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Faith Community Nurses Key to Promoting Health in At-Risk Communities: AN INTEGRATIVE REVIEW

ABSTRACT: *An integrative literature review was conducted to identify recommendations to implement culturally congruent and spiritually connected approaches to health promotion in at-risk faith communities. Five themes emerged from an analysis of 48 articles meeting criteria for the review. Review results repeatedly highlighted the impact nurses—more specifically faith community nurses (FCNs)—can have on at-risk population outcomes and bridging the gap between minority communities and the healthcare establishment. Five recommended action steps provide program guidance to FCNs for promoting faith-based health in at-risk minority communities.*

KEY WORDS: *African Americans, at-risk communities, collaboration, faith-based, faith community nursing, faith-placed, health promotion, integrative review, minorities, nursing*

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Minority and at-risk communities face serious health disparities. For example, the heart disease burden for African Americans (AAs) is significantly higher than in other racial groups (National Center for Health Statistics, 2019). Compared with non-Hispanic whites, AAs are 40% more likely to be affected by hypertension (HTN) and less likely to have HTN under control (Office of Minority Health, 2022). Additionally, Hispanics and AAs have higher rates of obesity and diabetes (National Center for Health Statistics, 2019). However, individuals within these minority groups are at greater risk for reduced access to healthcare (Centers for Disease Control and Prevention, 2022).

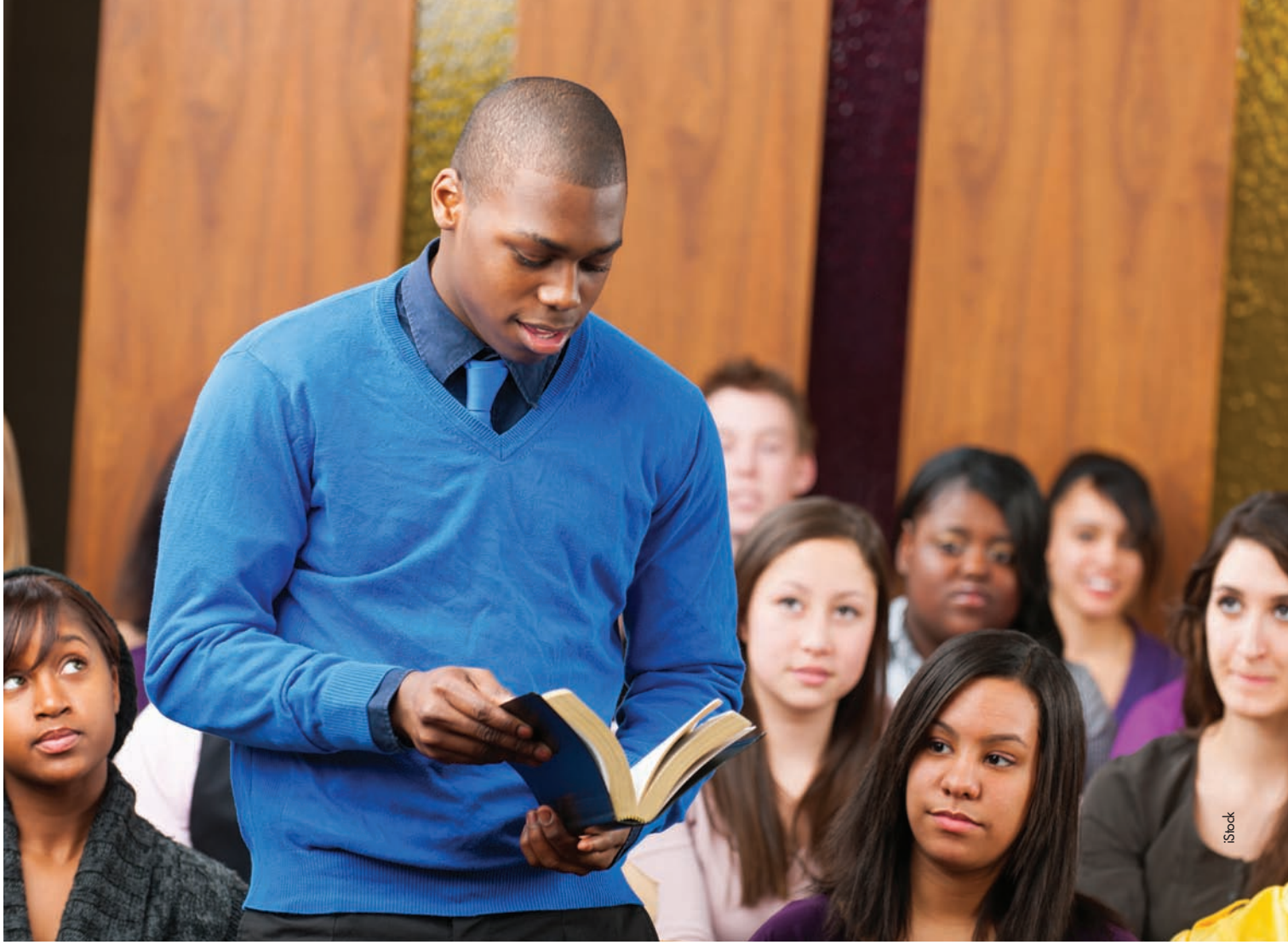
At the same time, AAs have greater involvement in religious and spiritual practices—including regular attendance at worship services—than those who do not identify as AA (Mohamed et al., 2021). Furthermore, people in this ethnic group more frequently integrate faith into their perceptions of health (choices, outcomes, and opportunities) than other ethnic groups (West & Hollis, 2012). Many AA communities have a significant number of freestanding faith-based organizations—churches, synagogues, temples—as a testament to their connection to spirituality and religion in day-to-day community experiences. Data from the 2014 Religious Landscape Study showed the majority of Latinos also admit to at least some belief in God or a higher power (Pew Research Center, 2022). It is through belief (and faith) in God that many individuals, families, and communities within ethnic groups identify their ability to achieve a higher level of health.

