



Engaging Faith-Based Organizations to Promote Health Through Health Ministries in Washington, DC

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Abstract

This article describes capacity building and formative assessments completed at five faith-based organizations (FBOs) in Washington, DC to inform sustainable health promotion programming led by certified health ministers. Five FBO partners were recruited with two congregation members from each FBO completing a health minister certificate program. A series of health assessments were conducted to assess each FBO's capacity to implement evidence-based lifestyle change programs that are responsive to congregation members' health needs. Results indicated a need for programming to support older adults in managing high blood pressure and arthritis. Health ministers represent a significant opportunity for building capacity within FBOs to deliver programming that can improve health outcomes.

Keywords Faith-based health promotion · Community health · Capacity building · Health ministers

Introduction

Nearly two-thirds of Americans will be affected by chronic disease in their lifetime, with over 40% experiencing multiple chronic conditions (Buttorff et al., 2017). African Americans disproportionately face unfavorable social conditions that create greater risk for chronic disease including hypertension, diabetes, and stroke (Cuffee et al., 2012; Fei et al., 2017; Gaskin et al., 2014; Tsao et al., 2022; Williams et al., 2019). Lifestyle interventions yield some promising improvements in clinical outcomes relevant to chronic disease, such as blood

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pressure or dietary choices (Lemacks et al., 2013); however, additional strategies are needed to cultivate broader environmental and systems supports (Kumanyika, 2019), as well as enhance program engagement and retention (Lemacks et al.). To date, faith-based organizations (FBOs) have been an underutilized setting for health promotion (Levin, 2014), although success of these settings in achieving improved health outcomes across a variety of indicators has been shown (Brown et al., 2019; DeHaven et al., 2004; Hardison-Moody & Stallings, 2012; Hardison-Moody & Yao, 2019; Whisenant et al., 2014).

FBOs are a longstanding source of strength and support in the African American community, making them uniquely positioned to encourage healthy lifestyle modifications (Brewer & Williams, 2019). African Americans are the most likely ethnic group in the United States to report a belief in God, to report that religion is very important in their life, and to attend church services regularly (Pew Research Center, 2020). Indeed, FBOs are frequently described as the hub of the African American community, providing not only opportunities for worship, but also community resources and connections related to education, housing, social support, and food (Brewer & Williams; Mohamed et al., 2021; Williams et al., 1999). Thus, FBOs are familiar, trusted settings for African Americans to receive health information. Moreover, many African Americans perceive a strong connection between their health and spirituality (Holt & McClure, 2006), further highlighting the promise of FBOs in health promotion. Aspects of biblical scripture also align with health promotion, such as the notion of the “body as a temple,” which should be kept healthy, along with the promotion of a more holistic idea of health that considers spiritual, physical, and mental health (Holt & McClure).

Faith-based interventions are commonly conducted by a health ministry that connects components of faith with health concepts, often in partnership with health professionals (Allen et al., 2015; Bopp et al., 2012). Their activities support the overall mission of the FBO (Levin, 2014). A central component of many faith-based interventions involves training congregation members to serve as lay health advisors, or “health ministers” (Ammerman et al., 2003; Kim et al., 2008; Lee et al., 2018; Yeary et al., 2011). Health ministers are respected, active members of the church who can facilitate health-based programming and generate interest in participating. Certified health ministers look at policies, systems, and environmental strategies that will support the health of the broader congregation, in addition to identifying the programs that are responsive to the needs and interests of congregants to create positive health outcomes (Health Ministries Association, 2018; Simoni et al., 2011). Utilizing a peer-to-peer approach for health-based programming increases cultural responsiveness and relevance to one’s faith-based community, while also enhancing capacity and sustainability of these programs (Allen et al., 2015; Chaudhary et al., 2019; Newlin et al., 2012). Faith-based intervention strategies implemented by a health ministry include individual-level strategies (e.g., motivational interviewing with congregation members), group-level interventions (e.g., a walking group), and church-level strategies (e.g., providing healthier food offerings at church events) (Lancaster et al.; Wilcox et al., 2010).

