CE 3.0 contact hours

ABSTRACT: *High mortality rates continue among African Americans related to complications of uncontrolled hypertension. The purpose of this study was to determine if a faith-based self-management education program would improve self-care activities related to the management of hypertension among African American adults. Ten African American adults who reported a diagnosis of hypertension for 6 months or longer completed an 8-week education program focused on strategies for hypertension management. The education program was enhanced with the utilization of spiritual components of prayer, Scripture reading, and journaling.*

KEY WORDS: *African Americans, faith-based, hypertension, nursing, Reed's Self-Transcendence Theory, self-transcendence*

A Faith-Based Intervention to Improve HYPERTENSION MANAGEMENT Among African Americans

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African Americans have the highest prevalence of hypertension, with more than 40% of non-Hispanic African Americans being diagnosed with hypertension (American Heart Association, 2016). Associated chronic diseases such as kidney disease, heart disease, and stroke contribute to high mortality rates of African Americans with high blood pressure. Successful management of chronic diseases such as hypertension requires self-care behaviors that foster healthy outcomes and limit morbidities and mortalities.

The beneficial use of faith-based approaches to improve health behaviors among African Americans is well documented. This practice project sought to determine if a faith-infused intervention would improve health outcomes for African Americans with hypertension. The clinical question addressed was: Among African Americans diagnosed with hypertension, will a faith-based self-management education program improve self-care activities related to hypertension management?

LITERATURE REVIEW

Considerable health-related literature acknowledges the importance of spirituality, as it contributes to physical, social, and emotional well-being (Lewis, 2011). For this reason, The Joint Commission (2011) encourages healthcare organizations to assess and support spirituality. To empirically illustrate how faith and healthcare can connect, Dodani, Arora, and Kraemer (2014) conducted a study that documented how use of spiritual practices such as reading sacred

Scriptures, attending a behavioral intervention at a church, and prayer encouraged healthful lifestyle and hypertension self-care behaviors among African Americans ($N = 34$).

Culturally appropriate models of care contribute to improved health outcomes (Lewis, 2011). Historically, the African American church community has played a significant role in engaging and influencing individuals to adopt health-promoting behaviors (Woods-Jaeger et al., 2014). Thus, church venues can be successful for disseminating health information and promoting healthy behaviors. Churches offer a safe and trusted environment for most individuals and foster an environment where positive influence and behavioral changes can be learned and acquired.

The church is a strong force for bridging the gap between healthcare systems and African American communities (Parrill & Kennedy, 2011). Furthermore, churches can be a platform for health promotion (Butler-Ajibade, Booth, & Burwell, 2012). Suggestions for effective health promotion include making access for participants easy and creating an environment in the church where values and attitudes that contribute to living a "good" life are learned.

Boltri, Davis-Smith, Okosun, Seale, and Foster's (2011) study to identify the effectiveness of a research-designed Diabetes Prevention Program in African American churches provides an illustration of how church settings can promote health. Information from this study provides insight about program cost and suggests the appropriate time frame for implementation of successful health programs in an African American church setting. For example, Boltri et al. (2011) compared outcomes of a 6- and 16-session program and found that attendance was lower at the church where the 16-session program was offered. Also, the researchers recognized the need to offer interventions at times that did not compete with other planned church activities. Their study documented the positive effects of spirituality on health behaviors and the possible role of churches in supporting persons to improve their health.

Similarly, Lewis' (2011) qualitative study of older African American women diagnosed with hypertension revealed how theistic beliefs and practices fostered positive attitudes and behaviors. That is, prayer, Scripture reading, and discussion with members of the same faith who are faced with the same challenges (e.g., medication adherence)

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proved to be effective in promoting health practices. Participants also gained support from congregation members and leaders. Aspects of religion appeared to increase their motivation to implement healthful practices. Lewis concluded that use of faith-based interventions consistent with African American cultural beliefs is beneficial in improving health behaviors and outcomes.

THEORETICAL FRAMEWORK

The *Theory of Self-Transcendence,* which attempts to explain how people promote well-being in the midst of adversity (Reed, 2018), was used to explore health behaviors and spirituality among African Americans. The theory proposes that a significant change in one's health will result in an increased awareness of one's vulnerability. The awareness of vulnerability (in this context, hypertension) will prompt self-exploration and a greater awareness of relationships with others, the environment, and personal spirituality. This heightened awareness fosters the desire to improve circumstances (in this context, improve health behaviors) and to seek a life that is more meaningful. In addition to vulnerability and well-being, key concepts of the theory include self-transcendence—a fundamental component of spirituality (Coward, 2010).