The purpose of this literature review was to identify specific recommendations for implementing culturally congruent and spiritually connected approaches to health promotion for at-risk faith communities. Clear identification of specific actions and measures is needed to address health disparities.

FAITH-BASED NURSING LITERATURE REVIEW

Healthcare has a long history of faith-based organization (FBO) partnerships. All registered nurses receive foundational education in the delivery of culturally and spiritually supported care (American Nurses Association [ANA], 2021). Care is completed throughout the nursing process (assessment, diagnosis, planning, implementation, evaluation) in a variety of ways (e.g., assessment of religion, spiritual influence, and culture upon admission to health facilities). Providers are expected to conduct religious assessments as part of initial evaluation with the goal of supporting culturally competent care. However, spiritual and holistic approaches to healthcare often remain adjacent to—rather than interwoven with—traditional medical treatments (Cone & Giske, 2017).

The authors conducted an integrative review as a tiered process (identification, analysis, categorization) to determine methods selected by nurses for effective collaboration with FBOs. Effectiveness was defined as demonstrable changes in the risk-taking behaviors or the overall health status of the congregants. Search



terms for the review were selected to acquire a thorough assortment of existing literature (experimental, quasi-experimental, and nonexperimental) and to ensure a variety of sources were considered (e.g., editorials). The terms "health promotion" combined with "faith nursing" and "parish nursing" were used for this search to ensure a focus on nursing interventions. The search was limited to articles published within a 10-year window (2010–2020), although some studies outside of the 10-year range were included due to their foundational knowledge and insight into the topic. Emphasis was intentionally not placed on articles focused on AA communities but was placed instead on references to minority or at-risk populations to expand the results and explore diverse approaches to promotion of health.

Many articles related to faith-based approaches to health are published in faith-oriented journals and fall outside of traditional nursing publications. Search engines such as EBSCO Host Academic Search Index, OVID Complete, Cumulative Index of Nursing and Allied Health Literature (CINAHL) Complete, Medline, and ProQuest Health and Medicine were utilized. The search was limited to articles available in English (with an abstract), with studies conducted in the United States, published in peer-reviewed journals, and with full-text availability.

