FAITH LEADERS AS PUBLIC HEALTH INTERVENTIONISTS

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Abstract

This study investigated how faith leaders developed and changed health promotion programs at their institutions. Data collected provided a foundation for understanding how faith leaders discerned their roles as influential when addressing the social determinants affecting population health. Additionally, the data described how faith leaders identified and prioritized health promotion services to implement at their respective faith institutions. This study also highlighted how faith leaders understood their legitimacy as active change agents in public health and clearly outlined the structural supports needed to successfully evaluate, improve, and expand their service delivery systems of care. This evaluation of principle and practice further directed an exploration into the challenges of distributive justice under the faith organizational umbrella. Data was analyzed through memoing, concept, and in-vivo coding to support the organization and categorization of the five themes which emerged from the data. These themes were broken into two categories: Category (A): Core functions of a faith leader, which included (1) Influential roles in public health and (2) Personal experiences motivated organizational changes. Themes associated with Category (B) included: (1) Obligation to become involved in public health; (2) Challenges with health promotion program development, implementation, and sustainability; (3) Public health as a social justice initiative. Findings from this research revealed that faith leaders regularly interfaced across the complexities of the public health landscape and understood their roles to be essential, influential, and diverse. Faith leaders spoke to the urgency of their involvement across social issues including, but not limited to, poverty, food insecurity, mental health, and physical health of people and communities. Furthermore, faith leaders expressed real challenges with gaining access to fiscal and administrative resources needed to support the development and sustainability of health promotion programs at their institutions.

The implications from this study were examined with an emphasis on social work practice, education, policy changes, and future research.

Keywords: faith leaders, health belief model, interventionists, public health, transtheoretical model of change

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Dedication

"But seek ye first the kingdom of God, and his righteousness; and all these things shall be added unto you." Matthew 6:33.

To the matriarch of our family, my grandmother, Reverend Glennie M. Todd, I dedicate this dissertation. The foundations of our family have been preserved through your presence, unshakeable faith, and love. We remember to pray and to maintain an established relationship with the God of our understanding. Our family is grateful for your wisdom.

This dissertation is dedicated to my loving parents, my father, Kenneth and my mother, Myra. To my beautiful mother, lovingly called Penelope, a woman of God, grounded in her faith, and a faith leader, you are the epitome of strength. With hands that nurture everything that she touches and a smile that opens the skies, the gratitude, joy, and honor of being your daughter transcends my existence. I love you! I Thank You! I am nothing without you! I am forever grateful for your continued guidance, support, vision, leadership, sacrifices, friendship, and most of all, your demonstration of infinite and unconditional love; not just for me, but for the love you give to everyone you encounter. To my dearest father, Kenneth, Thank You for the countless hours of comedy relief, the sharing of family pictures and stories, and a reminder that life is precious and that you must having fun as much as you can. May God continue to bless and keep you both as you are the rock of my existence and loves of my life. This writing is for you.

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It is in the footsteps of my ancestors that I charge forward!

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Tables and Figures

List of Acronyms/Definitions

NASW National Association of Social Workers

ODPHP United States Office of Disease Prevention and Health Promotion

FBO Faith Based Organizations

Public Law (P.L.) 104-1932

Personal Responsibility and Work Opportunity Reconciliation Act of 1996

OFBNP Office of Faith Based and Neighborhood Partnerships (OFBNP)

NIMH National Institute of Mental Health (NIMH)

CHAPTER ONE

INTRODUCTION

This qualitative study examined the experiences of faith leaders as interventionists in public health. The data was gathered using semi-structured interviews and analyzed using thematic analysis inclusive of memoing, concept, and in-vivo coding of verbal transcripts from interviews as outlined in Creswell and Poth (2016). The following NASW Codes of Ethics relevant to this research are: social justice, competence, and the importance of human relationships.

Background

More than ever, faith leaders have been called upon to develop diversified partnerships with legislative officials and citywide health social service delivery systems with the goals of comprehensively addressing health disparities across populations. Their specialized knowledge, contributions to community health, and world view, make them a sought-after population of experts in health promotion practice and research. Therefore, faith leaders were selected as the targeted group of respondents for this study.

Utilizing a qualitative study design and foundations of Corbin and Strauss's (2015) grounded theory, this study contributed to social work practice knowledge in health promotion research. The selected theoretical framework which guided this study was grounded theory and considered to be most applicable to the study design as it allowed for the development of new hypotheses and theory to emerge from the raw data collected from respondents.

Statement of the Problem

While there were many faith leaders who have been successful with formulating and implementing health promotion programs at their institutions, others experienced challenges with gaining access to the relevant and necessary resources to do so. Some of these challenges include, but are not limited to, finances, guided infrastructure program design thinking, technical assistance, and training; all of which are key elements to the execution of successful operations, long-term sustainability, and programmatic growth. This inequity in resource allocation is not only detrimental to the faith institutions who are active in health promotion, but also detrimental to the smaller or newer faith institutions who are eager to learn how to become active in the work of health promotion. Limitations, specific to the availability of benefits, entitlements, and opportunities for faith leaders to professionally advance, further stagnates opportunities for interdisciplinary collaboration and comprehensive partnership building.

Purpose of the Study

Considering the aforementioned points, this study acknowledged the essential roles of faith leaders across the public health landscape and served as a reference tool for outlining foundational strategies which conceptualize health promotion service delivery from a faith-based perspective.

Social Work Values and Anticipated Contributions to Practice

The National Association of Social Workers (NASW) Codes of Ethics practice principles applicable to this study were social Justice, competence, and importance of human relationships (NASW, 2021). In direct line with the role of social workers' responsibilities to practice in an ethical, competent manner, it is also incumbent upon social workers to develop skills as culturally sensitive and culturally competent practitioners while serving diverse groups of

individuals and communities. By gaining a deeper understanding into the multifaceted roles, attitudes, and motivations of faith leaders implementing public health agendas, social workers, positioned to practice their specialized skills in faith-based settings, have a unique opportunity to learn about health promotion from the ideology of spirituality, faith, and ritualism, and can partner with faith leaders to advance their efforts through the utilization of interdisciplinary approaches rooted in the social sciences. This critical responsibility of creating environments which advance regular exchanges of ideas and diversified expertise are needed elements for envisioning improved population health.

Finally, through ongoing efforts to build alliances, social workers, with their training around advocacy and leadership, can uplift faith leaders to address the needs of their communities. Social workers, standing united with faith leaders, can further advance the urgent requests for equal access to resources needed to promote the improved well-being of people across interfaith foundations. These contributions to social work policy illustrated the importance of faith institutions' credibility as a viable health promotion stakeholder with active roles in advocacy at the city, state, and federal levels of government.

This study examined the efforts of faith leaders as they embarked upon campaigns of implementing health promotion programs at their institutions. Data collected provided a foundation for understanding how faith leaders discerned their roles as influential to addressing the social determinants affecting population health. Additionally, the data described how faith leaders identified and prioritized health promotion services to implement at their respective faith institutions. The study also highlighted how faith leaders understood their legitimacy as active change agents in public health and clearly outlined the structural supports needed to successfully evaluate, improve, and expand their service delivery systems of care. This evaluation of principle

and practice also further directed an exploration into the challenges of distributive justice in health equity under the faith organizational umbrella.

CHAPTER TWO

STUDY PROBLEM

Public health and health promotion have been at the forefront of academic and policy agendas for social work researchers as they examine the social determinants of health impacting the well-being of individuals and communities. According to the World Health Organization (WHO), social determinants of health (SDH) are defined as the "non-medical factors that influence health outcomes" **(**World Health Organization [WHO], 2022 **).** These non-medical factors include, but are not limited to, education, employment, income, housing, food insecurity, environmental conditions, and access (WHO, 2021). The aforementioned factors are essential to the achievement and sustainment of one's well-being. However, there are varying degrees of equal access to necessary services and distribution of resources for certain groups. Revealed across social welfare and health promotion literature, issues of equity are noted as a social problem which predominately impacts people of color and those living in poverty-stricken communities (Hinterland, 2018, WHO, 2021).

WHO defined health equity as, "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically" (WHO, 2022, Tab 3) . These concerns around the declining health and safety of communities have prompted a "call to action" among practitioners and special interest groups, such as faith leaders, to begin to explore and address the apparent inequities of population health. With the goal of mitigating the impact of health inequities, faith communities have taken a grassroots approach to improving the lives of people.

Faith Leaders

Research indicates that faith leaders have an essential role to play in public health and health promotion, and historically, faith-based organizations have been equipped with members and clergy to serve as "first responders" during public health crises (Schoeburg, 2017; Terry et al., 2015). Many denominations identify a "Lay Leader" whose role is to work collaboratively with the faith leader to promote the mission and vision of the congregation (Conte et. al, 2021). Although not ordained as clergy, a lay leader is a member of the congregation who holds a leadership position as it relates to the faith organizational business and agenda setting in tandem with clergy and/or other faith leaders (Conte et. al, 2021).

Operational Challenges Among Faith Institutions

While faith leaders have sought to take a stand against the deterioration of their communities, with the best intentions, they often struggle with obtaining access to financial support which impacts the successful sustainability of health promotion programming at their institutions (US Department of Health and Human Services, 2019). Faith institutions are challenged by a lack of fiscal resources, formal training infrastructure, and limited plans for program sustainability as they frequently rely on the generosity of sponsors and donations (Clerkin & Gronbjerg, 2007; Twombly, 2002). Therefore, they are more likely to host health promotion programs through a "faith-placed" format versus a "faith-based" format (Dehaven et al., 2004). A "faith-placed" program consists of a health promotion program designed and presented by an outside entity, usually a citywide or government funded organization. A "faith-based" program consists of a program designed and facilitated by the faith institution through their internally identified key personnel (Dehaven et al., 2004).

Other challenges which exist for newer and smaller faith institutions who wish to engage in health promotion program planning include limited space to hold activities, partial knowledge about navigating complex funding application processes, and evaluation methods using metrics and measurements, small circles of workforce support, and limited opportunities to successfully shadow and partner with other more established faith institutions practicing this scope of work (Woodward et al., 2020).

This research study contributes to social work education and practice knowledge specific to highlighting strategies to effectively partner with faith leaders seeking to explore the initiation of health promotion programs and procedural knowledge needed to be successful. As social workers act to minimize the devastating impact of poor health in communities in tandem with faith organizational leadership, this study promotes a message that all people have the right to an improved quality of life. Additionally, this study contributes to social work policy by illustrating the importance of faith institutions' credibility as viable health promotion stakeholders.

Defining Public Health and Health Promotion

The World Health Organization (WHO) defines public health as the art and science of preventing disease, prolonging life, and promoting health through the organized efforts of society (WHO, 2021). The term health promotion is defined as a process of enabling people to increase control over and to improve their health (WHO, 2021). The intersectionality between public health and health promotion is evidenced by one's profound knowledge about health as a tool for successful living and health promotion as the practice of engaging people in a process of healthy lifestyle activities supporting long term successful living. The advancement of health is contingent upon factors outside of any one individual or community and is heavily contingent

upon government's fiscal supports and policies which promote activities strengthening society (WHO, 2021).

The United States Office of Disease Prevention and Health Promotion (ODPHP) has issued a call to action for faith leaders, researchers, medical providers, and allied health service practitioners to support their initiative entitled Healthy People 2020**,** with the goal of "increasing quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life"(ODPHP, n.d., p. 5). Today, the Healthy People 2030 objectives have expanded to include special attention to population health through rigorously evaluating factors which impact social determinants of health among special populations (ODPHP, n.d., p.13). Further investigation involves an evaluation of health behaviors, settings, and systems through which people interact in relationship to health outcomes overall (ODPHP, n.d., p. 39). The Healthy People 2030 initiative provides faith leaders with a major opportunity to share their expertise and institutional spaces to support improvements toward population health.

Faith Based Organizations: History and Policy

The distinguished activities of Faith Based Organizations (FBO) are linked to the expansion of the "Charitable Choice" provision of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. During this period, national attention was drawn to examine policies surrounding government spending, poverty, and social welfare reform (Cox 2002; Personal Responsibility and Work Opportunity Reconciliation Act, 1996).

Bielefeld and Cleveland (2013) outlined the typologies of faith-based organizations and defined their elements to include the following distinct characteristics which includes the

following: 1) a shared religiosity and expressed identity of faith; 2) independent organizational control which allows for internal management and flexibility of resources; 3) an individual selection of programs and/or services to implement representative of the organization's ideology (p. 446).

Legislative priorities of President Bill Clinton's administration included an expansion of community-based services to incorporate and legitimize social services delivery through small organizations and religious groups. The aim of increasing their access to government funding was to facilitate services which promoted a reduction of poverty and minimization of dependency on public assistance benefits (Personal Responsibility and Work Opportunity Reconciliation Act of 1996). Following the administration of President George W. Bush, the White House Office of Faith-Based and Community Initiatives was established, but political analysts noted potential challenges for entanglement of ideologies and breeches of the Constitution specific to the "separation of church and state" created a potential for the intermingling of funds and endorsement of specific faiths or practices supported by these funds (Cnaan & Boddie, 2002; Kramer, 2010; Terry et al., 2015).

Upon conclusion of President Barack Obama's presidency, the office was renamed to the Office of Faith Based and Neighborhood Partnerships (OFBNP) which emphasized the urgency of collaboration across smaller and larger systems of care to comprehensively address psychosocial and socioeconomic needs of the population. On May 3, 2018, under the leadership of President Donald J. Trump, Executive Order 13831 outlined the establishment of a White House Faith and Opportunity Initiative which was designed to advance the efforts of faith-based organizations to strengthen the lives of individuals and communities with programs to improve

social concerns and to ensure regular consultation between faith leaders and the President (Exec. Order No. 13831, 2018).

Today, under President Joe Biden's administration, the rapprochement of the OFBNP's agenda to revitalize its goals and objectives is underway. At the forefront of this legislative agenda is a call for research and innovation supporting increased opportunities for disadvantaged communities to access services and increased efforts for diversified global partnerships which address the impact of systemic racism (White House Office of Faith -Based and Neighborhood Partnerships, 2021).

The formulation and endorsement of faith-based programs and their services is promising and evidenced by the continuing increase of faith organizations and faith leadership personnel who initiate health promotion activities. This further lends itself to the expansion of community health knowledge through a spiritual, holistic lens.

Health Inequities in New York City

Faith leaders are essential to the improvement of public health outcomes. As they begin to assess the needs of their communities, they are challenged by the wide range of presenting problems specific to the social determinants of health and identifying the most appropriate, relevant, interventions and services needed to address them. In response to these quality-of-life concerns, faith organizations have responded and developed partnerships with public health leaders to address health inequities as they are positioned to intervene in a special, intimate way, through engaging people in a non-traditional setting (Yanek et al., 2001; Bopp & Fallon, 2011; DeHaven et al., 2004; US Department of Health and Human Services, 2019). Non-traditional settings are referred to as settings outside of structured medical practices or health clinics (Yanek

et al., 2001; DeHaven et al., 2004). The comprehensive approach to healing, through a "mind, body, and soul" connection, serves as a key characteristic which encourages a deeper understanding of one's self-worth, self-efficacy, and promotes wellness (DeHaven et al., 2004; Taylor et al., 2000).

The following section offers a brief overview of population health concerns faced by residents in New York City which faith leaders have attempted to address through health promotion programming services offered through their institutions.

Population Health in Central Harlem, New York

The New York City (NYC) Community Profiles Report provides comprehensive information about the health of New York City's residents across the five boroughs: Brooklyn, Bronx, Queens, Staten Island, and Manhattan. Prepared by the New York City Department of Health and Mental Hygiene (DOHMH), the Community Profiles Report provides a foundation for further evaluating the specific types of social and environmental elements in each community and the availability of relevant resources to address social concerns. The report also highlights the connection between improved community health outcomes and its barriers which advance systemic racism, minimizing opportunities for achieving health equity.

In an effort to take a closer look at how community needs are evaluated and potential prompts by which faith-based community organizations may become activated in public health in NYC, this section will describe a few characteristics of the borough of Manhattan, specifically the area of Central Harlem. According to the Health Profiles Report, Central Harlem was indicated as a neighborhood with the highest incidents of people experiencing significant mental

health complications, declining physical health, and increasing environmental health concerns in 2018 (Community Profiles Report; DOHMH, 2018; Hinterland et al., 2018).

Heart Disease, Cancer, and Access to Health Care.

Premature death is defined as death before the age of 65. Lung cancer, colorectal cancer, and breast cancer, among women, were the three leading causes of cancer-related premature deaths. Cancer and heart disease were the leading causes of premature death for residents of Central Harlem included cancer and heart disease. Additionally, Central Harlem's adult obesity rate is 34% higher than the rest of NYC and more than 700,000 adult New Yorkers have been told they have diabetes (Community Health Profiles, 2018: Central Harlem; Hinterland et al., 2018).

According to the Community Profiles Report, the rate of adults in Central Harlem who experienced "avoidable hospitalizations," defined as hospitalizations which could have been prevented due to care access, is more than double of the citywide rate (Community Profiles Report, 2018). Efforts to support New Yorkers with accessing health insurance continue and has been successful over the last few years. However, challenges still exist specific to people's lack of enrollment in health insurance and proactively participating in the recertification of their insurance plans as scheduled. This further promotes the creation of gaps in care which may negatively impact one's health conditions.

Mental Health.

A 2019 report prepared by the National Institute of Mental Health (NIMH) indicated that 51 million United States adults live with mental illness with varying degrees of severity (National Institute of Mental Illness, 2021). The rate of adult psychiatric hospitalizations in Central Harlem is the highest citywide and is noted to be reflective of the challenges residents in this

under resourced neighborhood face, including difficulty accessing preventive services and frequent interruptions in health insurance coverage (Community Health Profiles, 2018: Central Harlem; Hinterland et al., 2018).

Identified as a crisis and public health problem, serious mental illness can create "functional impairments," contributing to difficulties which significantly interfere and limit a person's abilities when performing basic activities of daily living (National Institute of Mental Health, 2021). Additionally, mental illness negatively impacts one's "functioning in social, family, and vocational or educational contexts" including communication, engagement, and interacting with others (Drake, 2005). However, research shows that people with serious mental illness, who are involved in their treatment experience in a holistic manner, supports reduction of stigma, and have improved outcomes including attendance in care and medication adherence (Lee-Tauler et al., 2018). While faith leaders are traditionally sought after for spiritual guidance and faith-oriented education, pastoral counseling services are frequently utilized to address a wide range of psychological and emotional concerns among members of their institutions and non-members alike.

Education.

The community profiles report pointed out significant statistics regarding education and employment for Central Harlem residents indicating that nineteen percent of adults have not completed high school, and three out of five high school students graduate in the allotted four-year term which is lower than the New York City average. Additionally, Central Harlem's school absenteeism rate was higher than the citywide rate of New York City overall (Community Health Profiles, 2018: Central Harlem; Hinterland et al., 2018).

Economic Stress.

Central Harlem reports an unemployment rate twelve percent higher than the citywide average of nine percent, and approximately twenty-one percent of Central Harlem residents live in poverty (Community Health Profiles, 2018: Central Harlem; Hinterland et al., 2018). More than thirty percent of resident's income is directed to rent thereby creating challenges for people to be able to afford their basic need items such as food, health care, and clothing.

Other public health concerns outside of the Community Profiles Report for Central Harlem addressed in the next section are Homelessness and Incarceration.

Homelessness.

Homelessness is an important risk factor for declining health (Campbell, 2020; DHS, 2020; WHO, 2020). The New York City Department of Homeless Services (DHS) fiscal occupancy data dashboard report for 2019 indicated that there were 38,000 families living in their shelter systems (DHS, 2019). The risks of communicable and infectious diseases are extremely high in these settings due to active chemical dependency, minimal safety regulations, and a combination of limited fiscal and programmatic resources to maintain pristine levels of cleanliness in the settings (DHS, 2020).

While some faith organizations and other community service providers attempt to offer respite-style housing on an emergency basis, one must consider the elevated levels of transiency and challenges in sanitation among communal residences such as halfway houses, shelters, residential treatment programs, and drop-in crisis respite centers.

