



By Indea May and Nancy George

Faith Community Nursing: Faith Element Enhances Cardiovascular Risk Reduction Program Outcomes

ABSTRACT: *The high prevalence of hypertension among African Americans makes faith-based education programs culturally appropriate. Faith-enhanced health education is a way to reach these often healthcare-disenfranchised populations. With Every Heartbeat is Life (WEHL), a community-based heart health program, was enhanced with Scripture and prayer for this project. The program took place in an African American nondenominational church. The Scripture-enhanced WEHL program emphasized biblical teachings of self-care with standard lessons on nutrition, exercise, smoking cessation, and disease management interventions that increased knowledge of hypertension and associated cardiovascular risks.*

KEY WORDS: *African Americans, faith-based, faith community nursing; hypertension, nursing, With Every Heartbeat is Life*

FAITH-BASED RISK REDUCTION

Deaths from cardiovascular disease disproportionately affect people of color and those with socioeconomic and environmental community issues (Benjamin et al., 2019). Hypertension, or high blood pressure, is a risk factor for cardiovascular disease (American Heart Association, 2019; Kjeldsen, 2018) and disproportionately affects African Americans (American Heart Association, 2020). The age-adjusted prevalence of hypertension among non-Hispanic Blacks is 57.6% for men and 53.2% for women (Benjamin et al., 2019). Controlling high blood pressure is a key strategy for heart disease prevention (Medline Plus, 2015), but Flynn and colleagues (2013) found that African American families face challenges of hypertension self-management and treatment adherence. Community-based programs are one strategy to address reduction of cardiovascular health risks. Benjamin et al. (2019) showed that these programs can help individuals improve health behaviors by providing long-term support. The church community is often considered the most important social institution for African Americans.

The purpose of this article is to describe the faith-based enhancement and evaluation of an established evidence-based community health risk reduction program developed to be culturally relevant for African Americans. *With Every Heartbeat is Life* (WEHL), created by the National Heart, Lung, and Blood Institute (NHLBI, 2014), was translated into practice based on the faith community nursing model in a large urban area in the midwest United States. Balint and George (2015) described how the faith community nursing model incorporates the elements of faith into health and healthcare delivery, and in the case of this program, provided the structure for translation of WEHL with faith enhancements (i.e., biblical framework).

REVIEW OF LITERATURE

A systematic review of electronic bibliographic databases (CINAHL, Medline, PsycInfo, and PubMed) was completed utilizing the search terms blood pressure, hypertension, cardiovascular, health education, faith-based, faith community nursing, medical mistrust, and health disparities for the period January 2004 to December 2019. The search was supplemented by a manual review of reference lists of each article. Finally, the United States government and the National Institutes of Health websites were reviewed for further information. Articles were selected if a relationship between the terms was obvious. Only articles that addressed the United States population were chosen because of the differences in insurance and access to healthcare in other countries. There was consensus among the authors regarding the definition of health disparities impacting African Americans and the role of faith organizations. The reliability and validity of the components of the



WEHL program were established by the NHLBI. What follows is a review of the state of the science based on a larger, more comprehensive review of the literature not presented here.

The African American community has a high level of medical mistrust due to historical experience of medical hubris and ethical misconduct.



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Add to this a healthcare system that demonstrates institutional discriminatory events that continue to this day (Eiser & Ellis, 2007). Due to past and present experiences of research abuse, healthcare disparities, and the lack of cultural competence among some healthcare providers, African Americans with chronic illness may lack trust in the scientific community and evidence-based medicine (Eiser & Ellis; Mbe, 2017). Thus, to bridge the levels of understandable mistrust can be a challenge when implementing a community-based program such as WEHL. Faith-based organizations provide access to bridge this divide in trying to implement a program that has been proven to reduce cardiovascular risks among African Americans.

Engagement in faith-based activities is high among African Americans in the United States who have some of the most consistent church attendance; they are more likely to engage in prayer and worship services than other racial/ethnic groups (Hayward & Krause, 2013). A Pew Research Center survey

found that religion was important to 75% of African American respondents, and nearly half (47%) attended church at least weekly (Masci, 2018). More importantly to this project, Rowland and Isaac-Savage (2014) reported how pastors of African American churches found that high blood pressure was the most common health concern affecting African Americans in the congregation and the larger community. It is clear that the church has an important role in the lives of their African American members and is the cornerstone of many African American communities. These religious institutions invest in the welfare of members and the community through supporting and investing in health and wellness, meeting socioemotional needs, and keeping families intact (Nguyen et al., 2019; Taylor et al., 2016). Engaging church leadership (Condrasky et al., 2013) and churchgoers with community-based health education programs has higher success rates (Mbe, 2017). Christian faith plays an important role in many African Americans' lives, so culturally

appropriate, faith-enhanced risk reduction programs are key to positive outcomes in communities of color.

