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Overcoming initial barriers in implementing faith-based health education programs: Insights from HeartSmarts

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Abstract: Faith-based health education programs are effective in improving the health of participants. Specifically, programs facilitated by churches have provided much-needed health resources and information to underserved communities. Research in this area has focused primarily on the effectiveness of faith-based health interventions. However, it is also important to highlight potential barriers to program implementation. The purpose of this paper is to share the lessons learned from the HeartSmarts faith-based cardiovascular health education program in regard to issues that could occur at the beginning of the program. One year after the completion of the HeartSmarts ambassador training, 18 peer health educators, representing 14 Black churches, provided feedback through a survey with both open- and closed-ended responses on their experience with trying to start HeartSmarts classes in their churches. The results were analyzed, and themes were extracted. These themes in regard to effective program implementation were participant position in the church and length of church membership, presence of an active health ministry, culture of wellness within the church, participant recruitment, pastor involvement, space for classes, and ability to be placed on the church calendar. Best practices for overcoming barriers are shared.

ABOUT THE AUTHOR

Dr. Naa-Solo Tettey is an assistant professor of public health at William Paterson University and the principle investigator of the HeartSmarts faith-based cardiovascular health education program. The HeartSmarts program uses a faith-based curriculum to increase knowledge of heart disease and its prevention in underserved, high-risk communities. The goal of the program is to reduce the incidence of cardiovascular disease in these communities and improve health behaviors related to cardiovascular health.

PUBLIC INTEREST STATEMENT

Faith-based health education programs, particularly those offered in churches, have been effective in creating positive behavior change among participants. However, there are many norms, practices, and guidelines that must be understood to ensure successful program implementation. This paper explores potential barriers at the beginning of a program that may hinder success and offers strategies for overcoming them. Researchers administered surveys with open- and closed-ended questions and obtained information about the various issues they faced when starting the program. The results of these surveys were organized based on recurring themes in the responses. The study findings indicated that the main barriers were participant position in the church, length of church membership, presence of an active health ministry, culture of wellness within the church, participant recruitment, pastor involvement, space for classes, and ability to be placed on the church calendar. Best practices for overcoming these issues were shared.

Subjects: Population Health; Preventative Medicine; Community Health; Health Education and Promotion

Keywords: faith-based; health education; health promotion

1. Introduction

Cardiovascular disease (CVD) is the leading cause of death in the United States, affecting all racial and ethnic groups (Hoyert & Xu, 2012). African Americans, however, are more likely to be diagnosed with CVD and to experience higher morbidity and mortality rates (Hurley, Dickinson, Estacio, Steiner, & Havranek, 2010; Kurian & Cardarelli, 2007; Martins, Tareen, Ogedegbe, Pan, & Norris, 2008; Safford et al., 2012; Sundquist, Winkleby, & Pudaric, 2001). Compared to their White counterparts, African-American men and women across all age groups have higher incidences of myocardial infarction and stroke (Safford et al., 2012). Further, African Americans have a higher prevalence of hypertension, diabetes, and obesity, which can be prevented or improved through participation in effective health education programming and lifestyle changes (Kurian & Cardarelli, 2007; Sundquist et al., 2001).

Culturally tailored community health education programs are a cost-effective approach to health promotion. Faith-based organizations in many communities serve as venues for culturally relevant health promotion and education (Levin, 2014), and Black churches are at the forefront of these health initiatives. African Americans ask their pastors and spiritual leaders for health advice, which makes these venues a logical choice for health education programming (Campbell et al., 2007; Hippolyte, Phillips-Caesar, Winston, Charlson, & Peterson, 2013; Yanek, Becker, Moy, Gittelsohn, & Koffman, 2001). Training peer health educators to work in religious institutions can allow for greater dissemination of culturally sensitive health education to high-risk populations, such as older adults and minorities, who are also more likely to attend church services (Boscarino & Chang, 2000; Gallup, 2000). In this study, the terms peer health educator, ambassador, and community health worker are used interchangeably.