Incarceration and Health.

Cancer, respiratory disease, suicide, AIDS, chronic medical illnesses, chemical dependency, and mental illness are of those conditions most afflicting justice involved persons (Berzofsky & Maruschak, 2015; Cuddleback, 2006; Massaglia & Remster, 2019; Mitchell, 2017). Upon release, many formerly incarcerated persons are returned to the communities from which they left, where criminal networks, poverty, and social stressors exist. For those cycling in and out of correctional settings, issues surrounding sanitation, disconnected medical care, high risk sexual practices, and other mitigating factors contribute to increased utilization of emergency room settings, impromptu medical visits to local clinics, medications, and costly billable services (Berzofsky & Maruschak, 2015; McDonnell et al., 2014). It is also important to consider that many justice-involved persons have pre-existing conditions, many of which may have not been treated for extended periods of time prior to incarceration. Post release, these conditions are exacerbated requiring higher levels of health intervention and exacerbated due to challenges with successful community reintegration (Hoffman, 2016; Massaglia & Remster, 2019).

In summary, the health inequities presented here are just a snapshot of the larger issues present today and faith communities are rapidly mobilizing to support the reduction of risk and increase of protective factors to support improved quality of life for people.

The Role of the Social Work Profession

The National Association of Social Workers (NASW) provides guidance for ethical practice standards, values, and competencies for social work professionals. Social work values are service, social justice, dignity and worth of a person, importance of human relationships, integrity, and competence (NASW, 2021).

Two core values include: service and the importance of human relationships. Service refers to a social worker's responsibility to address social problems through proactively utilizing their skills and professional attributes to address them and contributing to improvements in the greater society. The importance of human relationships addresses the responsibility to establish and maintain strong relationships which promote self-determination and positively enhance collaborative experiences with groups, communities, and individuals (NASW, 2021).

Social workers with a macro-practice lens are cognizant of the relevant legislative and policy implications impacting populations and the urgency around the development of strong alliances and partnerships with community service providers. At the mezzo levels, social workers seek to investigate the efficacy of the interactions between individuals and social systems with the goal of crises and risk reduction. At the micro level, social workers delve into the social, mental, behavioral, emotional, factors which manifests themselves throughout the lives of individuals, families, and groups. Faith leaders in health promotion may find themselves working across all these systems in direct alignment with social work practice principles. Most importantly, supporting people with developing self-advocacy skills and promoting self-determination are core activities at the heart of both disciplines.

Social work practitioners, reflective of their ethical obligations in service, seek to connect to client systems through processes of thoughtful engagement, understanding, and critical thinking. As societal problems impacting the quality of life among people continues to emerge, social workers are tasked with the responsibility to establish and strengthen therapeutic alliances, such as those with faith leaders, to strategically evaluate the policies which life course outcomes associated with premature death, disruptions in social order, and generational decline.

In summary, considering the efforts of faith organizations to advance improved population health outcomes, it is beneficial to capture the depth and breadth of the lived experiences of faith leaders' efforts to identify special interests and align themselves with social justice causes such as health promotion. Furthermore, social workers, employing a wide range of therapeutic approaches and theoretical frameworks to achieve and promote social justice, are positioned to work collaboratively with faith leaders in their efforts toward the establishment of legitimacy as key agents in public health. Such legitimacy is demonstrative of advocacy efforts which encourage lifting the voices of faith leaders to achieve legislative agenda prioritization and advance equity and equality across service delivery systems of care.

Conclusion

Considering the efforts of faith organizations to advance improved population health outcomes, it is beneficial to capture the depth and breadth of the lived experiences of faith leaders as they begin to identify special interests and align themselves with social justice causes. The following literature review provides context for exploring the experiences and contributions of faith organizational leadership as they embark upon campaigns of planning and implementing health promotion agendas at their institutions.

CHAPTER THREE
LITERATURE REVIEW

This section will summarize peer-reviewed research regarding the role of faith leaders and their participation in health promotion activities. The literature review will provide a foundation for learning about the diverse ways in which faith organizations identify health promotion program agenda items to implement at their institutions and their experiences with navigating these entities.

Literature Review Methodology

Literature Review Search Process

The following method was utilized to organize literature obtained for this review. Search parameters for articles between 2000 through 2022 were selected as most relevant to the subject matter. Articles were accessed through PubMed, Google Scholar, PsycINFO, and EBSCOhost Discovery Service. Relevant search terms used to find literature on faith leaders in public health included *"public health and faith", faith leaders and health', "pastors and health", "faith and mental health", "faith leaders and health," "attitudes of faith leaders* AND *public health", "spirituality and health", "public health and pastors", "faith-based programs", "faith placed programs", "faith and public health education", "the church and public health", "public health and pastors", "faith and health", "public health and faith", "prevention education and church", "chronic health conditions of church members", "pastors and health", "COVID-19 prevention* AND *faith institutions* AND *church", "COVID", COVID-19 safety* AND *churches" "faith and public health education", "partnerships* AND *faith communities", " Christian Social Workers", "Social Workers in churches", Social Workers* AND *public health", "Spirituality* AND *social work", "faith and health", "public health and faith", "faith leaders and health'*

"attitudes of faith leaders +public health", "vaccine AND *church* AND *health", and "spirituality* AND *health*.

Results

After finalizing the selections for the review, articles only written in the English language with full text available in the Yeshiva University library were included. Articles which were not peer reviewed were excluded from this review. However, international peer reviewed articles, book reviews, and governmental reports in social work, nursing, public health, religion, and health promotion were included. At the conclusion of the search process, a total of twenty-six articles were selected for this review.

The following four themes emerged from a review of the literature:

Theme 1. Faith leaders are influential figures in public health and foster communities of learning;

Theme 2. Faith leaders are liaisons to health service delivery systems of care;

Theme 3. Faith leaders serve as "first responders" during the COVID-19 pandemic;

Theme 4. Collaborations between faith leaders and social work practitioners can be beneficial.

Literature Review Findings

The following literature review describes the ways in which faith leaders have contributed significantly to health promotion service delivery systems with the goal to improving community health outcomes.

Faith Leaders are Influential Figures in Public Health and Foster Communities of Learning

Faith leaders are identified as influential figures by their members and communities. Their proficiency in spiritual texts, captivity of the audience, and persuasive communication styles promote faith leaders' status as credible. Furthermore, faith leaders who are specifically engaged in public health initiatives, understand the depth of their roles and influence (Anshel, 2013; Baruth et al., 2015). From information sharing to serving as key liaisons to health services delivery systems of care, faith leaders are often presented with situations where they are called to respond quickly to de-escalate crisis and to act as an advocate for those who need one. Faith leaders also create community centered environments with the goal of promoting unity and collective strength (Anshel, 2013; Baruth et al., 2015).

Data collected through semi-structured interviews with faith leaders reported that creating a culture and space for health and well-being supports the mobilization of congregants to improve themselves spiritually and physically (Anshel, 2013; Baruth et al., 2015). Faith leaders who organize programs in faith communities are just as important as the programs themselves as they play a critical role in the recruitment, organizing, and prioritization of health promotion program related agendas (Campbell et al., 2007; Majee et. al, 2022; Paltzer, 2018).

In a qualitative study seeking to evaluate the effectiveness of a government faith-based health promotion program, Live Well by Faith (LWBF) in Missouri, results of (N=21) in depth interviews conducted among program participants, faith leaders, and LWBF lifestyle coaches, found that faith leaders are gatekeepers for the development of programs, are tasked to critically evaluate the appropriateness of services, and are representative of the population. Faith leaders

are also tasked with ensuring the presence of cultural sensitivity to ensure that messages are clear, consistent, and support long term impact (Majee et al., 2022).

While the study addresses their limitations around a small sample size as challenging generalizability, their contribution to health promotion program planning is essential to the understanding of best practices for community health education delivery on a broader scale. This includes prioritizing that social justice and issues of health inequity are not only discussed by the faith-based program representatives but are incorporated as a regular discourse within and across faith communities led by the faith leadership. In addition to the important considerations, a gap in research surrounds the lack of information gathering directly from faith leaders about their motivations for initiating and leading initiatives of this type. These findings have implications for considering expanding partnerships across faith institutions and government actors and both informs and supports empowerment, knowledge, and expanded platforms for faith membership sustainability.

A qualitative pilot study which examined the processes by which faith leaders raised awareness around public health concerns found that communication, transparency, honesty, and openness about the faith leader's personal lived experiences, with their own health, served as a motivation for congregation members to proactively engage in their own health promotion activities (Lumpkins et al., 2011).

A Kansas City, Missouri study gathered data utilizing semi-structured interviews with six pastors seeking to explore their attitudes and perceptions around operational definitions of health, healthy behaviors, and their contributions to health promotion involvement. Key themes and findings emerged indicating that the initiation of health promotion activities is directly related to the specificity of the linkage between health and spirituality, the need for more of an

organized approach to the development of specialized ministries, and to educate their congregations about the multifaceted roles of the faith organization as a conduit to community-based health supports as needed (Lumpkins et al., 2011).

Faith leaders who demonstrate transparency about their interactions within health promotion systems serve as models for their congregants. In a study which examined the presence of obesity and chronic health conditions among pastors of African Methodist Episcopal (AME) churches in South Carolina (N=40), key findings indicated that clergy are most committed to the health and personal improvements of their congregations and acknowledge their responsibility to "*practice what they preach*" as it relates to self-care and improved health outcomes (Baruth et al., 2014).

After administering a 14-week psychoeducation program inclusive of physical activity and nutritional education, indicators showed that directed health interventions should first start with the organizational leadership, independently, prior to dissemination to the larger congregation (Baruth et al., 2014). Considering their full participation, this personal buy-in of the faith leader allows for critical reflection to identify the benefits of an identified behavior change and offers an opportunity to strategically review ways to address barriers which limit one's propensity to make changes. For example, where there are meal choices high in sugar and fat provided through the generous donations of the dining ministry, leadership would offer recommendations for incorporating more fresh fruits and reduced sodium content at events where meals are served.

This study contributes to the body of knowledge as it supports the application of a theoretical framework, the TTM and HBM, to support faith leaders with understanding and connecting clinical elements of behavior change.

Faith Leaders are Liaisons to Health Service Delivery Systems of Care

Faith based health promotion programs are determined to be effective in support of educating their congregations around risk reduction and prevention of cardiovascular disease (Young et al., 2003). These supportive environments have been shown to promote successful recruitment, retention, and engagement of participants (Agho et al, 2012; Sbrocco et. Al, 2005). It is important to acknowledge that these programs would not be provided without the "buy in" of faith leadership. Furthermore, programs have been shown to promote improved engagement of participants and closure of care gaps for preventive tests such as mammograms and colonoscopies, for example (Agho et al., 2012, Baruth et al., 2014; Sbarcco et al., 2005; Watson, 2003).

Collaborations between federally funded nutritional programs and faith communities have shown great promise to effectively address needs for health education programs which address obesity. Considering the efficacy of faith community partnerships and the increasing national rate of people diagnosed with obesity and its related conditions, a nine-week psychoeducation faith-based health promotion program in Alabama, *Live Well Faith Communities* (LWFC), was developed from an ecological theoretical framework with the aim to assess individual, group, community, and institutional health behavior activities across (N= 737) of 14 faith communities (Powers et al., 2019).

After participating in the course, key findings across the sample included increased thoughtfulness around dietary choices, collective congregational decisions around mandatory nutritional meal choices to include fruits, vegetables, and water at events, and the inclusion of increased opportunities for physical activities interwoven into regular services offered. Furthermore, in support of community partnerships, increased access to low-cost produce and

access to local farmers served as an essential change to support sustainable dietary choices (Powers et al., 2019).

Faith institutions are essential conduits to the health care system. In a qualitative study which examined the low rates of vaccinations among African American women, specific to the human papillomavirus (HPV), Lahijani et al. (2020) conducted several rounds of focus groups at an African Methodist Episcopal (AME) Church in Atlanta, GA. The goal of the research included examining the role of religion and religiosity specific to the community's perceptions of the HPV vaccine. Using a stratification method of group members, (N=49), participants in small mixed groups of church leaders, members, nurses, adolescents ages 9 – 17, 18 – 26, and parents, explained their perceptions of the HPV vaccine and were educated about the disproportionate rates of cervical cancer among African American women versus Caucasian women.

Key findings noted some diversity in perceptions among members about the necessity of the HPV vaccine, finding it to be unnecessary for adolescents as there is an expectation of sexual abstinence among them. Also, one's general mistrust of the health care system, due to the historical unethical medical practices involving African Americans, were found to serve as a barrier to vaccination. It is important to also highlight the diverse mixture of participants in each group as it allowed for an open sharing learning circle across ages and experiences.

Themes emerged from the data indicating the benefits of a social and behavior change communication (SBCC) conceptual framework used to support health behavior change for targeted populations is beneficial due to its systematic methodological nature (Lahijani et al., 2020).

While limitations of the study noted that the findings were specifically from one church, with one religious denomination represented, AME, the benefits and findings were transferrable to other elements of faith-based health promotion specific to communication strategies around social behavior change (Lahijani et al., 2020). Messaging, endorsement by faith leaders and institutions, presenting health knowledge with urgency with the diversity of opinions, supports improved, informed decision making. Also, this presents an opportunity to discuss other health risks such as sexual and reproductive health knowledge, support for creating safer environments to discuss concerns with trusted allies, and full support of reducing judgement with help seeking.

Without the partnership of the faith leader endorsing this health education activity as essential to the wellness of the congregation, successful attendance at multiple mixed focus groups would not have been achieved. This study's findings are essential to understanding how the mobilization of a community, with a pointed approach to health education, can support informed decision making and overall disease risk reduction.

A qualitative study inclusive of (N=99) African American clergy in New Haven, CT, participated in a semi-structured interviews which sought to explore and describe how they "conceptualize, structure, and experience" their pastoral counseling, including receiving and making referrals (Young et al., 2003). From chemical dependency counseling and prevention to the identification of signs and symptoms of mental illness, clergy have found that their contact and intervention for one's social or behavioral health problems is often the first point of access in a series of collaborations with specialized services and referrals. Furthermore, faith leaders, struck by the depth and breadth of needs of those which present for services, have been able to identify their efficacy as non-judgmental, objective agents, who are a part of a larger system of community health. Therefore, their commitment to serving those that seek their services requires

advanced education and training, along with an active network of providers to support these processes (Baruth et al., 2015; Bopp, 2011; Brand, 2019).

With a myriad of learned approaches, including prayer and bible-based knowledge through scripture, Young (2013) explained that faith leaders noted that their sessions lasted from 15 minutes to 45 minutes, and even longer in some cases, with the goal of helping one bring clarity, make connections between their thoughts and emotions, and helping one to identify next steps in their process. Major findings of this study highlight the role of the church as a health-promoting entity and can be essential to behavior change, directly and indirectly. Furthermore, this study's strengths, included the robust sample population where the clergy of churches who participated ranged from strong fiscal foundations, mid-level finance structures, and small churches with minimal resources; many of which are led by pastors who are women.

In a study which evaluated options to improve mental health care continuity between faith-based organizations and medical practitioners, Milstein et al., (2008) created a joint psychoeducation program, Clergy Outreach and Professional Engagement model (C.O.P.E) designed by the Weill Cornell Medical Center in New York City. This partnership between the Cornell Department of Psychiatry, City University of New York Graduate Center sought to highlight the expert knowledge of both the medical practitioners in psychiatry and the faith community with equal legitimacy (Milstein et al., 2008).

Essential to strengthening the knowledge of both parties, a peer led program about the brain, its components, psychopharmacology, and "spectrums of care" exploring the intersectionality between the rituals of faith, spiritualty, and health were administered (Milstein et al., 2008). Concerns around boundary setting, balancing the mental health of individual congregants versus the larger group of congregants, and examining the role of religiosity in emotional development

were explored with psychiatry expert consultations and an applicable framework created (Milstein et al. 2008). The greatest benefit noted from the program was the transferability and applicability across denominations and the shared goal of extending intervention activities to support improved emotional health of all people.

Left unaddressed in the research were the details around the faith leader's individual processes for decision making around who they elected to participate in the training and what factors contributed to their decisions for these elections.

This study will further explore the content as it points to how faith leaders identify key attributes to develop and strengthen for their team members partnering on health promotion initiatives with them.

Faith Leaders Serve as "First Responders" during the COVID-19 pandemic

Globally, interdisciplinary practitioners are charged with deeply examining the impact of the COVID-19 pandemic across populations. With a cumulative and aggressive focus on identifying COVID-19 vaccinations, questions around care access, eligibility for services, and resource allocation of all kinds have emerged.

During the current COVID-19 pandemic, faith institutions have once again responded to a call to action to contribute to health promotion agendas. Collaborations between faith and medical communities have shown to be instrumental in the urgent tasks of widespread communication about COVID-19 and other comorbidities. The diversity of their approaches, in concert with the necessity for collaboration with other service providers, has encouraged faith organizational leadership to strongly consider streamlining their processes through formalized methods of information sharing. From ensuring that communities are flooded with the

availability of spiritual counsel, food, social services, and personal protective equipment (PPE), to supporting science and medicine to increase knowledge about COVID-19 vaccination services, the role of faith-based entities in public health today has been extraordinary (Campbell, 2020; WHO, 2020).

With the faith communities' unique strategy of identifying and connecting with vulnerable populations and medical communities' focusing on the provision of treatments and relevant interventions, the methods which support health literacy and targeted communication across these populations are just as critical as the treatments themselves (Galiatsatos et al., 2020).

Illustrated through a mixed-methods design study inclusive of interviews and surveys of faith and community leaders, a working knowledge of COVID-19 resources, preventive care access, and policies was assessed. Through a structured series of phone banking community calls, each series with advancing psychoeducation and utilization of best practice approaches for engaging community members, needs included advocacy for allocation of PPE, information about pharmacological interventions, nutrition, and other relevant resources reached vulnerable populations (Galiatsatos et al., 2020).

This article highlighted strategies for establishing a pointed outreach approach and directly supported activities for risk reduction around COVID-19. Important insights included how the collaborations between faith communities and medical communities, regardless of denomination, can coordinate their efforts to protect their constituencies during pandemics or natural disasters of the future using cost effective methods.

While the COVID-19 pandemic has provided exceptional opportunities for faith-based institutions to offer support and information about services, faith leaders engaged people at an

increased level and offered consultation and prevention education. Gildea (2021) found that people of certain religious affiliations leaned more on their faith leader as an expert as it related to health promotion, but other people did not.

Findings from a 2018 study which surveyed 8,000 people who identified their faith orientation to be Christian, Buddhist, Hindu, Jewish, Sikh, Muslim, or atheist provided important insights for faith leaders which indicated that levels of influence from faith leadership may vary around health-related activities across religious affiliations (Gildea, 2021). When asked to respond to the following survey question, "To what extent would you trust health advice that came from your religious leaders?" responses indicated that people of the Hindu (34%) and Buddhist (31%), followed by Christian (27%) faiths were more likely to trust their faith leader regarding health care advice. Those who identified as Jewish (37%), and Sikh (31%) indicted "distrust." Also, while faith institutions mobilize to address the social determinants of health, there tends to be an overgeneralization and concentration of people of certain ethic groups. Results of the survey found that people highly regarded their faith leader but would also defer to their health practitioner for official healthcare recommendations.

The findings from the study did not minimize the importance of a faith leader's influence or contribution. However, the findings did suggest that faith leaders have an ethical obligation to set appropriate limits as it relates to their areas of expertise, where applicable, and to encourage members to remain connected to the relevant preventive systems which they are affiliated medical care as needed. Again, not faith leaders alone, but faith communities, have a shared accountability to encourage increased collaborations with larger systems of care (Gildea, 2021).