These trends indicate the church as a feasible setting for a faith-based community health program. A faith-based community health model has been used for reduction of health risk behaviors and improvement of self-management with positive outcomes (Harvin et al., 2020; Nguyen et al., 2019). Topics such as weight loss (Fitzgibbon et al., 2005) and cooking using the Dietary Approaches to Stop Hypertension (DASH) method to improve nutrition (Condrasky et al., 2013) are successful. Schoenthaler et al. (2018) found that a faith-based approach to lifestyle interventions significantly reduced systolic blood pressure in the Black church community. Thus, community health programs with spiritual components can result in desired health risk reduction outcomes. Health education programs embracing the essential role that faith-based institutions play in the lives and communities of African Americans have consistently demonstrated the usefulness of a faith-based approach to health promotion and risk reduction

for this population (Condrasky et al.; Patestos, 2019; Schoenthaler et al., 2018). Faith-based organizations are vital avenues for healthcare systems and providers to engage to improve the health of African American individuals and communities.

Evidence-based practice

The growing impact of cardiovascular disease among African Americans and their communities prompted the National Heart, Lung, and Blood Institute (NHLBI, 2007) to develop WEHL, an educational intervention for African Americans to combat heart disease and stroke. According to the community health worker's program manual (NHLBI, 2007), lesson content was designed for cultural relevance to African Americans. This collaboration among stakeholders gives the program greater effectiveness in the target population. Although NHLBI is no longer updating content for WEHL, the program continues to be used by community organizations (Randolph County Caring Community, 2017) and shared through social media (Center for Healthy Communities, 2019). Organizations across the country have free access to WEHL

and are using this culturally responsive program.

Thus, this evidence-based program implementation took a well-established community-based program, WEHL, and incorporated Scripture to guide the context of the risk reduction learning sessions. By sharing the implementation process and impact that resulted from a biblically-enhanced WEHL program in a faith setting, this article adds to the literature that may guide future adaptations of evidence-based community health programs into faith-based organizations.

METHODS

Aims of the project

This evidence-based project implementation and evaluation began by engaging the faith community in a large urban midwestern city. Time was spent in a faith-based community development corporation to ascertain the community's concerns around cardiovascular health. Based on the feedback from key stakeholders (i.e., community members and workers, healthcare providers, and researchers), a faith-based approach was chosen. The project took place in an African American nondenominational

Table 1. Biblically Enhanced WEHL Lessons and Scripture

WEHL Sessions	WEHL Lesson Topic	Corresponding Biblical Scripture
Session 1: Lessons 1 & 2	1. Knowledge Is Power: Know Your Risk for Heart Disease 2. Act in Time to Heart Attack Signs	"My people are destroyed for lack of knowledge: because thou hast rejected knowledge" (Hosea 4:6, KJV). "Wisdom is the principal thing; therefore get wisdom: and with all thy getting get understanding" (Proverbs 4:7, KJV).
Session 2: Lessons 3 & 4	3. Get Energized! Say YES to Physical Activity 4. Help Your Heart: Control Your High Blood Pressure	"What? know ye not that your body is the temple of the Holy Ghost which is in you, which ye have of God, and ye are not your own?" (1 Corinthians 6:19, KJV).
Session 3: Lessons 5 & 6	5. Be Heart Smart: Keep Your Cholesterol in Check 6. Embrace Your Health! Aim for a Healthy Weight	"A merry heart doeth good like a medicine: but a broken spirit drieth the bones" (Proverbs 17:22, KJV).
Session 4: Lessons 7 & 8	7. Protect Your Heart: Take Good Care of Your Diabetes for Life 8. Make Heart Healthy Eating an Everyday Family Reunion	"Beloved, I wish above all things that thou mayest prosper and be in health, even as thy soul prospereth" (3 John 1:2, KJV).
Session 5: Lessons 9 & 10	9. Eat in a Heart Healthy Way—Even When Time or Money Is Tight 10. Take Control of Your Health: Enjoy Living Smoke Free	"Whether therefore ye eat, or drink, or whatsoever ye do, do all to the glory of God" (1 Corinthians 10:31, KJV).
Session 6: Lesson 11	11. Review and Graduation (Potluck)	"I beseech you therefore, brethren, by the mercies of God, that ye present your bodies a living sacrifice, holy, acceptable unto God, which is your reasonable service. And be not conformed to this world: but be ye transformed by the renewing of your mind, that ye may prove what is that good, and acceptable, and perfect, will of God" (Romans 12:1-2, KJV).

church. The basis for evaluation of the project focused on three aims:

- 1) Stakeholders will participate in the evaluation of a faith-adapted, culturally-focused, community-based program that emphasizes the heart health of African Americans, addressing hypertension and its risk factors in a faith-based setting.
- 2) The participants will demonstrate increased skills and knowledge related to self-management strategies for cardiovascular health.
- 3) Biometric measures of blood pressure and waist circumference of the participants will improve upon completion of the program.

