 136 participants engaged in the 23 health sessions. However, some participants did not participate every week but attended sessions based on interest and personal availability. Extra copies of handouts and flyers were left with the host FBO for members unable to attend. Participants and faith leadership reported feelings of appreciation for this informal approach.

Demographic breakdown of the event participants was 82% female, 18% male, and 93% African American. The majority (60%) of session participants were college educated and had an annual household income of $40,000 to $50,000. This is a significant difference in income when compared to the city of focus (median income of $31,936) and county of focus (median income $56,128; US Census, 2019). The age ranges for the session participants were split across two age groups (40-60= 35% and 61-80= 37%).

Survey results

The results of the modified REALM- R© health literacy analysis revealed the participants were at risk for poor health literacy with an average score of 10.6 out of 16. This is significant in that health literacy is defined as the ability to understand and act on basic health information (Centers for Disease Control and Prevention, 2021). The results from the modified REALM-R© demonstrated that session participants required additional assistance and support in understanding healthcare information. In addition to the health literacy assessment, pre-session participants also shared information on existing health habits. Initial responses revealed 46% of participants reported they drank alcohol in some manner. Additionally, although 25% shared that they had given up smoking, 4% of participants stated they continued to use tobacco. More than a quarter of the participants (28%) admitted to a sedentary lifestyle and only engaged in light activities like sitting at a desk. When asked about perception of diet, 23% of participants reported their current diet to be healthy.

Some changes in health habits were noted in participants at various points during the program. After completion of the program there was a 15% decrease in alcohol use and a 21% decrease after 12 months. Additionally, none reported continued smoking of tobacco at the 12 month evaluation. Immediately after completion of the health sessions, participants reported a 16% increase in activity levels from light to moderate and a 35% increase when evaluated at 12 months post session delivery. Survey respondents also reported a 24% increase in daily exercise post session from none at all to exercising 30 minutes to two hours. At 12 months post session completion, the group reported a 26% increase from no exercise to exercising two to four hours in one day. When asked about perception of current diet post event, 28% of participants reported their diet as being healthy while 28% reported it was healthy pre-session. However, only 17% of

participants reported perceptions of engaging in a healthy diet at 12 months post session participation. This suggests additional support may be needed to promote persistence.

At the 12 month follow up, 88% of participants stated they had changed their health habits since the original health education sessions. When asked about the area of greatest change, respondents reported the following: blood pressure, exercise, and nutrition. Participants also shared that they believed they needed additional support in diet and nutrition, exercise guidance, and coaching to make and maintain healthy lifestyle changes. Survey participants shared similar comments on personal effort for better outcomes. Comments from congregants included:

- “Information was informative…encourages to continue to make changes.”
- “…lack of motivation (is) reason for lack of exercise…”
- “Health and exercise are very important to the overall function of a person. Thank you for adding value for the 6 weeks in my life.”
- “I have changed my lifestyle and lost 57 pounds!”
- “.... The health literacy project was timely, informative and beneficial, the information has been useful in continuing dialogue and continued improvement in lifestyle changes.”
- “The health literacy raised my awareness which enables me to use the knowledge to make better choices when I can.”

Faith Leader and Organization Characteristics

Faith leaders were contacted early in the planning phase to gain insight to FBO needs and preferences for delivery options. Pastors were contacted in-person or by telephone in FBO 1, 2, and 3 while a health ministry leader was consulted in FBO 4. All leaders welcomed initial meetings to discuss the details of the health education sessions. Further engagement varied

among the four faith leaders. For the purposes of this paper, engagement is defined as active involvement with planning, delivery, and evaluation of the health education sessions. All four leaders were supportive of follow up congregational evaluations of health status at three, six, and twelve months. Details on the characteristics of the faith organizations and the health promotion sessions are included in Table 1.

Table 1 Characteristics of FBO health education session delivery.

Designation	Contact Person	Day of Program Delivery	Timing of Program Delivery	Location of Program Delivery	Modified REALM-R Avg. Score*	Number of total HP sessions	Continued Engagement of faith leader **
FBO1	Pastor	Sunday	Middle of Sunday service	Main sanctuary	12.2	6 sessions (consecutive weekly)	Yes
FBO2	Pastor	Sunday	After main Sunday service	Main sanctuary	10.8	6 sessions (consecutive weekly)	Yes
FBO3	Pastor	Sunday	After main Sunday service	Classroom, off-site (next door to church)	8.8	4 sessions (spread out over 6 non-consecutive weeks)	No
FBO4	Health Ministry Leader	Mid-week (Wednesday-Thursday)	After Bible class	Back of main sanctuary	10.8	4 scheduled but only delivered 3 sessions per request (consecutive weekly)	No