Collaborations Between Faith Leaders and Social Work Practitioners Can Be Beneficial

The relationships between faith organizations and social workers have been proven to be effective as it relates to engaging in social justice initiatives, program planning, and organizational design thinking strategies (Galiatsatos et al., 2020; Harper, 2020; Placido & Cecil, 2014). Engaging in research is important for social workers as it provides opportunities to increase knowledge about client populations, the systems through which they interact, and to establish standards for evaluating effectiveness of practice methods and interventions (Rine & LaBarre, 2020). With social workers' specialized training in the areas of research and aptitude for conducting vigorous needs assessments, their contributions can greatly support faith leaders with reconceptualizing their institutional missions and visions to inform individualized programming (Placido & Cecil, 2014; Ross & de Saxe Zerden, 2020). Social workers practicing with faith organizations form fruitful partnerships with faith leaders to support their efforts to "avoid stagnation and isolation" of their communities (Placido & Cecil, 2014, p. 3).

Collaborations between social workers and faith communities have been effective as it relates to addressing the needs of special populations. An article which assessed the knowledge of end-of-life care planning documentation led to interesting findings. In a study which administered a Directive, Knowledge, Attitude and Utilization Scale to N=27 individuals, more than 80% of respondents did not have end-of-life planning or advance directive documentation completed (Davis, 2013). African American older adults were found to have limited knowledge about the processes for preparing and filing important end-of-life planning documents and a strong reliance on community-based programs, such as faith institutions, to support their spiritual well-being and health (Davis, 2013).

This study highlights that social workers' roles in the community to intercept people needing and requesting community-based programs is more frequent than not, and it is essential for social workers to be involved with proactively engaging with health promotion opportunities at varied access points. This supports the minimization of barriers to care and supports a reduction of emotional distress most affiliated with complex health social services systems and their documentation (Davis, 2013; Ebear et al.,2008). However, research findings continue to indicate that faith organizations support many facets of one's quality of life. Their efforts are best achieved by the development and maintenance of diverse interdisciplinary relationships. Collaborations between faith leaders and organizations have shown to have major parallels in practice and ideology.

Even though there is a resounding theme of small sample size and homogeneity of sample populations which create challenges with generalizing results, it is empowering to see that faith institutions continue to show promise and flexibility in their approaches to evaluating needs of their congregations – even as far as to create specialized screening and assessment instruments as needed. The small sample size of the study was addressed as a limitation, but the implications for social work practice superseded this factor.

The benefits of engaging faith communities in social justice continues to be explored and social workers are noted to be strong allies. Historically, social work practice in faith-based settings has supported the dissemination of valuable information to communities and have served as safe spaces for healthy dialogue around sensitive issues such as equity, racism, and addressing the psychosocial needs of people (Harper, 2020). However, some faith leaders may find it difficult to independently manage controversial dialogues where others embrace this as a part of their biblical responsibility.

In a case study, Harper (2020) conducted in-depth interviews with two N=2 Christian pastors about their experiences with interfacing around social justice issues and facilitating these discussions at their institutions. Faith leaders indicated that the skills to create an environment which supports evocation among members was found to be in direct relationship with one's readiness and knowledge to address the wide range of social justice topics. Others questioned whether the faith institutions are an appropriate setting for social justice dialogue overall and worried about the concept of a "separation of church and state" when presenting these topics (Harper, 2020). To mitigate this learning gap, deliberative dialogue, was presented a training tool for faith leaders, thereby encouraging social justice information to be incorporated as a regular course of discussion or teachings with members (Harper, 2020).

Findings from this article provided important insights which speak to the importance and benefits of social work alliances with faith leaders. Social workers, with their specialized training in ecological frameworks and keen knowledge about the emotional needs of people, have an opportunity to work in alliance with faith leaders in their preparation, research, and strategies for community engagement specific to social justice issues. This pushes beyond the day-to-day functions of direct care on behalf of the faith leader and the social worker and offers an opportunity for expanded leadership roles, structured advocacy efforts, and wider reach of knowledge to the community at large.

Faith leaders and social workers are strong allies in the work of crime reduction and play a critical role in building safer communities, responding to traumatic events, and supporting resiliency (Alexander, 2020; Knight et al., 2021). Over the years, there has been an increase in school shootings which have claimed the lives of many innocent people. Efforts to raise awareness around warning signs and safety contingency plans continues to be developed through

diverse community partnerships including those with faith communities. It is with people's faith and spiritual connections that they have been able to cope with the traumatic losses and have found the individual strength to share and support others through their grief. However, while some have leaned into their faith, there has also been some controversy that school shootings have had "overtly spiritual" responses (Alexander, 2020).

In a study which investigated the ways in which the role of faith served as a critical intervention for trauma, Alexander (2020) utilized a case study design to illustrate how a person's "faith-related" beliefs inform their interactions with a traumatic event, and through meaning making, ground their ability to cope (p. 67). A survivor of the 1999 Columbine High School shooting was the subject of the study and participated in a series of interviews with the researcher from Baylor University. Themes emerged from the data which supported the research participant's strategies to cope which included an enriching relationship with her faith and faith community which promoted forgiveness, love, and protection. Essentially, these beliefs, along with the relationship with the God of her understanding, remained at the forefront of her life practices. This did not mean minimizing the impact of the devastating event, but to "make meaning" of the occurrence (Alexander, 2020).

Social workers, with their skills to respond to crisis, support people and communities while utilizing a variety of person-centered therapeutic interventions. Aimed at promoting strength and movement forward, faith leaders and social workers are positioned to work collaboratively within faith communities to build strong programming, supports, and mobilize communities of faith when responding to community crisis such as Columbine. These are essential implications for social work practice in faith communities.

Partnerships between faith leaders and social workers are valuable in community safety and violence prevention. In a qualitative study conducted in the Mid-West with 27 faith leaders and nonprofit organizations conducting anti-trafficking work agreed to participate in a culturally sensitive discourse around anti-sex trafficking. Considering the ethical foundations of social work and Christianity, a dialogue which engaged a variety of views to support sex trafficking survivors prompted important acknowledgements of social justice, specific to the levels of risk, protective factors, and the intersections between spirituality, morality, and religiosity (Knight et al., 2021).

Findings which emerged from the interviews and focus groups highlighted the contrast between social work values and Christianity specific to the role of social justice as a regular course of interactions with people and systems, the importance of supporting self-determination and strengths based health promotion for service seekers, the responsibility for competence and education to inform practice approaches when providing services, and to challenge areas of difference through promoting equity and equality for all as it relates to access to care across the broader spectrum (Knight et al., 2021). Research findings continue to indicate that faith organizations support many facets of one's quality of life. Their efforts are best achieved by the development and maintenance of diverse interdisciplinary relationships.

Collaborations between faith leaders and organizations have shown to have major parallels in practice and ideology. The proposed study seeks to fill a gap in this research to dig deeper into the reasons why faith leaders would engage in such a process of inquiry.

Literature Review Conclusion

A review of the literature indicates that faith leaders are essential contributors to improved population health. What is known is that the types of health promotion programs across faith institutions vary in size and scope, including but not limited to, teaching and prevention approaches, availability of access to health experts specific to the needs of the community, and the availability of health-related information for distribution.

The research also points out that there is more research conducted with larger faith institutions versus smaller ones. This creates a knowledge gap where the efforts and contributions of smaller institutions may not be recorded using a formalized methodology thereby leaving out valuable information around strategy and identifying needs for support. This also limits opportunities to access administrative and fiscal support for programming.

Upon review of the literature about faith leaders processes for implementing health promotion programs at their institutions, a gap in research exists surrounding their experiences with civic engagement, participatory action, and navigating the many bureaucratic systems through which they rely on to gain relevant fiscal and operational support; along with increased opportunities to partner with interdisciplinary institutions. This, in tandem with strategies for creating and maintaining sustainable health promotion programming, must be further assessed from the lens of distributive justice and health equity.

Other research gaps include limited explanations about the intricacies of faith leaders' processes for building therapeutic alliances and collaborative partnerships with non-secular entities. Additionally, there is limited information available about the experiences of faith leaders in health promotion who are women informing special attention to their defined roles.

What is not known is what prompts faith leaders' interests for engaging their communities around health and how faith leaders discern which coalitions, advocacy groups, or learning circles to join to support the creation of effective, sustainable programming at their institutions. Across literature, gaps in knowledge call for studies which delve into the utilization of grounded theory as a foundation to support further exploration into this phenomenon.

Considering the aforementioned information, this study seeks to investigate how faith leaders begin to embark upon a process of behavior change as it relates to their participation in health promotion and how their awareness leads them consider making institutional changes and advancements.

The following section introduces a theoretical framework as it relates to behavior change among faith leaders and how this informs action-orientated service delivery.

CHAPTER FOUR

THEORETICAL FRAMEWORK

Overview of Theoretical Framework

As social scientists, we seek to understand the relationship between human behavior and the social environment. Looking to explain these interactions in context, we identify theories and develop theoretical frameworks which serve as a baseline for exploring complex phenomena. The following discussion presents two theoretical frameworks which grounded this study in social work knowledge and research, specific to understanding the psychology of behavior change conceptualized through self-efficacy among faith leaders and their efforts toward implementing health promotion programs at their institutions. The relevant theories selected for this study are the Transtheoretical Model of Change (TTM) and The Health Belief Model (HBM).

The Transtheoretical Model of Change (TTM)

Centering this study around the context of improved population health, behavior change, and health promotion, Prochaska and DiClemente's (1983) Transtheoretical Model of Change (TTM) has been selected as most applicable to this grounded theory study. The TTM, also known as the Stages of Change, blends psychological theoretical frameworks and interventions which illustrate decision-making processes around health promotion behavior change.

During their research in the late 1980s, DiClemente and Prochaska examined the processes by which people elected to make health behavior changes, specifically around smoking cessation. Their discoveries lead to important findings about the implications for sustaining the health behavior change among those who made self-directed changes versus those who made a change utilizing treatment interventions (Prochaska & DiClemente, 1983). The group of people

who were indicated to have stopped smoking were considered "ready" to stop smoking and the people who were "ready" to stop smoking engaged in a decision-making process which was gradual, ending with their decision to make a desired behavior change (Prochaska & DiClemente, 1983). Also, full behavior change was not expected right away, and found to include transitions between stages at one's own pace.

The dynamics of the decision-making processes and the concept of "readiness" sparked further interest among behaviorists and additional information emerged about this model's transferability across disciplines in health promotion and social science. While the TTM and Stages of Change is widely referenced in addiction research, it is important to note that this model outlines a process and strategy for decision-making in relationship to a planned behavior change, applicable to other aspects of health promotion research (Prochaska & Valicer, 1997).

The Stages of Change

The decision-making process for behavior change occurs in stages, referred to as the Stages of Change. According to Prochaska & DiClemente (1983), the Stages of Change are: precontemplation, contemplation, preparation, action, maintenance, and relapse.

In the precontemplation stage, one does not see their behavior as a problem, has no intention of changing their behavior, and is not thinking about making a change. In contemplation, one does not commit to making a behavior change but may consider the risks and or benefits associated with the change. The consideration of the potential for change instills hope and one may be willing to learn more about how the change can have an impact on their lives.

Moving into preparation, after an evaluation of the risks and/or benefits associated with the change, one begins to take early steps in deciding if a behavior change is needed. At this

stage, one is less ambivalent about whether a change should occur. The benefits of the change outweigh the risks, and the person is seriously prepared to take additional steps toward the change.

In stage of action, the planned change is activated and may include gathering necessary support and buy-in from supporters. External accountability, healthy confrontation, and monitoring, promote the sustainability of the planned change as well.

During the maintenance stage, one is successful at "keeping on track" with the new sought out behavioral outcome.

During termination or relapse stage, one abandons the identified behavior change and returns to old behaviors prior to the change. Earlier iterations of the stages of change model indicate relapse as a normal part of the behavior change process.

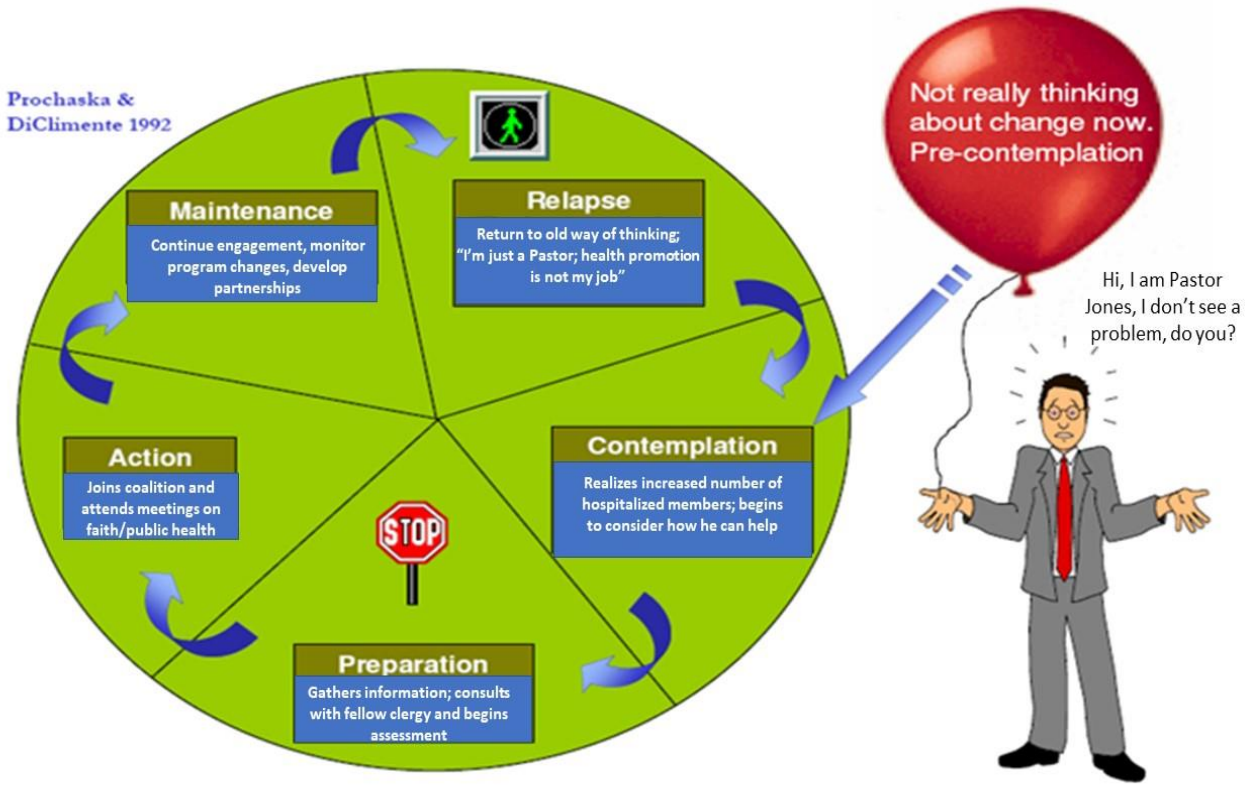
The TTM has been criticized for having some limitations including being slightly "ambiguous" or "unclear" in its application. Meta-analysis studies examining construct validity report that there lies difficulty with categorizing finite terms associated with the length of time one interfaces across change stages and evaluating the "actual" stage of change at a given point (Littell & Girvin, 2002). The model is also described as lacking standardization among instruments used thereby creating difficulty when evaluating the change stage.

Finally, the model assumes one's individual strength in cognition and mental capacity, the presence of logic, and an ability to articulate and fully conceptualize a decision-making process (Littell & Girvin, 2002).

Applying the Stages of Change to Faith Leaders

The applicability of Prochaska and DiClemente's findings can inform the decision-making stages engaged by faith leaders who task themselves with becoming ambassadors in health promotion at their institutions. A hypothetical scenario and visual depiction of how a faith leader may transition through the stages of change, specifically addressing population health, is illustrated in the Figure 1 below.

Figure 1. Visual illustration of a faith leader considering implementing health promotion programming at their institution utilizing the TTM 's Stages of Change Model.



Note. Illustration of a faith leader's movement through the Stages of Change Model when considering implementing health promotion programming at their institution. Illustration created by the author and adapted from Ashton, 2017.

Figure 1 provides an illustration of a fictitious faith leader, Pastor Jones, and his movement through the stages of change process as he considers engaging the health needs of one of the members of his congregation.

Consider a scenario where Pastor Jones might learn about the declining health of a congregant. He is alerted by a fellow clergy about a recent change in the lives of one of his members. The faith leader, traditionally focused on activities related to the institutions 'operations, physical plant, congregation membership data, preparation for religious functions, or other duties as assigned by executive leadership, is alerted about a member who found to be experiencing feelings of worry and anxiety. A recent change in income resulted in the loss of medical benefits, leaving the member unable to obtain access to prescribed routine maintenance medications. Based on the faith leader's subjective experiences managing their own health challenges, or previous experience with a loss of income and medical benefits, the faith leader may begin a process of moving from "no awareness" about the urgency of the member's conditions to the starting point for change: the entry to the stage of change of pre-contemplation. His ambivalence to explore the details of the member's current conditions by identifying that his role is of a faith leader only might require an innovative approach. As Pastor Jones moves to contemplation, his reflection on his role may expand a bit, and transcend beyond that of a spiritual support guide to include serving as a key access point to a medical system of care and function of advocacy for the member. Now, Pastor Jones moves to the preparation stage of change, where he might include implementing strategies to support his role in the action stage of change. Pastor Jones evaluates the risk and protective factors associated with the member's well-being with the goal of proactively attempting to ensure their safety and quality of life through stabilizing access to necessary social services and resources if he can. Pastor Jones continues

through the change stages to maintenance where he has initiated the practice of weekly follow up calls, not just to the member, but with most members on his roster, with a laser focus on those with fixed incomes or who present with serious medical conditions and medication management support needs. The relapse/termination stage may be reached should Pastor Jones be faced with a variety of mitigating factors or new priorities which result in his no longer prioritizing these tasks as a function of his role.

In summary, Prochaska and DiClemente's Stages of Change model can be successfully applied to the understanding of decision-making processes used by faith leaders considering taking steps toward improvements in their institutions. Noted in the scenario, the faith leader's role is pivotal in facilitating key points of access to care and safety for congregants.

Finally, the faith leader is in a strong position to utilize their influential role as an agent of trust (DeHaven et al., 2004; Glanz et al., 2008). Their awareness, followed by an astute understanding that there is an internal responsibility to act when they can, sets the stage for the faith leaders to engage in critical thinking and decision making to support initiating organizational changes thereby improving the quality of life of its members and community at large.

Health Belief Model (HBM)

The Health Belief Model (HBM) is one of the earliest health behavior theories and offers a description around one's rationale for making a behavior changes. Explaining and predicting behavior change are at the core of the HBM and originated during a time where increasing resistance among people to utilize health departments for preventive services and resistance to further comply with medical interventions as recommended (Glanz & Bishop, 2010).

Developed by Hochbaum and Rosenstock in the 1950s, this model offers an explanation about the factors which inform behavior change. The HBM suggests that a person's understanding of the significance of a threat of an illness or disease are more likely to adopt a new behavior to prevent such illness or disease (Hochbaum, 1958). Here, the focus on one's personal perception of the benefits or shortfalls of a behavior change drives their decision to implement the change (Hochaum, 1958). The HBM attempts to explain and predict behavior change by examining a person's belief about their potential risks for disease (Ajzen, 1991; Glanz & Bishop, 2010; McKeller & Sillence, 2020; Steckler et al., 2010).

There are six constructs of the Health Belief Model (HBM): perceived susceptibility, perceived severity, perceived benefit, perceived barriers, cues to action, and self-efficacy.

Perceived susceptibility refers to a person's perception of the risk of acquiring an illness and/or disease.

The perceived severity is a person's perception of the depth and seriousness of a related health condition with full consideration of its impact on their quality of life on social, medical, and financial foundations.

The perceived benefit is a person's understanding of the benefits and effectiveness of a change and an acceptance of the effectiveness of such changes which can reduce the negative impact.

The perceived barriers are specific to a person's feelings about the barriers, challenges, risks or benefits that exist around taking steps to make health action changes.