Stakeholder engagement

Implementing a program in an African American population that is often disenfranchised within the healthcare system can be complex or controversial. Stakeholders are necessary for program success and their insight can sharpen evaluations (Centers for Disease Control and Prevention [CDC], 2012). Community stakeholders assisted the project lead in assessing the cardiovascular education needs of the community. Stakeholder engagement also allowed the program to be promoted and ultimately sustained. Planning meetings with pastoral leaders of the faith organization, the church pastor, and the congregation's responses to the community participation survey provided data for the formative evaluation. Prior to initiating WEHL, the project lead met with the pastor to explain the goals and focus of each session and gain input for adaptations.

Biblical enhancement of WEHL

According to the community health worker's program manual (NHLBI, 2007), lesson content was designed for cultural relevance to African Americans (NHLBI, 2014). At the request of the pastor in the nondenominational church, the faith enhancement started with replacing of WEHL program-provided quotes with contextually appropriate Scriptures as the starting point of the lessons. In addition to adding Scripture readings, the pastor

Table 2. Biblical Integration of WEHL

Scripture reading and prayer preceded each session.
PART 1—Introducing the Session <ul style="list-style-type: none">• Welcome the group members.• Review the information from the last session.• Ask the group members to talk about their weekly pledges.• Explain what you will talk about in today's session.
PART 2—Conducting the Session <ul style="list-style-type: none">• Present new information.• Lead the group in fun and educational activities.• Ask the group members questions.• Allow the group members to ask questions about what they have heard.
PART 3—Review of Today's Key Points <ul style="list-style-type: none">• Ask questions to help the group members review what they just learned.• Emphasize the important points.
PART 4—Weekly Pledge <ul style="list-style-type: none">• Help group members come up with a pledge to make healthy lifestyle changes that relate to the information they have learned during the session.• Give several examples of pledges that are specific and realistic.• Share the personal value. The value helps encourage participants to keep their pledges and gain confidence to make lasting lifestyle changes.
PART 5—Closing <ul style="list-style-type: none">• Thank the group members for their comments and ask them what they thought of the session. <p>https://www.nhlbi.nih.gov/health-pro/resources/heart/african-american-health-manual</p>

requested that each session began with prayer. The Scriptures focused on spiritual activities that would motivate participants to make appropriate health behavior changes and corresponded to the session lesson plan (Table 1). For example, the first lesson of WEHL was “Knowledge Is Power: Know Your Risk for Heart Disease,” and the corresponding Scripture was, “My people are destroyed for lack of knowledge: because thou hast rejected knowledge” (Hosea 4:6, KJV; Table 1). With the exception of the Scripture and prayer, the structure of the WEHL sessions followed the recommended outline of the program manual (NHLBI, 2007). The outline allowed the project leader to use the same five-part structure during each session: introduction, conducting the session, review of the key points, weekly pledge, and closing. The program lasted for 6 weeks, with each session lasting 1.5 to 2 hours (Table 2). The WEHL program manual (https://www.nhlbi.nih.gov/files/docs/resources/heart/aa_manual.pdf) includes picture cards to accompany the lessons, a cookbook (*Heart Healthy Home Cooking, African American Style*), and a book of family-oriented activities (*On the Move to Better Heart Health for*

African Americans; NHLBI, 2007). The WEHL lessons focus on cardiovascular disease, group fitness, nutrition and wellness, hands-on educational activities (i.e., cooking demos), and comorbid issues such as weight control, diabetes, and smoking cessation.

Setting

The project lead, a registered nurse (RN), met and discussed the project with the pastor of a nondenominational church to help guide the project's faith component. The pastor confirmed that the congregation was eager to participate in the program. The project lead attended church services, engaged in conversation with church members, and assessed willingness to participate in cardiovascular risk reduction classes.

Participants

The project participants included African American males and females of various ages. Members became project participants through the work of the interest assessment, which included a description of the WEHL program. There were no inclusion or exclusion criteria for this project. Participants were free to join or leave the educational sessions at any time.

No personal identifying information was recorded and data are reported only as aggregated data. This project was qualified as an institutional review board (IRB)-exempt project, based on national guidelines, by the Wayne State University IRB.

Program evaluation: Aims and objectives

Program process and outcome evaluations were used to determine how well participants received the implemented faith-enhanced WEHL program. As an evidence-based program, the WEHL program was previously evaluated for validity and reliability. The purpose of the evaluation of the roll-out of the Scripture-enhanced WEHL program was more about how well WEHL would work in a Christian church setting. Based on the feedback from the pastor and church congregants, strategies were developed that guided the project's educational components (NHLBI, 2007). To this end, the program lead monitored participants' satisfaction through postlesson feedback using 3 × 5 cards. These cards also were used for participants to write questions they had about the content already covered.

