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Purpose: This article reports on the interest within the religious community in a medical–religious partnership model designed to address some of the health challenges communities face as the population continues to age and become more diverse. Design and Methods: A geographically and religiously diverse group of 183 clergy who were attending a continuing education program on theology and preaching were invited to complete a 16-item survey asking about their interest in working with hospitals to offer health-related programs and activities in their congregations. Another sample, this one consisting of 524 individuals from a religiously diverse group of congregations in Florida, was also asked about their interest in having health programs offered in their congregations. Results: Of the 54% of clergy who completed the surveys, 72% said it was “very important” and 28% said it was “somewhat important” to actively address the health needs of their congregations. Support for specific programs was also strong, with at least 80% reporting it was very likely they would support screenings, preventive interventions, and health-related classes in their congregations. Strong support was also found among the laity surveyed, with 85% expressing interest in faith-based health programs and 45% reporting they would be interested in helping organize and promote such programs. Implications: Health care systems and other organizations interested in addressing health needs of older adults can look to religious institutions for assistance in providing the information and support patients and family members need to prevent or minimize the impact of chronic illnesses.

Key Words: Medical–religious partnerships, Faith-based health programs

The aging of the American population is creating major challenges for health care systems. One of the most significant challenges is the increasing prevalence of chronic conditions (Institute for the Future, 2000). Currently, more than 100 million Americans are estimated to have chronic conditions, and this number is expected to rise to 148 million by 2030 (Hoffman, Rice, & Sung, 1996). Because responsibility for the day-to-day management of most chronic conditions rests largely with patients and their families, medical institutions committed to improving the health of their communities must develop programs that engage older adults, their families, and caregivers and that provide the ongoing information, motivation, and support needed to manage chronic conditions (Von Korff, Gruman, Schaefer, Curry, & Wagner, 1997).

Another challenge facing health care systems is the increasing ethnic diversity of their communities. It is expected that, by 2010, minority ethnic and racial groups that accounted for 20% of the population in 1980 will make up 32% of the U.S. population (Institute for the Future, 2000). Increasingly, health care systems will have to develop programs that are responsive to the special medical needs of various minority groups and that reflect an understanding of the values and traditions of these groups. Additionally, when minorities are worked with, special attention will have to be given to the issue of trust (Matheny, 1994), because mistrust of medical institutions can be a significant barrier to the delivery of needed services.

How can health care systems establish and maintain regular contact with their communities as they become older and more diverse? One option is to develop alliances with other institutions and organizations that are already well established and accepted within the community (Wandersman, Goodman, & Butterfoss, 1997; Warden, 1999).
Religious institutions are often suggested as good candidates for such partnerships and coalitions (Boscarino & Chang, 2000; Lasater, Becker, Hill, & Gans, 1997; Matheny, 1994; Olden, 1998). There appear to be several advantages to developing alliances with religious organizations. One major advantage to working with religious institutions is that older adults, the age group with the highest prevalence of chronic medical conditions, are likely to be affiliated with religious congregations and to attend religious services on a regular basis. Gallup (2000) found that 67% of adults in the 65- to 74-year-old age group and 69% of those in the 75 and older age group reported attending church or synagogue “about once a month” or more frequently (“at least once a week” or “almost every week”). Furthermore, attendance at religious services has been found to be even higher among racial minorities (Gallup, 1996).

In addition to being in regular contact with people who need education and support on health matters, religious institutions have at least three important features they can bring to a medical–religious partnership. First, they are not only located in the community but are generally established and governed in large measure by residents of the community. Thus, they are likely to reflect the traditions and values of community residents and to be trusted by them as well. Second, most religious congregations have well-established communication networks that allow them to stay in touch with their members. Information can be disseminated by announcements during congregational gatherings, bulletins distributed at worship services, mailings to members at their homes, and volunteer phone networks. Third, and perhaps most important, are the human resources found within religious congregations. Religious institutions have strong traditions of volunteerism and civic engagement (Putnam, 2000). In every congregation there are members, especially among the elderly population, who are willing not only to volunteer their time but also to participate in congregational training programs that enhance their ability to step into leadership roles and to be of service to others in their congregations and communities.