THE PROJECT

This practice project implemented a pre- and posttest quasi-experimental design to explore the effectiveness of a faith-based educational program in improving self-care behaviors among African Americans diagnosed with hypertension. Approval was obtained from the institutional review board at an investigator's university. Standard ethical practices were observed; informed consent was obtained from all participants.

African American adults diagnosed with hypertension for 6 months or longer comprised the sample ($N = 10$). This project was conducted at a church in Baltimore, Maryland, where members of the congregation are predominately of African descent. Leadership at the church voiced concern regarding the health and well-being of the congregational members and volunteered to host the program. The church building was spacious with adequate classrooms, one of which was used for all sessions.

This project illustrates how biblical passages, prayer, and reflection can be integrated in an educational intervention for African Americans with hypertension.

Participants attended an enrollment session that provided an overview of the program. Preintervention questionnaires were completed and included a demographic form, the Spiritual Perspective Scale (SPS) (Reed, 1986, 1987), the Self-Transcendence Scale (STS) (Reed, 1991), and the Hypertension Self-Care Activity Level Effects Scale (H-SCALE) (Warren-Findlow, Basalik, Dulin, Tapp, & Kuhn, 2013). After the intervention, the SPS and H-SCALE were completed at the last session to identify if changes had occurred. In addition, a program evaluation form was completed to gain further insight regarding the effectiveness of the program. The STS scores achieved prior to exposure to the hypertension management sessions were used to identify participants' level of self-transcendence.

The faith-based self-management education program was comprised of eight educational sessions, each lasting 45 to 60 minutes and held at the church. The sessions were scheduled biweekly over 4 months. One of the investigators served as the course instructor; assistance also was provided as needed by a registered nurse who was a member of the church's health ministry team.

Program content was guided by the *Understanding and Controlling Your High Blood Pressure* booklet from the American Heart Association (2015). Topics include understanding high blood pressure, measuring blood pressure, risk factors, consequences of hypertension, and treatment (including nutrition, exercise, medication). Biblical passages were introduced and discussed at each session as well (Table 1).

Teaching and learning strategies employed lectures utilizing a PowerPoint presentation, distribution of written materials, and open discussion prompted by reflection questions developed by the investigators (Table 1). Each session included a lecture, introduction of pertinent scriptural texts about health, open discussion, and closure with prayer. A final wrap-up session involved collection of postintervention data and a potluck dinner of healthy food options.

Participants reflected about the challenges and victories of implementing hypertension self-management during open discussions and through journaling. A journal was provided, and participants were encouraged to reflect on daily challenges and triumphs related to the management of their hypertension and the scriptural texts presented during the sessions. Reflection during the open discussion was prompted by investigator-designed questions that allowed participants to consider how their faith might interact with their health behaviors. For example, participants were asked questions such as, "How have you honored God this week in managing your blood pressure?" Participants were actively engaged during the open discussions and also shared their journaling.

MEASURING SPIRITUAL PERSPECTIVE, SELF-TRANSCENDENCE, SELF-CARE

To compare pre- and postintervention health status and behaviors, spiritual perspective and various aspects of hypertension self-care were measured. To obtain a baseline description of participants, a demographic survey was completed and self-transcendence was assessed.

The *Spiritual Perspective Scale* (SPS) is a 10-item questionnaire that measures the extent to which individuals hold spiritual views and how often they engage in spiritually related behaviors (Reed, 1986;1987). Items that inquire about frequency of spiritually related behaviors include, "How often do you engage in private prayer or meditation?" and "I seek spiritual guidance in making decisions in my everyday life." Responses range on a Likert-type scale from *Not likely* (1) to *Always* (6) (Runquist & Reed, 2007, p. 9). Averages were used to determine a spiritual perspective score. Positive correlations between the scale and spiritual backgrounds have been

Table 1. Project Bible Readings[a], Discussion, and Journal Prompts

Session 1: Understanding High Blood Pressure

- Scripture: "Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore, honor God with your bodies." 1 Corinthians 6:19-20
- Discussion Prompts: Through Scripture we know that God values our bodies. Our bodies are said to be a temple of the Holy Spirit, and we are called to take care of and honor God's temple. God's Words lead us to use our bodies and the gifts he has given us to achieve the will of God. How did you treat your body this week?
- Journal Entry: What do you perceive to be your challenges? What have you learned from this lesson about high blood pressure that you did not know before?