The present paper presents the methods and formative research results for “Faithfully Fit,” a faith-based program that aims to create a culture of health and wellness in five FBOs in Washington, DC. Faithfully Fit uses a social ecological framework (Bergeron et al., 2017; Bronfenbrenner, 1981) to improve the management and prevention of chronic disease. A social ecological framework identifies the spheres of influence on behavior, beginning with the individual factors of knowledge and attitudes, expanding to the interpersonal sphere of social relationships, then further expanding to the context of one’s role within the broader environment of organizations including schools, workplaces, faith-based communities, and finally considering systems and policies (Bronfenbrenner). In applying the social ecological model within a faith-based intervention, relevant factors include the individuals connected to the FBO (both members and leadership) and their personal beliefs, knowledge, and practice of health behaviors; the interactions of FBO leaders and members that create the social fabric of each unique place of worship; the physical environment as a place of gathering and community, and the direct and indirect information members receive about health; and finally, the influence of the broader community in which the church is located, the available resources and inputs, and the links to other community events and happenings (Fig. 1). Overall, there are numerous outlets and opportunities in which faith leaders and congregants send and receive messages connecting faith and health, and the importance of each, in daily life. This social ecological approach also aligns with Kumanyika’s Equity-Oriented Obesity Prevention Framework (2019), which recommends building on community capacity through strategic partnerships that empower communities to engage in healthy behaviors.

Faithfully Fit uses a two-pronged approach to influence the social environment of each FBO. First, the program assists in building the capacity of each FBO by identifying current members who are interested in participating in a health minister certificate program. This use of a peer-to-peer approach is grounded in the notion that a shared cultural background between health ministers and congregation members facilitates greater credibility and understanding in the delivery of interventions, while also building capacity within the organization itself (Eng & Hatch, 1991; Eng & Young, 1992). Second, Faithfully Fit will assist these newly certified health ministers in delivering health promotion programs that serve the needs of each congregation and are more sustainable over the long-term.

Herein we describe the work accomplished in the first year of Faithfully Fit, which focused on establishing our partnerships with each FBO, capacity building via health minister training, and formative assessments of the existing resources and efforts within each FBO. To lay a strong foundation for health ministry programming going forward, the program team sought to establish trust and build relationships while better understanding the culture of each partnering FBO; their priorities; and the unique assets, needs, and resources of each congregation that support capacity and build readiness to offer sustainable health ministry programming going forward.

