Health Promotion in Faith Settings:
Developing a Guide for Nurses to Create a Health Program in their Faith Communities

By

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Abstract

Preventive health is underutilized in the United States despite the high prevalence of chronic disease. Reasons for underutilization include cost, distrust, and convenience. This indicates the need for more accessible and effective health promotion and education resources. Faith organizations provide an appropriate venue for health promotion interventions. Some health programs held at churches incorporate spirituality into the content, whereas others take a more secular approach and simply present the facts and education without any spiritual inclusion. All the studies found where health promotion was implemented in a faith community rendered positive results. Because the health of the general population is a significant concern in nursing, it is important to involve nurses in community health promotion efforts. Using current literature, examples of previous ministry health-related guide material, and information gathered from local churches, an online resource has been created to guide nurses through the process of how to implement a health promotion program in their faith community. A nurse practitioner, a nurse, and a pastor served as the expert reviewers and helped contribute valuable changes to the end product. The goal of this educational resource is it will inspire and equip nurses to use their knowledge and talents to implement health programs in their faith community.

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Introduction

Statement of the Problem

Today, approximately half of Americans have at least one chronic illness (Centers for Disease Control and Prevention [CDC], 2018). The United States (US) spends more than 75% of health care funds on preventable chronic diseases, including cardiovascular disease, obesity, diabetes, and osteoarthritis (National Center for Chronic Disease Prevention and Health Promotion, 2017). Poor nutrition, lack of exercise, tobacco use, and excessive alcohol intake are the main culprits of chronic disease development (CDC, 2018). Preventive health is underutilized in the United States, with Americans engaging in only half the suggested preventive services (CDC, 2017). Cost is one of the primary reasons people do not take advantage of preventive services (CDC, 2017). The high rate of chronic disease development and lack of preventive health utilization indicates the need for more accessible and effective health promotion and education resources.

Background

Healthy People 2020 encourages that health promotion initiatives come from various sites in the community (U.S. Department of Health and Human Services [USDHHS], 2012). Health promotion programs can be found throughout the community in schools, workplaces, and churches. Faith communities may be an appropriate venue for health promotion due to the consistent community that is created among the attendants (Bopp & Webb, 2013). A faith community is a group of people who have similar beliefs and practices in relation to faith, and often meet regularly (American Nurses Association, 2012). Various examples of health promotion efforts within faith communities will be shared in following sections. Here are some key terms and definitions that are important to understand.

Key Terms:

Faith-based programs: health classes or gatherings that are implemented by the congregation or pastoral leadership (DeHaven, Hunter, Wilder, Walton & Berry, 2004); these may or may not include components of spirituality such as scripture reading (for example the Bible for Christian-based faiths), prayer, etc.

Faith-placed programs: health classes or gatherings that outside health providers carry out within the church to evaluate an intervention (DeHaven et al., 2004)

Collaborative programs: health classes or gatherings that include a mixture of faith-placed and faith-based features (DeHaven et al., 2004)

Relevance to Nursing

Public health nursing involves advocating health in the general community and limiting the spread of disease and chronic conditions (Association of Public Health Nurses, 2018). Because the health of the general population is a significant concern in nursing, it is important to make resources and health activities easily accessible in different sectors of the community. Places such as school, work, and churches are areas where individuals and families are already connected. Incorporating health education or initiatives into these areas may be one effective way to encourage healthy behaviors (Healthy People 2020).

Faith community nursing is an area of nursing that offers health promotion by targeting a faith community. A faith community nurse can be a licensed vocational nurse (LVN), registered nurse (RN), or nursing assistant who weaves the spiritual practices and values of a particular community into their care. They serve their faith communities by educating, advocating, and linking to community and health resources (Abbott, 1998). Nurses with advanced education may be able to more appropriately design and implement evidence-based programs.