The initial search yielded 244 articles. Initial results were analyzed to evaluate article titles and abstracts for congruence with the purpose of the integrative review and duplicity. This refined the results to 121 articles which were then assessed for the level of evidence of design, quality, validity, and applicability (Melnyk & Fineout-Overholt, 2005). Occasionally, article titles or abstracts were unclear and were more closely evaluated for consistency with the review purpose. Additionally, articles were screened using a literature review matrix to compare and contrast the scope, depth of design, and similarity. A final total of 48 articles was included in this review.

A categorization of nursing interventions as *faith-placed*, *faith-based*, or *collaborative* also was performed following similar definitions as offered by previous researchers (Bopp et al., 2012; DeHaven et al., 2004). *Faith-placed* is when the faith organization was used by the nurse to test an intervention; *faith-based* is where the selected health program was integrated into the FBO's ministry; and *collaborative* describes when the intervention included a combination of both features. This final categorization was applied to determine the impact of design on perceived effectiveness of the nursing intervention. Not all

interventions are designed in this manner, and clearer understanding of the differences in approach will support addressing specific recommendations for nurses. However, 79% of the articles reviewed for this study fit into one of the three groupings. Faith-based approaches to nursing care made up the largest category of articles (38%), but faith-placed (15%) and collaborative approaches (17%) have results similar to faith-based methods. Several of the articles (21%) did not clearly fit into one of the concepts related to spiritual and faith-based nursing care. These articles were included in the review despite their lack of inclusion of original research in their design due to the value added to this discussion on spiritual and faith-focused nursing care.

SYNTHESIS OF RESULTS

The review results were categorized under five common themes that emerged from analysis: 1) trusted resource and social support, 2) access to underserved populations, 3) endorsement from faith leadership, 4) level of FBO involvement, and 5) faith community nurses providing health education and support with a focus on faith-related nursing care. The themes were persistent across real and perceived effectiveness of the health promotion interventions. Articles were a mix of case studies, reviews, educational interventions, phenomenological, and quasi-experimental studies. A shared thread across the articles included a focus on minority communities and provision of support for various minority and at-risk populations.

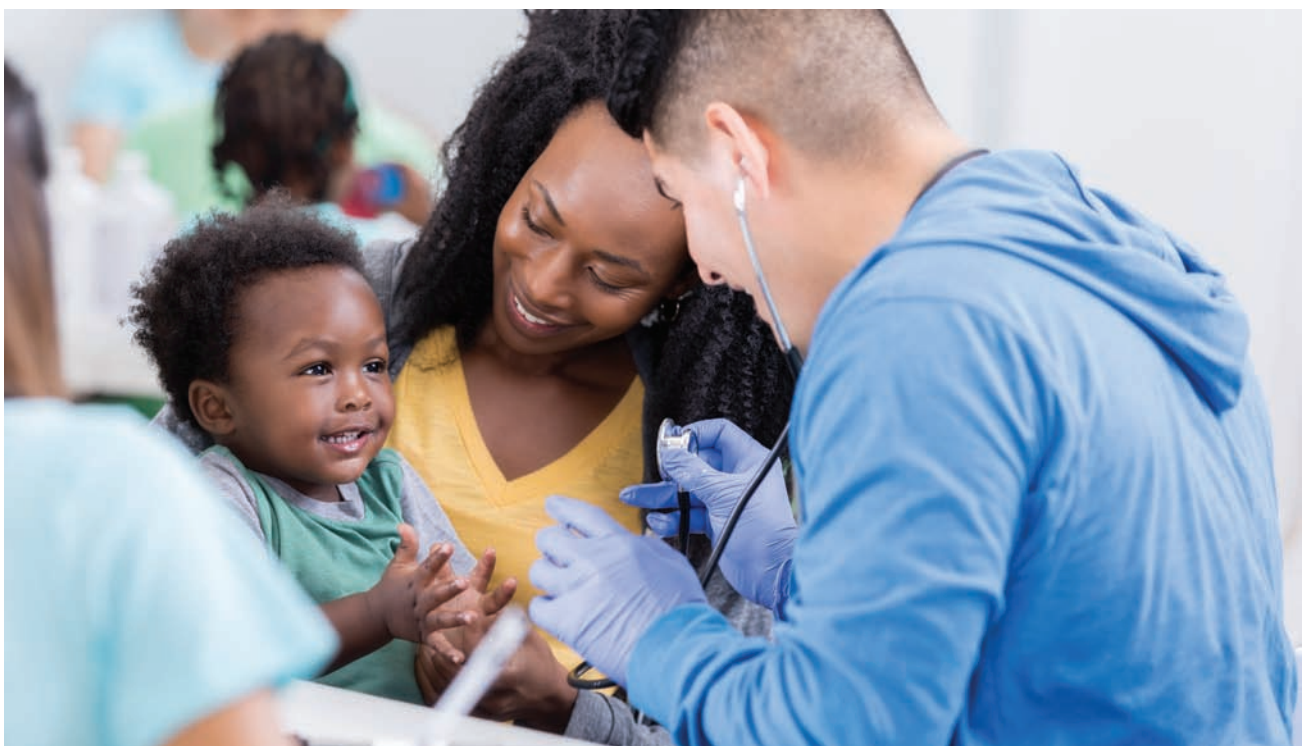
Review results repeatedly highlighted the impact nurses—and more specifically FCNs—can have on the outcomes of at-risk populations by the regular incorporation of health education and supportive interventions.