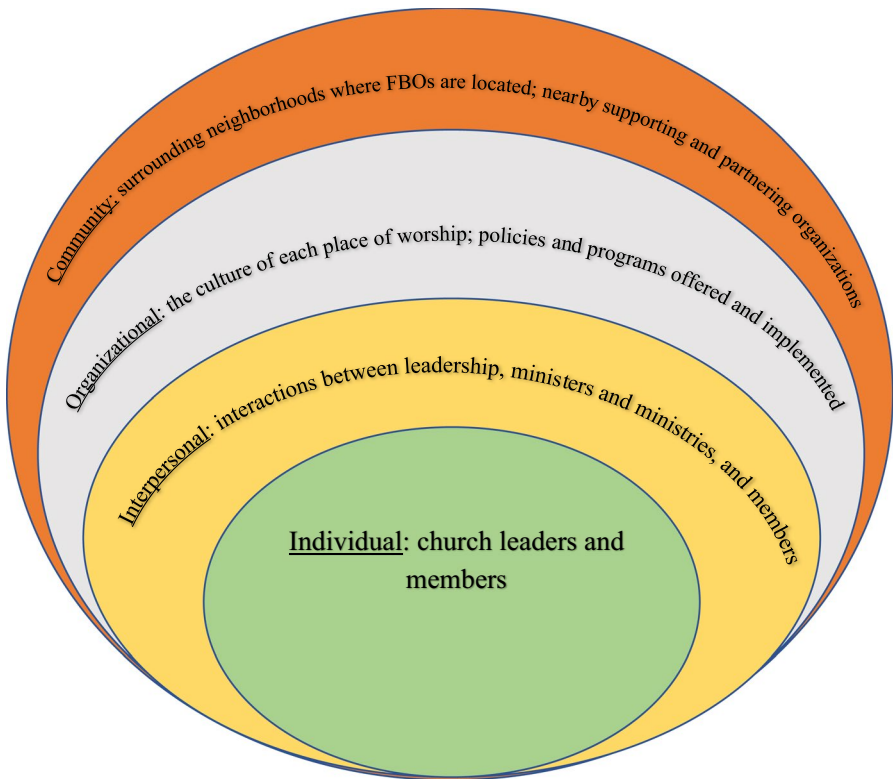


Fig. 1 Application of the social ecological model to faith-based organizations

Methods

Participating FBOs

The origin of this work was built on the pre-existing connections and partnerships between the Heal the Sick program (described below) and faith-based organizations that were developed prior to the start of this project. Crucial to the commencement and sustainability of Faithfully Fit were the already trusting and established relationships in place with predominantly African American FBOs in Washington, DC. This history, and the respected linkages between FBOs and the Heal the Sick Program, created a strong foundation upon which to launch the project. Initially, seven faith-based organizations were invited to participate in the Faithfully Fit program based on recommendations from the existing network of churches who have participated in the health ministry certificate program. All participating FBOs are located in communities where disparities in chronic conditions including heart disease and diabetes exist (District of Columbia Department of Health, 2011; Kret et al., 2014). FBOs were selected based on their location, ability to use technology to fulfill program requirements, pastoral leadership

and support for the project, an already active health ministry, and strong pastoral presence in the community and in their current ministries; criteria aligning with the seven key elements identified by Peterson et al. (2002) for effective faith-based health promotion. The components of church leader engagement and a pre-existing health ministry are “pillars” that were essential for meaningful capacity building and future sustainability. They demonstrate attention to and an investment in building the infrastructure for delivering consistent and relevant programming within the congregation (Austin & Claiborne, 2011). These two pillars are key for FBOs to successfully incorporate health promotion programming within their congregation (Johnston et al., 2018; McDonnell & Idler, 2020). Though seven FBOs were identified at the start, two decided the timing of the project did not align with other current priorities and did not participate. Ultimately, the group included five partner FBOs. All research procedures were approved by the American University Institutional Review Board prior to the study start date.

Health Minister Training

Two congregation members from each partner FBO were selected to take part in Heal the Sick, an 8-week hybrid (a combination of in-person and online modules) health minister certificate program that trains members of faith communities to support whole person health. The course was held during the summer of 2019. The certificate program provides foundational language, concepts, critical thinking, self-care, and asset mapping skills in faith and health and explores different health ministry roles and models in numerous faith and health settings. The curriculum is based on national best practice models and standards outlined in the Health Ministries Association’s publication “Health Minister Role: Guidelines and Foundational Curriculum Elements, 2nd Edition” (2018). The hybrid certificate was adapted from the in-person health minister certificate developed in 2014 and the online health minister certificate which began in 2017 by Wesley Theological Seminary. The hybrid certificate addresses a need for whole person health education using the Health Ministries Association’s core curriculum elements and covers 10 educational modules. Each module is 2 to 2 ½ hours in length. Module topics cover nutrition and wellness education, chronic disease management, health ministry models, health insurance, mental health, communication and organization of health ministries, advance care planning, legal considerations, and self-care practices. Participants in the program complete post-course surveys assessing perception of changes in knowledge, competence, and skill resulting from the health ministry course material. Ten congregation members enrolled in the Heal the Sick program. Two dropped out due to other obligations. Eight congregation members completed the program and received the health minister certificate.

Formative Assessment Measures

Environmental Scan

The Faith Community Health Assessment Survey tool (Faithful Families, 2018) was used to assess existing resources and barriers to health promotion. The tool consists of 29 questions covering five areas: Health and Wellness, Physical Activity Policies and Environments, Physical Activity Programs and Education, Healthy Eating Policies and Environments, and Healthy Eating Programs and Education. This measure was completed by church leaders at each of the partner FBOs in June 2019.