Spirituality is a fundamental component of one's well-being and can help motivate people to form and maintain positive health behaviors (Peterson, Atwood, & Yates, 2002). Initially, medicine was practiced in religious centers, so physical and spiritual health were addressed simultaneously (Peterson et al., 2002). Advances in technology have allowed us to cure many diseases and prolong life, but some health providers have neglected the spiritual origins of healthcare (Puchalski, 2001). Florence Nightingale emphasized a holistic approach in patient care, but due to the complexity of our healthcare system, this has been difficult to maintain (Peterson et al., 2002). Spiritual care has been written off as "unscientific and antiquated" despite the research indicating that spirituality and religion are associated with greater overall health and longevity (Peterson et al., 2002, p. 402). As mentioned in the key terms, many of the faith-based health programs incorporate a clear element of spirituality, but this is not required as part of the definition of these programs.

As illustrated by the staggering number of Americans affected by chronic diseases, further education and guidance in pursuing healthier behaviors is needed. In order for healthy behaviors to be maximized, nurses should consider becoming involved in health promotion in diverse settings, including faith settings, throughout communities. Health promotion is the foundation of nursing practice.

Project Purpose

The purpose of this project is to create an educational resource to guide nurses through the process of implementing a health promotion program in their faith community. The hope is to raise awareness and spark creativity in nurses who are involved in their faith communities to step into leadership positions that make an impact on their community's health. Many nurses may not realize this is an area of influence where their opinion is trusted. Nurses often have

access to the newest and most reliable health resources, and can use this to educate their community.

Literature Review

The databases PubMed, Google Scholar, and the UC Davis Library Catalog were searched with the following key words: "health promotion in faith communities," "health and wellness" with "church," and "church-based health promotion." Some articles were identified from the reference lists of formerly accessed articles. In this section, a selection of themes gathered from the research will be shared and discussed. These themes include faith-based health promotion, faith-placed health promotion, collaborative health promotion, availability of health resources in faith communities, and the role of faith community based health promotion in potentially addressing health disparities.

Faith-based Health Promotion

When referring to faith-based health promotion, this implies health promotion initiatives that originate with the congregation. There are prominent examples of this type of health promotion presented in this section.

Gutierrez et al. (2014) conducted a study that evaluated a 12-week program created to prevent diabetes, called Fine, Fit, and Fabulous (FFF). The target populations included black and Latino individuals in faith communities. Church members carried out this program and included scripture from the Bible in addition to education on healthy eating and activity. The research team administered before and after surveys and logged weights in order to gain data. In this situation, the implementation of the intervention was done solely by the congregation, and the researchers gathered data on their own, not in collaboration with the congregation. At the end of this intervention, participants reported noticeable changes in health behaviors including increased amounts of exercise and fruit and vegetable intake (Gutierrez et al., 2014).

The Thin Within Program and the Weigh Down Workshop are examples of weight loss programs offered through churches and online. The Thin Within Program is a 12-week program that began in 1975 and offers in-person group sessions. They have expanded and now offer online meetings as well. These sessions incorporate Bible studies and consider the program a "Non-Diet Grace-Based Approach" (Thin Within, 2014). Weigh Down Workshop began in 1986 and has a similar method, by recognizing the God-given hunger cues and seeking help from God in situations when one is tempted to overeat (Weigh Down Workshop, 2017). The program encourages regular Bible study and prayer. These include clear elements of spirituality. Those who participated in this reported that the support from group members and inclusion of prayer were effective in changing their eating habits to only eat when recognizing true hunger cues, which resulted in weight loss (Reicks, Mills, & Henry, 2004).

Faith-Placed Health Promotion

Faith-placed health promotion, as mentioned previously, is a term that refers to an intervention implemented in a faith setting by health professionals outside the faith community (DeHaven et al., 2004).

Nam (2013) organized a ten-week weight loss program in which 74 African American women participated. The control group, consisting of 29 women from a church in South Carolina, engaged in a non-spiritual intervention. The intervention included education about the benefits of exercise, exercise safety, balancing energy, portion sizes, minding food labels, logging a food journal, etc. The treatment group, consisting of 45 women from a different church in South Carolina, engaged in the spiritual intervention, which included all the topics that the non-spiritual group covered, plus spent time discussing New Testament scriptures and the connection to health and mindfulness. Nam (2013) reported the mean weight loss to be 0.847 pound in the non-spiritual group and 3.581 pounds in the spiritual group.