**Scores of <=12 indicate reduced health literacy*
*** Engagement = active involvement with planning, delivery, and evaluation of the health education sessions*

Upon completion of the health sessions, the four faith leaders were surveyed and all reported that they believed that the health sessions were effective, that the congregation would implement the methods discussed in the sessions, and that they would implement formal health education as a part of their ministry. Half of the respondents reported they did not receive any training on health education as a part of their formal ministry and none reported having a parish or faith

community nurse in their organization. However, all agreed they would be interested in developing such a program. Comments from faith leaders included:

- "…sessions were very effective with moderate expectations of sustained change in health habits."
- "I am an advocate for health and fitness. I am working to lead by example."
- "The health literacy program was a valued part of our ministry construct and bringing the information to the congregation was most helpful. The dialogue in regards to improving overall health has sparked great interest and additional information and sessions are requested. Thank you so much…"

Discussion

The health promotion education sessions reached a total of 136 persons at four different faith organizations and generated changes to existing and future health habits for participants. This is significant in that it demonstrates the impact of coordinated efforts to promote sustainable improvements for knowledge and health of at-risk communities. Additionally this study highlights the potential use of health professionals in the supportive role of program planners as opposed to being used strictly for health assessments and educational content delivery. The health assessments, education and coaching were provided by SMEs with a focus on a given topic. This allowed the health promotion organizers the opportunity to focus on programming details, additional FBO support and management of program delivery.

The health education sessions were designed with the participation of SMEs brought into the congregants' environment as opposed to having them attend the training sessions at outside community clinics, schools or other centers. This is important as it promotes community-

centered care, allows health professionals to engage with the public in their own settings, and promotes trust (Derose et al., 2019). The concept of community centered health promotion (CCHP) is not vastly different from the clarifications currently existing in the literature regarding community health and community-based health. Goodman et al. (2014) acknowledge that community health is the integration of population health management. This is often non-medical interventions which require multidisciplinary efforts, evidence-based strategies and a focus on health equity. Community-based care is focused on the delivery of health care services such as assessments, education, and treatment within the community and outside of traditional health settings of clinics and hospitals. The prospect of bringing health care services especially primary prevention modalities such as education to traditional community settings like churches supports convenience, commitment to relationship development, and capacity building. All of these aspects are necessary to establish a trusting relationship with minority populations (DeCorby-Watson et al., 2018). Trustworthiness is a primary focus for healthcare providers wanting to support effective delivery of care and adherence with healthcare guidance (Griffith et al., 2010). The decision to bring the healthcare education services to the various faith groups demonstrated a commitment from healthcare professionals toward the congregant and a desire to build trust within the communities.

Lessons Learned

There were several lessons learned from the implementation of this project. One of the most important aspects of the project revolved around fluidity of design. The researchers recognized very early in the developmental stage of the project the need for flexibility in program delivery. This was often based on initial requests of the faith leader and the varying needs of the congregation. For example, FBO4 was originally designed to receive four health

sessions over four consecutive weeks on Tuesdays after Bible class. During a session in week two the participating congregants reported they would prefer to limit the sessions to only one more week so that they could begin planning a long-anticipated church event. This required the participants to stay longer than the planned 60 minutes and it also required the planning team to begin presenting subsequent materials to the participants sooner than planned and without immediate SME support. Despite this change participants were appreciative of the introductory materials and openly shared the new schedule and introductory educational materials with other congregants. This positively impacted attendance at the third and final event with twice as many participants than anticipated. Feedback from the participants was overwhelmingly positive and they voiced appreciation of the willingness to adjust planned program delivery.

Another lesson learned was that continued support and follow up was not only desired but also needed by the health promotion session participants in the program. Survey participants reported decreased perception of engagement in a healthy diet at twelve months post- health session delivery. This suggests an opportunity for continued support to the FBOs. However, that may not be sustainable for many healthcare providers and in fact may be an opportunity to develop an FBO-based program within the church where outside healthcare professionals are utilized as consultants or program developers for FBO-based lay health coaches. The lay health coaches could support the delivery of current medical information and coordinate involvement of SMEs similar to this program for recurring sessions to promote engagement and development of healthy lifestyles. Several studies have demonstrated positive outcomes with such a model and this approach may be beneficial with future efforts (South et al., 2014; Lancaster et al., 2014; Galiatsatos et al., 2016).

A recommendation for future delivery of this and similar health initiatives would be to compare attendance rates of the health education sessions to attendance at the prior church service. Despite at least one FBO having the health education sessions on a week night instead of a Sunday, all FBO health education events occurred after attendance at a pre-scheduled church meeting. Knowledge of the potential influence of attendance at a prior church session may better guide program design and encourage additional attendance at the follow up health promotion event.