Cues to action are the internal prompts which may include a personal or direct experience of consequences relating to a mal-adaptative behavior needing change. External prompts can be

messaging or advisement from core allies, family, or other valued persons which address the need to make changes.

Finally, self-efficacy is a person's belief or strong confidence that they can make the desired identified change (Ajzen, 1991; Glanz & Bishop, 2010; McKeller & Sillence, 2020; Steckler et al., 2010).

The following section provides an illustration of the HBM and applies its concepts to a faith leader considering implementing health promotion programming at their institution.

Applying the Health Belief Model to Faith Leaders in Health Promotion

As referenced in the literature and informing this study, when thinking about faith leaders moving through their own individual stages of change, and reflectively transitioning using the HBM, the goals remain the same – to thoughtfully explore how behavior change models can address the pressing needs in health promotion and to strongly consider how the professional uses of self among faith leaders is a springboard to advance the structure of their institutions and improve the quality of life of its members.

To further illustrate how a faith leader might consider the initiation of implementing a health promotion program at their institution, with the application of the Health Belief Model, consider the scenario provided throughout Figure 2.

Figure 2. Hochbaum & Rosenstock's Health Belief Model (HBM)

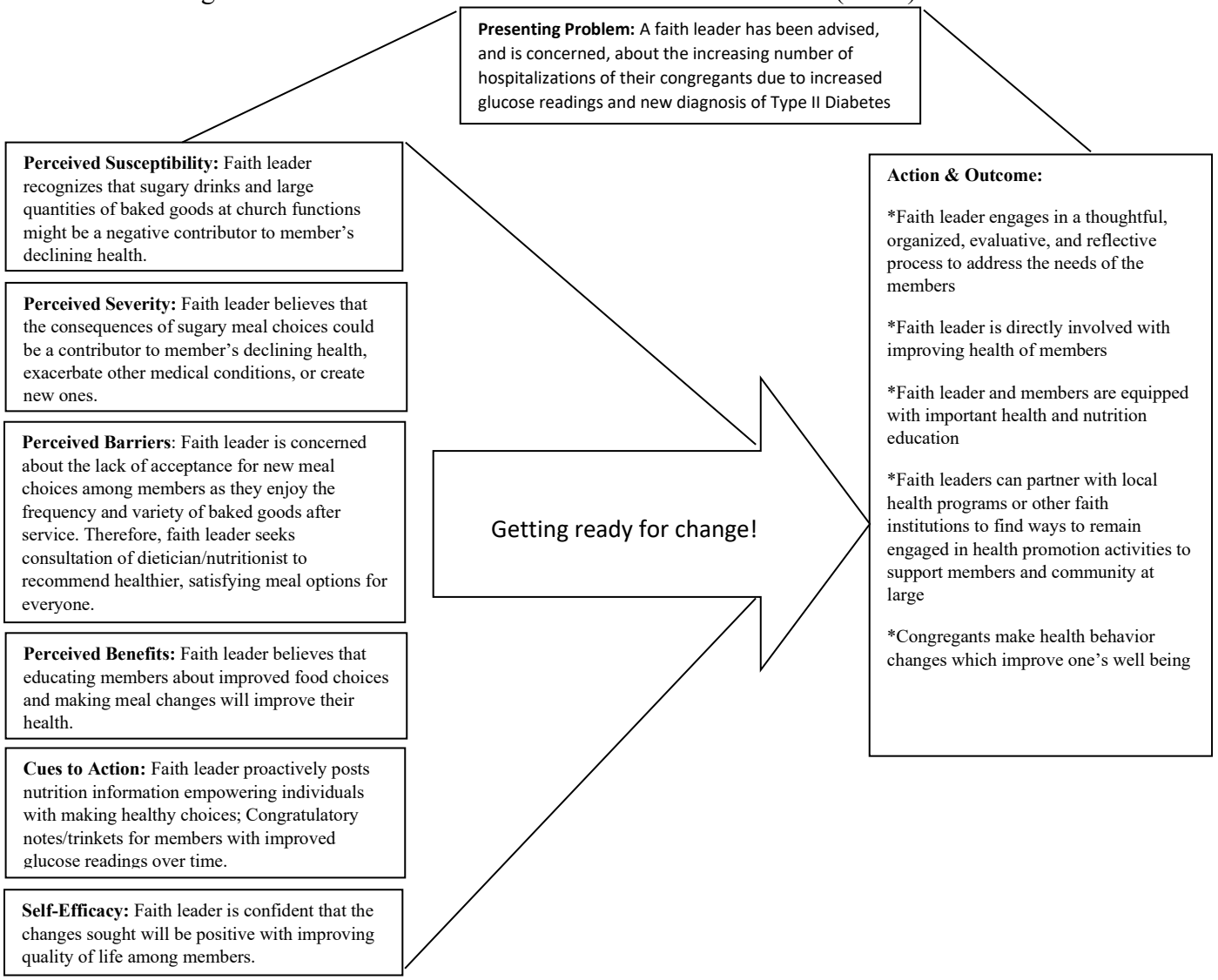


Figure 2. Illustration of how a faith leader may initiate a health and wellness initiative from the perspective of the Health Belief Model (HBM) developed by the author and adapted from Chin et al., 2019.

The Health Belief Model (HBM) is not meant to serve as a structure of activities or strategy for making changes, but to help illustrate the processes by which one engages in a cost and benefits analysis in decision making. Furthermore, it should be noted that the HBM lacks consideration of the economic and environmental factors which may contribute to one's motivation for, and ability to, execute a health behavior change.

In closing, the TTM and HBM have been selected to inform the research methodologies in the study as they are most applicable to the inquiries around how faith leaders develop and change health promotion programs at their institutions. Both models directly address one's personal motivation and decisional making processes which are essential to the evaluation of risks and benefits to behavior change. The consideration of both personal and environmental factors which motivate behavior change underscores the initiation of one's propensity to act. Faith leaders' roles position them to reflect more deeply on the conditions which impact their lives and the lives of the followers further advancing their focus on strategies which support improving their overall health and well-being.

The crafted research questions and design methodology are rooted in the foundations of the exploratory processes of behavior change, the acute impact of such changes specific to health promotion strategies, and ways in which long term sustainability in population health can be achieved.

In conclusion, an evaluation of the TTM and HBM highlight that one's perceptions of the benefits of change can support the initiation of action steps and strategic planning supporting improvements outside of an individual to also include at risk groups.

CHAPTER FIVE

RESEARCH QUESTION AND RELATED HYPOTHESES

This qualitative research explores the experiences of faith leaders as interventionists in public health. The study took a closer look at the faith leaders' understanding of their uses of "self" and its relationship to advancing the health and well-being among their congregations and communities at large. An inquiry into the processes by which faith leaders gather information and evaluate the diverse needs of their congregations was investigated as it relates to their decision-making processes informing program design and implementation considerations.

Due to the qualitative study design, no hypothesis was developed. While the research on faith organizations highlights their success, a gap in knowledge exists around understanding the processes by which faith leaders independently discern engaging in health promotion and how they access and navigate the necessary systems needed to successfully implement, deliver, and sustain their programs.

Considering the information gathered from the literature review and the application of the theoretical and conceptual frameworks presented, the following main research question was proposed: How do faith leaders develop and change health promotion programs at their institutions? Additional sub-questions were:

SQ1: What are the experiences of faith leaders in health promotion as they seek to strategize the implementation of health promotion programs?

SQ2: What are the ways in which equity is achieved specific to access and eligibility for fiscal resources and technical support at their institutions?

SQ3: How do faith leaders utilize their organizations to navigate the public health landscape?

SQ4: How do faith leaders' interface with the social determinants of health with the goal of achieving equity in their community?

The important insights obtained from this study offered critical information around the role of faith leaders as ambassadors in public health and health promotion. The following section outlines the methodology used to answer the proposed research question.

CHAPTER SIX
RESEARCH METHODOLOGY

Research Design and Setting

This qualitative grounded theory research study explored the remarkably diverse roles of faith leaders as public health interventionists. Delving into faith leaders' perceptions, attitudes, and motivations which drove decision-making processes around health promotion priorities at their institutions, personal and expert knowledge about public health, and the strategies selected to support contributing to improved population health outcomes are all critical elements to understanding this context. Incorporating the underpinnings of faith leaders' real life, or "lifeworld" experiences with implementing health promotion activities at their institutions, this study obtained candid responses from faith leaders, on the ground, who are engaged in grassroots health promotion activities, and the important reflections about their experiences.

Creswell & Poth (2018) points out the benefits of qualitative designs as an opportunity for the researcher to engage directly with the identified subjects, thereby offering more of an in-depth comprehensive view of the individual, environmental conditions, and the complex relationships which exist (p.41). Qualitative methods of inquiry support depth of a narrative which may otherwise not be captured using quantitative methods. The extraction of salient themes resulting from the researcher's qualitative inquiries supported gaining important insights into the experiences of the subject (Creswell & Poth, 2018).

Grounded Theory

The qualitative research design methodology selected for this study is grounded theory. Originating from their work in health promotion, specifically examining the experiences of

patients who were terminally ill in the 1960s, Glaser and Strauss laid the foundations for empirical qualitative design methodology, strategies for organization, and data analysis for researchers (Tie et al., 2019).

In grounded theory, the data gathered from the respondents is analyzed resulting in the development of a new theory, specifically gathered from the data (Tie et al., 2019). In health promotion research, especially when investigating behavior change, models of inquiry generally start with a hypothesis to test, called hypothesis-testing versus seeking a hypothesis emergent from the research, defined as hypothesis-seeking (Mullen & Reynolds, 1978). Grounded theory's framework is from a hypothesis-seeking perspective and is found to have positive efficacy to support the expansion of knowledge. This method places the respondent and their distinct perspective at the center of investigation supporting the organic manifestations of themes emergent from the data.

Mullen & Reynolds (1978) discussed Glaser and Strauss' grounded theory method indicating that synergy exists between qualitative data analysis and comparative data analysis. Empiricism in the grounded theory methodology can be identified through four key elements: generality, control, fit and understandability, and analysis of processes versus analysis of units (Mullen & Reynolds, 1978, p. 286).

Generality is achieved in grounded theory by the propensity to gather as much information as possible from respondents, thereby allowing for a wide range of concepts to emerge from data collected (Charmaz, 2009).

Practitioners engaged in research are inherently positioned as experts in the field they practice and may be challenged by their own biases and boundaries specific to a subject matter. The element of control, in grounded theory, is an essential element as it supports the researcher

with promoting the subject as the expert and their responses, circumstances, and experiences – regardless of terms – contribute to the creation of the theory (Charmaz, 2009).

Fit and understandability in grounded theory appear through the uses of examples which are applicable to the subject and may include relevant scenarios or jargon (Charmaz, 2009; Khan, 2014). The benefits of fit and understandability, emergent from grounded theory approaches, support a wide range of audiences and specialized groups to really understand the content and context of issues. This contributes to the establishment of a baseline and further rich data analysis where applicable.

Finally, the analysis of processes versus analysis of units in grounded theory addresses the terms set forth through the research from the lives and experiences of the respondents as they present at different points in time and various places versus that of a pre-established point in time or criteria for reflection (Charmaz, 2009).

In this study investigating how faith leaders develop and change health promotion programs at their institutions, previous data gathered during the literature review pointed out that certain challenges existed among faith organizational leadership specific to their limited capacity to successfully manage the administrative functions and priorities of their programs due to a lack of formalized documentation processes, clarifying utilization service units, fiscal challenges to support stronger administrative structures, or even overall difficulty completing tasks due to its complexity at times. To further explore these elements, a qualitative study with a grounded theory approach, can support allowing a deeper inquiry into the reasons for the identified gap in services, and through the responses of the subjects, a newer theory may emerge indicating characteristics which may not have been captured by the research already. The grounded theoretical iteration, based on the proposed data collected from the study, might find that a new

theory emerged; that faith leaders are least likely to ask for help due to repeated disappointments or unfulfilled requests for help in the past resulting in the dissolution of their programs. At face value, the problems sought to be explored in the research may be targeted toward administrative concerns, but the researcher may learn about the presence of frustration, distrust, and lack of motivation to reignite their goals.

Finally, this critical information may be followed up with recommendations for developing specialized support platforms for faith communities versus other entities for health promotion program brainstorming and training.

As previously mentioned, grounded theory is most appropriate for this study. Methodological literature reviews evaluating health promotion programming and service delivery with special populations recommend that more studies consider grounded theory approaches in qualitative research due to its benefits in broad based behavior change knowledge (Newlin et al., 2012).

Context for the study

In the New York City area, there are approximately 2,000 churches. The primary point of recruitment for subjects of this research study included faith leaders who are members of the following coalitions: the City of New York Office of Faith-Based and Community Partnerships, the New York City Department of Health and Mental Hygiene's (DOHMH) Office of Faith Based Initiatives (OFBI) in New York City, NY, The Interfaith Center of New York (IFCNY), New York City Health and Hospitals Public Health Advisory Council (PAC), and the NYU Grossman School of Medicine Institute for Excellence in Health Equity – Faith Communities Steering Committee), and the Interfaith Assembly. The current department administrators and

their affiliates served as key liaisons to this researcher for the advertisement and recruitment of respondents for this study.

The duration of the study occurred between August 2022 and December 2022. The location of the interviews was established at the time of each participant's acceptance to the study.

Sampling

A total of twenty-seven (n=27) faith leaders across New York City participated in an in-depth semi-structured interview between August 2022 and October 2022. For the purposes of this study, faith leaders are operationally defined as persons who are licensed, ordained, commissioned, clergy or institutional lay persons, who have been elected or accepted into their roles and serve in an authoritative decision-making capacity within the faith institutions. All faith leaders who agreed to participate met the specified study criteria inclusive of faith leaders serving within the five boroughs of New York City (Brooklyn, Bronx, Manhattan, Queens, and Staten Island).

Selection of Study Participants

The research study included faith leaders who are members of the following coalitions: the City of New York Office of Faith-Based and Community Partnerships, the New York City Department of Health and Mental Hygiene's (DOHMH) Office of Faith Based Initiatives (OFBI) in New York City, NY, The Interfaith Center of New York (IFCNY), New York City Health and Hospitals Public Health Advisory Council (PAC), and the NYU Grossman School of Medicine Institute for Excellence in Health Equity – Faith Communities Steering Committee), and the Interfaith Assembly.

Recruitment

Upon receipt of a participant networking list, this researcher made outreach telephone calls, sent emails, and posted recruitment flyers on both in person and electronic bulletin boards of faith-based health promotion coalitions. The research participants indicated their interest to participate in the study via phone, email, in-person verbal confirmation, and/or telephone and text messaging methods. Additionally, the researcher visited faith institutions in person to introduce the study and recruited participants for the study.

It is important to note that there were challenges to recruitment due to the moment in time of this research study. For some denominations, during annual conference convenings in late summer and early fall, many faith institutions undergo executive leadership changes resulting in a shift in organizational priorities and/or role reassignments to new institutions. The aforementioned changes contributed to some limitations around faith leader recruitment and availability to participate in the study.

Snowball sampling was one of the most effective recruitment strategies to identify participants for this research study accounting for 63% (17/27) of respondents. The remaining 37% (10/27) of participants responded directly to the researcher after direct listserv outreach.

Sample Composition

This study primarily consisted of faith leaders who were middle-aged adults, age 50 and over (M = 52.7 years old). Female faith leaders were mostly represented in the sample (62.9%). Additionally, faith leaders most represented in the study identified their religious denominations to be Baptist, Seventh-day Adventists, Protestant, and African Methodist Episcopal (AME). The inclusivity of faith leaders from more diverse denominations would have further contributed to

the richness of the data collected should the catchment area of recruitment for study participants been expanded.

Potential issues of social desirability may also lead to response bias among respondents thereby resulting in possible exaggeration of successes or shortfalls during self-report in qualitive studies (Latkin et al., 2017). This limitation was applicable to this study as this research found that some faith leaders were eager to share the positive attributes of their programming, but reluctant to share other difficulties they faced with members, the public, their peers, and executive leadership.

The researcher provided a participation incentive in the form of a gift card from Target Department Stores in the amount of $25.00. The researcher independently funded the incentives for this research study and absolutely no affiliation, partnership, or dual relationship with Target Department Stores or its personnel existed. At the conclusion of each interview, a gift card was mailed to each participant.

Measures

The proposed study utilized a semi-structured interview guide to explore the motivations, knowledge, skills, and attitudes of faith leaders around how they developed and changed health promotion programs at their institutions.

The semi-structured interview guide is available in Appendix A. Furthermore, the guide supported a discussion which explored how faith leaders understood the needs of their members and communities at large and the emerging concepts from both the TTM and HBM theoretical frameworks as a foundation of behavior change.

The semi-structured interview guide also helped to transition into an inquiry regarding faith leaders' navigations of social systems, specific to the processes by which they sought support with organizing programs at their institutions, including but not limited to, financing, technical training, program design planning, and partnerships. The guide led the inquiry and reflective discussion around the personal contributions of each faith leader specific to their lived experiences with health systems and how these contributed to the further advancement of their institution's mission and vision for a healthy congregation.

Data Collection and Interview Procedures

The study used a live-online secured video meeting platform, Zoom Video Communications Inc., to conduct semi-structured interviews. The researcher contacted the prospective participant via telephone and conducted a brief pre-screening interview to determine eligibility for a formal interview. Once eligibility was determined, an interview time and location were established. The researcher prepared a secured zoom link and password which was sent to the participant prior to the start of the interview.

The interviews were conducted after the researcher provided the subject with the required safety protocols and informed consent was obtained. Interviews lasted 60-75 minutes and included the participant and researcher only. Video interviews were recorded upon approval by the participant and saved in a password protected format. Participants had the option of interviewing with their video camera off or on. However, most participants elected to be interviewed with their cameras on.

The researcher used field notes to keep track of valuable information and emerging themes gathered during the interview. Along with the zoom application, a transcription service, Rev Transcription Services and Otter Transcription, were employed to provide verbal transcripts

of interviews for the researcher. Only the researcher had access to the transcriptions and upon completion of interviews, all field notes were kept in a locked box and only accessed during times when data analysis occurred. To protect the participants' information, Rev Transcription services encrypt all data both in transit and were stored on protected AWS servers and upon request of the researcher, this information was discarded. The researcher has the transcription from Otter password protected.

Data collection continued until saturation was reached and no added information was gathered relevant to the research content.

Data Analysis

With the wealth of information collected, this researcher engaged in thematic analysis processes inclusive of memoing and coding utilizing ATLAS.ti Qualitative Data Analysis Software. Memoing, concept, and in-vivo coding from verbal transcripts of subject interviews occurred throughout the study. Creswell & Poth (2018) explain that coding and category building are essential for qualitative research as it allows the author to strategically describe and classify information from which sub-categories can be developed (p. 190). This offered an important opportunity for this researcher to identify gaps in research. Direct quotations and salient themes were also coded and categorized as required.

Rigor and Trustworthiness

There are many factors which contribute to validity and credibility of qualitative research, many of which have been the subject of great debate specific to its value and measurements (Leninger, 1985; Lincoln & Guba,1985; Sadelowski, 1986). While the data collected is important to understand the set of circumstances which impact the respondents, it

was equally as important that this researcher critically evaluated the data collected and reported their findings with accuracy (Leninger, 1985).

This study utilized the Model of Trustworthiness of Qualitative Research as described by Guba (1981) where the four elements of truth value, applicability, consistency, and neutrality were present.

Truth Value

The proposed study measured its truth value which is linked to its credibility of information gathered by respondents (Johnson et al., 2020; Lincoln & Guba, 1985; Nowell et al., 2017). In this case, this researcher was responsible for ensuring that the data collected is demonstrative of the experiences of its subjects, specifically faith leaders. Language, tone, and references gathered during data analysis, reviewed by other faith leaders, should have a pre-established working knowledge of the terms and experiences informing research credibility.

