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Utility of a congregational health assessment to identify and direct health promotion opportunities in churches

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ABSTRACT

Purpose: The church is a focal point for health education efforts in minority communities due to its status as one of the most prominent and stable institutions. This paper highlights an approach for identifying health programming targets in minority churches.
Methods: Twenty-four churches participated in a one-year Health Ministry Institute (HMI), designed to help churches develop sustainable ministries for health promotion. HMI attendees were instructed on conducting a Congregational Health Assessment (CHA) to identify prevalent health conditions and related behaviors in their churches. Churches collected CHAs over a one-month period. Data were analyzed and results were discussed during a HMI session and used to prioritize health-related issues that could be addressed at individual churches.
Results: Seventeen churches (71%) returned surveys ($n = 887$; 70% female; 73% African American). Prevalent health conditions, participation in health-promoting behaviors, interest in learning to live healthy, and interest in health ministry activities were identified using the CHA.
Conclusions: The CHA shows promise for health assessment, and can be used to identify health issues that are of interest and relevance to church congregants and leaders. The CHA may assist churches with implementing effective and sustainable programs to address the identified health issues.

1. Introduction

Health education is a critical component of strategies designed to promote health, prevent disease and reduce racial and ethnic health disparities. Among low-income and minority communities where the benefits of community programs to implement health promotion and disease prevention activities have been documented, churches are often the community's first source of support (Goldmon & Roberson, 2004; Olson, Reis, Murphy, & Gehm, 1988). Within minority populations, particularly African-Americans, the church is often a focal point for health education programs due to its status as one of the most prominent and stable social institutions within minority communities. It is well recognized that churches are important sources of information not only for their congregations, but surrounding communities as well. A recent report found that 47% of all American adults, 52% of African Americans, 50% of women, and 51% of Southerners attended a religious service in the past week (The Barna Group, 2007). Data from the Pew Forum on Religion and Public Life indicated that, compared to the U.S. population, a higher proportion of African Americans report having absolutely certain belief in God, say religion is very important in their lives, pray at least daily, interpret Scripture literally, and attend worship services at least weekly (The Pew Forum on Religion and Public Life, 2008). Church membership and associated activities are particularly important to African American women, who are more likely to report attending church, reading the Bible, attending Sunday school classes, or participating in small groups, or ministries, that meet during the week than any other race/ethnic and gender group (The Barna Group, 2007). In addition, church membership tends to remain relatively stable over time in that church members tend to remain at one church for years and, in many instances, generations. For this reason,

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churches are considered an ideal venue in which to conduct programs that require long-term follow-up.

Development of effective health education programs includes the need to have participants feel the issues addressed are pertinent to their own health needs or the needs of their families and peers. The variable effectiveness of previous health education programs located within churches may be related to the strategies used to define the included topics (Lasater, Wells, Carleton, & Elder, 1986). While large epidemiologic studies have collected population-based data to describe health and health-related behaviors in varying communities (National Center for Health Statistics, 2013), using locally collected data to direct the focus of health education programs and involving local ministries early and continuously throughout the program development process promotes ownership and greater support for the ensuing programs. It also ensures that relevant and culturally appropriate issues are addressed and incorporated. This paper highlights a promising approach for determining the health concerns within minority churches. We describe a method for involving churches in the collection of information as well as the health-related findings that were collected using the method.

2. Methods

The Congregational Health Assessment (CHA) tool, described below, was used and analyzed within the context of a larger program designed to help churches develop sustainable ministries for health promotion in their congregations and communities, the Health Ministry Institute (HMI). Fifty-one participants from 24 churches serving predominantly African American congregations met monthly and heard topics from the rationale for church involvement in health to strategies for addressing health-related issues within the congregation. Participants received notes, PowerPoint presentations and relevant resources that could be incorporated into health ministry activities at each church.