Community Windshield Wiper and Walking Tour

As part of the Heal the Sick health minister certificate program coursework, health ministers were tasked with completing a tool to assist them in getting to know the neighborhood surrounding their faith community (McKnight & Kretzmann, 2001). Health ministers were asked to travel around their local community by foot and/or car to identify the health services available (e.g., hospitals, wellness centers, clinics, neighborhood centers), along with facets of the local community that detract from health (e.g., fast food, lack of sidewalks). They were also asked to map out nearby grocery stores, parks, recreational facilities, playgrounds, etc. They were then asked to explore what health messages were promoted on billboards and other signage (e.g., alcohol or cigarette advertisements). Finally, they were asked to summarize challenges and observations noted during the tour, feelings experienced, and what was discovered that could help in planning health activities for their respective congregations. This component intentionally bridges health ministers with their community and lays the groundwork for future programming. It was completed by each health minister on a single day during the summer of 2019.

Health Minister Post-Course Survey

At the end of the Heal the Sick certificate program, health ministers completed a brief survey evaluating their perceptions of the quality of the program and its benefits. Items assessed the perceived value of the certificate (responses given on a 5-point scale from No Value to Excellent Value), the degree to which they would use the knowledge in future (responses given on a 5-point scale from Unlikely to Very Likely), the relevance of the certificate to their work in faith communities (responses given on a 5-point scale from Not at All Relevant to Very Relevant), their degree of knowledge about health ministry (responses given on a scale 5-point scale from No Knowledge to Thorough Knowledge), their perceived competency as a health minister (responses given on a 5-point scale from Not at All Competent to Very Competent), and overall satisfaction with the program (responses given on a 5-point scale from Dissatisfied to Extremely Satisfied).

Faith Community Needs Assessment

Congregation members completed an assessment to measure their individual health behaviors and health needs. The program team followed guidelines from the UMC Health Ministry Network Toolkit (UMC Health Ministry Network, n.d.) to develop a single-page, double-sided needs assessment survey. One item assessed perception of personal health (responses given on a 5-point scale from Very Poor to Excellent). One item assessed health or medical issues that interfered with daily life (participants checked all health conditions that applied from a list of 14 conditions). One item assessed the perceived relationship between health and faith (responses given on a 5-point scale from No Relationship to Strong Relationship). One item assessed neighborhood walkability (responses given on a 5-point scale from Not Walkable to Very Walkable). One item assessed specific health-related activities participants would be most interested in (participants checked all that applied from a list of 11 options, such as “cooking demos” or “walking programs”). Demographics questions assessed age, gender, and race. Each health minister was provided paper copies of the surveys to distribute to congregation members and program team members were available to help administer them at events including health fairs and weekly services. Canvas bags with the Faithfully Fit program logo were provided as an incentive to those who completed the surveys. These surveys were collected during the summer of 2019 at various FBO events.

Data Analysis

Data obtained from the Environmental Scan, Community Windshield Wiper and Walking Tour, Health Minister Post-course Survey, and Faith Community Needs Assessment Survey were examined to provide a full picture of the strengths, weaknesses, and opportunities for health promotion at each faith-based organization. Data were examined using SPSS version 28.0 (*IBM SPSS Statistics for Windows*, 2021). Descriptive statistics were used to calculate the means and standard deviations of health ministers' post-survey responses, congregation members' perceptions of their health, the relationship between faith and health, and neighborhood walkability by gender and age. Frequencies were used to assess the number of resources and barriers listed by each FBO's leadership in the Environmental Scan, the resources and challenges noted by health ministers in the Community Windshield Wiper and Walking Tour, and the medical issues and health-related activities of interest checked by congregation members in the Faith Community Needs Assessment. The program team created one-page summaries for each FBO/health minister that summarized the assessment results and suggested programming ideas for the second year.