There were notable differences in the starting average body size of the members in the spiritual and non-spiritual groups, so this may have skewed the results. Because this was only a ten-week intervention, there is no way to determine whether these women maintained the weight loss, and whether what they learned through the intervention rendered lasting results. During recruitment, there was a more enthusiastic response from one church for the spiritual intervention than the other, which likely had an effect on how motivated the group was to lose weight.

Collaborative Health Promotion

Most of the studies that implemented a health promotion intervention within a faith community utilized a collaborative approach. Five studies explicitly stated their use of a community-based participatory research (CBPR) approach (Austin and Claiborne, 2011; Austin and Harris, 2011; Brewer, Balls, & Berry, 2016; Campbell et al., 1999; Kim et al., 2008). CBPR includes participation from the community involved in the issue being researched (Viswanathan et al., 2004). While CBPR shares ideals with the before-mentioned collaborative approach, it is important to note that true CBPR includes the participants in each step of the process, including selection of the research topic, method, implementation, and interpretation (Austin & Harris, 2011). This requires time, effort, and patience to build this partnership. Each party must allow time for both teaching and learning in order to be productive. It creates a unique dynamic where each group can build on each other's strengths. When the researcher and the community members work together, this creates an environment of respect and partnership. Viswanathan (2004) states that this trust built between the two groups strengthens the quality and quantity of data gathered. The following examples apply aspects of community-based participatory work.

Examples. Kim et al. (2008) worked with the University of North Carolina at Chapel Hill along with several church representatives and members to create a research group. This was their first step in creating the CBPR setting. They then administered a survey to determine the

health needs of a Southern rural community. The results from the survey indicated body weight was a main concern. The research team then conducted focus groups at the three participating Protestant churches to determine how to incorporate their intervention. Thirty-six African American women participated in the resulting WORD program, which is an acronym for Wholeness, Oneness, Righteousness, and Deliverance. This program included weekly group meetings to discuss nutrition, activity, and the connection of faith to health. Kim et al. (2008) reported a mean weight loss of 3.60 +-0.64 pounds in the treatment group compared to 0.59 +-0.59 pound loss in the control group. The group participating in the intervention with the spiritual component had a significantly higher weight loss than those who were a part of the control group. The use of a community-based participatory approach assured that the content they incorporated mirrored the needs of the community. Both the researchers from University of North Carolina and the church representatives worked together through each phase of the research process.

In another study, thirty seven individuals from three African American churches participated in a study that evaluated the effect of a 16-week cardiovascular health promotion intervention called “Fostering African-American Improvement in Total Health," or "FAITH!" (Brewer, et al., 2016). These churches initially showed interest in participating in this health program, and the pastors selected individuals within the church to be representatives to partner with the researchers. They measured progress by obtaining a baseline Life's Simple 7 (LS7) score, created by the American Heart Association to determine cardiovascular health. This score is determined by asking participants questions about weekly duration of physical activity, fruit and vegetable intake, smoking habits, as well as obtaining weight, height, waist circumference, blood pressure, blood sugar, and cholesterol. A blood sample was obtained from each participant for lipid and hemoglobin A1C levels. All other information was gathered from a

survey that each participant filled out. The researchers and church representatives also evaluated knowledge of cardiac risk factors through a survey. This data was measured at baseline and three months after the program ended. As part of the intervention, a personalized manual and cookbook was provided to each participant. Every other week they would meet for 90 minutes at one of the churches and engage in a variety of activities including prayer, presentation, discussion, videos, cooking demonstrations, and exercise classes. The results of this study showed increased cardiovascular health knowledge and improved LS7 scores for the participants.

In a different study, Galiatsatos and Hale (2015) utilized the Lay Health Educator Program at St. Matthew United Methodist church in Baltimore, Maryland. This is a program designed to provide individuals with information about common health issues and how to educate the community in regards to health and wellness. A lay health educator is someone who may not have medical background or formal education, but is trained to educate groups of people regarding health issues. In this study, the program was held at John Hopkins Bayview Medical Center. Galiatsatos & Hale (2015) approached the church's pastoral leader and proposed that using lay health educators would be a cost-effective way to positively influence the health of the community. Lay health educators who are a part of the church body have the advantage of understanding the language, values, spirituality, and traditions of the congregation (Galiatsatos & Hale, 2015). After several meetings between the researchers and the pastoral staff, they created a partnership that resulted in extensive participation by church members in the Lay Health Educator program. In addition, many members started walking to church and bringing healthier food items for church-related functions. They also hosted a health fair, where the members were challenged with a goal to lose 1,000 pounds collectively by the coming year. A nurse, who was also a member of the congregation, got involved in this initiative and

encouraged the faith community to partake. In this situation, the introduction of the lay health educator program into the church inspired this nurse to use her own knowledge and background to help further promote a culture of health. This is the only study found that mentioned a nurse becoming involved in a health promotion effort in the faith community.