Applicability

Applicability in qualitative research allows for an "application" of theory or context outside of the proposed study. It is important to note that applicability is "researcher driven" and successful when the research context can be connected to a different construct (Lincoln & Guba,1985). For example, this study sought to understand how faith leaders developed and changed health promotion programs using a behavior change theoretical framework of TTM and HBM. These same models were previously applied to smoking cessation or other addiction research. In this study, this researcher offered as much of a detailed description of the subject as possible to allow for the applicability of other models or research contexts.

Consistency

Consistency in the data collection process is linked to trustworthiness as it considers whether the findings from the research could be replicated (Lincoln & Guba,1985; Nowell et al., 2017). For example, this proposed research study uses a semi-structured interview guide which is categorized into themes based on the body of literature around faith leaders and their experiences addressing the social determinants of health in their communities. Consistency would be demonstrated should another researcher ask the same questions to another group of faith leaders engaged in health promotion activities addressing the social determinants of health. Where there may be some differences with each individual respondent, there is a general theme around how faith leaders' interface with health promotion in their communities overall. This study measures consistency through its formalized semi-structured interview format with structured sub questions.

Neutrality

Neutrality informs trustworthiness in qualitative research. It addresses the importance of the information gathered from the respondents to be free of bias on behalf of the researcher. For example, the researcher, considering their relationships and knowledge of the subject matter, may arrive to preliminary conclusions which may cloud the data collection process – such as going off script during interviews if they identify with a subject – or maintaining a dual relationship with a respondent creating a conflict of interest (Krefting, 1991; Lincoln & Guba,1985). This study addressed concerns around neutrality through ensuring that there are no pre-existing relationships with the research participants including affiliations of faith institutions or groups.

The following strategies were employed for this proposed study to support trustworthiness and rigor. Peer examination occurred by providing an overview of the research, its methods, and relevant findings with an expert in faith-based health promotion and considering relevant feedback to support credibility and truth value of responses.

Coding and recoding occurred to ensure that the data collected was organized, succinct, and able to be replicated while accurately reflecting the depth of the narrative obtained from respondents.

Through member checking, this researcher used active listening and skills such as paraphrasing and summarizing of responses to ensure that information collected is accurate. As discussed here, truth value, applicability, consistency, and neutrality as outlined by Guba (1981) are critical concepts for consideration when conducting qualitative research.

Data Analysis and Coding

All participant interviews were audio-recorded and transcribed. To organize the data for analysis, each participant in the study was de-identified and assigned an identification code in compliance with IRB regulations ensuring respondents' anonymity and confidentiality.

To begin organizing themes which emerged from the data, information was coded supporting data analysis procedures. The ATLAS.ti Qualitative Data Analysis Software was used for thematic analysis processes inclusive of memoing, concept, and in-vivo coding. Creswell & Poth (2018 p. 190) explain that coding and category building are essential for qualitative research as it allows the author to strategically describe and classify information from which sub-categories can be developed. This offered an important opportunity for the researcher to identify gaps in research. Direct quotations and salient themes were coded and categorized.

Through conducting in-depth semi-structured interviews with leaders across the New York City area (n=27), the researcher answered the following research question: *How do faith leaders develop and change health promotion programs at their institutions*? At the conclusion of the interviews completed, saturation was reached, indicating that there was no new data available.

Delving more deeply into faith leaders' experiences navigating the public health landscape, it was evident that faith leaders were deeply concerned about the lives of people which they encounter, acknowledged their influential roles to be essential across the public health landscape, and have utilized the infrastructure of their institutions to facilitate health promotion programs.

Protection of Human Subjects

As the study was obligated to confidentiality, all identifying characteristics and information of the participants in the study was removed, and a coding system was used to protect the identity of the participants.

All interviews were recorded using a digital recording system. All recordings and demographic data were coded with a numbering system, and kept in a secure locked location, with the researcher's sole access only. Information containing any identifying characteristics of potential respondents was kept in a locked file cabinet. Tapes and transcripts were stored away in a secure and locked location for the duration of the study, and after which, transcripts and tapes were destroyed.

Electronic copies of interviews and transcriptions were kept on a password protected file in a cloud server which can only be accessed by this researcher. All information received from participants was only used during the scope of this study.

The following chapter will discuss the results of the study.

CHAPTER SEVEN

RESULTS

The following chapter outlines the results of the study. An overview of the demographics is outlined, followed by the processes used for data analysis and coding. Emergent themes from the data are categorized and described in addition to salient quotes from participants.

Participant Characteristics

The average age of female faith leaders, n=17, was 53.8 years old. The average age for male faith leaders, n=10, was 50.8 years old. Female faith leaders represented 62.9% of the sample, followed by male respondents at 33.3%. The mean age of participants in this study was 52.7 years old with SD=15.12.

Individual faith leaders who identified as Black or African American ethnicity counted for more than half of the sample population at 59.2 % (16/27). White/Caucasian faith leaders comprised 11.1% (3/27) and Latino/a/x respondents counted for 7.4 % (2/27). Faith Leaders who identified their ethnicity as "Other," including Jamaican, East Indian, West Indian, Arab, Haitian, and Pakistani descent counted for 22.2% (6/27).

Faith leaders' highest level of education completed among study participants varied from undergraduate 22.2% to doctorate level degrees 18.5%. More than half of the respondents earned a master's and/or professional degree 55.5%.

Regarding gender and education, there were more men that completed doctorate level education 15%, earning degrees such as Doctor of Philosophy (PhD), Doctor of Ministry (DMin), and theological studies. Females who earned a PhD and one Juris Doctor (JD) counted for 7.4%. However, more females 30% who earned master's degrees had a wide range of

specializations including Master of Public Health (MPH), Master of Divinity (MDiv), and Master of Social Work (MSW), Organizational Psychology, Consumer Finance, and Theology.

Male faith leaders were ordained longer than their female counterparts with an average of 14 years in comparison to females ordained an average of 8 years. The ordained faith leaders in this study reported having served an average of 10.5 years in their current titles.

Most faith leaders in the sample were married 48% (13/27), followed by those who reported as single 11% (3/27). More women faith leaders reported being single 22% (6/27) versus men 7% (2/27).

Table I

Sociodemographic Characteristics of the Participants

Sample Characteristics	*n*	*% of sample population*
Gender		
Men	10	37
Women	17	63
Race		
Black/African American	16	59
Latino/a/x/or Hispanic	2	7
White	3	11
Other: Jamaican, East Indian, West Indian, Haitian, Arab, Pakistani	6	22
Education		
Bachelor's Degree	6	22
Master's degree	14	52
Professional Degree (JD)	1	3
Doctorate (PhD, PsyD, DMin)	5	19

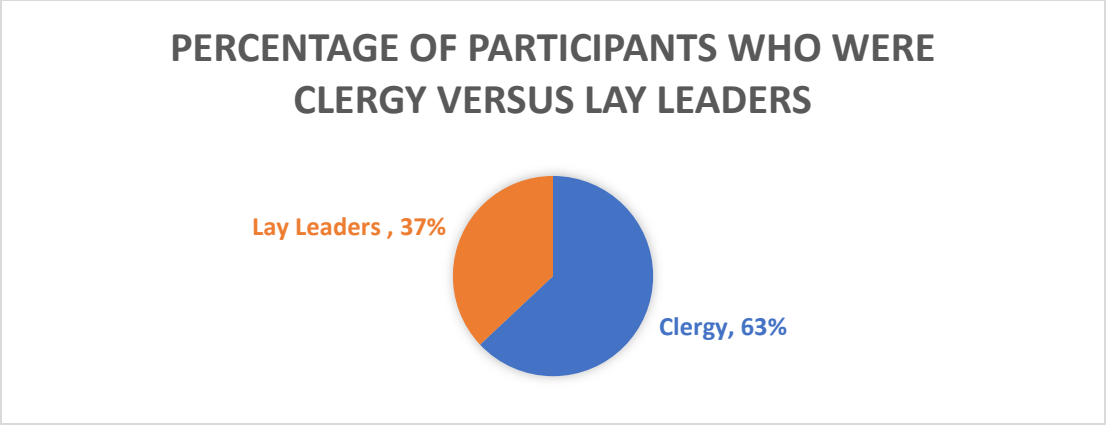
Other Cultural Religious Education	1	3
Role		
Clergy/Ordained Minister	17	63
Lay Leader	10	37
Marital Status		
Single	9	33
Married	13	48
Divorced	3	11
Widow	2	7

Note. N=27. Participants were on average 52.7 years old (SD=15.12)

Many faith leaders and congregations identify a "Lay Leader" whose role is to work collaboratively with the faith leader to promote the mission and vision of the congregation (Conte et. al, 2021). As discussed in Chapter 2, a lay leader is a member of the congregation who holds a leadership position as it relates to the faith organizational business and agenda setting in tandem with clergy or faith leaders. This study included more clergy 63% than lay leaders 37%, members of the congregation who also hold leadership positions in faith organizations, as shown in Figure 3.

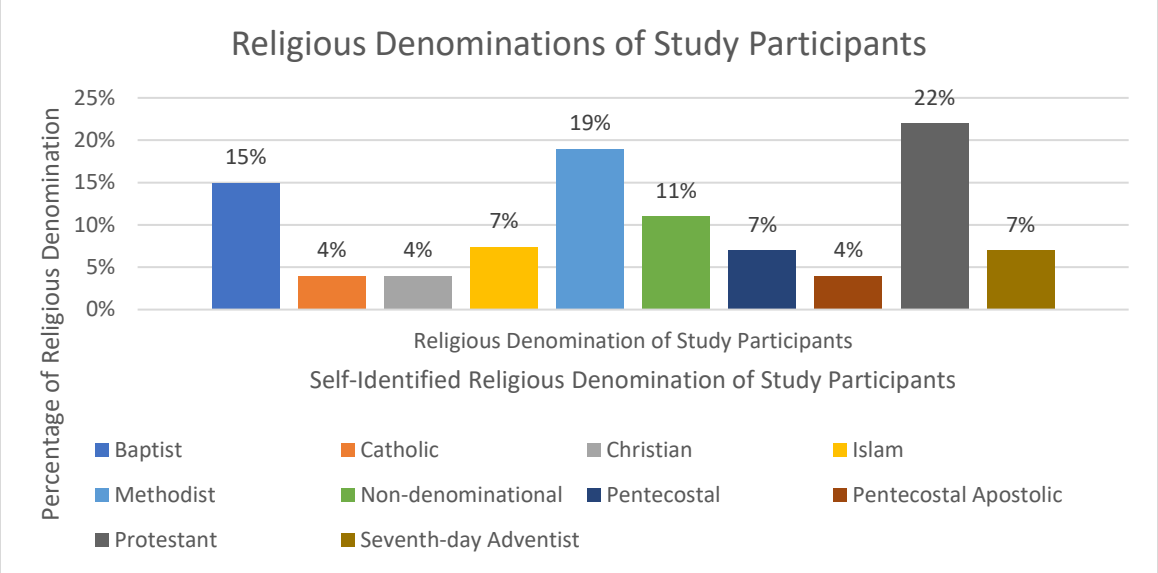
The lay leadership roles were predominately held by females who had a wider breath of academic and specialized knowledge, with certifications, which supported their abilities to practice independently in their roles on health promotion ministries and committees. Examples of this advanced knowledge include, but are not limited to, nursing (psychiatry/addictions), psychology, social work (training in dialectical behavioral therapy), political science (international relations), law, consumer science, finance, business management, and philosophy.

Figure 3. Percentage of participants in the study who were Clergy versus Lay Leaders



Faith leaders in the sample identified a range of religious denominations and affiliations.

Figure 4. Religious Denominations of Study Participants



Faith Leaders in the sample identified a range of religious denominations and affiliations. Study participants who identified as Baptist 15% (4/27), Methodist 19% (5/27), and Protestant 22% (6/27) were most represented in the study. Also, when responding to questions around denomination, faith study participants indicated belonging to subsidiaries of denominations such as African Methodist Episcopal, Christian Methodist Episcopal, United Church of Christ, United Methodist Church, and United Pentecostal Assembly.

Data Analysis and Coding

This researcher used memoing to capture key points referenced during faith leaders' interviews. To organize the data collected during faith leaders' semi-structured interviews, an inductive coding methodology was applied. The process of inductive coding supported the development of themes or theories from the raw data collected during faith leaders' interviews.

For data analysis, in-vivo coding was utilized and considered most appropriate for this qualitative study as it lends itself to the development of new ideas, concepts, and theories which emerged directly from the data collected during faith leaders' own words.

During the initial review of faith leaders' interview transcripts, a group of codes were created which included key words used to describe their experiences engaging in public health activities. For example, words such as "trust," "spirituality," "religious teachings," and "ministry" were coded to reflect a larger theme around activities associated with their roles as faith leaders.

A secondary review of the data included further coding, line by line, which resulted in the emergence of larger concepts for thematic analysis and the creation of a codebook. The table outlining the contents of the codebook is available for review in Appendix E.

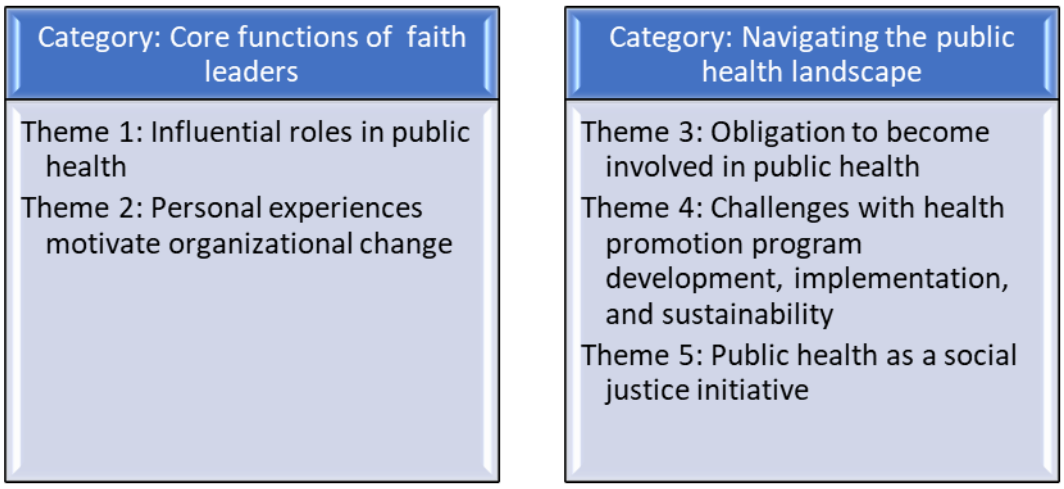
Themes

Data collected from semi-structured interviews with faith leaders resulted in the identification of quotes which were then coded and organized into five themes. Each theme was

operationally defined and organized into a codebook which outlined code names and corresponding direct quotes.

Emergent from these themes were two categories. The two categories which organized the themes were: (A) Core functions of a faith leader and (B) Navigation of the public health landscape.

Figure 5. Category titles and corresponding themes.



For category, (A) Core functions of a faith leader, the following themes were applicable: (1) Influential roles in public health and (2) Personal experiences motivate organizational changes. For Category (B) Navigation of the public health landscape, the following themes were applicable: (1) Obligation to become involved in public health; (2) Challenges with health promotion program development, implementation, and sustainability; (3) Public health as a social justice initiative. Figure 5 provides a visual of the aforementioned information.

While each category positioned faith leaders at the center of public health, there were meaningful indicators around how faith leaders developed and changed health promotion programs as they recognized themselves at the core of change, starting with their own behavior.

This critical process of self-awareness prompted the initiation of organizational changes at their respective faith institutions to improve population health of the greater community.

The following provides an explanation of the overarching category, Core Functions of Faith Leaders, and two corresponding themes: Influential Roles in Public Health and Personal Experiences Motivate Organizational Changes.

Core functions of faith leaders

Theme 1. Influential roles in Public Health

Defining public health and ministry.

One faith leader offered their definition of public health as " …the collective effort with the goal of helping individuals become whole, whether it is mental, emotional health, and physical health, especially" (Methodist Pastor). Defining ministry and its connection to service, one faith leader explained that helping people to improve their lives is a part of their "calling" and a core value to practice in their role sharing, "There is something that we are all called to do, and it's outside of ourselves…a lot of that is going to be through serving the communities, through being a servant, which is the definition of a minister" (Pentecostal Apostolic Faith Leader).

Trust and Inclusivity.

Faith leaders connected their trusted and influential roles to go beyond that of teaching the gospel, but to ensure that there is a service element which is appropriate and relevant to the needs of the person or community served. This process of critical thinking and awareness is

essential to understanding opportunities to engage and support one's quality of life improvements.

Further explaining the importance of trust and inclusivity as a core value of their service, faith leaders explained, "One thing I have learned through my work, many years of this work, is that faith leaders are the trusted sources within their communities" (Muslim Faith Leader). Another explained, "…whether individuals joined the denomination or not, I have a responsibility to help them with their health" (Methodist Pastor).

A non-denominational faith leader stated, "I am an epicenter for the resources in whatever community that I'm serving, whether physically, whether online, or any community that I'm connected to. As a pastor, in my role, I am an essential component…" (Non-denominational Faith Leader).

Public health in religious texts.

Faith leaders described the relationship between biblical teachings and foundations for wholistic health promotion practices: "Much of what I'm called to do is to continue Jesus's ministry to people, people's bodies, and minds. I think that public health addresses that ministry, less so on an individual basis, but on a broader scale, and to remind people of God's intention for our wellness and wholeness (Apostolic Faith Leader)."

A Seventh-day Adventist faith leader described health promotion in the context of a "tripartite" aspect of ministry pointing out, "We are seeing the dire need, especially in the city areas where people are suffering so many ailments, and as a church, we believe that we have to go beyond preaching the gospel, the gospel has to be practical." This faith leader continues to explain the connection to religious texts, "Jesus, the Bible tells us, went out preaching, teaching

and healing, right? So, we utilize these three, this tripartite aspect of our ministry, we preach, we teach, and focus on health" (Seventh-day Adventist Faith Leader).

To further illustrate examples of how health was addressed in the Bible, a faith leader described stories in the Bible which referenced Jesus Christ as the earliest person to organize health clinics for people and the importance of health being a part of ministry indicating, "Jesus was setting up health clinics everywhere he goes … I think a lot of ministers may not think about this in those terms, that public health, for sure shows up all over the Bible, but also, it should show up all over our work, our ministries, and churches" (Apostolic Leader).

Theme 2: Personal Experiences Motivate Organizational Change

Faith leaders indicated that their own personal health journey contributed to their participation health promotion activities. The conceptual and theoretical frameworks of the Health Belief Model (HBM) and the Transtheoretical Model of Change (TTM) grounding this served as an applicable foundation for understanding how faith leaders conceptualized issues of susceptibility and severity of consequences associated with poor health behaviors, the role of self-determination, and one's motivation to change (Hochbaum, 1958; Prochaska & DiClemente, 1983). These insights around risk and self- efficacy directly informed faith leaders' propensity for lifestyle changes, in both mental and physical health, resulting in the emergence of organizational changes as well.

Personal views about health.

Reflecting on their own personal experience of initiating a weight loss journey to improve their own health and the severity of complications which can be brought upon with obesity, a faith leader indicated, "When I began to educate myself around health standards, and

what we needed to do to affect positive change in our individual lives, and the lives of our community, obviously, I started to do things that were different in my own personal life." Further referencing their position as an influential role model and public figure in public health research and their engagement with health promotion, this faith leader continued to explain, "At one point, I was almost 400 pounds, and so, you could not preach health and look like, you know, you are not doing, or implementing anything in your own life that you're talking about." Faith leader further explained, "… my having taken the health message out to my community supported my own change in what I had to do as an individual" (Faith Leader, United Church of Christ).

With a professional and academic foundation in science, another faith leader referenced a growing concern around the prevalence, susceptibility, and severity of Type II Diabetes diagnosis among people of color explaining, "I have certainly been concerned about it, and then when an opportunity came along for me to be involved in a community project where we were trying to discern what health statistics we might approach or attempt to address, I was quick to say, diabetes" (Baptist Faith Leader). Further reflecting on a long family history of this condition, this faith leader comedically shared his ideology about diabetes prevention, "My mom says, diabetes runs in our family. So I tell her, then let it run past me! So, I've tried to live in a way that helps that happen. Fortunately, I have not developed diabetes" (Baptist Faith Leader).

