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ORIGINAL PAPER

An Examination of Denomination-Level Efforts in Congregation Health Programming

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Abstract
Large denominational faith-based organizations (FBOs, e.g., conferences, dioceses) have potential to impact population health, though current activities are largely unknown. This study examined how large denominational FBOs approach health promotion programming and relevant barriers and issues related to capacity. A self-report survey via email and mail collected responses from representatives of FBOs about their health programming. The sample (n = 154) was diverse and included Catholic, Presbyterian, and Lutheran traditions. The most common activities were inclusion of health-related topics at organizational events and the provision of educational resources. Working with FBOs at a macro-level has potential implications for population-level health improvements.

Keywords Denomination · Environment · Health promotion · Capacity

Introduction

Faith-based organizations (FBOs) have been a consistent partner for health promotion as well as offering their own programming (DeHaven et al. 2004). These institutions offer an opportunity for widespread reach within the community as well as an opportunity to build culturally tailored programs around the extensive social support networks found in FBOs. Data from the Pew Forum on Religion in the Public Life indicated that in 2014, more than 75% of American adults report some kind of religious affiliations, and attendance at religious services at least once a week is estimated between 20 and 36% (Hartford Institute for Religion Research 2012; Pew Research Center 2014). Higher attendance is reported among older adults, women, and ethnic minority groups, indicating that FBOs are a good place to reach underserved populations who are in need of health-related programs (Pew Research Center 2014).

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Though numbers vary based on the definition, it is estimated that there are more than 200 denominations in the United States (USA), with the Roman Catholic Church (67 million members), Southern Baptist Convention (16 million members), and United Methodist (8 million members) as the largest reported denominations (Hartford Institute for Religion Research 2012; Pew Research Center 2014). It is common in the USA that denominations often mirror a hierarchical structure, with a national organization overseeing regional organizations (e.g., convention, diocese, conference, district, presbytery), and in turn, these organizations oversee individual congregations (Zech 2003). Within each denomination, doctrine remains fairly consistent across the USA; however, logistics and operational procedures vary widely depending on the degree of autonomy granted to individual congregations. For example, the Southern Baptist Convention (1992) resolved that individual congregations affiliated with the denomination are autonomous bodies, "with full power and authority to conduct its own affairs and is thus free from any power of coercion by other local churches or any general Baptist body." Other denominations, such as the United Methodists have a well-established infrastructure and allocate resources related to health that is easily disseminated to conferences and individual churches (United Methodist Church 2018). One of the main benefits for delivering health promotion programming within a denomination is the opportunity to develop strategies that are culturally and spiritually tailored to the population. This approach also allows for working within denomination structure in terms of communication, organization, and existing ministries.

Within individual congregations, the decision to deliver health-related activities is often made by a clergy member with input from other key congregational leaders and volunteers (Levin 2014). Therein, support for health-related programming from the denomination for clergy from individual FBOs is a critical element. A survey of more than 900 clergy from different denominations revealed that having support from the denomination was essential and was related to individual FBOs offering more health- and wellness-related programming (Bopp and Fallon 2011). A qualitative study with Christian clergy also voiced the importance of support at the denomination level for logistical support and resources, as well as the development of organized initiatives, such as health ministries or parish nursing programs (Bopp et al. 2014). This study also noted how denominational doctrine could influence the perception of health, including interpretation of how the Bible discusses health, holistic views of health, and the importance of stewardship.

The potential for widespread reach for programming by implementation and dissemination through FBOs is a relatively untapped resource, though some initiatives have recognized the prospective benefits. For example, in the National Physical Activity Plan Faith-based sector, one of the suggested strategies included working within large FBOs and denominations to help with developing and delivering tailored physical activity programs for constituents (National Physical Activity Plan Alliance 2016). Some denominations have already laid the foundation for health promotion. For example, the United Methodist Church has outlined a framework for health ministries, targeting both clergy and congregation health (UMC Health Ministry Network 2017). Other denominations have instituted health ministries that provide parish nurses and other resources aimed at promoting the health of the congregation (AME Health Commission 2018; LCMS Health Ministry 2018). Despite the documented importance of denomination-level support, relatively little research has addressed how denominations can support individual FBOs to deliver health and wellness programming. Therefore, the purpose of this study was to examine how large denominational FBOs (e.g., conferences, dioceses, conventions) approach health promotion programming and to document barriers and issues related to capacity and how these influence health programming.