Results

Environmental Scan Results

Church leadership at each partner FBO provided responses to the environmental scan (Table 1). This scan identified numerous strengths across FBOs, as well as opportunities for each health ministry to expand their work. For example, an active health team and/or a designated person responsible for health-related activities were present in all FBOs. Church leadership at each FBO had also publicly promoted physical activity in the last 12 months as well as public promotion through posters, flyers, bulletins, or other written materials. The majority of FBOs (80%) had space and equipment needed for nutritious food preparation, indicating an opportunity to sponsor healthy eating demonstrations and cooking classes. The environmental scan

Table 1 Church leadership responses to items assessing the presence of health promotion infrastructure in the environmental scan

Item	% Yes (n)
Does your faith community have a person appointed to be responsible for health-related activities?	100% (5)
Has your faith community had a relationship with another health, health promotion, or human services agency to provide services to your members in the past 12 months?	100% (5)
Do you know of existing community partnerships that add health services to your congregation?	80% (4)
Does your faith community have a playground?	80% (4)
Has leadership promoted physical activity in a public speech or sermon in the past 12 months?	80% (4)
Has your faith community specifically promoted physical activity through posted information in the past 12 months (e.g. bulletin board, posters, flyers, leaflets)?	80% (4)
Has your faith community specifically promoted physical activity in the bulletin or newsletter in the last 12 months?	80% (4)
Does your faith community have a kitchen or place to prepare meals?	80% (4)
Has leadership promoted healthy eating in a public speech, sermon, talk or homily in the past 12 months?	80% (4)
Does your faith community have equipment that allows for preparation of healthier food (steamers, blenders, salad bars etc.)?	80% (4)
Has your faith community distributed any healthy eating guides or healthy recipes to faith community members in the past 12 months?	80% (4)
Has your faith community promoted healthy eating in the bulletin, program or newsletter in the past 12 months?	80% (4)
Does your faith community have any exercise equipment onsite?	60% (3)
Has your faith community organized walking groups in the past 12 months?	40% (2)
Does your faith community have a policy supporting physical activity opportunities at meetings/functions (e.g., prayer walks)?	20% (1)
Does your faith community have a garden or farmer's market on-site?	20% (1)
Has your faith community organized or provided any other nutrition-related classes or groups in the past 12 months?	0% (0)

also uncovered challenges facing partner FBOs, including lack of prior experience facilitating programs related to nutrition (0%), the existence of policies supporting physical activity during church events (20%), and access to community gardens or farmers' markets where fresh produce might be procured (20%).

Community Windshield Wiper and Walking Tour Results

Each health minister toured their FBO's respective neighborhood to assess potential resources and challenges to health programming. Positive attributes of the respective neighborhoods included the presence of recreation centers (noted by 100% of health ministers), libraries (noted by 50% of health ministers), and food banks (noted by 50% of health ministers). Negative attributes of the respective neighborhoods included a lack of grocery stores (noted by 50% of health ministers), many fast food restaurants (noted by 50% of health ministers), and a lack of health clinics (noted by 50% of health ministers).

Health Minister Post-Course Survey Results

Health ministers were asked to evaluate aspects of the Heal the Sick training program on a scale of 1 to 5, with higher scores representing greater satisfaction. Six health ministers completed the survey. Health ministers responded favorably to each of the items, with all scores ≥ 4 on a 5-point scale including the perceived value of the certificate ($M=5$, $SD=0$), the likelihood of using the knowledge ($M=5$, $SD=0$), overall satisfaction with the program ($M=5$, $SD=0$), the perceived relevance of the certificate to their work in faith communities ($M=5$, $SD=0$), their knowledge of health ministry ($M=4.33$, $SD=0.52$), and perceived competency as a health minister ($M=4.33$, $SD=0.52$).

Faithfully Fit Community Needs Assessment Survey Results

Across the five FBOs, a total of 266 people completed the Faith Community Needs Assessment Survey. Participant demographics are presented in Table 2. The average age of respondents was 53.89 years old ($SD=16.91$). The majority of those surveyed identified as women (68.42%) and Black or African American (86.47%). Participants responded to several items related to their health and their community. On a scale of 1 to 5 (Very Poor to Excellent), respondents rated their average health as 3.39 ($SD=0.80$). On a scale of 1 to 5 (No Relationship to Strong Relationship), respondents rated the average relationship between their health and faith as 4.28 ($SD=1.17$). On a scale of 1 to 5 (Not Walkable to Very Walkable), respondents rated the quality of sidewalks in their neighborhoods an average of 3.69 ($SD=1.35$). Table 3 indicates the average response to each of these items by gender and age group. Collectively, participants reported that the most common health or medical issues that interfered with their daily lives were hypertension (51.88%), arthritis (33.83%), diabetes (27.44%), stress (22.56%), obesity (22.18%), and depression (19.55%). Collectively, participants reported that the health programs they would be