2.1. Congregational health assessment

Survey description. The CHA was initially developed as a method for assessing the readiness of black churches to engage in research on health disparities (De Marco et al., 2011). The original survey, which was designed for adults $\geq$ 18 years, included 15 items that asked respondents to rate their confidence in the ability of their church to carry out research-related activities, including identifying leadership for programs, planning programs within church activities, identifying program participants and volunteers, encouraging enrollment and retention in programs, and organizing and participating in assessment-related activities. One investigator involved in the HMI (MVG) was also involved in the development of the CHA. Following the initial development of the CHA, the instrument was further modified to assess respondent health (e.g., current health conditions, participation in health related behaviors), as well as respondent perceptions of health among family and loved ones, level of concern about the health of family and loved ones, perceived responsibility of the church concerning health, and perceived health and lifestyle/environmental issues impacting members of the church. All survey responses were categorical and responses were either affirmative/negative (e.g., yes/no) or reported on a 5-point likert scale (always/most of the time/sometimes/rarely/never OR strongly agree/agree/neither/disagree/strongly disagree OR not a problem/small problem/moderate problem/big problem/very big problem). For the purposes of data collection within the HMI, demographic questions (e.g., gender, age, race/ethnicity, education, and church attendance) with categorical responses were added to the survey. The full survey is included in Appendix A. The full survey included 50 items and took 10–15 min to complete. No identifying information was collected with the surveys (e.g., name, address, etc.). Because of the nature of the questions on the survey, the project was deemed exempt from IRB approval.

Training for survey administration. During an early HMI session, participants were provided with information about the importance of health assessments when planning health ministry activities, and were provided with instructions for how to conduct a CHA within the church. Participants were instructed that the CHA was a questionnaire measuring a variety of variables, including demographics, health conditions, healthy lifestyle behaviors, and the prevalence of lifestyle and environmental issues that affect health. The purpose of the CHA was to obtain general information about the congregation as a whole, which was then used to identify priority areas for the church's health ministry, to determine the resources needed to address health ministry priority areas, and to develop health ministry activities that would address the needs, concerns, and priorities of congregations.

The survey was designed to be self-administered and each HMI participant was provided with a master copy of the survey and instructed to make as many copies as needed for their church. Computer-based survey administration was not available at the time the HMI was conducted, nor was it feasible for the majority of the churches enrolled in the HMI. HMI participants were instructed to ask congregation members to complete the questionnaire on their own and were provided with suggestions for administering the survey to individuals who requested assistance (e.g., individuals who could not read/write well or who had trouble reading the print because of vision problems). HMI participants were cautioned to not assist participants with interpreting survey questions. All HMI participants completed the CHA during a HMI session so they would understand the nature of the questions being administered and the expected length of time for completing the survey. HMI participants were able to ask study staff to assist with interpretation of any questions that were ambiguous or unclear during the training session.

Survey administration/data collection/results and interpretation. HMI participants were given one month to administer the CHA and collect data from their congregations. All HMI participants were advised to identify and select a team of volunteers from the church to assist with and to devise a plan for administration and collection of survey data before approaching the congregation. HMI participants were advised to consider how many surveys they could reasonably collect with $\geq$70% of the congregation as a suggested target. Suggested methods that could be used to inform congregations about the survey, including scripts, were provided to HMI participants. Study staff was available to answer questions about survey administration during the data collection period. Completed surveys were returned at the following HMI session; extensions were granted if churches requested additional time to administer the survey for their congregations.

Study staff hand entered all collected data into Excel spreadsheets and data were analyzed by a statistician (see "Data Analysis" section below). Each church received a summarized report of their congregants' responses. Aggregated data were also provided, which indicated how specific churches compared to the entire population of churches participating in the survey. HMI participants used their individual summary reports to identify health-related needs in their churches and to plan health ministry activities for the coming year (e.g., churches that had a high number of participants reporting a previous diagnosis of hypertension planned blood pressure screenings and identified health-related information about blood pressure risk factors, prevention, and treatment that could be delivered to the congregations via bulletin inserts and educational announcements). Study staff reviewed health ministry plans with each church individually and