Although commonly referenced in faith-based care, not all articles specifically discussed parish nursing or faith community nursing. Yet, all interventions involved nurses in some format, at-risk populations, and involvement of faith groups. The articles addressed challenges with promoting healthy lifestyles (e.g., nutrition, cardiac health, obesity) amidst societal and cultural norms that influence health choices and outcomes. Studies occurred in a variety of regions throughout the United States and included varying age groups. The aforementioned themes remained present despite the different foci of the nursing interventions.

An evidence-based summary table of all 48 articles included in the review is available online as supplemental digital content at http://links.lww.com/NCF-JCN/A99. The five themes are discussed below with sample articles.

Trusted resource and social support

The role of the church in the holistic framework of minority experiences is vast and deeply embedded in the cultural norms of the population. This is especially true for



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AA communities where faith settings offer support, guidance, education, and trusted leadership. Timmons (2015) posited that the church is viewed as a trusted group in the promotion of wellness, suggesting clear documentation and reporting of positive outcomes positions the church as a valued community health resource.

Baig et al. (2012) discussed a study with Latino youth who reported feelings of trust and preferences for the church as a location to engage in difficult conversations related to their health. This belief was persistent across many of the articles reviewed, and highlights an important area of consideration for nurses and other healthcare professionals interested in providing healthcare support for at-risk groups.

Unfortunately, continued mistrust of the healthcare community from decades of racism and unequal treatment exists within many minorities (e.g., African American, Latino), creating challenges to provider–patient communications and access to care. West and Hollis (2012) discussed the impact of historical trauma and its influence on development of trust between the healthcare system (e.g., providers) and communities of color. The researchers collaborated with a local church to study and address the obstacles in completion of advanced directives, reporting that the most trusted location in the community for AA to connect with providers is the church. Derose et al. (2019) suggested collaboration and support of the faith organization with health initiatives may circumvent mistrust of healthcare personnel because of the placement of trust assigned to local congregational and church leadership. Understanding the influence of religious and spiritual organizations within minority communities is key for providers focused on supporting health (West & Hollis, 2012).

Griffith et al. (2010) suggested that development of trust with FBOs be considered a primary focus for all healthcare providers wanting to gain the trust of the community, joining a host of researchers that acknowledge the importance of perceived trustworthiness in effective healthcare delivery. Without trust, individuals are less likely to follow the guidance and recommendations of providers, thus reducing their likelihood of achieving effective and equitable health outcomes. Methods for establishing trust include clear support and partnership with faith leaders, repeated participatory engagement, partnership with members from the community, exhibition of humility, and continual sharing of information (Baig et al., 2012; Cooper & Zimmerman, 2017; Derose et al., 2016; Derose et al., 2019; Griffith et al., 2010; Wilkinson, 2019). Recognition of the role that FBOs have in such communities is an important aspect for care delivery, but this remains a challenge for many nurses to incorporate into traditional modalities of care. Although some aspects of spiritual assessment are included on healthcare documentation, such as admission questions on religious beliefs, nurses and other providers may fail to effectively utilize the assessment data to partner with faith groups when attempting to address health conditions (Cone & Giske, 2017).