Session 2: Measuring Your Blood Pressure

- Scripture: "Don't you know that you yourselves are God's temple and that God's Spirit lives in you? If anyone destroys God's temple, God will destroy him; for God's temple is sacred, and you together are that temple." 1 Corinthians 3:16-17
- Discussion Prompts: How sacred is your body to you? The Scripture speaks of God destroying those who destroy the temple. What habits do you have that could be destroying your temple?
- Journal Entry: What were the challenges you encountered this week? Over what did you triumph in managing your blood pressure?

Session 3: Risk Factors

- Scripture: "Therefore, I urge you, brothers, in view of God's mercy, to offer your bodies as living sacrifices, holy and pleasing to God—this is your spiritual act of worship. Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing and perfect will." Romans 12:1-2
- Discussion Prompts: Can you offer your body to God in its current state of health? Would it be pleasing to him? Understanding how uncontrolled high blood pressure can affect your body, are you hindering his will for your life by your health behaviors?
- Journal Entry: Managing high blood pressure is a journey. Where are you on your journey?

Session 4: Consequences

- Scripture: "Praise the LORD, O my soul; and forget not all his benefits--who forgives all your sins and heals all your diseases, who redeems your life from the pit and crowns you with love and compassion." Psalm 103:2-4
- Discussion Prompts: God provides all that we need for healing. What is the result when we do not utilize resources to control high blood pressure?
- Journal Entry: What have you learned that can help improve your health practices along your journey? Share what you have learned about signs and symptoms of a stroke and heart attack.

Session 5: Treatment/Nutrition

- Scripture: "So whether you eat or drink or whatever you do, do it all for the glory of God." 1 Corinthians 10:31
- Discussion Prompts: Do you consider God when you choose what to eat or drink? How can what we consume bring glory to God?
- Journal Entry: Start a food diary, writing down all of the food that you consume over the next 2 weeks.

Session 6: Treatment/Exercise

- Scripture: "And my God will meet all your needs according to his glorious riches in Christ Jesus." Philippians 4:19
- Discussion Prompts: God will provide you with all that you need. Does this include strength to exercise? What is your excuse for not moving?
- Journal Entry: Use a pedometer or device of your choice to record your steps for the next 2 weeks. Challenge yourself to start an exercise regimen with your healthcare provider's approval.

Session 7: Treatment/Medications

- Scripture: "Let us draw near to God with a sincere heart in full assurance of faith, having our hearts sprinkled to cleanse us from a guilty conscience and having our bodies washed with pure water." Hebrews 10:22
- Discussion Prompts: Do you believe that God makes healthcare providers available for our health and well-being? Has he provided you with wisdom to discover medications that will help with your illness? Is it a challenge to take the medications prescribed for your high blood pressure? Why or why not?
- Journal Entry: Make a list of the medications that you are currently prescribed. Indicate the medications from this list that you are taking regularly. If you are not taking them, describe why not and identify what you plan to do that will help you to be compliant.

Session 8: Treatment/Medications (Part II) and Wrap-Up

- Scripture: "My son, pay attention to what I say; listen closely to my words. Do not let them out of your sight, keep them within your heart; for they are life to those who find them and health to a man's whole body." Proverbs 4:20-22 "Praise the LORD, O my soul, and forget not all his benefits—who forgives all your sins and heals all your diseases." Psalm 103:2-3
- Discussion Prompts: How often do you stop and give praise to God for healing and your health?
- Journal Entry: What did you learn about treatment regimen for high blood pressure? What do you plan to do differently to control your blood pressure?

[a]All quotes are from New International Version.

noted and researchers have observed strong internal reliability, interitem scale correlations, and criterion-related and discriminate validity (Conner & Eller, 2004; Gray, 2006).