A number of investigations have demonstrated the potential of collaborative efforts between health care organizations and religious congregations. Campbell and Demark-Wahnefried (1999), in a program funded as part of a National Cancer Institute initiative and conducted in African American churches in North Carolina, found at their 2-year follow-up that members of the intervention group were consuming significantly more servings of fruits and vegetables than were members of the comparison group. Resnicow and colleagues (2001) reported a similar increase in the consumption of fruits and vegetables in an investigation conducted in African American churches in Georgia. McNabb, Quinn, Kerver, Cook, and Karrison (1997) reported that their church-based weight loss program for women at risk for diabetes conducted in African American churches in Chicago produced significant results, with members of the intervention group losing an average of 10 lb (4.53 kg) and control group members gaining an average of 1.9 lb (0.86 kg).

Erwin, Spatz, Stotts, and Hollenberg (1999) studied the impact of having African American women who had survived breast or cervical cancer speak in churches in two counties in Arkansas about the importance of early detection. They found that the subsequent increase in the practice of breast self-examination and mammography was higher in these counties than in the two comparison counties. Along similar lines, Duan, Fox, Derose, and Carson (2000), working with African American, Latino, and White congregations in Los Angeles, reported a significant effect for a church-based telephone counseling program on mammography adherence.

Yanek, Becker, Moy, Gittelsohn, and Koffman (2001) found that participants in their program, based in churches in Baltimore, achieved statistically significant and clinically important changes in cardiovascular risk profiles. These included improvements in body weight, waist circumference, systolic blood pressure, dietary energy, dietary total fat, and sodium intake.

There are published reports of other faith-based programs led by investigators who believe that, in spite of the absence of scientifically rigorous research designs, their experiences allow them to conclude that medical–religious partnerships are an effective means of reaching individuals and enhancing community health. For example, Smith and Merritt (1997) reported that their church-based hypertension education program for African Americans resulted in a significant decrease in blood pressure among participants. Oexmann and colleagues (2000) found similar effects on blood pressure among participants in their church-based program, along with significant short-term improvements in weight and triglyceride levels. Kotecki (2002) looked at the impact of a faith-based educational program focused on health-promotion practices and disease-prevention strategies. She reported a statistically significant increase in health-promotion knowledge along with a high degree of participant satisfaction.

Other programs that investigators believe have demonstrated the value of using religious institutions to reach and influence health practices include ones focused on diabetes (Briceoe & Pichert, 1999); cervical cancer screening (Davis et al., 1994); cancer, diabetes, and other chronic health problems (Jackson & Reddick, 1999); breast, cervical, prostate, and colon cancer (Mann et al., 2000); and cardiopulmonary resuscitation (Todd et al., 1999).

The aforementioned programs have relied largely on congregational volunteers who worked closely with professionals from health institutions to carry
out the interventions. Another model of medical–religious collaboration is that of parish nursing. In this model, responsibility for the faith-based health programs rests with professional nurses who have completed additional training to prepare them to function in seven roles within their congregations—health educator, personal health counselor, referral agent, coordinator of volunteers, developer of support groups, integrator of faith and health, and health advocate (Westberg, 1999). According to the surveys and reports of parish nurses, most of their activities and interventions revolve around health promotion and illness prevention (Coenen, Weis, Schank, & Matheus, 1999; Tuck, Wallace, & Pullen, 2001; Weis, Schank, Coenen, & Matheus, 2002), and older individuals are the ones most likely to receive services (Coenen et al., 1999).

Although parish nursing programs, along with those that rely on volunteers, illustrate the potential of faith-based health programs to meet some of the needs of the elderly population, there has been little information reported about programs that specifically focus on the broad range of health concerns of older adults. One medical–religious partnership program that was designed to address these concerns by capitalizing on the strengths and resources of religious congregations is the Lay Health Educators program. In this program, volunteers from congregations are recruited and trained to serve as health-education coordinators for their congregations and communities (Hale & Bennett, 2000; Hale, Bennett, Oslos, Cochran, & Burton, 1997). This program, currently in operation in five central Florida counties, is sponsored by community hospitals, with local health care professionals providing the training and ongoing support for the volunteers. Among the topics covered in the program are heart disease, hypertension, cancer, depression, dementia, diabetes, medication management, advance directives, accidents and falls, community resources, and the steps people can take to reduce their risk of premature illness, disability, and death. Participants are also given strategies for disseminating information to their congregations.

The Lay Health Educators program appears to have the potential to bring together medical and religious institutions in other communities that have to address the health needs associated with an aging population, but such programs can succeed only if there is sufficient interest among both clergy and laity. Medical institutions are unlikely to invest resources in these programs unless there is clear evidence of support within the religious community. This article describes the results of two surveys we conducted (a) to assess the degree of interest among clergy and members of congregations in a medical–religious partnership program and (b) to determine which types of congregational health programs and activities clergy and congregants were most likely to support.