Methods

Participants and Recruitment

The largest denominations within the USA were identified (Pew Research Center 2008), including both Catholic and Protestant (Baptist, United Methodist, Lutheran, Presbyterian, United Church of Christ, African Methodist Episcopal, Pentecostal) traditions.

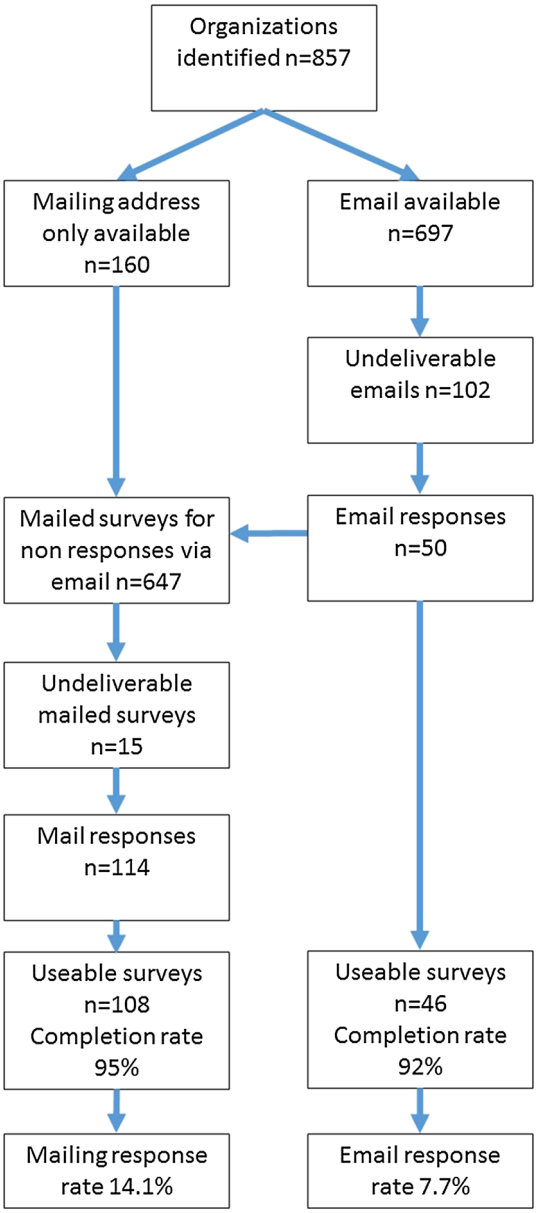

Fig. 1 Recruitment and response rate (n = 857)

Recruitment is shown in Fig. 1. Regional organizations for each of these denominations were identified (n = 857, e.g., dioceses, conferences, conventions), and the Web sites of each organization were examined for contact information for the leader of the overall organization or a representative whose responsibilities for the organization included health (the preferred contact). An initial email was sent to this individual inviting them to take part in the study and encouraging them to forward the email to another individual within their organization if they didn't feel prepared to answer questions about health in their organization. A link in the email took participants to an informed consent statement and then into the web-based survey (Qualtrics, Provo, UT). An email reminder was sent to the same email one and 2 weeks after the initial invitation. For organizations where we were unable to identify an email, a paper copy of the survey was sent along with a cover letter introducing the study and the informed consent statement. A postage-paid envelope was provided for return of the survey. Additionally, for those who were invited via email and did not respond or had an undeliverable email, a paper version of the survey was mailed. The final overall response rate for the survey was 20.9% (n = 154). This study was approved by the institutional review board at Pennsylvania State University and is in compliance with all ethical standard practices of research.

Measures

Organizational Demographics

Representatives were asked to report how many individual churches were a part of their organization, what their primary religious affiliation was (open-ended), and what region of the country they primarily served from a standard list of nine US Census regions (cite). Religious affiliation was categorized by the primary denomination, resulting in seven specific denominations and one category for other.

