Enhancing the role of faith-based organizations to improve health: a commentary

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Abstract

Researchers, policymakers, and community members increasingly recognize the potential to leverage faith-based organizations (FBOs) to improve health. This commentary complements Leyva and colleagues' article on whether and how members of FBOs view such a role. The commentary draws on our 13+ years operating a faith-based and community-based research organization, Faith Moves Mountains, in the Appalachian context. Issues to be addressed in the further development of faith-based health promotion include sustainability; adherence to the evidence-based operations of interventions, training, and privacy and protection protocols; and understanding the changing landscape of American public life.

Keywords

Faith-base, Health promotion, Disease prevention, Community-based interventions

The synthesis of spirituality, religious practice, and health has a long and well-documented history. Evidence from ancient Egyptian and Greek temples suggest an integration of physical and spiritual domains to promote health and prevent disease, a melding of religious leadership and health practice, and physical structures that supported this enmeshed world of spirituality and health [1]. In the West, the first hospitals were conceptualized, constructed, and administered by religious institutions and practitioners. For centuries, clergy served as health care practitioners, licensed by the religious order in which they served. Such an integration of healing and religion persists in diverse contexts in the contemporary world, including faith healing, religiously affiliated hospital systems, and congregational health ministries [2].

Over the past several decades, national and community leadership has recognized the potential to integrate physical and spiritual domains. Faith-based organizations (FBOs) increasingly have been called on to serve as key players in health promotion and disease prevention efforts. Such FBOs, most specifically religious congregations, have been recognized for their potential to provide mental and physical health programming. Their capacity to reach underserved populations experiencing the nation's worst health

Implications

Researchers or Research: In developing faith-based partnerships, researchers must consider program sustainability, evidence-based interventions, training, and privacy and protection protocols.

Practitioners or Practice: Faith-based organizations can be excellent health promotion partners

Policymakers or Policy: Religious practice is declining, which should be acknowledged in future policy and research development.

inequalities have led to initiatives promoting their involvement in health programming. In the USA in 1996, for example, the Clinton administration initiated the "charitable choice" doctrine, which permitted religious organizations to provide federally funded services similar to other providers as long as they adhered to constitutional parameters. Five years later, the Bush administration created The White House Office of Faith-Based and Neighborhood Partnerships. Although later renamed by the Obama administration (as the Office of Faith-Based and Neighborhood Partnerships), these activities undertaken by ideologically diverse administrations underscore the important connection between faith communities and health [3].

Health promotion practitioners and researchers, too, acknowledge the role that FBOs can play in enhancing programming. While noting concerns regarding separation of religion and state, governmental efforts to leverage the FBOs' capacities to appropriately and rigorously promote well-being has led to funding initiatives to develop evidence-based faith-based or faith-placed health interventions. These initiatives have coincided with the acknowledgement that, despite considerable investment in biomedical and public health infrastructures, certain communities and individuals continue to be plagued by pernicious health inequities [3, 4]. Transformative research orientations, including community based participatory research (CBPR), further encouraged recognition of

the expert vantage point of community members and the unique contributions of community and academic collaboration [5].

Research efforts have evolved over these decades beyond acknowledging the potential to engage FBO to determining the efficacy, effectiveness, and feasibility of such academic-community partnerships. In Leyva and colleagues' article, "Understanding Organizational capacity among Churches for Implementing Evidence-based Cancer Control Programs: A Community-Engaged Approach," interviews were conducted with key informants to illuminate the potential and limitations of evidence-based health promotion programming. Their findings converge with others': that many FBO aspire to deliver or enhance their current capacity to deliver health programming, viewing it as consistent with an overall healthy mind, body, spirit connection; acknowledging their unique potential to reach vulnerable populations; and noting that their physical and social capital capacities render them an appropriate delivery organization [1, 6]. The authors' findings on resource gaps and capacities are consistent with existing literature, including limited knowledge of substantive health issues and organizational, time, and human resource constraints. Their helpful list of strategies to facilitate FBO capacities to deliver evidence-based interventions includes: the enhancement and development of health ministries; the development of easily implemented and culturally appropriate interventions; the provision of learning opportunities for parishioners; extensive opportunities for technical assistance to FBOs; development of intra- and extra-ecclesial partnerships; and, of course, the ever important and frequently missing financial and material support of FBOs and health promotion programming.

These observations about FBO fundamental capacities, limitations, and recommendations raise several additional thoughts, namely: (1) capacity: the importance of sustainability; (2) limitations: the challenges of adhering to the evidence-based operations of interventions and training and adherence to privacy and protection protocols; (3) recommendations: the importance of understanding the changing landscape of American public life.

Capacity: sustainability—While faith organizations have often been held up as a model of potential sustainability, a more critical stance raises some questions. First, in many contexts, FBOs actually are vulnerable to change, dissolution, or reconfiguration. In the Appalachian context, for example, churches often splinter, dissolve, or, in rarer cases, amalgamate, throwing into question the assumption of perpetuity [7]. Granted, in other contexts, a FBO may be in a community for centuries, but it is important to remember that diverse practices have diverse histories, throwing into question the assumption that they will always be there. Additionally, as government safety net programs recede, FBOs often find themselves under increased pressure to increase their services. In already resource-strained congregations, developing a health ministry or

implementing a health promotion program may exceed their capacity.