The last collaborative study to discuss included initiating a CBPR study where they evaluated the outcomes of a health program implemented by the health ministry committee at Northeastern Church (Austin and Harris, 2011). The program was based on the content of "Body and Soul: A Celebration of Healthy Living," an educational initiative promoted by the American Cancer Society that advocated increased intake of fruits and vegetables specifically for African American churchgoers (National Institutes of Health [NIH], 2005). The researchers contacted the committee chair to find out if the church would be open to a partnership in which they could perform research together. As a group, they produced a survey to determine whether the participants felt the information provided to them was valuable and applicable. About 66% of the participants felt they had learned something from the literature that they did not previously know, which indicates a significant amount of education took place. Because this method is self-reporting, there is no guarantee that these participants would be able to appropriately demonstrate understanding of what they believed they had learned. Also, simply because they learned something new does not mean this is something that is applicable or helpful to their health needs.

Availability of Health Resources in Faith Communities

Based on the findings by Bopp and Webb (2013), medium-sized churches (5,000-10,000 members) offered more health wellness promotion compared to smaller or larger churches (Bopp & Webb, 2013). This may be due to the difficulty for larger churches (more than 10,000) in coordinating and providing for all their members (Bopp & Webb, 2013), and the potential lack of

funding or volunteers in smaller churches.

Funding is a factor that affects the availability of health promotion efforts in faith communities. From the 110 congregations represented in the study by Bopp and Webb (2013), 44% allotted only $0-$499 a year for the health and wellness budget. However, 28% allowed more than $2,000 a year for the health and wellness budget (Bopp & Webb, 2013). Churches must prioritize their funds, and due to the decrease in tithing amounts (Bopp & Webb, 2013), churches are forced to reduce funding in certain areas. Tithing is when an individual or family reserves 10% of their income and contributes this to the church (James & Jones, 2011). According to State of the Plate (2013), only 10-25% of families within churches tithe, which means the church cannot count on consistent funding in this area. This may explain why there is not a substantial amount of monetary supply left for health ministry. Sixty two percent of the surveyed church leadership considered health and wellness to be "somewhat important" or of "great importance" to them, and yet the funding allotted to health promotion does not adequately match (Bopp & Webb, 2013). Some pastors expressed frustration that some religious individuals believe that God will keep them healthy and they therefore remove from themselves the responsibility of adopting healthy behaviors (Markens, Fox, Taub, & Gilbert, 2002). In this way, the pastors welcome holistic health promotion activities and the way they advocate individual accountability for one's own health. However, these pastors also shared the reality of their limited personal time available to commit to these programs. One pastor stated that if the duty to organize and deliver these programs was placed on him, then it would not be feasible to offer (Markens, Fox, Taub, & Gilbert, 2002). This is why establishing relationships and calling on volunteers within the church and community is so vital to the development of these health programs.

Any health promotion efforts require time, and often funding. Because churches have established buildings and other amenities such as kitchens and restrooms, this helps keep costs down. In addition, the federal government has allowed faith organizations to apply for Federal grants related to health promotion in the past, recognizing that they are a prime venue for reaching people (Campbell et al., 2007).

Some faith organizations count on individuals already within the congregation who are passionate about health and would welcome an opportunity to educate others. Churches have the advantage of reaching diverse groups of people, including those who may not have access to healthcare or who have a general mistrust of the common health care avenues (USDHHS, 2000; Campbell et al., 2007).