Health Programming Details

Organizations were asked to report whether they had an organized health ministry (yes/no), a parish nursing program (yes/no) and how it was staffed (with volunteers, paid staff, or combination of both), and if their organization had any affiliation (yes/no) with hospitals, clinics, nursing homes or foundations specifically related to health. Respondents indicated (yes/no) if their organization had received external funding for health promotion programs in the past 5 years, and how aware their organization was of external funding opportunities for health (1–10 scale from 1 = not aware at all to 10 = very aware). Respondents were asked to indicate (yes/no) if their organization offered any activities targeting congregation member health, including: trainings or workshops to build capacity for health promotion among clergy or lay leaders, inclusion of health-related topics at organizational-level events, and the provision of ready-made health programs, educational resources, Web sites or tools targeting congregation members. A sum of the number of activities offered by the organization was computed. Using a 1–10 scale (1 = not at all interested to 10 = very interested), respondents indicated whether their organization would be interested in partnering with outside organizations for developing and delivering health promotion programs.

Importance of Health-related Programming

Participants used a 1–10 scale (1 = not at all important to 10 = very important) to respond to two questions: how important it was for their organization to provide health-related activities, education and programming for church members and how important it was for their organization to provide churches with resources and tools related to promoting health among their members. An open-ended question was asked about the reasons why it is important for the organization to include health in organizational activities. These responses were analyzed for major themes, and categories were identified. The responses were then coded into these categories, and the frequency of categories was noted.

Barriers to Health Programming

Based on common barriers to health programming noted in previous studies (Bopp and Fallon 2011, 2013; Campbell et al. 2007; Peterson et al. 2002), a list of eight possible barriers were presented to respondents, and they were asked to indicate (yes/no) what some of the organizational barriers to health promotion for church members, including a lack of trained staff, financial resources, space for activities, technological resources, interest from clergy or organizational leadership, as well as competing interest with other church events and a wealth of other options for health already available in the community. Respondents were then asked to select items which were the top three barriers to programming for their organization.

Analysis

Basic descriptive statistics and frequencies were used to describe the sample and responses. Differences by denominational affiliation were examined via ANOVAs and χ^2 tests. For all denominational differences, the "other" category was not included, since it represented multiple traditions and was not representative of any one denomination. Cramers's V was used to further examine the association between categorical variables. Significance values were set at $p < .05$, and all analyses were conducted in IBM SPSS, version 24.0 (IBM, Armonk, NY).

Results

The demographics of the sample ($n = 154$) by denomination are shown in Table 1. Catholic traditions ($n = 33$) were most commonly represented, followed by Presbyterian ($n = 29$) and Lutheran traditions ($n = 29$). These organizations were primarily from the Great Lakes region ($n = 51$), Gulf Coast ($n = 27$), and Mid-Atlantic ($n = 25$) regions. Organizations reported that 130.91 ± 123.93 individual churches were a part of their organization, and all organizations together reported that 20,842 individual churches were represented by these 154 organizations.

Methodist respondents most frequently reported having an organized health ministry ($n = 7$, 70%), whereas Lutheran respondents most frequently reported having a parish nursing program ($n = 17$, 60.7%), though neither of these were statistically significant findings ($\chi^2 = 7.79$, $df = 6$, $p = .24$ and $\chi^2 = 10.68$, $df = 6$, $p = .09$, respectively). Most denominations reported some affiliation with nursing homes, hospitals, community clinics or health-related foundations. Catholics were most likely to report affiliation with hospitals

Table 1 Demographics of the sample (n = 154)

Variable	Episcopal (n = 13)		Baptist (n = 18)		UCC (n = 13)		Lutheran (n = 29)		Catholic (n = 33)		Methodist (n = 12)	
	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)
Number of churches in the organization		69 (38.3)		237.3 (193.6)		121.4 (71)		158.2 (153.2)		111.1 (58.3)		184.3 (133.7)
Region of the country												
Northwest	1 (7.7)		2 (11.1)		3 (23.1)		6 (20.7)		4 (12.5)		1 (8.3)	
Southwest	1 (7.7)				1 (7.7)		1 (3.4)		2 (6.3)		1 (8.3)	
Great Lakes	5 (38.5)		2 (11.1)		3 (23.1)		16 (55.2)		11 (34.4)		5 (41.7)	
Gulf coast	1 (7.7)		8 (44.4)		0		3 (10.3)		7 (21.9)		1 (8.3)	
New England	0		1 (5.6)		3 (23.1)		0		1 (3.1)		0	
Mid-Atlantic	4 (30.8)		1 (5.6)		3 (23.1)		2 (6.9)		4 (12.5)		2 (16.7)	
South Atlantic	1 (7.7)		2 (11.1)		0		0		1 (3.1)		2 (16.7)	
Southeast	0		2 (11.1)		0		1 (3.4)		1 (3.1)		0	
Pacific Islands	0		0		0		0		1 (3.1)		0	
Has received external funding for health (%)	1 (7.7)		2 (11.1)		1 (7.7)		14 (48.3)		6 (18.2)		1 (8.3)	
Awareness of external funding for health (1–10 scale)		3.17 (2.48)		2.19 (1.68)		2.45 (2.69)		3.57 (2.25)		3.21 (2.34)		3.18 (1.88)
Has organized health ministry (%)	3 (25)		4 (28.6)		3 (23.1)		13 (48.1)		12 (37.5)		7 (70)	