One faith leader pointed out how family history, nutrition, and limited treatment options advanced the severity of uncontrolled diabetes across the life course of some of their relatives resulting in the rapid decline of physical mobility and overall quality of life, "So, my family has a line of diabetes. My uncle lost the leg, my aunt was two legs, my mother's eyesight was gone, and everything, and now, my cousin has it." However, further sharing an astute knowledge and

proactive approach to disease prevention, this faith leader was also able to contribute to population health by successfully becoming an organ donor and shared, “I was able to donate a kidney. I had to have certain things in place where I was healthy enough because they don't take your kidney if you're going to be at risk of developing diabetes and kidney disease and things like that” (Baptist Faith Leader).

Mental Health

A faith leader candidly shared how they found empathy for others and life’s purpose while in the midst of mental and emotional uncertainty at one point in life which lead to a commitment to become involved in public health and health promotion. Described as a peak of “deep sadness” and “functional addiction,” the faith leader shared, “I would say that it started at my own crossroads. I don't know the word to put it. A mental breakdown? There was this very deep emptiness that I could not understand.” Further clarifying the symptoms, they experienced, “It was an emptiness. It was sadness. It was a peak of functioning addiction, for me too. I was drinking a lot, I was smoking a lot, and I was just unhappy (Pentecostal Faith Leader).

Finding themselves in a communal environment in what was described as a “healing circle,” the faith leader observed that “everyone was just in such a terrible place… just in life. It was death that they experienced in the family, not knowing what they're going to do, not knowing, my next step, what is happening in life” (Pentecostal Faith Leader). After starting to pray for the “first time in a long time,” the faith leader explained that she began to pray “for everyone sharing,

> “I just started praying for everyone in the circle, including myself, and I remember going to the car and just having this moment where I'm just like, Lord,

> like, this cannot be it! This can't be it!... and that was the moment for me that got me involved (public health). That's when I was led to my faith leader, someone who was actually doing things in the community. A church that was not just to go to church on Sunday, and then go home, and be the same person you are. That's when I was led to real service of always wanting to help people…. and so, in that prayer for service, I found myself serving" (Pentecostal Apostolic Faith Leader).

In the role of Health Advisor at their employment and faith institution, one faith leader discussed the experience transitioning through the stages of change which prompted engagement in health promotion activities specific to the specialty medical condition of cancer care and systems. The firsthand experience of a friend's life course with a breast cancer diagnosis raised awareness around the impact of the illness. It was this experience which led to pursing advanced education about cancer and participation in advocacy efforts leading to advanced research and community support.

Describing their experience further, a faith leader shared, "The trigger was ignorance! One of my really, really, good friends, she had passed with breast cancer, and it was then that I started volunteering with the Cancer Society." "I was 25 years old, living, had a job and everything. She did say that she had cancer, but I had no idea what that meant" (Apostolic Lay Faith Leader). The faith leader further shared, "I had not been close to anyone, but it was in her stage of decline when she said she was going for treatments. I had no idea what that meant" (Apostolic Lay Faith Leader).

After almost 25 years of service, this faith leader further discussed the frustrations of continuing to observe the increased frequency in deaths related to cancer despite many fundraising efforts, "With money that's been raised for cancer, people were still dying"

(Apostolic Lay Faith Leader). However, this faither leader asserts that the need to help others remains a foundation for continued participation in health promotion efforts, specifically around cancer prevention, “I started getting involved, being health advisor, giving information or volunteering. Then, I stopped for a few years because I got so discouraged! Then, you realize, whether you stop or you continue, there's still people that need help (Apostolic Lay Faith Leader).

One faith leader discussed a personal experience with understanding reproductive health and navigating specialized medical care while also having “a place to feel safe enough” and “not embarrassed” to talk about these sensitive issues. “When it comes to my health and how it has made me more aware, I've noticed that I'm growing up and maturing. Going to the GYN, and just being educated about those things like pregnancy and fibroids. I'm creating a community where there's a safe place to not only talk about those things, but also spiritually provide comfort.” (Non-denominational Faith Leader).

These experiences informed the foundations and development of a new initiative, including a women’s ministry at their institution, supporting open communication and information sharing among people with the same concerns*, “*I've created a safe place within our ministry, in the woman's ministry, to make sure that we're vocal about those things and to let people know, “Hey, these are really some common problems, even though they may seem very private, and there's resources out there to help” (Non-denominational Faith Leader).

The excerpts demonstrated how faith leaders’ personal experiences interfacing with the social determinants of health directly informed the development and prioritization of health promotion programming at their institutions and the applicable Stages of Change and Health Belief Models. These included prompts for taking steps toward weight loss, exercise, mental and

emotional health, and the attainment of social support and psychoeducation supporting long term health improvements.

The following provides an explanation of the overarching category, Navigating the Public Health Landscape, and three corresponding themes: Obligation to Become Involved in Public Health, Challenges with Health Promotion Program Development, Public Health as a Social Justice Initiative.

Category B: Navigating the Public Health Landscape.

Theme 3: Obligation to Become Involved in Public Health

Faith leaders expressed deep concern about the declining health and well-being of their congregations and communities at large and felt obligated to intervene quickly and proactively to minimize the negative impact it may cause regardless of one's faith affiliation or denomination.

Growing concerns about population health

Specific action steps employed by the faith leaders in this study included, but were not limited to, using their institutions as hubs for information sharing, increasing access to important prevention information, connecting people to necessary social services, and drawing connections to religious teachings which address one's obligation to care for their own health as a faith ritual.

Another faith leader shared growing concerns about population health and referenced years servicing the community which led to a career in nursing recollecting, "I have been interested in the health and well-being of folks from a young age until today, this is why I got myself involved, and did nursing" (Lay Faith Leader). While now retired, this faith leader reflected on their experience by sharing, "So, I am really, really concerned about people and their

well-being, and the statistics, and to really try to promote wellness and feed them with information that will contribute to their healthy well-being" (Lay Faith Leader).

A faith leader explained how an observation of "need" prompts a requirement to act, regardless of religious denomination or institutional membership, indicating, "See the need, meet the need!" (Methodist Faith Leader). Further explaining religious principles in context, this faith leader indicated:

> "There is, regardless of our differences in belief, there is one general principle that shapes all religions, "Do unto others as you would have them do unto you." I think, regardless of one's faith, religious tradition, we all have a mandate to meet the need of neighbor – and who is our neighbor? Everyone!" (Methodist Faith Leader)

This faith leader further elaborated on the term "everyone" to indicate: "To meet the needs of those who, particularly, who are oppressed, who are on the margins of society, who are downtrodden, so to speak. We have a mandate regardless of what our religious or spiritual affiliation might be." (Methodist Faith Leader)

Faith Leaders' Service During the COVID-19 Pandemic and Institutional Responses to the Social Determinants of Health

The essential work of faith leaders and their institutions during the COVID-19 pandemic highlighted opportunities for gathering important information and strategically organizing interventions to address health and/or other disparities impacting vulnerable populations. One faith leader described involvement in health promotion during the COVID-19 pandemic stating, "We've been hearing a lot about first responders, primarily during COVID-19, and faith leaders

are certainly part of that demographic. We are people who are really out there in the community. We must be in tune with what's happening in the community as well" (Episcopalian Priest).

Questioning the ways in which the social needs of people are addressed with authenticity, one faith leader reflected on a call "to return to church" since the COVID-19 pandemic, and expressed deep concern about current institutional value and whether faith institutions are equipped to appropriately address the needs of the community as evidenced throughout the pandemic:

> "I feel like, in many ways, I'm failing. We're failing. The church is failing our community. After COVID, I was like, get back to church, come back to church… and I'm like, why? Why are people coming back to church? What are you offering? What are you bringing to the table?" (Methodist Faith Leader)

A faith leader further elaborated on the needs of people beyond that of prayers and spiritual guidance to include intervention and management of other social determinants such as education, family, food insecurity, and poverty. Sharing an example of the types of inquires which are made by the public, faith leaders are often tasked with providing help on a wide range of issues:

> "What about the part of being a good steward over yourself, over your resources, over your life over your body? Isn't the faith community absent if we're not showing people how to do that? Yeah, I can pray, but when I get off of my knees, what do I do? I can't live in the church. I need a place to live. I'm hungry. Do you have a sandwich? I don't have any clothes. Do you have a coat? I don't have any money. Can you help me find a job? My kids are bad. Can you help me get

> counseling? My kids are on the street. What kind of youth programs do you have? I don't know how to manage my money. Can you show me how to do it? I need a house. Do you know how to buy a house? I would love to start a business and take care of my family. I don't even know where to start." (Pentecostal Lay Leader)

A faith leader further clarified the importance of faith institutions' being proactive in their strategy to address community needs, especially about health, and "not just kind of a "cookie cutter" approach explaining, "It really is about health, wellness. It really is about the whole person. It is about holistically addressing the needs of the community. Doing some investigating. Doing your research to find out what the needs of the community are" (Methodist Faith Leader).

Theme 4: Challenges with Health Promotion Program Development, Implementation, and Sustainability

Challenges with seeking, accessing, and maintaining financial support.

Faith leaders in this study shared that they faced real challenges with health promotion program development, implementation, and sustainability. A Muslim faith leader shared in this sentiment, "It's a little difficult as a faith leader to survive in New York City" (Muslim Faith Leader). They identified barriers to accessing fiscal resources which support program design and expansion where there is a broader reach of populations served at their institutions.

The depth and frequency of services offered is limited due to administrative and logistical barriers including, but not limited to, changes in leadership, leadership ideology, membership attrition, limited functionality of a volunteer workforce, and other administrative limitations.

Faith leaders explained how financial challenges set limitations on the regularity and sustainability of service delivery at their institution, and current program activities are funded by a donor, one person's personal income, **"**Another challenge is finances. There are things that we would love to do, for the community, but we are a small church. We do not have the budget… and so, we rely, heavily, on donations and relationships and partnerships" (Apostolic Minister).

Other faith leaders spoke to the challenges of understanding grant seeking procedures and limited access to skilled grant writing professionals who can, not only provide successful grant applications, but also to offer comprehensive training to the faith leaders so that they can increase their skills and independence to prepare requests on their own, "You do not have the infrastructure and the access to the to the expertise and the training to do grant writing" (Faith Leader). Another faith leader shared, "….just having that access to healthy grant writers and understanding the processes when it comes to getting funding is helpful" (Faith Leader).

While there have been some very recent improvements in their access to fiscal resources, a faith leader reiterated the difficulty of this burden on one person, "There's been times where, I've seen our leader come out of their own pocket to make things happen" (Apostolic Minister).

One faith leader, involved with interfaith public health advocacy initiatives, alluded to accessing funding as a "mystery," comedically stating, "There is funding out there. I haven't figured out the magic bullet how to get a lot of funding for the type of interfaith work I'm trying to do to make my program sustainable" (Lay Faith Leader).

An Imam, Muslim Faith Leader, described the general responsibilities of faith leaders to ensure that institutional facilities and services are regularly available for their members and that challenges with limited access to funding for operations creates hardships and "it's like a 24/7

job" (Muslim Faith Leader). Further describing this responsibility around fundraising, this faith leader explained:

> Well, in every Masjid, the problem is funding because we don't have funding. A person, whoever is a president or religious leader, it's their responsibility to interact with people, do the online fundraising, or request the fundraisings from different communities, or do the fundraising inside the Masjid (Muslim Faith Leader).

Further explaining their current financial obligations, this faith leader described the increasing operational costs of the Masjid, increase in population served, and stressors associated with ensuring that their roles are adhered to:

> "…right now, our mortgage is $8,500. I have to make sure that this is covered. We have this loan of a million dollars. We can survive easily, right now, because of this loan. My life is done, you know? I am always, like, running around like a beggar. People are not my friend! (Muslim Faith Leader)

Establishing programmatic priorities and getting "buy-in."

Faith Leaders discussed their methods for setting health promotion priorities at their institutions and challenges with managing difference of opinion as it relates to institutional "buy in." One faith leader described challenges with helping people understand that health is a critical element of life as described in the following narrative, "Well, one of the major challenges is, trying to help people understand that their health is their wealth, that being on top of our health is critical! That's one challenge." (Methodist Faith Leader). Further elaborating on challenges, this faith leader explained, "Another challenge, as an institution, is that everybody has different

opinions; everybody has different viewpoints. You know, everybody's not always on the same page with the mission and the vision" (Methodist Faith Leader).

Another faith leader pointed out, "Another challenge is really getting the congregation the buy in; getting them to see that this (health) is an important issue. You can do an assessment on a community, but if the community is not "buying in" to you, what the findings are, or they see the need, it's not going to go anywhere" (African Methodist Episcopal (AME) Faith Leader). Similarly, a Pentecostal faith leader asserted, "Fact is, there are people who don't think the same way about health" (Pentecostal Faith Leader).

Another faith leader shared an example of how nutrition and lifestyle choices are negotiated as a means to demonstrate a health promotion activity among leaders and congregants and explained, "One of the greatest barriers in some of our faith leaders within the church is those who might be resistant to a plant- based lifestyle" (Seventh-day Adventist Faith Leader). Highlighting the faith organization's endorsement of a vegetarian lifestyle, however, some differences of opinion about the advancement of a vegetarian diet may not be completely employed or endorsed by everyone despite the perceived nutritional benefits.

A faith leader described how their faith institution approached the wide range of perceptions, both from leadership and the public, around the COVID-19 pandemic and the ways in which their institution was utilized to increase knowledge about vaccinations, increase numbers of people receiving vaccinations in specific communities, and reducing vaccination hesitancy among vulnerable or marginalized persons. A faith leader indicated, "You have different views about things like, for instance, COVID-19 vaccine. There are a lot of people, even in this church and in leadership, who were not strong proponents" (Pentecostal Faith Leader). This Faith leader further explained that the negotiation process among leadership to

consider becoming a hub for the COVID-19 vaccination was challenging and required a real evaluation around the longer term consequences of not taking action on behalf of members and greater community at large indicating, “We've already lost people in our own church, who if they took the vaccine would still be here today, most likely, you know? So, I accept that there are going to be things that are well embraced, and things that have more controversy that are not.” (Pentecostal Faith Leader)

Management of health promotion program workforces and volunteers.

Participants described other challenges specific to difficulties with program design and implementation to include staffing, specifically, the establishment and maintenance of a consistent volunteer workforce.

When considering taking on a new program or initiative at their institution, a Methodist faith leader described their first thoughts of a viable workforce to ensure programmatic success sharing, “First of all, volunteers! Once you've gotten to a place where you say, okay, this (a health promotion program) is a good fit for us, do we have the volunteers to implement the program?” (Methodist Faith Leader).

Another faith leader echoed this notion by highlighting the importance of strategically planning contingencies, accessibility, and consistency of volunteer workforces, “The other challenge is to find or have volunteers on a consistent basis” (Seventh-day Adventist Faith Leader). Providing an example of a current concern where volunteers are needed at the time of the interview, the same faith leader shared, “For example, right now, today, as we speak, I'm preparing for our health expo. Something happened and the driver couldn't be there, and my challenge, today is to find a volunteer to go and drive the truck.” “So, volunteers are a challenge

because most people, especially in the city, they work two jobs and three jobs." (Seventh-day Adventist Faith Leader).

Volunteer Workforce Development.

When describing the essential roles of volunteers to support successful program implementation, one faith leader described them as a "critical piece" further explaining, "The volunteers, our volunteers, are a critical piece. Volunteers make it happen! So, build up your volunteers, train them on leadership skills, train them on how to serve. Make sure that you are continuously encouraging them because volunteering, it can be very challenging, so, definitely, continue to encourage them." (Lay Leader)

With a focused effort to develop a volunteer workforce which regularly engages with data at their institution, one faith leader with a strong foundation in research, described how data collection is used, "I know the one thing that we fall short on is data collection. You know, within the church, you just do what you do, and you move on." (Methodist Faith Leader).

Describing characteristics of volunteer workforce development including data collection:

> We understand what research is, and that we need to collect, but that's not necessarily important to the volunteer. Volunteers are the people who are, running and implementing the program! They just want to be of help, and that's great, but we have to bring up that level of research and data collection. That's one of the areas that I've been really working on. I think churches, and generally speaking, that's an area that we have to improve on because there's critical data that we're losing (Faith Leader).

Navigating changes in leadership

One faith leader reflected on their experiences around how changes in leadership can contribute to operational and organizational challenges when approaching new methods or initiatives at an institution. Issues with inflexibility and/or resistance can create limitations resulting in reduced morale when differences of opinion are not managed carefully, “I don't really like change so I'm gonna, make sure it's difficult for everybody and everything (Faith Leader).

Further describing a current challenge with organizational leadership, and their lack of success with recent activities, change continues to remain a challenge. One faith leader shared, “So, they've (current faith leadership) been doing it the same way forever and ever and ever… and that's the hindrance, oftentimes, because ministry is dynamic, right? It moves. It changes the way we deliver the model. So, getting people to move with us is a challenge (African Methodist Episcopal (AME) Faith Leader). The faith leader continues to assert, “It's a challenge even if their programs or their ministries had not been successful previously, but it makes it difficult sometimes because we've always done it this way, and so, this is all we know, and you're coming to change it? Many of us are territorial in our ministry” (AME Faith Leader).

Theme 5: Public Health as a Social Justice Initiative

Faith leaders’ multifaceted encounters with diverse populations, many who are vulnerable and/or otherwise at-risk for advanced illnesses, have caused greater concerns for the health and well-being of their congregants and community at large. Their goals to directly improve population health is demonstrated through faith leaders’ proactive approaches to health equity, advocacy and social justice. As highlighted by a faith leader, “I think that we can have

more of an impact if we are mobilizing faith communities more from a social justice lens." (Secular Franciscan Order Lay Leader)

Directly engaging the public

A Faith Leader whose work include providing psychoeducation at their parish explained, in order engage in true assessment, communication with the public is essential: "It's important to actually know who's in the community. I get a sense of that by having conversations with people." (Episcopalian Priest).

This faith leader further discussed that there is a resounding challenge of inequity across social systems and programming at their institution is built around exploring the impact of these issues and building solutions: "Yes, we're people of faith, but we're also citizens in the city of New York. So, what are some of the most pressing issues for people who live in the city of New York? We know those are issues of housing, issues of health care, access to health care, access to housing, food insecurity, and all of those things that are part and parcel of living in New York City at this time." (Episcopalian Priest)

Public Health is public safety

Another faith leader asserted, "Public health is public safety! It's looking at the demographics. It's looking at the needs of the entire community; holistic needs too, not just their physical, but their emotional, their spiritual, their financial, their mental. Everything." (Apostolic Faith Leader). Further linked to the well-being of a community, "Everything goes into public health, and everything that goes into public health also falls under public safety." (Apostolic Faith Leader)

Faith leaders viewed public health as an initiative in social justice and utilized the infrastructure of their institutions to facilitate health promotion activities. From the expectation that a faith leader has the answers to pressing spiritual questions to the perception that faith institutions have ever-flowing resources to immediately alleviate social crisis, faith leaders reported utilizing their institutions as a "hub" in their communities to access public health information.

Developing skills for community and organizational leadership

One faith leader described interfaith initiatives which focus on the professional development of other leaders in social justice, "We teach civic engagement, interfaith dialogue, legislation, policy, advocacy, community organizing, and a couple of other different sort of skill sets. We give grants and give stipends out for people to go back into their communities." (Interfaith Lay Leader)

Another faith leader discussed an extension of public safety through directly training faith leaders on special topics, "I'm working right now with more faith leaders that address gun violence within their community. They act as sort of Cure Violence interrupters, like violence interrupters, within their communities, and we're creating a faith leader training on anti-gun violence." (Interfaith Lay Leader)

Challenges of equity with seeking financial support

A Faith Leader described their experience with seeking and securing funding for their programs and partial knowledge with navigating complex application processes, "All the paperwork, and stuff, is most of the time, really difficult. We have no access to any information

about grants or anything, because technically, even if I see anything, I'm not an expert to apply for it" (Muslim Faith Leader).