Limitations

The limitations for the project included small sample size and varied characteristics of participants and therefore may not be generalizable to all populations. Although the researchers were able to obtain detailed demographic information on the participants completing the pre- and post-session health habits survey, they did not continue to collect that information at each of the health education sessions. The rationale for that decision was a desire to limit the emphasis on research and focus on the provision of needed education for the FBO community. The project team believed this was essential in the development and maintenance of trust with the faith groups. In addition, attendance was not formally taken at each of the sessions and sign in sheets were not utilized to further support an informal and open attendance culture. However, lack of these data limited our understanding of the possible influence of weekly health session participation on developing sustainable habits. Therefore, future delivery of this and similar programs are recommended to obtain informal attendance of the total head count, identification of prior session attendance and basic demographic data in order to follow and analyze continuation of engagement. This data would provide improved cross tabulation analysis that may lead to determine effective program design.

Although not specifically recognized as a limitation, timing of session delivery was noted as a potential influencing agent on participation by both member participants and faith leaders and pastors. Challenges were noted in maintaining interest in weekly attendance. Measures were taken to reduce formality and improve ease of participation by not requiring sign in sheets and providing open invitations for congregants not participating in prior sessions. However, this influenced the ability to track follow up and continued engagement. Despite this challenge, anecdotally the researchers noted the majority of participants (53%) that began the sessions completed the sessions and the post program evaluation. Additionally, the project team recognized that the health sessions with the greatest engagement from participants and faith leaders were FBOs deciding to host the health sessions either during or immediately after Sunday service in the main sanctuary. The decision to host the sessions either as a part of or adjacent to regular Sunday service may be a motivating factor and sign of trust from the faith leader to the congregation. This requires additional exploration. The role of faith leaders on establishing trust with the congregation can have a significant impact on any faith-based initiative (Opalinski et al., 2015).

Conclusion

The results of this program suggest changes in knowledge of health influence perception and action on healthy behaviors. Additionally, the results support a body of knowledge that promotes healthcare delivery within community-based faith settings. Nurses have an opportunity for an expanded role in reducing the health risks of faith-based organizational groups by the development and implementation of regular faith-based programming in support of health education and promotion. Nursing students were involved in the initiative as program assistants which provided them with a valuable learning experience by promoting diversity awareness and

the role of spirituality in healthcare decision-making (Preston, 2018). The collaboration with faith leaders provides opportunities for role modeling, capacity building, and sustainability.

Nurses are in a unique position to support the health of faith groups. The educational knowledge, practical skills and existing trust with the community allow for the development of a collaborative relationship with faith groups. Collaborative partnerships with FBOs link healthcare delivery to groups in need. Clear recognition and activation of this relationship may be a source to establishing impactful and sustainable community health.

References

Bass, P. F., 3rd, Wilson, J. F., & Griffith, C. H. (2003). A shortened instrument for literacy screening. *Journal of General Internal Medicine*, *18*(12), 1036–1038. https://doi.org/10.1111/j.1525-1497.2003.10651.x

Callaghan, D. M. (2015). The development of a faith community nursing intervention to promote health across the life span. *International Journal of Faith Community Nursing, 1*(2), 9-20.

Centers for Disease Control and Prevention. (2021). *What is health literacy*? Health Literacy Basics. https://www.cdc.gov/healthliteracy/learn/index.html

Chase-Ziolek, M. (2015). (Re)claiming the church's role in promoting health: A practical framework. *Journal of Christian Nursing*, *32*(2), 100-107. doi: 10.1097/CNJ.0000000000000153

Cone, P. H., & Giske, T. (2017). Nurses' comfort level with spiritual assessment: A study among nurses working in diverse healthcare settings. *Journal of Clinical Nursing*, *26*(19-20), 3125-3136. https://doi.org/10.1111/jocn.13660

County Health Rankings and Roadmaps. (2021). Indiana. University of Wisconsin Population Health Institute. County Health Rankings State Report. https://www.countyhealthrankings.org/

DeCorby-Watson, K., Mensah, G., Bergeron, K., Abdi, S., Rempel, B., & Manson, H. (2018). Effectiveness of capacity building interventions relevant to public health practice: A systematic review. *BMC Public Health, 18*(1), 684. https://doi.org/10.1186/s12889-018-5591-6

Derose, K., Griffin, B., Kanouse, D., Bogart, L., Williams, M., Haas, A., Florez, K., Collins, D., Hawes-Dawson, J., Mata, M., Oden, C. & Stucky, B. (2016). Effects of a pilot church-based intervention to reduce HIV stigma and promote HIV testing among African Americans and Latinos. *AIDS & Behavior, 20*, 1692-1705. doi:10.1007/s10461-015-1280-y