Access to underserved populations

Although current healthcare law dictates all individuals receive access to emergency lifesaving treatments, many communities fail to receive access to preventative services. Healthcare professionals readily acknowledge challenges in supporting the health of underserved communities. This is especially true when the community is culturally different than available providers (Goode & Landefeld, 2018). Collaboration with FBOs offers nurses an opportunity for the establishment of credibility and support within these communities, thus improving the access nurses have to populations which may be marginalized and have reduced access to care.

Faith-based organization collaboration is the basis of a model of care delivery specifically focused on nursing care for congregants. A formal practice of faith community nursing was developed in the late 1970s as a method for addressing the health needs of a congregation in such ways that fit with their culture and faith practice (ANA & Health Ministries Association [HMA], 2017). The use of FCNs to improve health access and support for at-risk populations is one method identified by researchers in this review. Zahnd et al. (2018) acknowledged that disparities in preventative care (e.g., screenings) can be addressed by the utilization of FCNs to improve access to populations requiring this support. Some of the strategies recommended include individual patient education, addressing health literacy, connection with faith leaders and lay health advisors to promote health education, and developing workshops. Shillam et al. (2013) also addressed this issue in a study focused on the limited access older adults have to various healthcare resources (e.g., insurance, providers). The authors found that collaborations between nurses and other providers with FBOs support initiatives designed to improve medication awareness.

Other researchers, such as Saunders et al. (2015), suggested the church is a practical option for reaching communities traditionally challenged with lack of healthcare access. The authors recognized the impact of placing health promotion activities for AA men (e.g., cancer screenings) within houses of worship versus traditional outreach approaches as a way to establish connection with the targeted group. Pappas-Rogich (2012) discussed challenges in supporting the immunization needs of elderly populations, acknowledging that access to healthcare providers may be limited to such a degree that an FCN may be the only provider routinely seen by many older adults. In this setting, the FCN can become an advocate for the promotion of routine healthcare initiatives (e.g., immunizations, regular screenings). However, FCNs may not be readily available in all AA communities.

Additionally, Chase-Ziolek (2015) offered suggestions for the church as a

favorable location for the implementation of health initiatives and the distribution of health services. She noted that the church is a clearly recognized site for compassionate care delivery and lends itself to being a credible resource and location to address equitable and culturally supportive care. This is further supported by Kegler et al. (2010) who suggested FBOs are possibly even more successful at community-based health promotion because community members rely on faith groups for information, support, and guidance.

Many underserved populations (e.g., ethnic minorities, urban, rural, elderly) face challenges when seeking or receiving healthcare services (Goode & Landefeld, 2018). However, these populations often have resourceful FBOs in their communities. The delivery of health support from FBOs to at-risk groups can demonstrate effective collaborations and advocacy for health promotion. Although many faith groups have taken on the role of supporting health initiatives within the church, there is continued struggle with sustainable outcomes (Bopp & Fallon, 2011). Despite the varying results, it is well documented that healthcare providers should consider FBOs as a primary site and collaborative partner when designing health interventions.

Endorsement from faith leadership

Faith leaders are considered a cornerstone of organizational, hierarchical, and relational community experiences. Within spiritual settings, this role is magnified and influenced by historical perspectives (including social constructs), biases (congregational and community), and knowledge related to community support (Harmon et al., 2018).

Several studies outline the importance of faith leaders' role in achieving effective outcomes for health initiatives. A common theme across multiple studies was the importance of faith leader endorsement or buy-in (Abell & Blankenship, 2019; Austin et al., 2013; Baruth et al., 2015; Cooper & Zimmerman, 2017; Kegler et al., 2010). Baruth et al. (2015) investigated faith leaders' perceptions on their influence on congregational health, finding that the involvement of faith leaders in health activities contributed significantly to improved participation and positive health outcomes. This perspective was voiced in the majority of the articles reviewed, but challenges exist for some FBOs in identifying prioritized actions. Some FBO leaders report feelings of hypocrisy when promoting health initiatives that they themselves do not follow (Baruth et al., 2015).