Table 2 Member demographics across partner FBOs

	FBO 1 (n)	FBO 2 (n)	FBO 3 (n)	FBO 4 (n)	FBO 5 (n)	All FBOs (n)
Participating members	82	13	51	61	59	266
Average age in years	58.32 ± 23.28	62.00 ± 5.92	56.18 ± 13.00	41.97 ± 17.89	56.90 ± 11.19	53.89 ± 16.91
	FBO 1 (M, SD)	FBO 2 (M, SD)	FBO 3 (M, SD)	FBO 4 (M, SD)	FBO 5 (M, SD)	All FBOs (M, SD)
	FBO 1 (n)	FBO 2 (n)	FBO 3 (n)	FBO 4 (n)	FBO 5 (n)	All FBOs (n)
<i>Gender</i>						
Men	25	3	7	10	18	63 (23.68%)
Women	51	10	40	50	31	182 (68.42%)
Non-binary	0	0	0	0	0	0 (0%)
No response	6	0	4	1	10	21 (7.89%)
<i>Race/ethnicity*</i>						
Asian American	0	1	0	2	0	3 (1.13%)
Black/African American	70	13	48	51	48	230 (86.47%)
Hispanic/Latinx	1	1	0	2	0	4 (1.50%)
Native American	1	1	2	1	1	6 (2.26%)
Pacific Islander	0	0	0	2	0	2 (0.75%)
White	0	1	1	6	4	12 (4.51%)
Other	0	0	1	3	1	5 (1.88%)
No response	7	0	2	4	8	21 (7.89%)
<i>Health and medical issues</i>						
Arthritis	31	6	17	13	23	90 (33.83%)
Depression	14	1	9	15	13	52 (19.55%)
Diabetes	25	5	16	12	15	73 (27.44%)
Hypertension	49	9	27	22	31	138 (51.88%)

Table 2 (continued)

	FBO 1 (<i>n</i>)	FBO 2 (<i>n</i>)	FBO 3 (<i>n</i>)	FBO 4 (<i>n</i>)	FBO 5 (<i>n</i>)	All FBOs (<i>n</i>)
Obesity	21	3	17	12	6	59 (22.18%)
Stress	13	1	10	20	16	60 (22.56%)

Respondents were instructed to select all options that applied

Table 3 Faithfully fit community needs assessment survey results by gender and age

Item	Men ≤ 59 (n = 31)	Men ≥ 60 (n = 31)	Women ≤ 59 (n = 77)	Women ≥ 60 (n = 75)
<i>Mean ratings and standard deviations</i>				
Overall health	3.45 (±.62)	3.17 (± 1.17)	3.44 (±.73)	3.45 (±.72)
Relationship of faith and health	3.77 (± 1.33)	4.26 (± 1.41)	4.52 (± 1.05)	4.51 (± 1.06)
Neighborhood walkability	3.70 (± 1.02)	3.32 (± 1.62)	3.88 (± 1.34)	3.93 (± 1.31)
<i>Percentages</i>				
Item	Men ≤ 59 (n = 31)	Men ≥ 60 (n = 31)	Women ≤ 59 (n = 77)	Women ≥ 60 (n = 75)
Most common medical issue	High blood pressure (38.71%)	High blood pressure (61.29%)	High blood pressure (70.13%)	High blood pressure (69.33%)
Health program of greatest interest	Exercise classes (32.26%)	Exercise classes (51.61%)	Exercise classes (54.55%)	Exercise classes (53.33%)

most interested in seeing at their place of worship were exercise classes (49.25%), nutrition education classes (36.84%), health fairs (36.47%), and weight loss programming (34.49%).