The *Self-Transcendence Scale* (STS) is a 15-item instrument measuring an individual's view of life and to what extent a person utilizes psychosocial resources and introspective means to promote a sense of well-being. Examples of this process include finding meaning in one's present or past experiences, having an interest in learning new things or sharing one's wisdom with others, and being able to accept help from others. For each of the 15 items, there is a 4-point Likert-type response option. The overall average of individual item averages was used to create the STS score, which ranged from 1.0 to 4.0 (Runquist & Reed, 2007). For this project, a score of 1 or 2 was interpreted as low, whereas 3 or 4 was considered high self-transcendence. In previous studies, Cronbach's alpha has ranged from 0.77 to 0.85 (Coward, 2010; Reed, 1991; Runquist & Reed, 2007).

The *Hypertension Self-Care Activity Level Effects Scale* (H-SCALE) is a self-report assessment designed to measure the degree to which a person implements recommended self-care activities known to control hypertension (Warren-Findlow et al., 2013). The H-SCALE is composed of six subscales: medication adherence, diet, physical activity, smoking, weight management, and alcohol.

The medication adherence subscale is composed of three questions regarding medication usage with Likert response options of 0 to 7 that measure how often respondents take their prescribed blood pressure medications. The possible range for the responses to these three questions is 0 to 21, where 21 is fully adherent to the medication regimen.

The 11-item diet subscale of the H-SCALE prompts participants to rate themselves on how often they consume healthy food items as prescribed by the Dietary Approach to Stop Hypertension (DASH) diet. Responses are summed and can range from 0 to 77. For this study, we considered scores less than 32 as a low diet quality, scores between 33 and 51 as medium quality, and scores of 52 or greater as adherent.

Participants were rated on how often they engage in physical activity by answering two questions. Responses were summed and could range from 0 to 14. For this project, scores of 8 or higher were considered adherent to the physical activity recommendations; lower scores were considered nonadherent. This threshold was chosen to ensure that participants had to report some combination of both physical activity and exercise to be considered adherent.

To assess smoking and exposure to secondhand smoke, participants were asked to provide the number of days during which they smoked or were exposed to smoking. Responses can range between 0 and 14. The score of 0 indicates adherence and any score above 0 is considered nonadherent.

The weight-management subscale includes 10 questions that assess how often over the past month weight-management activities, such as portion control and food substitutions, were practiced. Responses to the items range from *Strongly disagree* (1) to *Strongly agree* (5), with possible summative scores ranging from 10 to 50. Scores higher than 40 are considered adherent to good weight maintenance practices.

The alcohol subscale poses three questions to explore the frequency of the consumption of alcoholic beverages, recommended by the National Institute on Alcohol Abuse and Alcoholism (n.d.). Respondents indicate how often per day, per week, and within the last month they consumed an alcoholic beverage, where moderate alcohol consumption among men is <2 drinks/day (scores of 14 or less) and <1 drink/day for women (scores of 7 or less).

The H-SCALE tool also was designed to be a counseling tool to aid hypertensive patients who seek blood pressure control (Warren-Findlow et al., 2013). When administered to 154 patients with hypertension to assess self-care, Warren-Findlow et al. found that greater adherence to self-care was associated with lower systolic and diastolic blood pressure (BP) for five of the six self-care behaviors. The statistical Package for Social Sciences (SPSS) version 23 was used to manage and analyze data.

PRE- AND POSTINTERVENTION RESULTS

Ten adults with a diagnosis of hypertension participated in this project. The sample included two males and eight females. Participants' ages ranged from 48 to 81 years of age, with 50% of the participants being between 48 and 50 years of age. Whereas 40% were college graduates, 50% reported being high school graduates, and 10% had not completed high school. Family history was striking: 100% reported having a family history of hypertension. All participants, except for one who was in the process of searching for a new provider, reported being under the care of a healthcare provider. Poor responses to querying regarding frequency of visits to a healthcare provider leave lack of clarity about healthcare visits. Of the five participants who did respond,

one reported visiting every 3 months, three reported every month, and one reported every 6 months.

Prior to the initiation of the educational intervention, participants completed the STS to measure ability to utilize psychosocial resources and introspective means to promote a sense of well-being. The STS scores indicated that 70% of the participants possessed high self-transcendence and 30%, low levels. In addition, participants completed the SPS and H-SCALE. Scores indicated that 100% of participants had high spiritual perspectives prior to intervention (i.e., scored a mean of 5 or 6). H-SCALE scores revealed the most reported challenges included exercise, diet, weight management, and medication compliance, with 30%, 50%, 50%, and 60% (respectively) nonadherence being reported at baseline.