Partnerships with faith groups offer the ability to influence the health outcomes of communities at-large.

Additionally, some activities may not be considered as a priority for the FBO if other concerns are more demanding (e.g., lack of resources, time, money, small volunteer base, competing initiatives, etc.). Despite the aforementioned concerns, evidence exists suggesting more effective health outcomes if health promotion activities are developed and implemented with direct involvement and support of faith leaders (Bopp & Webb, 2013; Bopp et al., 2012; Opalinski et al., 2015; Patestos, 2019).

Level of FBO involvement

Collaboration is a well-accepted requirement for working with FBOs. However, collaboration often occurs in various formats with differing results. Partnerships between FBOs and nurses also differ in design and implementation strategies. The partnerships must meet the needs of the faith group and overall culture of the community (Opalinski et al., 2017). Therefore, it is important to understand the impact of assorted tactics for developing FBO and healthcare relationships. The articles reviewed for this paper discussed diverse approaches to working in faith settings. However, the majority of the studies demonstrated clear connection with at least one of the following categories: faith-placed, faith-based, or collaborative. This designation is important as it provides clarity on the design and focus of a health initiative.

DeHaven et al. (2004) recognized faith organization collaboration is often defined differently across varying groups. Some collaborations involve the use of the physical location, such as a synagogue or church, whereas others involve the FBO members to evaluate the outcome of an intervention. Other groups engage in a combination of both approaches. This specific designation is significant because some health promotion methods are designed to support the larger community but are based within faith settings as a way to establish trust and connection within the community.

FCNs provide health education and support

A major focus of most articles (73%) included in this review explored the utilization of faith community/parish nurses for effective health education and program implementation. The title FCN represents a specialty for experienced registered nurses educated in faith community nursing and applying an intentional focus on spiritual care (ANA & HMA, 2017). The objectives of FCNs focus on the needs of the population "as defined by the faith community" (ANA & HMA, 2017, p. 6).

An important area of focus for nursing is an increased emphasis on outcomes-driven educational actions in support of health promotion. Review results repeatedly highlighted the impact nurses—and more specifically FCNs—can have on the outcomes of at-risk populations by the regular incorporation of health education and supportive interventions (Abell &

Blankenship, 2019; Austin et al., 2013; Cooper & Zimmerman, 2017; Harris, 2011; Opalinski et al., 2017; Pappas-Rogich & King, 2014). Several of the articles included in this review recognized an opportunity and role for collaborative partnerships between FCNs and faith organizations to improve health outcomes (Harris, 2011; Nam et al., 2019; Rowland & Isaac, 2014; Shackelford et al., 2014). Two articles suggested FCNs be engaged as Ministers of Health in acknowledgment of the significant role played in the support of health education and positive outcomes (Balint & George, 2015; Chase-Ziolek, 2015).

Although most of the articles reviewed for this critical analysis included a focus on minority communities, many articles were unclear if the interventions by FCNs were from organizational-based FCNs (from within the FBO) or from a community partner FCN (local hospital or university). Despite the overwhelming evidence in support of FCN use, questions remain regarding the actual rate of use in minority communities or FBOs with at-risk populations.

Additionally, many FCNs are working in an unpaid volunteer capacity and the faith-based health delivery model can benefit from the additional support of traditional registered nurse volunteers (Pappas-Rogich & King, 2014; Strait et al., 2019).

IMPLICATIONS FOR PRACTICE

The articles in this review presented a variety of examples outlining the impact of a faith-based approach to health promotion within at-risk communities. Contact with these communities may be difficult to achieve and complicated by lack of trust (Young et al., 2015). Yet, collaborative efforts between nurses and FBOs have helped bridge this gap, particularly when combined with participatory research methodologies (Galiatsatos & Hale, 2016; Pappas-Rogich & King, 2014; Solari-Twadell & Ziebarth, 2020; Strait et al., 2019).