The majority focus was on the outcome evaluation to determine if the program's aims and objectives were met. Based on the assessment of the community and pastoral needs, specific aims and objectives were developed to guide the evaluation measures. To maintain participant safety, those participants with biometric measurements outside the expected norms

were referred to an appropriate healthcare provider.

These were the community-informed aims and objectives:

Aim One. Stakeholders will participate in the evaluation of a faith-adapted, culturally-focused, community-based program that emphasizes the heart health in African Americans, addressing hypertension and its risk factors in a faith-based setting.

Objective 1a. Participants will complete a program evaluation following each educational session.

Objective 1b. The minister of the congregation will express overall satisfaction and effectiveness of the WEHL program implementation at the church.

Aim Two. The participants will demonstrate increased skills and knowledge related to self-management strategies for cardiovascular health.

Objective 2a. Participants will be able to identify healthier food choices by completion of the program.

Objective 2b. Participants will report an increase in physical activity by completion of the program.

Objective 2c. Participants will report improved understanding of the community resources in monitoring blood pressure by completion of the program.

Objective 2d. Participants will demonstrate knowledge of heart-healthy food choices at a teach-back potluck at the completion of the program.

Aim Three. Biometric measures of participants' blood pressure and waist circumference will improve upon completion of the program.

Objective 3a. Group average systolic blood pressure measurements will

decrease by 6 millimeters of mercury (mmHg) by 2 months.

Objective 3b. Group average diastolic blood pressure measurements will decrease by 2 mmHg by 2 months.

Objective 3c. Group average waist circumference will decrease by 1.5 inches.

Data collection

Data collection involved measuring changes pre- and postimplementation. "Do You Know Your Risk?" addressed participant satisfaction with three questions: 1) rating quality of health, 2) concern for privacy, and 3) number of visits to their healthcare provider in the last year. These measures were used to assess the concerns identified in the literature that contributed to health provider mistrust. "Do You Know Your Risk?" also assessed knowledge of risk factors associated with cardiovascular health, including open-ended questions addressing nutrition, physical activity, and barriers to self-care related to health. A sample of this questionnaire is found as SDC at <http://links.lww.com/NCF-JCN/A80>. Biometric changes in systolic and diastolic blood pressure, determination of hypertension category, and waist circumference were measured preprogram, at end of the program, and again 2 months after completion of the program. The project leader used de-identified pre- and posttest knowledge change, biometric measures (pre-, post-, and 2 months postprogram), and satisfaction (weekly and at completion) to record the participants' changes in health risk behaviors and impact on biometric findings. Activities were performed with the participants to encourage lifestyle changes. Lastly, a log was kept that indicated which activities were implemented, the number of participants trained during each session, and the number of sessions taught.

Data collection tools consisted of outcome data forms for aggregated findings, referrals, class attendance, and follow-up after sessions. These tools were developed based on the needs assessment, project outcomes, and objectives. In addition, meetings, collaborating with community leaders, and questionnaires that evaluated processes

Figure 1. Preprogram and Postprogram Risk Factor Identification

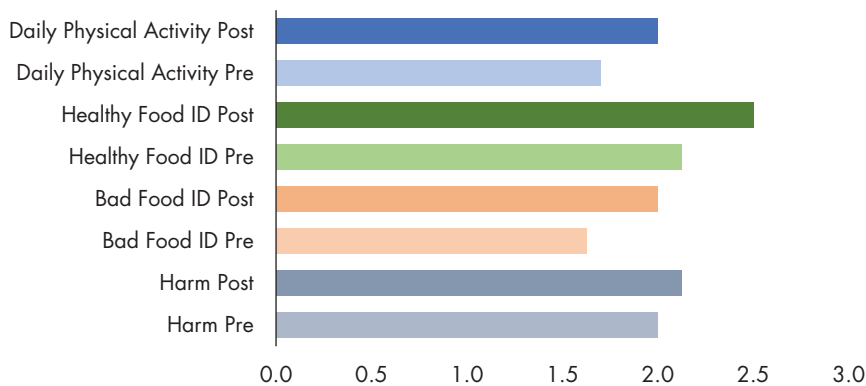


Table 3. Blood Pressure Recordings based on AHA Guideline Categories

Blood Pressure Category	Systolic		Diastolic	Participant Percentage (n = 8)	
				Start	End
Normal	Less than 120	and	Less than 80	12.5% (1)	12.5% (1)
Prehypertension	120–129	and	Less than 90	12.5% (1)	0
HTN Stage 1	130–139	or	80–89	12.5% (1)	37.5% (3)
HTN Stage 2	140 or higher	or	90 or higher	50% (4)	37.5% (3)
Hypertensive Crisis	Higher than 180	and/or	Higher than 120	12.5% (1)	12.5% (1)

Note. Based on American Heart Association guidelines. AHA = American Heart Association; HTN = hypertension.

needing improvement were used for the collection of process data. The quality of health question was on a scale of “1” being outstanding through “4” being poor. Privacy concerns addressed were rated on a scale of “1” outstanding, “3” adequate, and “5” poor. The number of visits to the participants’ health provider over the last year were assessed using a range from “1” have no health provider, “2” never visit health provider, “3” 1 to 4 visits, and “4” more than 5 visits. In addition, data collection tools incorporated ways of tracking progress toward goals at every stage of the project.