Table 1 continued

Variable	Episcopal (n = 13)		Baptist (n = 18)		UCC (n = 13)		Lutheran (n = 29)		Catholic (n = 33)		Methodist (n = 12)	
	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)
Has parish nursing program (%)	5 (38.5)		4 (23.5)		4 (30.8)		17 (60.7)		11 (34.4)		6 (54.5)	
Number of activities (SD)		1.58 (1.83)		1.27 (1.96)		1.61 (1.32)		2.41 (1.89)		1.28 (1.60)		2.36 (1.43)
Parish nursing program staffing												
With volunteers	5 (100)		1 (25)		1 (33.3)		5 (25)		4 (36.3)		2 (33.3)	
With paid staff	0		1 (25)		0		23 (30)		2 (18.1)		1 (16.7)	
With a combination	0		2 (50)		2 (66.7)		9 (45)		5 (45.4)		3 (66.7)	
Affiliation with healthcare organizations												
Hospitals	1 (8.3)		8 (44.4)		1 (7.7)		8 (27.6)		18 (58.1)		7 (58.3)	
Community clinics	1 (8.3)		5 (27.8)		0		4 (13.8)		4 (12.9)		2 (16.7)	
Nursing homes	4 (33.3)		6 (33.3)		5 (38.5)		14 (48.3)		14 (45.2)		5 (41.7)	
Foundations related to health	1 (8.3)		2 (11.1)		2 (15.4)		9 (31)		1 (3.2)		1 (8.3)	

Table 1 continued

Variable	Episcopal (n = 13)		Baptist (n = 18)		UCC (n = 13)		Lutheran (n = 29)		Catholic (n = 33)		Methodist (n = 12)	
	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)	n (%)	Mean (SD)
Importance of offering health-related activities, education and programming for church members (1–10 scale)		5.50 (2.39)		5.78 (2.23)		4.77 (2.13)		5.32 (2.23)		5.83 (2.76)		5.30 (2.75)
Importance of providing churches with resources and tools for promoting health (1–10 scale)		6.08 (2.78)		6.00 (2.03)		5.54 (2.02)		6.36 (2.21)		5.90 (2.73)		5.20 (2.78)
Interested in partnering with outside organizations for health promotion programming (1–10 scale)		5.08 (2.23)		5.78 (2.34)		5.15 (2.96)		5.29 (2.31)		5.19 (2.75)		7.09 (2.02)

Table 1 continued

Variable	Presbyterian (n = 29)		Other (n = 4)	
	n (%)	Mean (SD)	n (%)	Mean (SD)
Number of churches in the organization		74.5 (82.2)		86.7 (12.6)
Region of the country				
Northwest	4 (13.8)		0	
Southwest	0		0	
Great Lakes	8 (27.6)		1 (25)	
Gulf coast	6 (20.7)		1 (25)	
New England	1 (3.4)		0	
Mid-Atlantic	8 (27.6)		1 (25)	
South Atlantic	1 (3.4)		0	
Southeast	1 (3.4)		1 (25)	
Pacific Islands	0			
Has received external funding for health (%)	2 (6.9)		0	
Awareness of external funding for health (1–10 scale)		2.11 (1.73)		3.28 (2.14)
Has organized health ministry (%)	8 (28.6)		1 (25)	
Has parish nursing program (%)	8 (27.6)		0	
Number of activities (SD)		1.45 (1.59)		1.00 (1.15)
Parish nursing program staffing				
With volunteers	4 (50)		0	
With paid staff	1 (12.5)		0	
With a combination	3 (37.5)		0	
Affiliation with healthcare organizations				
Hospitals	5 (17.2)		3 (75)	