Methods

Survey 1—The Clergy

We were invited to distribute questionnaires to clergy who were attending a Pastors School at Stetson University. This was a weeklong continuing education program that drew 183 clergy from more than 20 states and a dozen denominations. It is important to note that the focus of this program was not on any health-related topic but on preaching and theology. We developed a 16-item questionnaire titled “Partnering with Hospitals: What Do You Think?” Respondents were asked to “assume that a hospital in your community wants to work with you to enhance the health of the members of your congregation. The hospital is offering various programs and resources to you at no cost, but it does ask that you support its efforts by providing leadership and assistance in certain areas.”

The first question asked about the respondent’s belief in the importance of religious institutions addressing the health needs of their members. Subsequent questions included 15 specific steps that might be taken to facilitate a medical–religious program, and respondents were asked how likely (very likely, somewhat likely, or not likely) they would be to take each step. Although the survey made no mention of the Lay Health Educators program, these items reflected specific activities or programs that congregational volunteers trained as Lay Health Educators are trained to organize.

Survey 2—The Laity

Our second survey, also designed to reflect the training and potential activities of Lay Health Educators, was distributed to adult members of religious congregations by undergraduate students from Stetson University. Students were instructed to ask parents or family friends who were members of a religious congregation to hand out the surveys to fellow members.

A brief paragraph at the top of the questionnaire informed potential respondents that “many hospitals and medical professionals would like to help churches (synagogues) address the health needs and concerns of their members. We would like to know if church (synagogue) members are interested in having health programs in their church (synagogue).” The first question asked if respondents would be interested in having educational programs on health matters presented at their church (synagogue). This was followed by 16 medical topics. Respondents were asked to check any of the topics they would like to have presented to their congregation. Next were two questions asking about their assessment of the likelihood that volunteers from the congregation would be willing to assist in organizing and promoting such programs. The last six questions asked about their perceptions of the need or interest among members of
their congregation in certain health-related measures. These included screenings, vaccinations, exercise groups, and programs for individuals in the congregation who were depressed or in need of support.

**Results**

**Survey 1**

Ninety-eight (54%) of the pastors in attendance completed the survey. Three fourths of these respondents came from five denominations (Baptist = 20%, Lutheran = 17%, Methodist = 13%, Presbyterian = 13%, and Disciples of Christ = 11%). In response to the question, How important is it for churches and synagogues to actively address the health needs of their congregations?, 72% said it was very important and 28% said it was somewhat important. None of the clergy said that it was of little importance or no importance.

Responses to the items describing the specific activities are presented in Table 1. These results indicate strong support among clergy for their congregations to become more involved in health programs. At least 80% of the clergy surveyed said they would be very likely to utilize congregational facilities for screenings, preventive interventions, and health-related classes, as well as to support volunteers who would be trained to provide assistance for members of the congregation who needed help at home or when they visited their physician. Two thirds reported that they would be very likely to utilize congregational publications to make announcements about screenings and to encourage their members to participate in these screenings. Two thirds also said that they would support the scheduling of special health-related programs outside of regular meeting times, with 59% indicating they would even support the presentation of health-related matters during regularly scheduled meetings of congregational organizations and groups.

**Survey 2**

There were 524 members of religious congregations who completed the second survey. Two thirds...
of the total sample came from five religious groups—Baptist (19%), Methodist (17%), Presbyterian (12%), Catholic (11%), and Lutheran (10%). Eighty-five percent reported that they would like to have educational programs on health matters presented at their church or synagogue. Their preferences for topics are reported in Table 2.

Of the total sample, 84% reported that they thought there were individuals in their congregation who would assist in helping promote health-education programs, and 45% indicated they would be interested in helping organize or promote health programs in their congregation.

Responses to the six questions on other types of activities that respondents felt might be needed in their congregation are presented in Table 3 and indicate the widespread belief that there is a need for preventive interventions, screenings, and support groups.

**Discussion**

Although the results of our study indicate considerable support among clergy and laity for addressing the health needs of their congregations and communities by partnering with health care institutions, we must note several limitations of our investigation. First, most of the clergy attending the continuing education program where we distributed our surveys were from mainline congregations that would be considered theologically moderate to liberal. We do not know if a similar degree of support would be found among pastors from more conservative congregations. Second, our response rate within this group was only 54%. There are also limitations with respect to the convenience sample of members of religious congregations. First, as with the clergy, the individuals we surveyed were largely from established, mainline congregations. Second, we had little control over the actual distribution and collection of surveys, relying on students who, in turn, relied on parents and friends.