Biometric measurements were utilized, using the standard approach as in research for measurement of blood pressure. Blood pressure was measured in the left arm using a manual cuff (Muntner et al., 2019); waist circumference was measured 1 inch above the hip bone. The project goals were compared with the project activities to assure that both elements enabled participants to reach the goals.

RESULTS

Demographic characteristics

A total of 11 church members initially agreed to participate through the participation interest survey. Attrition rate after the first week was 37.5%, with three church members dropping out due to lack of transportation. At the end of the 6 weeks, eight church members (two men and six women) had participated in all sessions. Female participants were predominant (75%), and half were overweight or obese according to BMI (50%). They ranged in age from 46 to 74 years ($M = 60.4$ years, $SD = 9.05$). One participant who dropped out after the first week attended the last session.

Three of eight participants stated they had monitored their blood pres-

sure at home. Initially, seven attendees underestimated their blood pressure reading, thinking it was lower than it was. The participants’ self-identified quality of health ranged from outstanding (90%) to poor (10%), in the latter case, due to chronic health problems (diabetes, renal failure, or hypertension). The participants lived throughout the metro area.

Process and outcome evaluations: Aims and objective results

Three project aims were used to address the process and outcome evaluation findings. These program aims were to evaluate a culturally tailored heart disease prevention program, develop self-management strategies for cardiovascular health and hypertension control, and improve the biometric measures of blood pressure and waist circumference. Each aim was met with varying degrees of success.

Aim One

Stakeholders will participate in the evaluation of a faith-adapted, culturally-focused, community-based program that emphasizes the heart health of African Americans, addressing hypertension and its risk factors in a faith-based setting. This was met. Overall, participants were totally satisfied (75%, $n = 6$); one was somewhat satisfied and one participant didn’t complete the satisfaction survey. The objectives within this aim (**Objective 1a**. Participants will complete a program evaluation following each educational session and **Objective 1b**. The church minister of the congregation will express overall satisfaction and effectiveness of the WEHL program implementation at the church) were met. These objectives were measured through three surveys

on quality of life (QOL), privacy concerns, and self-reported health provider visits. The average QOL measures identified some chronic health issues on a scale of “1” no health issues to “4” multiple chronic health issues. The average QOL score demonstrated that there were some chronic health issues (2.6). Most participants felt that there was “good” (2.4) maintenance of their privacy during the program. Finally, the reported number of the need for health provider visits for the participants was three per year. In addition, the pastor verbalized satisfaction with the program, which she felt was the right length, of benefit, and important for her aging, higher risk African American community (Objective 1b).

Aim Two

The participants will demonstrate increased skills and knowledge related to self-management strategies for cardiovascular health. This was met. **Objective 2a**. Participants will be able to identify healthier food choices by completion of the program was also met. The aggregate scores at the end of the 6-week program showed group improvement. Aim 2 objectives are illustrated in Figure 1. **Objective 2b**. Participants will report an increase in physical activity by completion of the program was met. The participants showed an improved understanding of the role of daily physical activity (1.76%) in controlling hypertension. **Objective 2c**. Participants will report an improved understanding of community resources in monitoring blood pressure by completion of the program was met. From a community perspective, participants were able to create a support network for sharing information about resources in their community.

Objective 2d. Participants will demonstrate knowledge of heart-healthy food choices at a teach-back potluck at the completion of the program was met. The participants demonstrated increased knowledge of healthy food choices (1.25%) and foods that were bad for blood pressure control and cardiovascular health (1.05%). All eight participants attended the potluck. Six healthy dishes (consistent with WEHL and DASH diet) and the recipes were shared that reinforced the nutrition discussed throughout the program. In addition, participants' ability to identify signs and symptoms of hypertension and heart disease and self-identified modifiable risks improved.

Aim Three

Biometric measures of participants' blood pressure and waist circumference will improve upon completion of the program; this was partially met. Initial blood pressure results (Table 3) demonstrated that only two of the eight participants had blood pressure that was controlled. One participant demonstrated blood pressures consistent with hypertension stage 1 and 4 with blood pressures consistent with hypertension stage 2. One person had blood pressures high enough to classify as a hypertensive crisis; this individual stated that she felt fine and didn't believe she needed medication despite her primary care provider prescribing medication for her. This participant was evaluated and had no current chest pain, dizziness, or headache and was

referred to her primary care provider.