Although churches provide an ideal setting, they also introduce various barriers to successful program implementation (Levin, 2014). Public health education program developers, however, are not always aware of the unique church practices that should be accounted for during the program planning and peer-educator training phases. Although some research has touched upon best practices in engaging churches, it does not have a specific focus on the issues that may occur in the time between the completion of training and peer educators' trying to begin their programs. Thus, the purpose of this paper is to highlight these issues using lessons learned from HeartSmarts, a successful faith-based cardiovascular health education program.

2. Background

2.1. HeartSmarts

The HeartSmarts program was developed in 2011 as a partnership between an academic medical center and faith-based organizations throughout the five boroughs of New York City. The program uses a community participatory research partnership model to educate African Americans about cardiovascular health and conducts health promotion in churches led by lay health educators (Tettey, Duran, Andersen, Washington, & Boutin-Foster, 2016). The foundation of the HeartSmarts program is a 10-week curriculum that combines biblical scripture and evidence-based health messages about CVD (Tettey et al., 2016).

The program trains peer health educators, also called HeartSmarts ambassadors, to use this faith-based curriculum to work with organizations in underserved, high-risk communities to increase their knowledge of heart disease and its prevention and, ultimately, to reduce the incidence of CVD in this demographic. The participants have had success in regard to improving

their blood pressure, losing weight, increasing exercise and consumption of healthy foods, and gaining knowledge about CVD (Tetty et al., 2016). The positive results of HeartSmarts indicate that faith-based programs that use peer health educators can be considered vital for achieving positive health behavior change, reducing CVD risk factors, and improving CVD-related health disparities.

2.2. HeartSmarts ambassadors

Peer health educators who are members of the New York City Department of Health Ecumenical council were recruited to participate in the HeartSmarts ambassador training. To be accepted into the training, potential ambassadors had to be active members of their church, 18 years of age or older, and speak fluent English. These ambassadors participated in a 12-week training, with each session lasting three hours. The trainings were held at a medical center in New York City and were conducted by various cardiovascular health experts at the hospital, including the author of this paper. Details of the HeartSmarts curriculum were delivered through lectures, readings, and videos about CVD, including its symptoms, treatment, risk, and prevention. Participants also learned motivational interviewing and group facilitation skills, as well as how to assess pre- and post-cardiovascular health knowledge and behavior and to measure weight, waist circumference, and blood pressure.

Upon completion of the training, ambassadors were required to teach at least two HeartSmarts classes at their church during the first year. Of the 14 churches that had representatives at the first ambassador training, 8 were able to offer 2 or more HeartSmarts classes in the first year, 4 were able to offer 1, and 2 did not offer any until the second year. As discussed below, there were various facilitators and barriers in regard to HeartSmarts classes starting in the churches once the ambassadors completed the training.

3. Methods

One year after completing the ambassador training, 18 peer health educators completed a survey to provide feedback about the process of beginning the HeartSmarts classes in their church. Fifteen of the ambassadors were women, 3 were men, and ages ranged from 48 to 71. All ambassadors had some college education, five with master's degrees and one with a doctorate degree. The ambassadors were from 14 churches which represented all 5 boroughs of New York City. Church size ranged from 200 to 2,500 members. Ambassadors were not paid during the training, but received \$10 per hour to teach the classes.

Several steps were taken to ensure the methodological rigor. The surveys were administered by program research assistants, who also completed the data entry. Data analysis was conducted by the three-member research team, including the author. All written responses for the open-ended survey questions were typed by the research assistants under the supervision of the research team. These responses were checked for accuracy. Any errors that were identified were corrected by the typist. The survey results included both open- and closed-ended responses. The open-ended survey questions allowed participants to provide detailed responses and explanations. Furthermore, open-ended survey questions were more cost-effective and less time-consuming than interviews. Qualitative research methods were used to assess the responses to the survey questions. Each response was read multiple times, similar responses were grouped to create concepts, and then these concepts were grouped to create themes in regard to the participants' experiences. This project was approved by the Human Subjects Committee at the medical center (Protocol # 1112012067R005).

The survey items were as follows:

- (1) What church do you belong to, and how long have you been a member of your church?
- (2) Approximately how many members does your church have?