Health Disparities

Healthy People 2010 highlighted the need to address the prevalence of health disparities. The CDC (2017) defines health disparities as an unnecessary discrepancy in the ability to achieve ideal health that affects certain disadvantaged racial, ethnic, and other societal groups. For example, the rate of diabetes diagnosis in the black population is 77% higher than whites (CDC, 2017), and Hispanics are 50% more likely to die from diabetes than whites (CDC, 2015). The CDC (2017) states that people who are disadvantaged socially, economically, or environmentally are even less likely than the average American to utilize medical preventive services. In general, individuals who are not insured are less likely to pursue necessary care (Schroeder, 2001). Some black individuals are distrustful of traditional healthcare due to past experiences of receiving inferior care relating to discrimination (Markens, Fox, Taub, & Gilbert, 2002).

Austin and Harris (2011) found that health promotion programs are utilized more frequently in faith communities consisting of minority races. This data is mirrored in that ten out

of thirteen studies found in this area included exclusively black men and women. According to the Pew Research Center (2014), 34% of white US adults attend church weekly, compared to 47% of black US adults, and 39% of US Latinos. These statistics suggest more consistent religious attendance from these minority groups.

The Black church, in particular, places great emphasis on health promotion and empowering their members to take responsibility for their health (Austin & Harris, 2011). Austin and Harris (2011) cite health promotion efforts starting in the 1920s by the Black church. Black churches have been known to offer cancer screenings (Markens, Fox, Taub, & Gilbert, 2002), diabetes education (McNabb, Quinn, Kerver, Cook, & Karrison, 1997), weight management (Kim et al., 2008), smoking cessation (Schorling et al., 1997; Stillman, Bone, Levine, & Becker, 1993), and nutrition education (Campbell et al., 1999). They often work closely with hospitals, researchers within universities, and health departments to execute their programs (DeHaven et al., 2004; Thomas, Quinn, Billingsley & Caldwell, 1994).

Discussion

The literature shows instances that faith-placed, faith-based, and collaborative health promotion can be valuable and effective. Perhaps it may be more effective for individuals who are more interested in their spirituality or are active in their church. A Gallup poll (2017) reported that 51% of Americans consider their faith "very important" to them. This would suggest that including a spiritual component might only be useful for a portion of the population. The sample success of some of these studies may be skewed, due to the possibility of participants having spiritual beliefs and motivations that already matched those represented in the program. They may be more likely to internalize and implement what is being taught, because they trust and believe in the ideals being presented. As a result, the findings may not be generalizable to the greater population. It is difficult to know what other factors could affect the

success of the individuals in each study. The degree of initial spirituality of an individual, support from spouses or family members, level of self-motivation, and incentive of a gift card could be factors that influenced the success of participants in these studies.

Research also shows that identifying with a religion and attending church leads to better physical and psychological health (Kark et al., 2006). This may be attributed to the support system available in a church network, as well as the practices of prayer and meditation that are often applied (Fiala, Bjork, & Gorsuch, 2002). However, there is a need for implementation within a variety of faith communities. Davis et al. (2014) implemented a non-theistic method that had Buddhist psychology, but used a mixture of other psychology and personal approaches as well. This is the only article found that was not affiliated with a Christian setting or practice.

The majority of the health programs have been implemented in Black faith communities. While this calls for more research in communities of diverse racial affiliation, it also suggests programs in this setting may be more effective for the Black community. There may be more interest coming from this population compared to Hispanics, whites, or other groups. The only bilingual program found in the literature was by Gutierrez et al. (2014).

It is possible that there are more health promotion programs in faith communities than many are aware of, due to lack of advertisement in the community and online. Some faith organizations have created their programs and classes specifically for their congregation, so their lack of visibility may be purposeful. The faith community's focus is often first to benefit their community, not necessarily for research purposes. This may be part of the reason it is difficult to consistently implement health programs in faith communities using the CBPR approach.

There was only a small number of randomized controlled trials implemented in these studies, so this creates a gap in proving the effectiveness and reliability of the programs. If these programs can be substantiated through favorable results in randomized controlled trials, they

may be more likely to receive funding. There is power in researchers partnering with faith communities to implement and evaluate health promotion interventions. Based on the published studies found, nurses are rarely involved in health promotion initiatives in the faith communities. Hopefully this can evolve as nurses further embrace their influence and take on roles leading health promotion efforts throughout the community.