In addition to the sustainability of the church and its capacity, there is the question of program sustainability. Given the "all volunteer army" of church health ministries, the loss of an advocate—for example, the director of the health ministry—can greatly diminish or even terminate a program. Smaller congregations, oftentimes with more vulnerable members, are particularly susceptible to the loss of human capital. Without extensive back up plans, cross-training of volunteers, fund raising, etc. FBOs are vulnerable to burn out and programmatic collapse.

Limitations: evidence-based operations of interventions and respect for privacy—Even in the most controlled environments, including laboratory settings, deviation from protocols takes place and undermines scientific rigor. Community settings are particularly susceptible to intentional or unintentional slippage or deviation. Intentional departures from a protocol may be due to perception that an approach or materials are not appropriate to the setting or may lack feasibility. Such misalignments often focus on who is delivering the intervention (is it appropriate to have a man deliver information on women's cancers?), what are the activities (is it consistent with the congregation to offer a dance to encourage physical activity?), or even the focal topic (will the congregation be open to addressing a cancer where sexual activities constitute a risk factor, e.g., cervical cancer)? [8].

Even if the interventionist, approach, materials, and topic are considered acceptable, there are ample opportunities for unintentional slippage. Such slippage often occurs as the interventionist becomes more and more comfortable with the program, sometimes reifying or reinforcing his or her own errors. In the absence of training, monitoring, and re-training, there are few guarantees that an evidence-based intervention will be delivered with fidelity. Implementing evidence-based interventions relies on employing standard protocols; deviations, even if more culturally suitable, raise well-founded concerns and may compromise success. At the same time, however, slavish adherence to procedures and operations that are inappropriate or otherwise problematic inevitably fail to achieve their stated goals. For example, in our rural Appalachian environment, a perpetual lack of transportation makes it difficult for the weekly in-person programming standard in many health promotion protocols. A more flexible approach of home-delivered intervention doses or bi-monthly group sessions may serve as a good substitute; however, such a practice may be inconsistent with the original intention of certain evidence-based interventions. While congregation members may be open to training, over time, refresher and retaining must take place to overcome knowledge and protocol slippage or errors. This refresher training must involve substantive experts, who may or may not be available to traditionally underserved congregations.

Another challenge to FBO organizations and evidence-based health intervention delivery pertains

to the need to safeguard privacy. Even when data are not being collected, concerns about protecting personal information and privacy is essential to all health programming, irrespective of the environment. While faith-based organizational representatives may have an advantage of garnering trust among those deemed “hard to reach,” there is risk inherent in sharing personal health information. FBOs that engage in health ministries and interventions must develop written, contractual guidelines to protect the organization, the intervention deliverer, and, most especially, the congregant or participant.

Recommendations: the changing landscape of American public life—It is important to acknowledge that the public life of people in the USA appears to be at a transition point. As Putman acknowledged long ago in his now classic work *Bowling Alone* [9], people seem to be retreating into more private domains and are less likely to engage in public life. This transition is exemplified by a trend or movement away from congregational affiliation. As recent evidence suggests, the percentage of non-religiously affiliated individuals (currently at nearly 23%) is increasingly precipitously, nowhere more so than the younger age groups [10]. This demographic shift has key implications for the future of religious life and practice. While it remains to be seen whether the young “nones” re-engage in religious life as they launch families or settle down, the movement away from religious congregations appears to be set in motion. Although affiliation with religious institutions is not expected to disappear anytime soon, especially among more vulnerable populations who have disproportionate levels of attendance, declines in membership may affect the capacities of FBOs to deliver health interventions.

In closing, as Leyva and colleagues highlight, the potential for faith-based organizations is great. Our community-based research organization, Faith Moves Mountains, has found congregational partnerships an authentic and productive source for health promotion activities for all of the excellent reasons cited by Leyva and the extant literature. Working in partnership with churches has helped many Appalachian community members quit smoking, obtain needed cancer screenings, and engage in other healthy lifestyle behaviors [11]. Without this partnership, these remote and severely affected communities may have briefly enjoyed access to a program or two that might cease to exist when grant funding ended. Embedded in existing structures with enhanced community capacity, such efforts can live on in a more culturally consistent and appropriate manner.

Despite this promise, there are considerations and trends that must be acknowledged, including longer term sustainability, intervention fidelity and training, adherence to privacy and protection protocols, and the changing landscape of American public life. As Leyva

and colleagues note, “tailored, interactive and community-engaged approaches” stand the best hope of successful and sustained implementation of evidence-based interventions, whether faith-based or otherwise. Over the millennia, the considerable confluence between spirituality, religious practice and health has manifested itself in various ways [12]. Faith-based programming has earned its credentials as a viable and desirable approach to health and well-being. Addressing health problems among marginalized populations remains one of the most pressing challenges of our times. As we have long known, it will take multiple levels, diverse organizations, and creative efforts to translate established evidence into community and individual health promotion successes. While keeping in mind these cautions and societal transitions, employing all possible approaches toward this most urgent effort is warranted.

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Compliance with ethical standards

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