The project proposed to address whether a faith-based hypertension self-management education program would affect outcomes among African Americans with hypertension. To assess the impact of the education program, pre- and postintervention data collected with the SPS and all H-SCALE subscales were compared using the Wilcoxon Signed Rank test. All participants' SPS scores remained either a 5 or 6 (Table 2), indicating high spiritual perspective. Considering that all participants were members of the hosting church, this finding is not surprising. Although not statistically significant, a decrease in spiritual perspective by two participants was observed at postintervention.

Results showed a statistically significant increase in medication adherence scores of the participants following the hypertension management sessions ($z = -2.117$, $p = .034$) (Table 3). There was an increase by 30% ($n = 3$) in the number of participants who were compliant with medication adherence after the intervention. In addition, there was a 20% decrease in the number of participants who reported not being prescribed medications (Table 2).

The scores of the remaining H-SCALE components (i.e., diet, weight management, activity, smoking, and alcohol) showed no statistically significant difference (Table 3) pre- to postintervention. In fact, some increases in nonadherence were observed for these behaviors contributing to hypertension. That is, for weight management and activity, a 20% increase in nonadherence occurred (i.e., two participants became less active and two reported fewer weight-management practices) (Table 2). Adherence to the DASH diet remained the same pre- and post intervention. All participants reported not smoking or consuming alcohol at baseline and postintervention.

A program evaluation survey was used to collect qualitative data postintervention. Participants reported valuing the information provided and perceived that those facilitating the sessions were genuinely concerned about the participants' health. Many enjoyed the group discussion and found that the biblical passages improved their perspectives regarding health. Participants expressed a desire to meet more often and continue the program.

DISCUSSION

Mortalities and morbidities related to uncontrolled hypertension continue to be problematic. The current healthcare environment does not allot providers sufficient time to offer thorough health education that will assist individuals with BP management. This practice project was designed as a pilot study to explore a strategy that can be utilized to fill the health education gap. This faith-based hypertension management program was designed to enhance the knowledge and improve healthcare practices among African American adults pertaining to hypertension.

Although spiritual perspective and several aspects of hypertension management behavior were not statistically different after the intervention, medication adherence was improved. Participants reported an increase in taking medications as prescribed, and those who reported not being on medications pre-intervention reported being on medications and adherent post intervention. It is presumed that there were participants who found it necessary to obtain care and were prescribed medications during the implementation of the program, contributing to the increase in medication adherence and the decrease in the number of participants who reported not taking medications. Discussions with the participants regarding medication regimens indicated as much. Considering the significant role that

Table 2. Pre- and Postintervention SPS and H-SCALE Scores ($N = 10$)

	Pre	Post
SPS (total mean score of 6)	90%	70%
SPS (total mean score of 5)	10%	30%
Medication nonadherent	60%	50%
Medication adherent	10%	40%
No medications prescribed	30%	10%
Diet adherent	30%	30%
Diet low quality	30%	30%
Diet medium quality	40%	40%
Weight management adherent	50%	30%
Weight management nonadherent	50%	70%
Activity adherent	50%	30%
Activity nonadherent	50%	70%
Smoking adherent	100%	100%
Smoking nonadherent	0%	0%
Alcohol adherent	100%	100%
Alcohol nonadherent	0%	0%

Table 3. Comparing Pre- and Postintervention Outcomes: Wilcoxon Signed Rank Test Results ($N = 10$)

	z	Asymptotic Significance
SPS	-1.414	.157
H-SCALE: Medications	-2.117	.034*
H-SCALE: Diet	-.421	.674
H-SCALE: Activity	-.281	.779
H-SCALE: Weight	-.280	.779
H-SCALE: Alcohol	-1.00	.317
H-SCALE: Smoking	.000	1.000

*Indicates significance ($p < .05$)

medication adherence plays in controlling high BP, this increase in adherence post intervention is consequential.