Describing further the challenges with fiscal equity, this faith leader explained, "Most of the accountants in our circle, they even are not qualified to help us. It's about who you know! All these new forms, and even, all these fundings people have received during the pandemic, we find out after they're no longer available" (Muslim Faith Leader).

Limited utilization of social workers in faith-based settings.

Faith Leaders in this study indicated limited representation and utilization of social workers on health promotion program teams at their institutions. Social workers have a limited presence on organizational planning and administrative teams and participants in this study expressed that they had limited knowledge about how to incorporate social workers' skills across their greater scope of work. For some institutions, the social workers are primarily called upon to assist with social service referrals, resource coordination, or to help people experiencing an acute crisis during religious services or at health fairs.

One Faith Leader described services provided by social workers at their institutions, "More or less, it has been for like consultation and direction, and, you know, they could help make referrals. They have been able to, kind of, do consultations with people if they had a problem. They will work with that person." (Baptist Pastor).

Another Faith Leader indicated services provided by a social worker are at health fairs, "So, we have a table with resources on it to get people connected to social services in New York. We also had a social worker at that table who could help people get connected to services." (Pentecostal Lay Leader).

For people experiencing an emergency, social workers provide appropriate and relevant referrals for people in need, “Let's say if a sister goes into the “x” ministry, and says, I'm having a problem with this; let's say she needs finances and whatnot, the social worker will know where to send her to get that. This is how to utilize social workers because they're in the system… to send an individual in need of a specific thing (Lay Leader).

Faith leaders described limitations around the extent to which they are able to provide social service interventions due to adverse consequences and issues of professional liability, “We are very careful about how we interact with people. More for consulting purposes because we are not an agency” (AME Pastor).

For faith institutions that have partnerships with larger social services agencies, access to social workers is of strong benefit and helps to reduce the concerns around liability and privacy for the service seekers, “I would say the partnership with Human Resources Administration (HRA) provides us with a consistent flow of professionals in that area. We've even taken ourselves out of roles as the leaders …. we want to let people know that we want to protect their integrity and what they need to release” (Faith Leader).

Conclusion

In conclusion, faith leaders shared important insights about their experiences as public health interventionists. From taking a moment to reflect on their personal health experiences to pinpointing opportunities to target specific social concerns impacting their congregants and communities was evident in their responses. As indicated by the themes emergent from the information gathered, faith leaders consider their roles in public health to be influential. Their

personal experiences are critical elements which sparked organizational changes. Through observing the depth of needs of those around them, they feel an obligation to become involved and identify solutions to solve these problems. Further, faith leaders find that there are operational challenges with facilitating these changes but are committed to taking the necessary steps to excel. Finally, faith leaders reference public health as a social justice initiative which provides for equal access and quality for people of all walks of life. Their institutions and administrative teams are key stakeholders to drive this human rights agenda.

CHAPTER EIGHT

DISCUSSION

The following chapter offers a discussion regarding the key findings from this qualitative study. It was important to examine faith leaders' experiences engaging in health promotion to develop an understanding about the depth of their evolving and expanding roles, the advancement of public health, and their approaches to address the needs of vulnerable populations.

The faith leader's core functions, including their professional use of self, and their navigation of the public health landscape, serve as the foundations for understanding how health promotion programs are conceptualized and executed.

Core functions of a Faith Leader

Faith leaders in this study regularly interfaced across the complexities of the public health landscape and understood their roles to be essential, influential, and diverse. Through proactively investigating the dynamics of the social determinants of health and how these impacted the well-being of individuals and communities which they serve, faith leaders in this study were able to clearly identify the strengths and shortfalls of the systems through which they interacted and reflected on their current standing as change agents across the public health landscape.

Faith leaders in this study noted that they were regularly called upon for spiritual guidance and pastoral counseling and were already serving many people in their communities with diverse social and emotional needs. However, during the COVID-19 pandemic, the depth and severity of social concerns was significantly elevated. Faith leaders reported that they engaged with the public around issues relating to poverty, transportation, food insecurity, physical health, mental

health crisis, homelessness, chronic health conditions, and other factors which contributed to people's poor health. They spoke to the urgency of their involvement in the social issues and the importance of the development of necessary skills to adequately address such a wide range of issues impacting members of their congregations and greater communities at large.

Findings from this study suggested that interfacing directly with the social determinants of health has deepened faith leaders' understanding of the social concerns impacting communities. Furthermore, faith leaders in this study indicated that their personal interactions with the social determinants of health raised an awareness around the elements of, race, class, gender, socio-economic status, and activated a new knowledge around the systematic barriers which exist and impact communities. This study elevates the voices of faith leaders from a lens of social justice and equity by demonstrating how they have been propelled into new spaces for advanced organizing, planning, and broad based-community service.

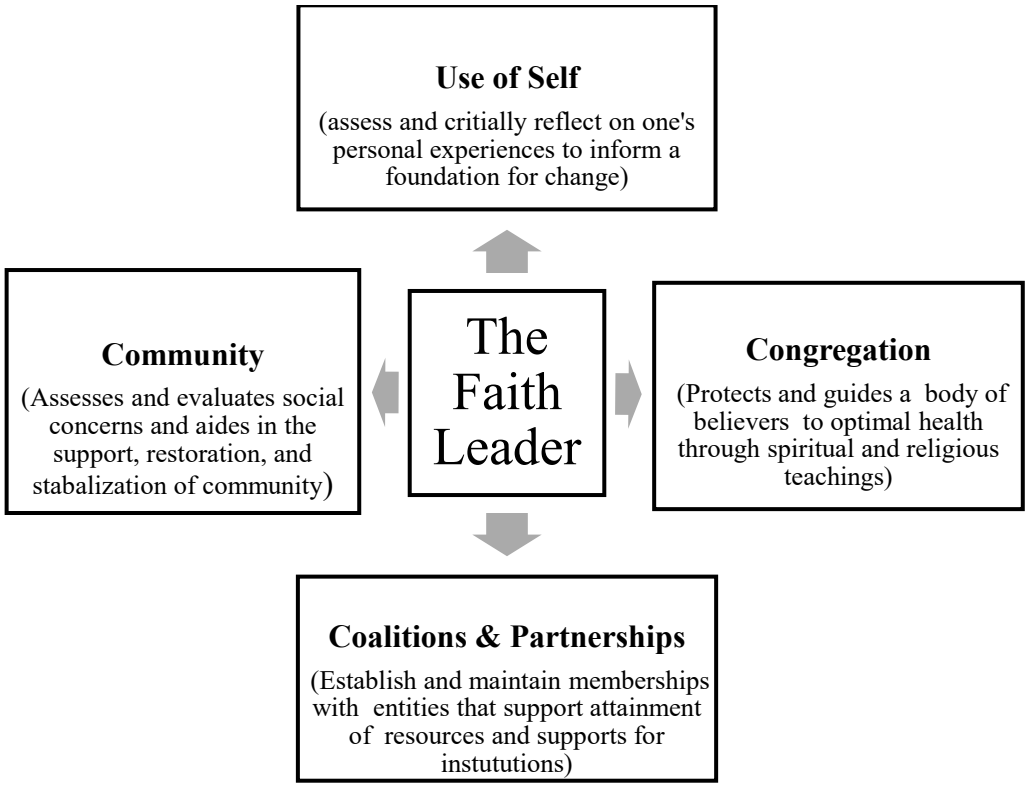
In contrast to previous research around faith leaders involved with public health, the results from this study highlight that faith leaders are essential agents in the advancement of holistic community health. It is through their credibility, unique styles of communication, and inherent profound knowledge of faith-based teachings and interpretations which supports faith leaders with meeting the unique needs of their communities (Anshel, 2013; Baruth et al., 2015).

Findings from this study indicated that the COVID-19 pandemic brought forth unique opportunities to engage with people around the development of their faith and inner strength as a mechanism for coping. This opportunity to engage with people to build strength and resilience could not have occurred without faith leaders' full immersion and understanding of their own influential roles.

Other findings from this study supported earlier evidence around the value of faith leaders' transparency and authenticity when sharing their experiences interfacing with their own personal health journey (Lumpkins et al, 2011). Faith leaders in this study pointed out that their own personal health journey has informed their commitments and contributions to improving population health (Baruth et al., 2014; Campbell et al., 2007; Majee et. al, 2022; Paltzer, 2018;). Faith leaders also highlighted the relationship between scriptures and/or other religious teachings about one's personal responsibility to demonstrate care over their "vessel," or body, and act as "stewards" over oneself. The resounding theme of the importance of "practicing what you preach" laid the foundation for trust and hope to be instilled upon their body of believers, but first starting with the faith leaders themselves.

Furthermore, faith leaders moved through a process of behavior change in direct alignment with the theoretical foundations which grounded this study, the Transtheoretical Model of Change (TTM) and the Health Belief Model (HBM). Faith leaders who identified with the needs and motivations for health behavior changes reflected on their firsthand experiences and acknowledgement of risk, severity, susceptibility, and decision-making implications specific to a health behavior change. It is with this notion that faith leaders discern a process of change beginning with their first personal insights.

Figure 6. A Faith Leader's process for considering how to develop and change health promotion programs at their institutions



Navigation of the Public Health Landscape

The findings from this study supported previous research which indicated that faith leaders are repeatedly called upon for their "world" knowledge, skillful negotiation strategies, and access to resources (Campbell, 2020). From information sharing to serving as key liaisons to health services delivery systems of care, faith leaders are often presented with situations where they were called to respond quickly to de-escalate crisis and act as an advocate for those in need.

Faith leaders in this study utilized their organizations to navigate the public health landscape in the following ways: 1) Regularly and objectively incorporating information about health and health promotion into sermons and keynote messages; 2) Highlighting the areas of scripture or religious teachings to indicate how health promotion is interwoven into faith practices; and 3)

Through the mobilization of volunteers as a specialized workforce around institutional health promotion program agenda.

A key finding in this study highlighted the effectiveness of faith leaders during the COVID-19 pandemic. One example of this included the distribution of Personal Protective Equipment (PPE), water, regular meals, and clothing as faith leaders in this study collectively mobilized and organized their services to meet the overflow of people's needs in their catchment areas. With their focus, flexibility, and willingness to pivot from traditional to new methods of communication, such as virtual and online formats for service delivery, their approaches supported increased access to the public and expanded opportunities for public health knowledge and information sharing.

As indicated in previous research studies, however, faith institutions face real challenges with accessing fiscal resources and rely heavily upon private donors, memberships with community coalitions, and citywide partnerships to support their institutional health promotion program endeavors. Many times, services and activities are funded from one's personal funds (Clerkin & Gronbjerg, 2007; Twombly, 2002; Woodward et al., 2020). This creates a major hardship for some faith leaders who may not be knowledgeable about the processes for access funding support resulting in their programs never starting or ending prematurely.

The New York City Department of Health and Mental Hygiene (DOHMH) Office of Faith Based Partnerships (OFBI) was one of the most widely referenced entities among which faith leaders in this study-maintained membership. Faith leaders sought membership to this group because of its direct link to three key areas: 1) Credible information about health and health promotion; 2) Opportunities to meet as a group regularly to ask questions about best ways to approach health promotion programming with a live person; and 3) Expanded point of access

to information about fiscal resources such as micro-grants which fund health promotion programs for faith institutions.

It is important to point out that while there are many more “faith-placed” grant opportunities available for faith institutions, the “faith-based” program grant opportunity announcements are more readily available and accessible through the OFBI entity, per participants in this study. Additionally, faith leaders made sure to mention that they are challenged by increased access to a wide range of fiscal resources to apply to because they are NOT affiliated with or holders of a 501I(3) tax exemption status. This limits their ability to apply for fiscal support to include private foundations, promotes a dependency on their overarching leadership’s ability to allocate funds for health promotion initiatives, and increases uses of their own personal funds to support programming.

Faith leaders across this study pointed out the necessity to hold membership with some form of specialized coalition or community partnership, such as the OFBI, and to have a forum to discuss their concerns with other like-minded persons. This study underscored the importance of specialized groups for faith leaders, as without this type of professional relationship, many would not have access to critical information or other administrative supports needed to envision the development of new programs or the motivation to participate in new health promotion initiatives. However, with regards to faith leaders who expressed concern about their ability to be considered for grant opportunities due to their parish size, challenges with institutional infrastructure, or lack of recognition as a viable entity to fund, an opportunity for further research exists to explore the reasons more fully.

In summary, this discussion identified the diverse approaches to health promotion program planning and implementation among this group of faith leaders. The depth of passion

for a “better world” was emergent from the narratives of the faith leaders who participated in this study and their efforts to critically reflect on lessons learned from their journeys thus far lays the foundations for further honest, and continuing dialogue between faith leaders and academics.

How do faith leaders develop and change health promotion programs at their institutions? They do it with courage, tenacity, and grit! They do it with a spirit of hope and vison! They do it with a deep mindfulness of their own power and influence and reflective their gifts to successfully assess and evaluate the needs of the community and respond accordingly.

Faith leaders in this study spoke candidly and acknowledged that they have the ear of the community – knowing that people tend to listen to them! Faith leaders are committed to serving, but eager to learn how to expand their services to be better.

Limitations of the study

Every study inherent to their designs has limitations. In this study, limitations included challenges with sample size and sample composition.

Smaller sample sizes in qualitative studies may create challenges with generalizability to a larger population when studying a phenomenon (Trotter, 2012). However, in this qualitative study, the small sample size of participants (n=27) allowed for greater depth during interviews and deeper analysis for the researcher. Additionally, study participants only included faith leaders from the New York City area and faith leaders’ experiences may differ from those serving in other geographic locations including the surrounding tri-state of New Jersey and Connecticut.

Study participants only included faith leaders with affiliations to a faith-based health promotion coalition. Therefore, the experiences of those faith leaders who were not enrolled in a

faith-based coalition were not captured, reducing sample size. Future research studies should consider including faith leaders who are both affiliates and non-affiliates of coalitions to expand knowledge.

There are two major limitations in this study that could be addressed in future research. First, the study could be enhanced by expanding the sampling strategy to include faith leaders from New York's surrounding states which include New Jersey, Connecticut, and Pennsylvania. Second, a recommendation for future research would include an expansion of the study design to include that of a mixed method approach inclusive of small focus groups, the development of a short survey, and an expansion of the semi-structured guide which focuses on fewer key areas thereby allowing more depth based on themes which emerged from the content of this study.

Implications

Social workers regularly engage with individuals, communities, and social systems in a variety of ways. Faith leaders, similarly to social workers, are challenged by the diverse range of social concerns and complex needs for those which they encounter, and in their roles, are expected to successfully minimize the negative impact which may be exist. In faith leaders' efforts to improve quality of life for people and their communities, the information gathered in this study serves as a foundation for further exploration around the benefits of interdisciplinary collaborations between faith leaders and social workers to jointly address population health.

This study contributed to the existing body of social work knowledge in the specialized area of health promotion and explores its implications to expand the development of social work education, advancement of social work practice, and social policy evaluation. The following section provides a summary of implications emergent from this research.

Social Work Education

One of the key findings from this study was that social workers in faith-based settings have been approached to utilize their expertise with regards to crisis intervention and community resource coordination. Regardless of the identified denomination of the social worker or faith institution in this study, social workers were expected to be ready when called upon to have a well-developed working knowledge of navigating social systems, a working knowledge and application of relevant laws and social services procedures when addressing pressing concerns, and the ability to demonstrate appropriate judgment when identifying and employing the most appropriate interventions based on problem scope and severity.

The findings from this study should be considered when evaluating ways to support the creation and enhancement of specialized curricula for social work practice in faith-based settings. Specifically, education which provides real world scenarios or vignettes for students to practice critical thinking about the context of each case can support an evaluation of the functions of race, class, gender, power, and influences. Specifically, fostering opportunities for new and seasoned social work students to explore the interweaving of social work ethics, principles, and spirituality as a normal course of learning diversifies the academic experience. To facilitate opportunities between academic institutions and faith-based organizations to expand social work field placement experiences also supports student development across skill levels and advances critical reflection needed to approach social problems more holistically while rooted in one's foundations of spirituality.

Finally, this study recognizes an expansion of the uses of theoretical frameworks. Used in other disciplines such as psychology and public health, the Health Belief Model (HBM), widely referenced in assessing disease risk and severity and the Transtheoretical Model of Change

(TTM), widely refenced in substance use disorder behavior change and recovery, were traditionally applicable to content outside of social work education. However, this study demonstrated how the uses of the HBM and TTM can be essential points of reference in developing tools which attempt to assess an understanding of one's personal process of decision-making and behavior change as noted throughout among faith leaders in this study. Furthermore, when conducting research which seeks to understand one's experience change, and evaluating self-efficacy and motivations for change, faith leaders in this study indicated that they welcomed an opportunity to engage in a dialogue which prompted reflective questions and indicated that their work did not have many opportunities to do this. Quite limited in their opportunity to self-reflect, the chance to clearly evaluate their rationale for making organizational changes focused on health promotion opened an opportunity for them to consider decision making processes for other areas.

These insights are important to social work education as students engaging in research and working with special populations, such as faith leaders, can develop the courage to diversify their methodologies and expand their cross disciplinary theoretical approaches to apply social work education and practice knowledge.

Social Work Practice

This study presents implications for social work practice through a recognition of the ways in which social work practitioners can facilitate important dialogues with faith leaders as it relates to their goals of improving population with their organizations as a conduit.

This study was intentional in its research design specific to the semi-structured interview guide with the goal of directly inquiring of faith leaders' the foundations for decision making and

health behavior change -first stating with themselves, followed by their organizations. This critical reflection allowed for faith leaders to recall early foundations regarding their start in health promotion and interestingly linked to the needs of the current day. This exploration into the development of awareness and motivation to become involved in health promotion was a parallel process for improvements not only for their organizations, but for themselves.

Centering the faith leader around a moment in time, set, and setting, were critical in creating an opportunity for self-reflection. Many faith leaders indicated that they "had not been asked these" questions about their motivations and hoped that "the same questions would be asked of their leadership" to facilitate a larger discussion about programmatic structure, feasibility, and organizational support. Social workers, trained in the areas of active listening, clinical interviewing, and data collection can utilize these skills to identify key themes which support opportunities for exploration, strengthening therapeutic alliances, and developing relationships with faith leaders as they work in tandem with one another.

The findings from this study built on findings from previous studies around faith leaders' eagerness to intervene to support improving the lives of people in their communities and indicated that they believed that facilitating from their institutions was beneficial. However, faith leaders' resounding concerns about the challenges of establishing and maintaining a well-developed volunteer workforce created challenges with program development and sustainability of programs. While other studies focused predominantly on the types of programs occurring in faith-based settings, and their programmatic outcomes, this study inquired about the issues of organizational "readiness" to facilitate such programs thereby directly exploring the factors which impact program design, sustainability, and feasibility. Social work practitioners are in a unique position to collaboratively learn with faith leaders about the best practices for

approaching data collection and other research methodologies to support improving their organizational design infrastructure.

This study found that there was a limited scope of practice among social workers serving at faith institutions. This study speaks to an opportunity for interdisciplinary collaboration between faith leaders and practitioners to learn about ethical practice which includes, but is not limited to, issues of burnout, healthy boundaries, and practitioner self-care. For example, one of the faith leaders represented in this study highlighted that social workers who attend their congregation may be conflicted with the expectation to respond to a social service need while they are in the middle of a worship experience.

Faith leaders learning from social work practitioners about limitations of practice can serve to reduce the burden of practicing without limits. As faith leaders across the city are searching for ways to creatively brainstorm interventions to address social concerns, reviewing the policies, practice principles, and ethics across disciplines can inform opportunities for effective collaboration. Furthermore, this study also serves as an opportunity for social workers to collaboratively develop streamlined processes which can limit practitioner burnout while also fostering continuity of care.