Discussion

Health promotion programs have largely focused on the places where people *live, learn, work, and play* as they represent the majority of where one's waking hours are spent. The addition of where people *worship* signals an evolution in both the transferability of evidence-based health promotion programs as well as the impact and reach of faith-based organizations in supporting the health of their members and surrounding communities (Bopp et al., 2012; Lancaster et al., 2014). FBOs are a unique environment in which many members not only attend weekly services, but are often involved in Bible study, prayer groups, church choir, as well as specific ministries and activities that meet at the FBO on multiple days each week allowing for regular touchpoints and sustained participation (Newlin et al., 2012). Herein we described our methods of building capacity and readiness during year one of the Faithfully Fit program through training of certified health ministers and formative assessments. These foundational efforts will guide the launch of a faith-based intervention that seeks to create measurable improvements in individual and congregational health markers.

Faithfully Fit seeks to support partnering FBOs in establishing two of the essential components, or “pillars,” of successful health promotion programs within faith-based settings as identified by Peterson et al. (2002) and Johnston et al. (2018). Diligence in establishing these components prior to program planning effectively builds organizational capacity for impactful and sustainable health promotion programs in FBOs long-term (Leake et al., 2007). As is the case in workplaces, engagement and buy-in from leadership is the starting point (Kent et al., 2016; Williams et al., 2018). The pastor and other church leaders' commitment to integrating health and wellness messages, programs, events, and policies as part of the culture of their FBO is a critical component of successful programs (Bopp et al., 2013). Through sermons, bulletin announcements, role modeling, and attendance at events that link faith and health (Baruth et al., 2015; Bopp et al., 2013; Tagai et al., 2018), pastors and other leaders in the faith community endorse the value of and belief in minding one's spiritual, physical, and emotional health (Heward-Mills et al., 2018; Williams et al., 2012). The role of leadership in supporting and amplifying the work of the health ministry underscores the merit of faith-based health promotion programs and communicates health is a priority of the congregation. This is perhaps the strongest key in building capacity (Anshel, 2010; Peterson et al., 2002).

The second pillar that establishes the foundation of effective health promotion programming in faith-based settings is a certified health minister (Ammerman et al., 2003). A certified health minister builds capacity within the congregation to apply best practices to support whole person health through the health ministry, thereby integrating health and wellness into the culture (Wesley Theological Seminary, n.d.; Williams et al., 2018). Supporting members of FBOs to plan and facilitate

programming aligns with a wide body of research on the benefits of using peers to promote health rather than outside health professionals, given greater perceived credibility and trust in peers (Eng & Young, 1992; Lee et al., 2018; Simoni et al., 2011). Training in and knowledge of evidence-based programs, as provided to health ministers through the Heal the Sick program, supports the effectiveness of health minister-led interventions (Johnston et al., 2018; Kaplan et al., 2009). Post-program feedback indicated that participants believed the program increased their knowledge and competence in health ministry, ultimately empowering them to develop strategies to improve the health and well-being of their congregation. A certified health minister may also belong to a cohort of other health ministers which further extends the impact each has. By serving as a source of support and guidance to one another, a peer network of home-grown expertise further builds capacity while emphasizing community engagement and sustainability (Eng & Young, 1992; Kumanyika, 2019). In Faithfully Fit, the certified health ministers completed the Heal the Sick certification program together and are in the same geographic area, making it possible for FBOs to multiply their impact by cross-referring members to events and programs at partner churches.

The focus and effort on establishing these pillars to build the capacity and readiness of each health ministry prior to program planning was intentional. With top level engagement and a well-equipped health minister in place, health ministries can now begin to chart their paths for supporting individual and FBO-wide health improvements. Faithfully Fit's utilization of formative assessments accounted for multiple spheres within the social ecological model—the broader community, the faith-based organization, and the individual—and established the baseline health status of each congregation. The results of these assessments provided valuable information to the health ministers and church leadership regarding the strengths to build on, resources available, and opportunities to grow the work of the health ministry. Areas of opportunity to explore for future programs and policies from the environmental scan include offering evidence-based nutrition education, incorporating physical activity at church events, and improved access to fresh produce. Through the Windshield Wiper and Walking Tour, health ministers increased awareness of the need to navigate an environment with barriers to healthy eating and access to health care and identified several community-based organizations for future collaborations and initiatives to support health. Feedback from post-course surveys highlighted health ministers' perceptions that the Heal the Sick course material was valuable for their health ministry work and provided the needed competencies to implement health programming in their respective FBOs.