Table 1 continued

Variable	Presbyterian (n = 29)		Other (n = 4)	
	n (%)	Mean (SD)	n (%)	Mean (SD)
Community clinics	1 (3.4)		1 (25)	
Nursing homes	8 (27.6)		4 (100)	
Foundations related to health	4 (13.8)		1 (25)	
Importance of offering health-related activities, education and programming for church members (1–10 scale)		5.21 (2.61)		3.50 (1.92)
Importance of providing churches with resources and tools for promoting health (1–10 scale)		4.76 (2.29)		4.25 (2.22)
Interested in partnering with outside organizations for health promotion programming (1–10 scale)		4.34 (3.23)		3.25 (1.71)

Table 2 Health promotion activities offered (n = 154)

Activity	Episcopal (n = 13) n (%)	Baptist (n = 18) n (%)	UCC (n = 13) n (%)	Lutheran (n = 29) n (%)	Catholic (n = 33) n (%)	Methodist (n = 12) n (%)	Presbyterian (n = 29) n (%)	Other (n = 4) n (%)	χ^2	Cramer's V
Trainings or workshops for clergy or church leadership on health-related topics with the purpose of building capacity for health promotion in churches	2 (16.7)	3 (16.7)	1 (7.7)	9 (31)	6 (20.7)	5 (45.5)	4 (18.2)	1 (25)	7.07	0.23
Trainings or workshops for lay leaders/members on health-related topics with the purpose of building capacity for health promotion in churches	1 (8.3)	2 (11.1)	2 (15.4)	5 (17.2)	4 (13.8)	5 (45.4)	1 (4.5)	0	10.71	0.28
Inclusion of health-related topics at organizational-level events	5 (41.7)	6 (33.3)	7 (53.8)	16 (55.2)	11 (37.9)	4 (36.4)	8 (36.4)	2 (50)	3.97	0.17
Provision of ready-made health programs to churches	1 (8.3)	4 (22.2)	0	9 (31)	3 (10.3)	2 (18.2)	3 (13.6)	0	9.01	0.26
Provision of educational resources to pass along to church members	5 (41.7)	4 (22.2)	9 (69.2)	18 (62.1)	8 (27.8)	5 (45.5)	7 (31.8)	1 (25)	15.12*	0.34*
Provision of a Web site tailored to church member health	3 (25)	3 (16.7)	2 (15.4)	6 (20.7)	3 (10.3)	3 (27.3)	5 (22.7)	0	2.63	0.14
Provision of tools for churches to deliver health-related activities to their members	2 (16.7)	1 (5.6)	0	7 (24.1)	2 (6.9)	2 (18.2)	4 (18.2)	0	7.65	0.24

*$p < .05$

(χ^2 = 22.93, *df* = 6, $p < .001$). Lutherans (n = 14, 48.3%) most frequently reported that they had received external funding for health, though there was no statistically significant difference for awareness of funding opportunities (F = 1.63, p = .14). There were no statistically significant differences in the number of activities offered by denomination (F = 1.69, p = .13). Interest in partnering with outside organizations for health promotion was moderate, and there were no statistically significant differences between denominations (F = 1.56, p = .16).

Types of health promotion activities offered are shown in Table 2. Overall the most common activity across all denominations was inclusion of health-related topics at organizational events (n = 59, 41.8%), followed by the provision of educational resources (n = 57, 40.4%). The only statistically significant difference for offering activities was the provision of educational resources (χ^2 = 15.12, *df* = 6, p = 02); Lutherans reported providing twice as many education resources to pass along to church members than other denominations.

In terms of the importance of the organization to provide health-related activities, education, and programming for congregation members, respondents indicated it was moderately important (5.38 ± 2.44, range 0–10). There were no statistically significant differences between denominations for this item (F = .39, p = .88). Similar findings were reported regarding the organization providing resources and tools related to promoting health to individual churches (5.66 ± 2.41, range 0–10), with no statistically significant differences by denomination (F = 1.29, p = .26). The open-ended question regarding why it is important for the organization to include health in organizational activities yielded a number of responses. The most common responses were a link between spiritual health (n = 21) and an emphasis on stewardship and self-care (n = 21). Other responses included a concern with general laity well-being (n = 10) and to address the needs of the congregation (n = 9), while only a few (n = 2) indicated that it was not important.