- (3) Describe the size of your church and the space available to have programs.
- (4) Describe the leadership role, if any, that you hold in your church.
- (5) Describe the health ministry in your church.
- (6) In what ways, if any, does your church promote healthy living?
- (7) In what ways, if any, does your pastor promote health from the pulpit and throughout the church?
- (8) Describe the experience of recruiting participants for your HeartSmarts class.
- (9) Describe the experience of promoting your HeartSmarts class to the congregation.
- (10) Describe the process of obtaining a space designated for your HeartSmarts class.
- (11) Describe the process of adding the HeartSmarts program to the church calendar.
- (12) Describe the overall experience of beginning the HeartSmarts class in your church.

4. Results

There was a 100% submission rate for the questionnaires. All survey questions were completed by the respondents. The respondents represented different denominations such as Seventh-day Adventist, Baptist, Catholic, Methodist, and Presbyterian. Church membership size ranged from 200 to 2,500. Length of church membership spanned from 2 years to 40 years. The presentation of the results for open-ended questions is organized by theme. The themes include overall experience, church membership and leadership position, health ministry and culture of health, class promotion, the pastor or church leader, and space and the church calendar.

4.1. Overall experience

All respondents expressed having an overall positive experience once their classes were complete. Ambassadors from larger churches with more members, space, and available resources, where the pastor was involved and/or supportive of the program, experienced greater success. Getting to the point of actually starting their classes, however, created many challenges, particularly for churches with a smaller membership and/or less space. Ambassadors expressed that, during the initial ambassador training, these challenges should have been discussed with strategies to overcome them.

4.2. The pastor or church leader

All respondents reported that the support of the church leadership is vital for program success. For the 14 churches that completed the program, all had pastors in a leadership role. The role of the pastor appears to be one of the most important factors in program success, as pastors are trusted leaders in their communities. The HeartSmarts classes for which the pastor was also a trained ambassador had the largest attendance. There were four pastors in the HeartSmarts training, three of whom were able to teach the required two classes, while one of the pastors taught one class during the first year. The pastor who was not able to complete the requirements for two sets of classes had too many other commitments. This underscores why it is important for pastors to complete the training with another member of the church. Classes held in churches in which the pastor had a desire to improve the health of the congregation, regardless of whether the pastor was a trained ambassador, also received greater support. When a pastor does not promote a culture of wellness, and a congregant tries to present a health program, it is usually met with resistance. To overcome such resistance, it is necessary for the peer-educator to form an allegiance with someone in a position of leadership in the church who can share with the pastor the importance of such programming for the congregation and the overall success of the ministry. In these situations, program developers also may need to meet with the pastor and church leadership.

4.3. Church membership and leadership position

All respondents mentioned their position in the church at least once when answering survey questions 7–12. The factors that affected the ambassadors' ability to teach their classes involved length of time as a church member and leadership role within the church. The ambassadors who

were able to complete two classes during the first year also had been members of their respective churches for over 10 years. This length of time created seniority and relationships within the church that allowed the class to begin smoothly. Two ambassadors who were not able to offer any classes during the first year were new to their church, having only been members for less than 3 years, and did not have the necessary connections to ensure that their program would begin. Ambassadors who served in a leadership role, such as deacon(ess), elder, or head of a ministry, particularly the wellness ministry, were also able to complete the requirement.

4.4. Health ministry and culture of health

A total of 15 of the 18 respondents had an active health ministry. Ambassadors who were members of a church that had an active health ministry and promoted a culture of health were more likely to have a smooth transition to begin their classes. In such cases, the program was embraced by the congregation and church leadership. In those churches that did not have a health ministry, the lack of a culture of health may have been the reason that the peer health educator was interested in bringing a health program to his or her church. Therefore, a helpful strategy would be to have program developers devise a plan to work with the peer health educator to create a foundation for the program at the church. Offering short activities, such as healthy cooking demonstrations, exercise classes, or movie nights, with a health focus can provide a platform to then introduce the health program. In addition, any health information that the sponsoring program can provide to the church to establish this culture of health is helpful.