Approach

The initial goal of this project was to develop an educational resource outlining a step-by-step guide for nurses involved in their faith communities to create and implement a needs-based health program. The overall desire for this project is that it will empower nurses to educate their faith communities in the area of health. It is my hope that this will positively impact the health of the community as a whole, and that it will generate a new awareness of health promotion in faith communities.

Action Steps

There were several main action steps set to complete this project. The first action step was to draft the content of the presentation. The next step was to add photos and design elements to make the presentation aesthetically pleasing. The following step was to obtain feedback from expert reviewers. The last step was to make any appropriate modifications to complete the Prezi. A Prezi is similar to PowerPoint, but has some different design elements.

Determining the Content

Research was done to determine whether an educational tool exists to guide individuals through the process of implementing a health promotion program in a faith community. I utilized databases and Google searches to locate articles and resources. Two similar guides were found, titled "Starting a Wellness Committee," and "Tree of Life." Each were created more like a booklet and did not have a specified audience like my project, which is geared for nurses. In

addition, research was conducted on community-based participatory research (CBPR) and the benefits of involving the target community in the production of a health program. The CBPR approach was used in many of the studies that informed this work. However, this is an action project rather than a research project, therefore this method was not used in the project described here.

Pender's Health Promotion Model was used to guide the production of this project. A graphic of this model is included in Appendix C. This model addresses the sociocultural and interpersonal factors that influence activities and behavior changes. Part of Pender's Health Promotion model describes a community model to promote health, which is the approach taken in this project. Pender encourages nurses to be advocates throughout the community.

There is a portion of Pender's model devoted to developing a health promotion prevention plan, which is precisely what is being facilitated in this applied project. The outline to the health-planning process offered by Pender, Murdaugh, and Parsons (2011) includes identifying health goals and outcomes, addressing facilitators and barriers to change, etc. These general steps helped shape the chosen numbered phases found in the finished Prezi. These include a) nurse empowerment b) health needs assessment tool, c) selection of program topic, d) formation of project team, e) planning process f) implementation, and g) evaluation. Pender's model emphasizes designing culturally competent health promotion programs, which is accomplished through the Needs Assessment (Pender, Murdaugh, & Parsons, 2011). Pender, Murdaugh, and Parsons will be referenced on the resource to give appropriate credit.

I called twelve local churches and researched their websites to inquire if they offered any health-related classes or programs. This gave me an idea of how many faith communities provide health-related support, how formal or casual their format and planning process was, and what types of health classes, if any, were available. Of the twelve churches contacted, five of

them had some type of health-related activity. Most of these were Christian affiliations, but a Buddhist, Jewish, and Muslim congregation were also included in the search. Some examples of health activities found are: bipolar awareness class, a hiking group, a yoga class, and educational classes about nutrition and physical health.

The draft content is based on literature, examples of previous ministry health-related guide material, the information I gathered from local churches, and self-knowledge. This draft was submitted to my thesis chair for feedback. Revisions were made based on this feedback. The outline was then expanded to the full Prezi format.

Description of Project

The Prezi outlines the suggested steps in implementing a health-related class. It includes a title page, objectives, a summary of the steps to be covered, a more in depth description of each step, and the references. A copy of the presentation is included in the Appendix. The text is written in English at an eighth grade reading level. This was evaluated using the standard Flesch-Kincaid tool available on the Word software. Even though nurses have higher than an eighth grade reading level, I want anyone involved in the process to be able to understand the content. It was written with Christian faith communities in mind, but could be applied to other faiths as well. In 2017, 68% of Americans identified as Christian or some denomination of Christianity (Gallup, 2017), so this is the most prominent spiritual affiliation in the United States. Based on this statistic, as well as my experience with Christianity, I chose to target this specific faith.

To assess the needs of the faith community, United Methodist Church (UMC) Health Ministry Network's Needs Assessment is included for nurses to distribute. This is also provided in the appendix. There are other Needs Assessments available for use, but this is one that is easily modifiable and straightforward. Community-based participatory research is what inspired

the use of the Health Needs Assessment found in this project. Although this project is not research, it is community-based participatory work, and holds the same premise.