Organizational barriers to offering activities to promote health among church members are found in Table 3. Across all denominations, a lack of financial resources for programming (n = 115, 74.7%) and a lack of trained staff (n = 109, 70.8%) were the most commonly cited barriers and noted to be the top barriers (resources n = 71, 46.1%, staff n = 74, 48.1%). Lutheran respondents were more likely to report a wealth of other options for health in the community as a barrier to offering activities (χ^2 = 16.17, p = .01) compared with other denominations. There were no other denominational differences for noted barriers or top barriers, though a lack of organizational leadership interest approached significance (χ^2 = 11.33, p = .07, Cramer's V = 0.28, p = .08).

Discussion

This study is among the few to examine programming for health within larger FBOs. The respondents from this study represented more than 20,000 FBOs from the largest denominations within the USA, providing insight into institutional-level influences on health for many Americans. Within other community institutions, such as schools or healthcare organizations, macro-level approaches have been more common, disseminating strategies through a larger organization (e.g., school district) that connects many smaller organizations and provides support. FBOs have not typically employed these methods; however, the findings from this study imply that this could be a fruitful strategy.

In terms of capacity, these organizations reported a wide variation in their ability to plan and implement health-related programs and disseminate these programs through their

Table 3 Organizational barriers to offering activities to promote health among church members (n = 155)

Barrier	Episcopal (n = 13) n (%)	Baptist (n = 18) n (%)	UCC (n = 13) n (%)	Lutheran (n = 29) n (%)	Catholic (n = 33) n (%)	Methodist (n = 12) n (%)	Presbyterian (n = 29) n (%)	Other (n = 4) n (%)	χ^2	Cramer's V
Lack of trained staff	7 (53.8)	13 (72.3)	12 (92.3)	19 (65.5)	28 (84.8)	7 (63.6)	20 (69)	3 (75)	9.39	0.25
Lack of financial resources	7 (53.8)	15 (83.3)	11 (84.6)	22 (75.9)	28 (84.9)	9 (81.8)	21 (72.4)	1 (25)	4.17	0.17
Lack of space to offer activities	1 (7.7)	4 (22.2)	5 (38.5)	7 (24.1)	11 (33.3)	2 (18.2)	7 (24.1)	1 (25)	5.07	0.19
Lack of technological resources to offer activities(e.g., Web site design)	1 (7.7)	3 (16.7)	2 (15.4)	2 (6.9)	8 (24.2)	3 (27.3)	6 (20.7)	2 (50)	4.97	0.18
Lack of interest from clergy to include their churches	10 (76.9)	10 (55.6)	10 (76.9)	19 (65.5)	21 (63.6)	7 (63.6)	19 (65.5)	2 (50)	2.6	0.13
Lack of interest from organizational leadership	6 (46.2)	6 (33.3)	9 (69.2)	8 (27.6)	10 (30.3)	6 (54.5)	16 (55.2)	1 (25)	11.33	0.28
Competing interests with other church events	8 (61.5)	9 (50)	10 (76.9)	20 (69)	19 (57.6)	8 (75)	16 (55.2)	4 (100)	3.82	0.16
A wealth of other options for health in the community means the church does need to offer these things	7 (53.8)	2 (11.1)	5 (38.5)	19 (65.5)	16 (48.5)	6 (54.5)	18 (62.1)	2 (50)	16.17**	0.33*

UCC United Church of Christ

*$p < .05$, **$p < .01$

network of churches. One concern was the relatively limited capability for seeking funding and the minimal awareness of opportunities for funding. For many FBOs, offering any type of program outside of the organizations typical services necessitates looking for additional resources, either personnel, technology or financial. Organizations who do not have a strong background in seeking outside funding may limit their ability to expand their health-related offerings. The current study also revealed that a lack of trained staff and financial resources impacted programming at the denominational level, similar to findings at the individual church level (Bopp and Fallon 2011; Campbell et al. 2007; Levin 2014). The compounded barriers of perceived lack of resources and capacity at the denomination level will certainly trickle down to individual congregations, resulting in less health-related programs.