Objective 3a. Group average systolic blood pressure measurements will decrease by 6 mmHg by 2 months; this was met. The average systolic blood pressure measurement prior to the program was 151.8 mmHg and after 2 months was 143.5 mmHg (Table 4), demonstrating an average 8.3 mmHg (Table 5) drop in systolic blood pressure. Although this met the goal overall, some participants were still outside the normal range of blood pressure with medication. If data for the individual in hypertensive crisis were removed, all other participants demonstrated an impressive 7.7 mmHg change in systolic blood pressure (Table 5). **Objective 3b.** Group average diastolic blood pressure measurements will decrease by 2 mmHg by 2 months. The average diastolic blood pressure measurement prior to the program was 83.9 mmHg and after 2 months was 82.9 mmHg, demonstrating an average of 1 mmHg drop in systolic blood pressure which didn't meet the objective goal (Table 4). However, if the individual in hypertensive crisis was eliminated from the data, the drop in diastolic blood pressure exceeded the objective goal with a drop of 3.8 mmHg. **Objective 3c.** Group average waist circumference will decrease by 1.5 inches was unmet. Although there was no increase in the average waist circumference, there also was no decrease (Table 4). Of interest is that some participants lost 10 lbs and had a reduction in waist circumference, whereas others experienced a gain in

weight and waist circumference accounting for no net reduction in waist circumference.

DISCUSSION

With Every Heartbeat is Life was successfully implemented in a small, urban faith-based setting with 99% completion of the planned exercises and activities. The outcomes of the educational intervention demonstrated positive health change. Overall, participants became more cognizant of food and nutrition selections as demonstrated by their eagerness to participate in the potluck.

Our program was small as finding participants was challenging; however, this is consistent with what was found in the literature by Lancaster et al. (2014). Maintaining participants also was difficult (Bangurah et al., 2017). Overall, it is feasible to overcome the issues of immersion into the community and trust building, finding a church, and recruiting participants for an educational intervention.

This project highlighted the importance of gaining stakeholder input from the beginning of the project. This project didn't experience what the literature described as problems in faith-based projects such as scheduling conflicts, leadership issues, and financial constraints that impeded the implementation. Fortunately, the project's Christian nondenominational church was fully engaged and supportive. At each Sunday service, the pastor summarized the weekly accomplishments of the WEHL program.

In addition, issues of trust cited in the earlier literature didn't exist, most likely due to the use of a faith community nursing model applied within the African American community. The trust factor within African American communities is a high priority. We found that if the program planner sought input from stakeholders, the RN or community health worker was welcomed into the Christian church or faith-based organization. Key to this project was the skill set of the RN as an educator, soliciting information and questions by asking participants to write them on cards so that all questions could be answered without an individual

Table 4. Average Blood Pressure and Waist Circumference Recordings

	SBP	DBP	Waist Circumference (Inches)
Preprogram	151.8	83.9	40.6
Postprogram	147.3	82.9	40.6
2 Months Post	143.5	82.9	40.6

Note. DBP = diastolic blood pressure; SBP = systolic blood pressure.

Table 5. Average Blood Pressure Change in mmHg

	SBP	DBP
BP All	-8.3 mmHg	-1.0 mmHg
BP w/o Outlier	-6.1 mmHg	-1.9 mmHg
2 Months Post BP	-7.7 mmHg	-3.8 mmHg

Note. DBP = diastolic blood pressure; SBP = systolic blood pressure.



Web Resources


- **Georgia Department of Public Health: Heart Health Resources: Faith-based/Community Organizations**
<https://dph.georgia.gov/heart-health-resourcesfaith-basedcommunity-organizations>
- **Million Hearts**
<https://millionhearts.hhs.gov/>
- **National Cancer Institute: The Faith, Activity and Nutrition (FAN) Program**
<https://rtips.cancer.gov/rtips/programDetails.do?programId=10977999>
- **South Carolina Department of Health and Environmental Control: Faith and Health Resource Guide**
<https://www.scdhec.gov/sites/default/files/Library/CR-011398.pdf>

one RN who didn't live in the community, it was challenging and time consuming. Engaging faith community nurses in collaboration with trained community health workers could assist with sustainability. A community health training program manual exists (NHLBI, 2007) and could be used to develop more faith-based community health workers. It was evident that transportation in some communities (i.e., rural, low income) can present additional barriers. This program lost three participants due to transportation issues. Possible solutions are incorporating the program into the church service schedule either immediately before or after the service.

Key to the success of this project was incorporating the spiritual needs of the participants as an integral part of the program. The pastor's contribution of weekly Scripture and prayer, a modification, was key to the success of the WEHL project in this setting. The ability to incorporate faith-based activities demonstrates the need for more healthcare and risk reduction research and evidence-based projects to be implemented within Christian and other faith-based organizations.