The data contributes to a clearer understanding of the limited representation and limited utilization of social workers on faith-based health promotion program teams. As previously mentioned, faith leaders continue to assess the social and emotional needs of the community. However, when asked about the presence and scope of work among social workers across their health promotion teams, many faith leaders in this study reported that they either did not have any social workers on these teams, they did not know who the social workers were in their congregations, or if they engaged with a social worker in programming, it was generally around

obtaining advice for a social services program or resource for someone. In some cases, perhaps very basic emergency emotional support for someone who may need it at an event.

Aside from the faith leaders who were social workers themselves and engaged across various facets of health promotion programming leadership at an institution, social workers were the most underutilized and under-represented profession on these teams. With social workers skilled training and expertise in the many areas such as engagement, assessment, research, and community organizing, social workers are positioned to stand firmly in alignment with faith leaders to develop needs assessments to explore current faith institutions' service delivery systems and collaboratively develop new knowledge for advancement.

Social Work Policy

As mentioned earlier in this study, Faith Based Organizations (FBO) are linked to the expansion of the "Charitable Choice" provision of the Personal Responsibility and Work Opportunity Reconciliation Act 1996. With special focus on welfare reform and government's approach to addressing poverty, community-based organizations, such as faith-based institutions, were endorsed to legitimize and expand their service delivery structures. A major part of this expansion was to increase access to government funding to facilitate their operations (Cox 2002; Personal Responsibility and Work Opportunity Reconciliation Act, 1996). While policies around the Charitable Choice Act are revisited periodically through the regular revitalization of the White House Office of Faith Based Partnerships, faith leaders in this study indicated that service delivery at their institutions is limited due to a lack of financial support to facilitate such programs.

While there were faith leaders in this study with the professional and academic capacity to independently navigate grant funding applications, and faith institutions with multiple programs in progress, it was discovered that their programs were directly linked to an external 501(c)(3) non-profit organization which maintained an administrative team to facilitate the fiscal elements of the work. Other faith leaders indicated that they did not have the administrative skills or infrastructure to begin searching for citywide or government grants opportunities, were discouraged by the complexity of grant applications, and had a limited knowledge about the grant seeking processes, thereby reducing their likelihood to apply.

Based on the challenges presented by faith leaders around issues of equity as it relates to grants and funding access, policies should be revisited to ensure that faith leaders have necessary supports to navigate grant funding and applications effectively. Additionally, Faith Leaders should have regular access to specialized training throughout the grant seeking, grant writing, and grant award periods. Furthermore, policies should include ongoing administrative support for faith leaders for a minimum of one year post award in addition to psychoeducation surrounding program sustainability programs which can foster opportunities to secure new grants in the future.

From a social justice lens, social workers are in a unique position to partner with faith leaders in policy advocacy for increasing organizational infrastructure and contribute to access for educational and training opportunities around grant writing, seeking, or other organizational finance procedures. This will support faith leaders with developing the necessary literacy skills needed to increase their propensity to apply for grants. Furthermore, social workers, in partnership with faith leaders and faith-based coalitions, such as the Office of Faith Based Initiatives (OFBI), can engage in assertive community mobilization efforts to advocate for

increased funding opportunities which initiate, sustain, and expand their health promotion programming. Finally, as the role of social workers employed in faith-based settings are limited, increasing funding opportunities to include an expansion of practice can strengthen the faith institution service delivery system.

Future Research

Social work research continues to expand significantly. Areas of future research should include studies about faith leaders and their experiences with implementing health promotion programming utilizing both qualitative and quantitative research designs (i.e., mix-methods). Specific areas of investigation should explore the lived experiences of early career faith leaders who are engaged in health promotion and ordained for five years or less. Research specifically around the lived experiences of female faith leaders, faith leaders who are social workers, and current social workers employed in faith organizations would expand social work knowledge significantly. Faith leaders would also benefit from health promotion training which also includes methods of evaluation around effectiveness as a regular part of their continuing education.

Conclusion

World Health Organization (WHO) research documents a rapid decline in population health across the world including physical, mental, and environmental elements. Furthermore, these indicators are related to one's experiences interacting across environmental systems and navigating the social determinants of health across the life course.

This study fills gaps in social work and health promotion research by taking a deep dive into the lived experiences of faith leaders as they embarked upon processes to assess and address

social concerns of the time. Through examining the ways in which faith leaders understand their "trusted" and "influential" roles to serve as a foundation for capacity building, thereby invoking long term quality of life improvements for the population, this study engaged faith leaders to evaluate their procedures, quality assurance protocols, and trajectories to build health promotion programs rooted in social justice and supported with clear aims and program sustainability protocols.

The foundation and applicability of the TTT and HBM were theoretical frameworks which should be considered more widely across faith-based program research as it can draw our attention to the subject's center – in this case, the faith leader. Research of this type also takes a pointed approach to allow for reflection and critical thinking about strengths and challenges beginning with oneself.

Faith leaders in this study were able to clearly articulate their areas of strength and shortfalls in relationship to institutional operations and highlighted challenges of fiscal equity which impact this non-traditional system of care. With increasing legislative and advocacy efforts to advance and legitimize the work of faith-based institutions, hope is instilled in the lives of faith leaders that they will be able to expand their reach with specialized support and education. Their voices are getting louder, and their messages are becoming clearer. Faith leaders are valuable change agents in communities.

Through exploring the intimate experiences of faith leaders as they discern their involvement across the public health landscape, it is evident that their service begins with honest and critical self-reflection, self-awareness, a stated commitment to growth and change, development of partnerships, and most importantly, courage

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APPENDICIES

Appendix A: Semi-structured Interview Guide
Faith Leaders as Public Health Interventionists

Thank you for your participation in the Faith Leaders in Health Promotion study. The information collected here will help to understand the diverse backgrounds of faith leaders and their experiences with implementing health promotion programs at their institutions. All participation and responses are confidential.

Religious Demographics

1.Please describe your religious denomination/affiliation.
2. Please provide a description of the congregation at your faith institution.

Defining roles of faith leaders

1. Please indicate your formal leadership title at your faith institution.
2. How long have you served as a faith leader at your faith institution?

Faith leaders define their roles health promotion (assessing behavior change)

3. Please describe what inspired you to join the faith-based health promotion coalition?
4. How would you define the following terms:
    - “public health
    - “health promotion”
5. How would you describe your role in public health?
6. What prompted you to get started in the area of public health?
    - What factors contributed to your transition from no action/activities to action/activities?
    - Describe how you went from an initial observation to taking an action to address what you observed.
7. In what ways does your own personal health journey contribute to your decisions to actively engage in health promotion activities/programming?

Strategies utilized by faith leaders to implement health promotion programs
“Health promotion is the process of enabling people to increase control over, and to improve their health.” Health Promotion Glossary, 1998 – World Health Organization.

8. Do you have a health promotion program team?
    - If so, how many?
9. Could you describe any special demographics of your team members?

10. Please describe the types of programs which are currently active at your faith institution.
    - Are the programs facilitated at your institution faith placed programs or faith-based programs?
    - **Would most of your programs be faith based or faith placed?

11. For those programs that were faith placed, and ended, have you continued with the program?
    -

12. Describe your decision-making process for considering which programs to implement at your institution.
    - How did you negotiate priorities?
    - What are some of the factors which contribute to this decision?

13. Tell me about a time when you developed a workgroup/team at your faith institution with the goal of creating a new initiative.
    i. What strategies were used?
    ii. Are social workers a part of your program design planning teams? If so, please describe their roles in working with you?

14. Tell me a success story about implementing health promotion programs.

15. Tell me about some challenges/barriers to implement health promotion programs at your institution?
    - Describe these challenges?
    - If you, could you go back, would you do anything different?
16. How do you negotiate differences of opinion when implementing health promotion programs?

Program sustainability

17. Please describe what you believe keeps your active programs running.
18. On the other hand, for programs that have ended, please describe the factors which contributed to this?

Faith Leaders interface with the social determinants of health (SDH)

19. According to the World Health Organization (WHO) (2021), social determinants of health (SDH) are defined as the "non-medical factors that influence health outcomes." These non-medical factors include, but are not limited to, education, employment, income, housing, food insecurity, environmental conditions, and access (WHO, 2021). The aforementioned factors are essential to the achievement and sustainment of one's well-being.
    - Describe your experiences navigating the social determinants of health in your community.

Faith leaders negotiate systems of care to address Health Equity

20. Please define health equity.

21. Would you please describe the presence of equity and inclusion at your institution?

- What methods or tools are used to evaluate equity and inclusion at your institution?

Faith institutions and their eligibility for fiscal resources and technical support

22. How are the health promotion programs at your institution currently financed?
23. When your institution has an interest in applying for a health promotion programming funding - Request for Proposal (RFP), please describe the process for applying.
    i. Who handles these tasks?
    ii. Is there a designated faith leader who handles these tasks or are they outsourced to other entities?
24. Please describe the factors which contribute to your decisions to apply for funding or not?
    i. Are the elements of parish size, current programming types, backgrounds of leadership considered?
    ii. Do current or previous successes contribute to your decisions to apply for funding? Please explain.
25. How would you describe your faith institutions' ability to competitively apply for citywide/government funding?
    i. Describe your institution's experience with applying for health promotion program grants.

Final reflections

26. How do you remain up to date with the latest trends and research around health promotion?
27. What advice would you give to a **new f**aith leader who was considering starting a health promotion program at their institutions for the first time? What would tell them?
28. What advice would you give to a **seasoned** faith leader who facilitates health promotion programs at their institution?
29. Considering your involvement with a health promotion coalition of faith leaders, what do you envision for the future of your faith institution?

Training

30. Have you received any training in health promotion?
    - If yes, please elaborate on your educational experience.
    - If not, please indicate the reasons for this.

Personal Demographic Information

i. To which gender identity do you most identify?

ii. Ethnic origin: (circle one)

- Black or African American
- Asian or Pacific Islander
- Latino/a/x
- White
- Native American or Indigenous
- Other _____
- N/A _____

iii. Age: _____

iv. Current marital status: (circle one)

a. Single/Never Married b. Married or domestic partnership c. Widowed d. Divorced e. Separated f. Other_____

v. Do you have any children: (circle one) Yes No

vi. Highest level of education completed: (circle one)

- Grade 0 – 8
- Some high school (grade 9 – 11)
- High school graduate
- General Equivalency Diploma (GED)
- Some college
- Trade/technical/vocational training
- Associate degree Specialization: _____
- Bachelor's Degree Specialization: _____
- Master's Degree Specialization: _____
- Professional Degree Specialization: _____
- Doctorate Degree Specialization: _____
- Prefer Not to Answer
- Other_____
- N/A _____

APPENDIX B: Consent Letter

Recruitment Letter: Faith Leaders as Public Health Interventionists

Dear Faith Leader:

My name is Kim Moore, doctoral candidate at Yeshiva University, Wurzweiler School of Social Work. I am requesting your participation in a study about faith leaders and their experiences with implementing health promotion programs at their institutions.

The purpose of the study:
This study examines the lived experiences of faith leaders and seeks to investigate how they develop and change health promotion programs at their institutions. The important insights obtained from this study will offer critical information around the role of faith leaders as ambassadors in public health, gather information about the ways in which faith leaders assess the needs of their communities and access infrastructure support, and take a closer look at the faith leaders' uses of "self" and its relationship to advancing the health and well-being of their communities.

Findings from this research will serve as a framework for faith leaders interested in initiating health promotion programming at their institutions and provide insight into the benefits of linkages with social work practitioners around this implementation process.

Interviews should take approximately 1.5 hours to complete. Additionally, a $25.00 gift card incentive will be given to all participants.

Consent Information: Individual interviews will be used to collect narrative information from respondents. In the interviews, we will gather information about your experiences as a faith leader, inquire about current or prospective health promotion initiatives you are involved with, and your experiences across these systems. To protect confidentiality, your institution and any related affiliations will be removed, and you will be assigned a participant ID number.

Per Federal regulations, all the information collected will remain in the custody of Yeshiva University for three years or until the end of the research project. Any hard copies or relevant information regarding the project will be destroyed.

WCG Institutional Review Board Committee has approved this study.

- Your participation is entirely voluntary and will be de-identified.
- You can discontinue participating in the study at any time without any penalty.
- All written and published information will be reported as group data with no references to faith institution, agency, or names of respondents.

Thank you so much for participating!

Should you have any questions, please feel free to contact the researcher, Kimberly Moore, at Kmoore1@mail.yu.edu or 347.423.2565.

Respectfully,

APPENDIX C: Consent Form

Research Study Title: Faith Leaders as Interventionists in Public Health

Researcher(s): Kimberly Moore, Wurzweiler School of Social Work, Yeshiva University –Wilf Campus, New York

Why am I being asked to participate in this study?

You are being asked to participate in this study because you have self-identified as a faith leader in New York City and a member of a New York City faith-based health promotion coalition.

What is this study about?

The purpose of this study is to examine how faith leaders develop and change health promotion programs at their institutions.

How long will I be in this study?

Should you agree to participate in this study, you will be asked to attend a virtual or in-person interview for a minimum of 60-75 minutes where you will be asked several questions specific to your experience as a faith leader in public health.

What happens if I say yes to participating in this study?

Upon agreement to participate in the study, you will be asked to sign a consent form and an interview time and date will be scheduled. Participating in this study is completely voluntary, and your decision not to participate in the study has no bearing on your relationship with the researcher or other entities which you are affiliated. Each individual interview will last for a minimum of 60-75 minutes.

What happens if I agree to be in this study but change my mind later?

You are welcome to terminate your participation and withdraw your participation from the study at any time without consequence. Should you elect withdraw your participation, the following steps should be followed:

- Inform the researcher via phone, email, or in person
- During the interview, inform the researcher utilizing the relevant platform
- All information that may have been collected will be destroyed

Are there any possible risks to me?

There is minimal to no risk with participating in this study. Should you experience any emotional discomfort at any point during your participation, emotional support is available for you to access independently. A mental health support resource guide will be provided to each participant.

Will I be paid for this research, or will it cost me anything?

There is no fee for participating in this study. While compensation will not be offered to participate in this study, an incentive in the form of a $25.00 gift card will be given in appreciation.

Who can see or use the information collected in this study?

There is some information captured during the interview process that the researcher will need for data analysis processes. You are welcome to identify yourself with initials or pseudonym should this support your comfort level with participating in the study. Since the study is obligated to confidentiality, all identifying characteristics and information of the participants in the study will be removed, and a coding system will be used to protect the identity of the participants. Wurzweiler School of Social Work provides oversight to this study solely for academic review purposes when assisting the researcher. All interviews recorded using a digital recording system. All recordings and demographic data will be coded with a numbering system, and will be kept in a secure locked location, with the researcher's sole access. Electronic copies of interviews and verbal transcriptions will be kept on a password protected file in a cloud server which can only be accessed from the researcher. All information received from participants will only be used during the scope of this study.

Will I benefit from this study?

Participation in this study may benefit you by highlighting the experience of faith leaders and gaining a deeper understanding into the multifaceted roles, attitudes, and motivations of faith leaders to share with the greater academic and research community at large. Furthermore, participating in this study can support reflection around the processes of implementing public health agendas thereby illustrating the importance of faith institutions' credibility as viable health promotion stakeholders.

Who can answer further questions about this research study?

If you have questions or concerns about this study, or have experienced research related problem or injury, contact the researcher, Kimberly Moore, Yeshiva University, Kimberly.moore@yu.edu 347 423 2565.

Dr. Shannon Lane, Associate Professor, Chairperson, Yeshiva University, Shannon.lane@yu.edu 646 592 6817.

For questions or concerns about your rights to speak with someone other than the research team about the study, please contact: WCG IRB 1019 39th Avenue., SE, Suite 120, Puyallup, WA 9837. Email: clientcare@wcgirb.com. Phone: 855 818 2289.

O Yes, I consent

O No, I do not consent

APPENDIX D: Mental Health Resources List

Saint Mark's Place Institute for Mental Health – UNITAS
Contact Info**:** (212) 982-3470
Web Link: https://www.unitas-nyc.org/
Location**:** 57 Saint Marks Place New York, NY 10003

LifeStance Health
Contact Info**:** (845) 279-5908
Web Link**:** https://www.carmelpsychologicalassociates.com/
Locations**:** 122 W 97th Street, Suites 130 &140 New York, NY 10025-6330
110 E 60th Street New York, NY 10022-1694

Blanton-Peale
Contact Info**:** (212) 725-7850
Web Link**:** https://www.blantonpeale.org/counseling/get-started/
Location**:** 7 West 30th Street, 9th & 10th Floors New York, NY 10001

Community Counseling & Mediation
Contact Info**:** (212) 564-6006
Web Link**:** https://ccmnyc.org/
Location**:** 115 West 31 Street, 5th Floor New York, NY 10001

Puerto Rican Family Institute
Contact Info: (212) 229-6942 Ext 1972
Web Link: http://www.prfiorg.com
Location**:** 145 West 15 Street, 5th floor New York, NY 10011

Karen Horney Clinic
Contact Info**:** (212) 838-4333
Web Link: https://www.karenhorneyclinic.org/
Location: 325 E. 62nd Street New York, NY 10011

Comprehensive Therapeutic Services
Contact Info**:** (212) 658-0977
Web Link: http://www.cts-nyc.com
Location: 450 Lexington Ave, 4th For New York, NY 10017

The Fifth Avenue Counseling Center
Contact Info: (212) 989-2990
Website Link**:** https://www.tfacc.org
Location: 5 East 17thStreet, 2nd Floor New York, NY 10003

Metropolitan Center
Contact Info**:** (212) 543-0004
Web Link**:** https://www.metropolitancenter.com/index.php

APPENDIX E

Codebook			
Theme	**Definition**	**Code Name**	**Narrative**
Influential roles in public health	Participants defined their roles as faith leaders to be trusted figures at their institutions and in their communities, and their participation in health promotion has a direct impact on improving overall community health outcomes.	Trust, Spiritual guidance Defining ministry, Listening, Needs of community, Access to information, Public health content found in religious texts, Inclusivity	"One thing I have learned through my work, many years of this work is that faith leaders are the trusted sources within their communities."
Obligation to become involved in public health	Participants expressed a strong desire to be actively involved in public health initiatives with a view towards prevention and reduction of risks associated with poor health and social concerns.	Religious test/teachings about good health, Message of hope, Create opportunities for psychoeducation, prevention, and advocacy efforts, Vulnerable people, social determinants of health (SDH), Poor health, Illness/Sickness, Health Conditions, People are getting sicker, Mental Health, Diabetes, Obesity Hypertension, Older Adults, Children, Literacy	"Much of what I'm called to do is to continue Jesus's ministry to people, people's bodies and minds and I think that public health addresses that ministry…"
Personal health behavior change motivates and informs organizational changes	Participants reflected on their personal experiences with health and explained how their discovered awareness motivated the initiation of services which support improving the health and well-being of their congregants and communities	Transtheoretical Model of Change/ Stages of Change Health Belief Model, Behavior, Thinking about health,	"I ran a weight watchers health ministry group for five years. I have a couple of people that told me I saved their lives."
Challenges with health promotion program development, implementation and sustainability	Participants described the multifaced organizational challenges with developing, implementing, and maintaining health promotion programs at their institutions to include fiscal, operational, and ideological elements.	Limited funding, Challenges with navigating complex government and social systems, Donations Getting "buy-in", Establishing priorities Volunteers, Differences in skills , Limited workforce skilled in program design, fund-raising, and development , 501(c)(3) / Third Party entities apply	"There is funding out there. I haven't figured out the magic bullet about how to get a lot of funding for the type of work I'm trying to do in order to make my program sustainable."

		for grants, Limited scope of practice and utilization of social workers	
Public health as a social justice initiative	Participants described the tenants of social justice to include efforts which advance population health and faith leaders/institutions to achieve health equity.	Public health is public safety, Advocacy, Health Equity, Increase access to resources, Wide reach of diverse populations, Isolation, Needs of people, Membership with health promotion coalitions , Organizational partnerships	"I think that we can have more of a impact if we are mobilizing faith communities more from a social justice lens"