Our findings indicated that there were some denominational differences with organized health programs, health ministries and parish nursing programs. A recent review of parish nursing highlighted the breadth of interventions and programming that these initiatives can address, with an emphasis on how support at the denomination level is essential for success (Dandridge 2014). Well-designed parish nursing programs can support many of the goals and objectives laid out in Healthy People 2020 (Pappas-Rogich and King 2014; U.S. Department of Health and Human Services (USDHHS) 2012). Many FBOs reported an affiliation with hospitals, clinics or nursing homes, suggesting an opportunity for expansion or collaboration to build capacity for health-related activities. Levin (2016) suggests that there is a long-standing connection between FBOs and medical sectors and indicates opportunities for collaboration to serve the broader population, especially underserved populations.

The findings indicated that, for the most part, FBOs didn't perceive health-related programming to be very important. Although there were some differences between denominations, overall, this was an unexpected finding, given that there is significant research indicating that FBOs perceive a link between faith and health and that there is support for it within their doctrine (Bopp et al. 2014; Levin 2014; Webb et al. 2013). This is also in line with the finding that FBOs cited competing interests within their organization and the availability of other options for health in the community as barriers to health-related program offerings. However, FBOs did indicate that the provision of resources for health to individual churches was important, indicating that the "trickle-down" effect could be a good strategy for widespread dissemination of health-related programming. Baruth et al. (2013) noted the importance of clergy and support from the denomination for these clergy further supported implementation of health-related programming, which has been confirmed with other research (Bopp and Fallon 2011). This further emphasizes the importance of higher-level support for individual churches to be successful with health-related programming.

Working at the denominational level has proven effective previously. The Health-e-AME and Faith, Activity and Nutrition studies have include the 7th Episcopal district of the African Methodist Episcopal church (Wilcox et al. 2007a; b, 2010, 2013). These series of projects used a community-based participatory model and included church leadership (e.g., the Bishop, church elders) in all phases of program planning, implementation and evaluation. Activities included both individually focused programs (e.g., praise aerobics, behavior change classes) and strategies to target church physical and social environment as well as policy. All materials were designed to be culturally and spiritually tailored to the population and church leaders helped to include elements of scripture and church doctrine into materials. Delivery of these interventions to large portions of churches throughout South Carolina allowed for the inclusion of intervention-related activities at statewide

church events (e.g., conferences and meetings), creating a sense of support between churches as they delivered the interventions (Wilcox et al. 2007b, 2013). These types of denomination-level strategies should be further explored for informing the development of tailored strategies.

Federal initiatives, such as the Center for Faith-Based Neighborhood Partnerships, have stressed the importance of partnerships between FBOs and other community entities in order for large-scale community programs focused on health to succeed (U.S. Department of Agriculture 2017). Despite this, results in the current study indicate that FBOs are not particularly interested in partnering with other organizations for health-related programming. This is unfortunate in that FBO partnerships with public health departments, academic institutions, healthcare organizations, and other entities have proven to be effective in improving health as well as expanding reach (Duff and Buckingham 2015; Levin 2014; Zahner and Corrado 2004). Related to this, the finding that many FBOs indicated that the plethora of health-related opportunities already available in the community was a barrier to delivering health programming within the FBO indicates that further partnerships may help to expand the reach of existing programs or provide congregation members with additional opportunities for health-related activities.

Although this study yielded a number of important findings, there are a number of limitations to consider. The sampling strategy attempted to gather information from the largest denominations in the USA, though this is not comprehensive enough to address all faith-traditions, especially with a growing number of non-denominational FBOs. The topic of the survey may have also led to some response bias, with those organizations more heavily involved in health more likely to respond. There is also potential for bias with the self-report survey. Organizations may not be able to accurately report on their activities, and responses to the perception questions likely represent the attitudes of the individual responding to the survey and may not reflect the entire organization. Lastly, we are limited in our generalizability to denominations not well represented in the sample.

Despite these limitations, these findings provide some insight on a previously unexplored issue: how large FBOs address health and the implications for their individual-level churches. With the extensive reach of FBOs across the USA, the capacity for delivering health-related programs is a relevant issue for public health. The potential for the development, implementation and evaluation of culturally and spiritually tailored initiatives that support health and positive health behaviors is tremendous and merits further study. Working at a macro-level has great potential for dissemination and sustainability with implications for population-level health improvements.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest to report.

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