The nurses would gather information from the members through the Needs Assessment about their health education needs to make sure an appropriate topic is targeted. Because the nurse already knows the values and culture of the faith community, they may be better equipped to meet the needs of the participants. Their role as part of the faith community creates an established relational trust, and their position as a healthcare professional generates confidence in their health knowledge. This is not suggesting that non-nurses or individuals outside the church are not fit to perform this role, but for the purposes of this project, nurses within their faith community were chosen as the main audience.

Nurses often have researcher contacts through work or health organizations, which makes the prospect of CBPR more plausible. Through the literature, I found that CBPR is effective but lacking in ability to be carried out. Many faith communities lack the connections and resources to carry out this type of research. The results and outcomes are not often reported (DeHaven et al., 2004). Nurses can alert researchers to the opportunity to be involved, and can help facilitate the CBPR process. This information is added in the Prezi as a resource, but not to deter a nurse from following through with the health program if they are not able to find a researcher to take on the study or if the faith community is not interested in participating in a study. Incorporating the health needs assessment helps tie in the community-based participatory approach, even if true CBPR is not possible in every situation.

Once the textual content of the draft was completed, it was submitted to the expert reviewers, including a community health nurse, nurse practitioner, and faith leader. Ideally, I wanted to add the graphics and photos before sending to the reviewers, but to avoid delaying feedback, my thesis chair and I decided it was wise to receive feedback on the textual content

alone. After this, I chose the graphics that were most appropriate. At this time, I made revisions and additions to my content based on the feedback from the expert reviewers.

Results: Expert Review and Feedback

An evaluation form was created to be distributed to the expert reviewers, and a formal email was sent to the nurse and nurse practitioner expert reviewer. The third expert, a faith leader, was added as a reviewer at a later date. The evaluation criteria sheet the expert reviewers used to provide feedback is included (see Appendix B).

The evaluation form included five "yes" or "no" questions, two open ended questions, and an opportunity to provide any additional comments. The focus of the evaluation was content, appropriate audience, accuracy, clarity, format, and strengths and weaknesses. The graphics had not been added at this time, so feedback could not be given in this area yet. I considered each comment and recommendation, and began to make the recommended changes to the Prezi based on this. Listed next are the main points that came across in the feedback from the expert reviewers. The first reviewer (nurse) answered each of the questions on the evaluation sheet, as well as provided comments directly on the PowerPoint. The second reviewer (nurse practitioner) provided free flowing comments separate from the evaluation form. The third reviewer (faith leader) provided brief answers to each question on the evaluation form. The following six paragraphs summarize the main themes that were addressed in the evaluation form.

Content. The first question of the evaluation sheet reads, “Is the content clear and logical?” to which the first expert reviewer said that she would need information about the presentation method – whether the content would be delivered verbally as a presentation, or used as an educational resource to be reviewed. I followed up with this reviewer and explained that the purpose of the project is to be an educational resource, not a live presentation. The second reviewer brought up the importance of presenting the basic research on the current health crisis

and lack of effective preventative health available. She also recommended including multiple ways to "assess the needs of the community," such as an interview, meetings, and other survey tools than the one originally provided in the resource. The third reviewer stated that the content was clear and easy to follow.

Appropriate audience. The first and third expert reviewer replied "Yes" to the question **"**Is the PowerPoint [or Prezi] appropriate for the targeted audience - nurses involved in their faith communities?" The first reviewer added that it would also be helpful for any individual who wishes to create and implement a health promotion program. The second expert reviewer suggested identifying the target audience in a more explicit way and asking probing questions of them such as "Would your faith community benefit from a health program?" or "Do you feel called to use your gifts as a nurse to serve your faith community?"

Accuracy. The first and third expert reviewer answered "Yes" to the question "Are the facts presented accurate and up to date?" The second expert reviewer did not provide a clear answer.

Clarity. The next question reads as follows: "Is the language appropriate and understandable?" to which the first and third reviewer answered "yes." The second reviewer pointed out that certain slides have unnecessarily academic language, for example she suggested the phrase "the process" could be changed to "an overview." She recommended using a phrase different from "nurse collaborative empowerment."