The engagement of church leaders in conjunction with the health minister certificate training has appropriately and adequately built the necessary components of capacity and readiness to support future health promotion program offerings. Indeed, having conducted a well-rounded needs assessment, health ministers can now effectively attend to health promotion program selection and implementation that is responsive to the health needs of their congregations and effects positive change (Leake et al., 2007). The individual-level findings from our formative assessment align with national rates of chronic conditions, particularly among the older adult population who represent the largest subset of congregants (Adams et al.,

2020; Tsao et al., 2022). Hypertension represented the number one health issue that interfered with daily life for respondents, followed by arthritis. Thus, it was particularly important to identify evidence-based lifestyle programs for implementation in year two of Faithfully Fit that were responsive to these assessment findings. As a result, a partnership with the YMCA was established to offer their Blood Pressure Self-Monitoring Program (BPSM) to congregants of one FBO as a pilot (YMCA, n.d.). The 4-month BPSM program challenges participants to take control of their blood pressure through twice monthly meetings with a Healthy Heart Ambassador and monthly nutrition seminars providing additional guidance on long-term lifestyle changes. Second, Walk with Ease, a program from the Arthritis Foundation (n.d.), was piloted with two FBOs in a virtual format due to COVID-19 social distancing policies. Walk with Ease is a 6-week community-based physical activity and self-management education program with an end goal of increasing the amount of weight-bearing activities which can assist with decreasing the onset and progression of arthritis. This multi-component program also includes health education, stretching and strengthening exercises, and motivational strategies. As Faithfully Fit has continued, additional health ministers have been certified at most congregations and programming has continued and expanded at FBOs. Faithfully Fit health ministers have been provided with tangible resources to continue their work throughout their congregations, including a comprehensive toolkit of assessments, strategies, and program ideas and access to a YouTube channel providing recordings of previous evidence-based programs and trainings. With support and technical assistance from the program team, health ministers have been willing to offer more comprehensive lifestyle change programs and their capacity and efficacy has increased, suggesting these programs and efforts will continue into the future.

Study Limitations

As with all community-based programs, this research faced certain limitations. During recruitment and data collection, challenges to participation included lack of access to and comfort using technology, along with obligations built into the church calendar that took precedence over Faithfully Fit activities. In addition, to promote equity among FBO partners, we did not partner with and collect data from control or comparison sites, which will limit our ability to infer any health improvements are a direct result of Faithfully Fit in the future. Further, the assessments implemented to establish baseline markers were all self-reported and the program team was not able to collect objective data to quantifiably measure health status. Lastly, the health minister role is an unpaid position most often done in addition to full-time jobs and family duties, leading to variations in health ministers' commitment and availability to dedicate consistent effort on a weekly basis.

Future Directions

As we move forward, quality improvement, seamless implementation, and evaluation of programs will be paramount. Equipping health ministers with the tools to

grow their programming menu and assess impact can lead to sustainable improvements in the health of FBO congregations and the surrounding community. The strong connection between faith and health, the trusted relationships that are created between church leaders and congregants, and the formation of a health ministry led by a certified health minister who can assess the needs of the congregation, all point to the promise of Faithfully Fit health promotion programming. Future research should explore the success of programs across the country that seek to recognize the critical role health ministers play in congregations, communities, and public health. Steady funding for health minister positions needs to be identified to support this work. As is the case for many programs focused on improving health, the difference between short-term success and lasting impact depends on empowering individuals to change behavior while also creating broader environmental and systems supports that build the capacity of communities to promote health.

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Declarations

Conflict of interest The authors have no conflicts of interest relevant to this article to disclose.

Ethical Approval This research was approved by the American University Institutional Review Board in July of 2019.

Consent to Participate Participants who completed materials online read a script and were asked to click "next" if they provided their consent to participate. Participants who completed paper surveys were provided with a description of the formative research and were asked to provide their verbal consent to participate if they agreed to take part in the research.

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