4.5. Class promotion

A total of 12 of the 18 respondents shared that they experienced some form of difficulty in promoting their classes or recruiting participants. Health programs based in churches may experience resistance from congregants to participate. However, churches in which the pastor or church leader openly promoted the HeartSmarts program during service had a greater participation rate. Churches that provided a platform for the HeartSmarts program director to speak to congregants and explain the program also had a higher rate of participation. Pairing the HeartSmarts program with a church theme or initiative focused on health, such as February Heart Month, also has been found to be effective. Strategies such as posting the flier for the HeartSmarts program in the church bulletin, on the church website, and in mailings have been shown to increase the level of interest.

4.6. Space and the church calendar

A total of 11 of the 18 respondents mentioned space as a barrier to program implementation. When churches are small or have many programs, it may be difficult to find a space for all programs, especially during coveted hours in the evenings or on the weekends. Some strategies to overcome this were to find other spaces within the community, such as libraries, schools, or community centers. Ambassadors who were not able to do this had to wait until an existing program ended before they could begin their class.

A total of 10 of the 18 respondents stated that the church calendar can also be a barrier to program implementation. Many church calendars that list activities for a specified time frame are planned 6 months to a year in advance. However, having a program accepted onto the church calendar can be challenging, depending on the process in a particular church or the position held by the person who requests the dates. It is important that individuals who wish to hold programs seek approval well in advance, and, thus, a good time to request an item on the calendar is once the peer-health educator signs up for a particular training.

5. Discussion

The purpose of the HeartSmarts program is to use a faith-based approach to improve cardiovascular health outcomes in high risk communities. Programs such as HeartSmarts play an important role in creating a culture of wellness within African-American churches. Although the program has had successful results, it is important to share some of the lessons learned, especially as it relates to implementation. Providing health education in churches can be met with certain challenges

based on the church leadership hierarchy, the process for new program approval, and the relative importance of the church's focus on health. Thus, in some instances, it can be difficult to start a program after the initial training or preparation of the peer health educator has been completed. In the case of HeartSmarts, having a trained ambassador did not guarantee that the class would be taught in a particular church. Because training peer health educators can be labor and resource intensive, it is beneficial to take a proactive approach to overcoming potential problems.

The majority of peer health educators are volunteers, and guidelines are needed for their participation to ensure that the program can be delivered successfully. Peer health educators should be interviewed to determine their role in a particular church; length of membership; church size and related availability of space and resources; church culture, including the commitment of the pastor to health initiatives and the overall health culture within the church; and the protocol for new program approval and adding a program to the church calendar. Peer health educators may not be aware of these issues until they start to become a hindrance to successful program implementation. Addressing these matters during the training will equip the peer health educators with the tools needed to complete a successful program.

One limitation of this study is the lack of generalizability. There is an underrepresentation of men among the respondents. This is related to a larger problem regarding the overall lack of male participants in community health education programs. The results from this study can inform strategies for increasing male participation rates such as using the strong influence of church leadership to recruit more men. Another limitation of this study is in using surveys as opposed to interviews which would have allowed for more detailed responses and further clarification from respondents. An additional limitation was in data analysis. The results of the study were not analyzed based on age, denomination, or gender, which would have provided more insight into the responses.

6. Conclusion

Public health educators and researchers have invested time and money in trying to create evidence-based interventions that help to reduce CVD-based health disparities. In recent years, the use of faith-based health education programming has grown, but such programming often occurs in environments that already lack resources. Faith-based health education is effective when implemented properly, and, to ensure its proper implementation, it is important to consider potential barriers. An effective program begins before the actual program starts, which highlights the need to use program planning tools, such as logic models, to identify the actions and resources required at each program stage as well as conduct program evaluation at all levels of the intervention. This paper used lessons from the implementation of the HeartSmarts program to show the challenges that can occur at the beginning of a church-based health program. Notably, in addition to being trained in effective program delivery, faith-based peer health educators need to be given strategies to successfully address these challenges.

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The author declares no competing interests.

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