CONCLUSION

The faith-based approach to health is important to address complex health problems such as hypertension in vulnerable populations, especially when there is mistrust of traditional health systems. Faith-based initiatives can support healthful lifestyles and demonstrate key components to improve outcomes. Further, these initiatives can improve community members' engagement with their primary care provider. In the current evidence-based implementation project, the Scripture and prayer enhancement of the WEHL community-based program created an important educational tool for hypertension health promotion and risk reduction. This program's focus on cultural relevance and adaptability to spiritual components suggests that it could easily be expanded to other faith-based communities to address the serious impact of cardiovascular disease and perhaps other debilitating chronic diseases (i.e., diabetes mellitus, asthma) in African Americans.

Cultural and religious competence are vital components of healthcare today. Clinical gaps and their relation to the improvement of clinical outcomes show that health programs in collaboration with faith-based organizations are effective. The increased saturation of patients' needs compared with the availability of primary care has shown that primary care cannot accomplish this alone. The community and the church and other faith-based organizations have been and remain the cornerstone of the African American community. 

participant being identified. Also, WEHL sessions were evaluated weekly by participants and results helped adjust the program as it progressed; participants felt they were heard.

Hypertension is a chronic condition, so long-term management and follow-up are necessary. During the program, questions were raised about self-management of blood pressure and what participants did at home. As most participants lacked blood pressure equipment in their homes, a key move was to identify community resources where individuals could get their blood pressure measured (e.g., pharmacy, firehouse, health department, health fair). Participants were educated about the types of activities that raise blood pressure (i.e., smoking) and were advised how to avoid these to get an accurate blood pressure measurement. To ensure the progress made, it may be helpful to reinforce and update information with refresher classes on an annual or semiannual basis.

Barriers

No program is without issues or challenges. Barriers need to be explored when determining if programs will be sustainable and what supports are required, as noted by Honeycutt et al. (2012). As this project was completed by

American Heart Association. (2019). *Nearly half of all U.S. adults have some form of cardiovascular disease*. <https://newsroom.heart.org/news/nearly-half-of-all-u-s-adults-have-some-form-of-cardiovascular-disease>

American Heart Association. (2020). *High blood pressure and African Americans*. <https://www.heart.org/en/health-topics/high-blood-pressure/why-high-blood-pressure-is-a-silent-killer/high-blood-pressure-and-african-americans>

Balint, K. A., & George, N. M. (2015). Faith community nursing scope of practice: Extending access to healthcare. *Journal of Christian Nursing, 32*(1), 34–40. <https://doi.org/10.1097/CNJ.0000000000000129>

Bangurah, S. S., Vardaman, S. A., & Cleveland, K. K. (2017). Hypertension in the faith community: A four-week, nurse led, diet/exercise intervention. *Journal of Christian Nursing, 34*(4), 225–231. <https://doi.org/10.1097/CNJ.0000000000000420>

Benjamin, E. J., Muntner, P., Alonso, A., Bittencourt, M. S., Callaway, C. W., Carson, A. P., Chamberlain, A. M., Chang, A. R., Cheng, S., Das, S. R., Delling, F. N., Djousse, L., Elkind, M. S. V., Ferguson, J. F., Fornage, M., Jordan, L. C., Khan, S. S., Kissela, B. M., Knutson, K. L., ..., Virani, S. S. (2019). Heart disease and stroke statistics—2019 update: A report from the American Heart Association. *Circulation, 139*(10), e56–e528. <https://doi.org/10.1161/CIR.0000000000000659>

Center for Healthy Communities. (2019). *Useful resource: With Every Heartbeat Is Life: A community health worker's manual for African Americans*. <https://centerforhealthy-communitiesadvocate.wordpress.com/2019/02/22/useful-resource-with-every-heartbeat-is-life-a-community-health-workers-manual-for-african-americans/>

Centers for Disease Control and Prevention. (2012). *Step 1: Engage stakeholders*. <https://www.cdc.gov/eval/guide/step1/index.html>

Condrasky, M. D., Baruth, M., Wilcox, S., Carter, C., & Jordan, J. F. (2013). Cooks training for Faith, Activity, and Nutrition project with AME churches in SC. *Evaluation and Program Planning, 37*, 43–49. <https://doi.org/10.1016/j.evalprogplan.2012.11.002>


Eiser, A. R., & Ellis, G. (2007). Viewpoint: Cultural competence and the African American experience with health care: The case for specific content in cross-cultural education. *Academic Medicine, 82*(2), 176–183. <https://doi.org/10.1097/ACM.0b013e31802d92ea>

Fitzgibbon, M. L., Stolley, M. R., Ganschow, P., Schiffer, L., Wells, A., Simon, N., & Dyer, A. (2005). Results of a faith-based weight loss intervention for black women. *Journal of the National Medical Association, 97*(10), 1393–1402. <https://pubmed.ncbi.nlm.nih.gov/16355489/>