Galiatsatos, P., Sundar, S., Qureshi, A., Ooi, G., Teague, P., & Hale, W. D. (2016). Health promotion in the community: Impact of faith-based lay health educators in urban neighborhoods. *Journal of Religion and Health*, *55*(3), 1089-1096. doi: 10.1007/s10943-016-0206-y

Goode, C. A., & Landefeld, T. (2018). The lack of diversity in healthcare: Causes, consequences, and solutions. *Journal of Best Practices in Health Professions Diversity: Education, Research & Policy, 11*(2), 73–95. https://www.jstor.org/stable/26894210

Goode, P. (2018). Integrating biblical principles into diabetes self-management education for African Americans. *International Journal of Faith Community Nursing, 4*(2), 1-7.

Goodman, R. A., Bunnell, R., & Posner, S. F. (2014). What is "community health"? Examining the meaning of an evolving field in public health. *Preventive Medicine*, *67 Suppl 1*(Suppl 1), S58–S61. https://doi.org/10.1016/j.ypmed.2014.07.028

Horton SE, Alvear EE, Horton DL. (2014). Health ministry partnerships: Creating a habit for health. *Journal of Christian Nursing, 31*(1):28-33. doi: 10.1097/cnj.0000000000000030

Johnston, J. A., Konda, K., & Ablah, E. (2018). Building capacity among laity: A faith-based health ministry initiative. *Journal of Religion and Health*, *57*(4), 1276-1284. doi: 10.1007/s10943-017-0445-6

Lancaster, K. J., Schoenthaler, A. M., Midberry, S. A., Watts, S. O., Nulty, M. R., Cole, H. V., Ige, E., Chaplin, W., & Ogedegbe, G. (2014). Rationale and design of faith-based approaches in the treatment of hypertension (FAITH), a lifestyle intervention targeting blood pressure control among black church members. *American Heart Journal*, *167*(3), 301-307. doi: 10.1016/j.ahj.2013.10.026

National Center for Health Statistics. (2021). Stats of the States. https://www.cdc.gov/nchs/pressroom/stats_of_the_states.htm

Opalinski, A., Dyess, S. M., Stein, N., Saiswick, K., & Fox, V. (2017). Broadening practice perspective by engaging in academic-practice collaboration: A faith community nursing exemplar. *International Journal of Faith Community Nursing, 3*(1), 1-8.

Pappas-Rogich, M. (2012). Faith community nurses: Protecting our elders through immunizations. *Journal of Christian Nursing*, *29*(4), 232-237. doi: 10.1097/CNJ.0b013e318266efe5

Pew Research Center. (2021). Religious Landscape Study. https://www.pewforum.org/religious-landscape-study/racial-and-ethnic-composition/

Preston, P. (2018). Faith community nursing in community/public health education: A positive student nursing experience. *International Journal of Faith Community Nursing, 4*(2), 8-12.

Sharpe, P. A., Wilcox, S., Kinnard, D., & Condrasky, M. D. (2018). Community health advisors' participation in a dissemination and implementation study of an evidence-based physical activity and healthy eating program in a faith-based setting. *Journal of Community Health*, *43*(4), 694-704. doi: 10.1007/s10900-018-0473-5

Shillam, C. R., Orton, V. J., Waring, D., & Madsen, S. (2013). Faith community nurses & brown bag events help older adults manage meds. *Journal of Christian Nursing*, *30*(2), 90-96. doi: 10.1097/CNJ.0b013e3182831eff

South, J., Purcell, M. E., Branney, P., Gamsu, M., & White, J. (2014). Rewarding altruism: Addressing the issue of payments for volunteers in public health initiatives. *Social Science & Medicine*, *104*, 80-87. doi: 10.1016/j.socscimed.2013.11.058

Tettey, N. S., Duran, P.A., Andersen, H.S., Washington, N., & Boutin-Foster, C. (2016). "It's like backing up science with scripture": Lessons learned from the implementation of HeartSmarts, a faith-based cardiovascular disease health education program. *Journal of Religion and Health, 55*(3)**,** 1078–1088. https://doi.org/10.1007/s10943-016-0196-9

Timmons, S. (2015). Review and evaluation of faith-based weight management interventions that target African American women. *Journal of Religion & Health, 54*(2), 798-809. doi:10.1007/s10943-014-9912-5

US Census Bureau (2019). QuickFacts: United States. https://www.census.gov/quickfacts/fact/table/US/PST045219

Zahnd, W.E., Jenkins, W.D., Shackelford, J., Lobb, R., Sanders, J., & Bailey, A. (2018). Rural cancer screening and faith community nursing in the era of the affordable care act. *Journal of Health Care for the Poor and Underserved, 29*(1), 71-80. doi:10.1353/hpu.2018.0008