In spite of these limitations, the results remain encouraging for those who would like to see greater collaboration between health care and religious institutions. The clergy we surveyed felt that religious institutions should be involved in responding to the health needs of their members and indicated that they would welcome the opportunity to work closely with hospitals to provide appropriate programs. When asked about specific ways clergy could facilitate their congregation’s involvement, they indicated strong support for a number of ways, including using congregational facilities and mailings, encouraging members to attend health-promotion events, and supporting the work of

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<thead>
<tr>
<th>Program</th>
<th>%</th>
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<tbody>
<tr>
<td>Stress management</td>
<td>56</td>
</tr>
<tr>
<td>Alzheimer’s disease (or other forms of dementia)</td>
<td>53</td>
</tr>
<tr>
<td>Cancer</td>
<td>51</td>
</tr>
<tr>
<td>Heart disease</td>
<td>48</td>
</tr>
<tr>
<td>Depression</td>
<td>48</td>
</tr>
<tr>
<td>CPR (cardiopulmonary resuscitation)</td>
<td>47</td>
</tr>
<tr>
<td>Living wills, do not resuscitate orders, and other</td>
<td></td>
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<tr>
<td>advance directives</td>
<td>45</td>
</tr>
<tr>
<td>Arthritis</td>
<td>40</td>
</tr>
<tr>
<td>Diabetes</td>
<td>38</td>
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<tr>
<td>Healthy meal preparation</td>
<td>37</td>
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<tr>
<td>Hypertension</td>
<td>35</td>
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<tr>
<td>Strokes</td>
<td>35</td>
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<tr>
<td>Pain management</td>
<td>32</td>
</tr>
<tr>
<td>Common medications</td>
<td>31</td>
</tr>
<tr>
<td>Eye diseases or vision problems</td>
<td>27</td>
</tr>
<tr>
<td>Accidents and falls prevention</td>
<td>23</td>
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**Note:** Survey participants were asked the following question: Which programs would you like to see offered in your church, either for yourself or for the benefit of others in your congregation? (Check as many as you like.)

<table>
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<tr>
<th>Question</th>
<th>Response (%)</th>
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<tr>
<td>Would you like for health screenings (e.g., blood pressure, blood sugar, cholesterol, or skin cancer) to be made available at church?</td>
<td>Yes 78</td>
</tr>
<tr>
<td>Would you like for important preventive measures (e.g., flu vaccinations) to be offered at your church?</td>
<td>No 18</td>
</tr>
<tr>
<td>Do you think there are people in your church who need more exercise and would be interested in joining a walking group or other exercise group that met regularly at your church?</td>
<td>None 4</td>
</tr>
<tr>
<td>Would you be interested in participating in a walking group or some other exercise group that met regularly at your church?</td>
<td>Yes 80</td>
</tr>
<tr>
<td>Would you think there are individuals in your congregation who may be depressed but aren’t getting the treatment or help they need?</td>
<td>No 14</td>
</tr>
<tr>
<td>Do you think there are individuals in your church who would benefit from being a member of a support group that meets regularly?</td>
<td>None 6</td>
</tr>
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congregational volunteers trained to help individuals needing assistance with medical matters. Interestingly, clergy were less likely to say they would encourage their members to modify health-compromising behaviors.

Equally encouraging results were found when we went directly to members of religious congregations. The overwhelming majority expressed interest in partnering with medical institutions and professionals, and almost half indicated they would be willing to assist in organizing and promoting health programs within their congregations. They reported wanting information on the major chronic conditions and on topics commonly associated with old age (e.g., Alzheimer’s disease and advance directives). Additionally, they felt there was a need within their congregations for vaccination programs, early detection programs, and groups that would provide ongoing support for those who wanted to make lifestyle changes or who needed help dealing with difficult emotional issues.

The dramatic increase in the prevalence of chronic conditions projected to accompany the aging of the population over the coming decades calls for innovative health programs. New, cost-effective approaches to giving older adults and their families and caregivers reliable information about chronic conditions and what they can do to prevent or minimize the impact of these conditions must be developed. New resources and strategies must be found. We believe that medical–religious partnerships that rely largely on congregational volunteers and that offer the types of activities and programs described in our questionnaires can creatively address many of these challenges. Furthermore, the results of our surveys indicate that many in the religious community recognize the need for their congregations to become more involved in meeting the health needs of their members, and they are ready to embrace medical–religious partnerships as one means of doing so. We hope these findings will encourage more religious leaders and health care professionals to explore establishing such partnerships in their communities.

References


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