- Flynn, S. J., Ameling, J. M., Hill-Briggs, F., Wolff, J. L., Bone, L. R., Levine, D. M., Roter, D. L., Lewis-Boyer, L., Fisher, A. R., Purnell, L., Ephraim, P. L., Barbers, J., Fitzpatrick, S. L., Albert, M. C., Cooper, L. A., Fagan, P. J., Martin, D., Ramamurthi, H. C., & Boulware, L. E. (2013). Facilitators and barriers to hypertension self-management in urban African Americans: Perspectives of patients and family members. *Patient Preference and Adherence*, 7, 741–749. <https://doi.org/10.2147/PPA.S46517>
- Harvin, L. A., Winter, D. M., Hoover, E. L., & Lewis, L. M. (2020). A faith-based intervention to improve hypertension management among African Americans. *Journal of Christian Nursing*, 37(1), 38–45. <https://doi.org/10.1097/CNJ.0000000000000676>
- Hayward, R. D., & Krause, N. (2013). Patterns of change in religious service attendance across the life course: Evidence from a 34-year longitudinal study. *Social Science Research*, 42(6), 1480–1489. <https://doi.org/10.1016/j.ssresearch.2013.06.010>
- Honeycutt, S., Carvalho, M., Glanz, K., Daniel, S. D., & Kegler, M. C. (2012). Research to reality: A process evaluation of a mini-grants program to disseminate evidence-based nutrition programs to rural churches and worksites. *Journal of Public Health Management and Practice*, 18(5), 431–439. <https://doi.org/10.1097/PHH.0b013e31822d4c69>
- Kjeldsen, S. E. (2018). Hypertension and cardiovascular risk: General aspects. *Pharmacological Research*, 129, 95–99. <https://doi.org/10.1016/j.phrs.2017.11.003>
- 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. <https://doi.org/10.1016/j.ahj.2013.10.026>
- Masci, D. (2018, February 7). 5 facts about the religious lives of African Americans. *Fact Tank, Pew Research Center*. <https://www.pewresearch.org/fact-tank/2018/02/07/5-facts-about-the-religious-lives-of-african-americans/>
- Mbe, K. A. (2017). Culturally competent health education in African-Americans' faith-based communities for better health outcomes: A literature review. *McNair Research Journal SJSU*, 13. <https://scholarworks.sjsu.edu/mcnair/vol13/iss1/11>
- Medline Plus. (2015). How to prevent heart disease. *U.S. National Library of Medicine*. <https://medlineplus.gov/howtopreventheartdisease.html>
- Muntner, P., Shimbo, D., Carey, R. M., Charleston, J. B., Gaillard, T., Misra, S., Myers, M. G., Ogedegbe, G., Schwartz, J. E., Townsend, R. R., Urbina, E. M., Viera, A. J., White, W. B., & Wright, J. T. (2019). Measurement of blood pressure in humans: A scientific statement from the American Heart Association. *Hypertension*, 73(5), e35–e66. <https://doi.org/10.1161/HYP.0000000000000087>
- National Heart, Lung, and Blood Institute. (2007). *With Every Heartbeat is Life: A community health worker's manual for African Americans*. <https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/ever-heartbeat-life-community-health-workers-manual>
- National Heart, Lung, and Blood Institute. (2014). *About With Every Heartbeat is Life*. <https://www.nhlbi.nih.gov/health/educational/healthdisp/communities-in-action/african-american/about-with-every-heartbeat-is-life.htm>
- Nguyen, A. W., Taylor, R. J., Chatters, L. M., & Hope, M. O. (2019). Church support networks of African Americans: The impact of gender and religious involvement. *Journal of Community Psychology*, 47(5), 1043–1063. <https://doi.org/10.1002/jcop.22171>
- Patestos, C. (2019). What is faith-based health promotion? A working definition. *Journal of Christian Nursing*, 36(1), 31–37. <https://doi.org/10.1097/CNJ.0000000000000558>
- Randolph County Caring Community. (2017). *Women's health initiative, Faith and fitness rural health innovations project*. <https://randolphcaringcommunity.org/programs/womens-health/>
- Rowland, M. L., & Isaac-Savage, E. P. (2014). As I see it: A study of African American pastors' views on health and health education in the black church. *Journal of Religion and Health*, 53(4), 1091–1101. <https://doi.org/10.1007/s10943-013-9705-2>
- Schoenthaler, A. M., Lancaster, K. J., Chaplin, W., Butler, M., Forsyth, J., & Ogedegbe, G. (2018). Cluster randomized clinical trial of FAITH (Faith-Based Approaches in the Treatment of Hypertension) in Blacks. *Circulation. Cardiovascular Quality and Outcomes*, 11(10), e004691. <https://doi.org/10.1161/CIRCOUTCOMES.118.004691>
- Taylor, R. J., Mouzon, D. M., Nguyen, A. W., & Chatters, L. M. (2016). Reciprocal family, friendship and church support networks of African Americans: Findings from the National Survey of American Life. *Race and Social Problems*, 8(4), 326–339. <https://doi.org/10.1007/s12552-016-9186-5>



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