The hypertension management components of diet, weight management, and activity did not change. Interestingly, participants identified diet (30%) and exercise (30%) as most challenging for them in their attempt to manage BP. Weight management and activity are directly related to these components which could contribute to the lack of significant change in these scores. These nonsignificant findings may be explained by the reality that the sessions were offered over a short period of time, not allowing enough time for the participants to implement and routinize exercise, weight management, and diet strategies. Participants' inquiries, journaling, and discussions, however, validated the need to provide information about these topics.

Given the faith-based nature of this intervention, it is of interest to know if the intervention affected spiritual perspective. Results suggest that it did not. There are various events that the participants could have experienced which may have contributed to the slight decrease in post SPS scores, such as lifestyle changes, stress, changes in their faith or relationship with their faith community. Although a slight decrease was observed, it should be noted that the lowest SPS scores still indicated high spiritual perspective.

In addition to providing relevant education in accordance with the American Heart Association, special attention was given to the incorporation of religious faith. Prayer and Scriptures that would inform how to address health challenges were shared at each session. This enhancement to the sessions prompted the exploration of spirituality and health. Indeed, participants described that during the intervention was the first time they connected their spiritual way of life with their health behaviors. Some participants reported that the thought of displeasing God through the lack of caring for their physical bodies was a new way of thinking. Thus, insight was gained regarding the impact of the spiritual components of the program.

All participants were engaged and contributed to the open discussions. The sharing of personal challenges and triumphs related to managing hypertension proved to be beneficial, as participants' journals mentioned how hearing that others are facing the same challenges was strong encouragement. Participants freely discussed their deficits and asked for help from peers. Although the quantitative results did not consistently demonstrate improvements, conscious effort to improve health behaviors was evident in the discussions and journaling.

LIMITATIONS AND RECOMMENDATIONS

Small sample size made parametric statistical analyses impossible. The sample was comprised of persons from one church; therefore, understanding how this intervention would be impactful in another denomination or religious culture is unknown. As yet, the spiritual components are not manualized or specifically evaluated. It is possible that although the faith components were intended to develop a holistic and religio-culturally sensitive perspective for hypertension self-management, these components could have inadvertently interjected guilt for past unhealthful practices or brought to awareness a spiritual struggle associated with trying to be healthful.

This pilot project stimulates considerations for future research. Although a multisited design and larger sample would have made findings more robust, it is important to consider the unique needs of a local congregation and plan site-specific interventions accordingly. Through this project, it was learned that some church members do not link their religion to their disease management and that an intervention that overtly makes this link may be beneficial. According to anecdotal comments, the pedagogical method of asking participants to journal and to share their personal experiences with hypertension management during group discussion was found to be helpful.

Sidebar: Strategies to Involve the Congregation in Health Education

1. Pastor

- Educate the pastor about the problem, the resources, the project/event, the effect on the congregation's well-being, community impact, and involvement
- Provide denomination-specific materials when possible
- Request general support, sermons related to the topic, announcements and endorsement from the pulpit, clergy and staff participation for personal health

2. Key Lay Leaders

- Enlist understanding and support to move the project forward and provide financial support
- Educate and gain the support from the unofficial leadership of the congregation at the beginning of a project
- Be sure that various women, Sunday School, men, youth, and specialty groups are included
- Recruit spokespersons from each group
- Highlight each group's participation

3. General congregation

- Involve congregants in selecting dates and times
- Involve all age groups in creating portions of the project and promoting
- Recognize groups for participation and support
- Make it personal, fun, and interesting so individuals and groups will want to be involved
- Have a part for everyone to participate from prayer to funding to preparing to hosting to follow-up

4. Follow-up

- Send thank you notes, write an article, post pictures

—Sharon T. Hinton, DMin, MSN, RN, Contributing Editor, JCN

CONCLUSION

Results of this project contribute to the evolving knowledge regarding spirituality and its potential role in managing chronic diseases, particularly among African Americans. Nurses, especially home health and faith community nurses who provide care for African Americans with hypertension, should explore how congregants' religious beliefs (e.g., how the body is the temple of God) and practices (e.g., reading the Bible or prayer) can encourage healthful choices. Strategies for engaging the community in health education appear in the sidebar. Nurses can also work to help church members participate in health-related support groups sponsored by churches. An educational intervention, such as that presented here, provides promise; it may allow nurses to harness spiritual and religious resources to more effectively and sensitively address chronic lifestyle-related diseases like hypertension.

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