Although the potential for partnerships between FBOs and health practitioners is well documented, researchers recognize that the full benefits of the relationships have yet to be realized (Chase-Ziolek, 2015). The role of FCNs within FBOs empowers parishioners to actively participate in the management of their own health by enhancing existing relationships with providers (Ziebarth, 2014). The ability to empower and promote adherence suggests that FCN involvement in faith-based health interventions may be the key in bridging the gap between minority communities and the healthcare establishment. The intentional integration of health promotion into faith routines supports a view of health as a way of honoring the gift of life and people created in God's image (Chase-Ziolek, 2015). Health promotion programs in the faith setting have demonstrated the ability for long-term success, with new health behaviors being integrated into the lives of parishioners even after the programs have ended (Shackelford et al., 2014).

Nurses are in a unique position to support and promote FBO health programs within AA communities by the intentional assessment of faith influences on health and deliberate integration of these influences into care options (e.g., connection to FCNs). Despite this position, effective application of this approach does not appear to be standard. The ANA (2021) acknowledges the importance of faith and spirituality when caring for populations. However, nurses may be unclear on how to incorporate spiritual assessment data into actual nursing care (Bone et al., 2018; Cone & Giske, 2017).

RECOMMENDATIONS FOR ACTION

The purpose of this review was to identify specific recommendations for implementing faith-based health initiatives within at-risk and AA communities. The results demonstrate this topic, in general, is ever present in healthcare research and has been for many years. However, the intentional, detailed, and routine implementation of spirituality in healthcare with a focus on minority communities may not be regularly considered. Some studies (Bone et al., 2018; Cone & Giske, 2017) suggest spiritual assessments may be conducted as a perfunctory task versus an informative one with the goal of incorporation into the treatment plan.

Review of the articles identified steps for nurses interested in supporting the health of minority communities (Sidebar). Research overwhelmingly demonstrates positive outcomes when using these methods. However, questions remain on the sustainability and frequency of delivery within AA FBOs.

It is well known that nurse-led, more specifically FCN interventions, work for addressing health promotion in at-risk faith settings. However, it is unclear how many FBOs have access to FCNs and what type

Sidebar. Recommended Action Steps for Faith-Based Care

- Deliver healthcare initiatives in active collaboration with local faith-based organizations (FBOs).
- Build trust within the FBO community with participatory collaboration of faith leaders.
- Utilize faith community nurses (FCNs) as a part of the program design and delivery.
- Assess the degree and depth of FCN accessibility for FBOs.
- Explore the degree to which spirituality is included in healthcare treatment plans.

Web Resources

- **Westberg Institute for Faith Community Nursing**
  https://westberginstitute.org
- **Health Ministries Association**
  https://hmassoc.org
- **Health & Human Services Center for Faith-Based and Neighborhood Partnerships**
  https://www.hhs.gov/about/agencies/iea/partnerships/index.html

of program participation occurs. Although information is available in support of the inclusion of spirituality in health promotion activities, opportunities remain for determining the best approach for establishing collaborative partnerships with faith leaders to develop trust. Additionally, questions remain on the influence of the perception of trust and how healthcare providers assess and include spirituality within the treatment plan. A major limitation to this analysis is that this was not an exhaustive review of literature. The subject matter is frequently discussed in research and additional search terms should be considered for a complete analysis due to varying methods by which nurses interact with faith communities.

CONCLUSION

Spirituality influences healthcare outcomes and is considered a mandatory component of quality nursing care. However, as nursing is a practice-based profession, emphasis is needed on the evidence-based actions to improve the health of at-risk groups. This requires nurses to consider improvements in traditional approaches to health delivery and more routinely utilize faith and spirituality as a mechanism for achieving improved health outcomes. This is especially true for minority communities affected by health disparities. Although faith settings are ideal for connecting to minority populations, it is important to remember that these settings are not merely a venue for sharing health information but are a mechanism for improved understanding of the culture of communities served (Cochrane et al., 2014).

Faith community nurses are in a prime position to support faith efforts in the promotion of healthier living. Collaborative partnerships between nurses and faith leaders may bridge the gap of the physical and spiritual, thereby normalizing faith-centered approaches to health promotion. Recognition of the shared role of faith leaders in the coordination, implementation, and maintenance of sustained change may be the link to achieving long-lasting community health results.

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