Format. When asked, "Is the format of the PowerPoint [or Prezi] appropriate and clean?" expert reviewer number one explained that some of the slides sounded wordy and should be re-visited. This also relates to the clarity. The second reviewer stated that some of the slides have font that is too small and difficult to read, so she suggested expanding to multiple slides. The third reviewer stated that it appeared clean and aesthetically pleasant.

Strengths and weaknesses. Lastly, the reviewers were asked to identify any strengths and weaknesses of the project overall. The first reviewer noted that the framework was easy to follow, but made many comments directly on the slides encouraging defining certain phrases, where to go into more detail on a certain topic, and when content should be split into multiple slides. The second reviewer did not identify any particular strengths and weaknesses. The third reviewer liked that the presentation had groups and sub-categories, and that each slide was not cluttered. The third reviewer observed that there were no graphics or photos, and noted that this would enhance the presentation. This reviewer also felt that the Prezi order jumped around a lot when transitioning from one slide to the next and could be smoother.

Results: Suggestions Applied

Before the following changes were made, the content from each PowerPoint slide was transferred onto a Prezi slide. I made this change because I felt the Prezi had an easier format to work with and had more template options for my purposes. I added a slide defining community-based participatory research (CBPR), and another slide explaining how to pursue this approach, but making sure to not deter the nurse from moving forward with the health program if CBPR was not possible. I separated the three examples of health promotion classes into three individual slides. I added two extra slides to the Health Needs Assessment portion and included more detail about how to utilize the assessment. To allow for better viewing, I created a completely separate slide for the photo of the Health Needs Assessment.

I added two additional slides to the "Formation of Project Team" step, to go into more detail on who should be a part of the team and some examples of the roles that need to be filled.

For the "Planning Process" step, I added four slides so that I could distribute the nine "questions to consider" and go into a bit more detail in certain areas. I included a slide instructing to create specific, measurable goals and gave examples.

Limitations

There are several limitations to acknowledge in the production of this resource. In the search for current similar tools, the key words used for searches may not have been the best to find the health promotion guide resources. I tried many different combinations including "healthy ministry guide," "church-based health promotion guide," "faith community health promotion program," etc, but there may have been other items I was not able to locate. Also, I do not have any previous experience with graphic design and formatting. Because of this, I chose to use the free internet program Prezi. This program requires Adobe Flash Player, so if someone does not have this and does not wish to download it, they will not be able to access the resource. One expert reviewer saw the product in its Prezi form, while the other two reviewers saw it in the PowerPoint form. An updated Prezi format was sent to these two expert reviewers, but feedback has not yet been obtained. A graphic design reviewer was not utilized, which may have been helpful in offering feedback on photos, spacing, and choice of template. Currently, this resource has not been distributed to the public or to any faith communities.

Faith communities are in a unique position to offer a venue and access to an established group of people to provide health education to. This educational resource can be utilized to inspire nurses and others to use their knowledge and gifts to provide health education. Presenting preventive health education in non-traditional arenas throughout the community assures that different groups of people are being reached. This is emphasized in the Healthy People 2020 goal to involve numerous areas of the community in promoting healthy behaviors (USDHHS, 2012). The Prezi explains community-based participatory research and how to perform this. The research indicates CBPR is an appropriate approach in creating a health program for a community. If the individual or group following the steps of the resource cannot organize CBPR, they should not be deterred from carrying through with it. It would, however,

be a way to add to the research determining the effectiveness of these health programs. Receiving feedback from nurses and pastoral staff on the content, format, and flow of the Prezi resource is vital in assuring its clarity and ability to call its readers to action. Health programs should be implemented and researched in all sectors of the community, including diverse faith communities.

Potential Distribution

The first page of the Prezi could be printed out and posted as a flyer in faith communities, with the link typed out at the bottom, so the people who are interested could take this flyer and research further on their own.

There may also be opportunities to include the link to the Prezi on hospital websites. It may be best to start with Human Resources to see if they could provide contact information to the appropriate person.

Future Research

The topic of health promotion in faith settings requires further research. The small amount of experimental studies, as well as the lack of diversity in the faith base and population of participants warrants further research. It may be beneficial to ask the participants of a health program in a faith community led by a nurse if they felt more benefit having the program led by a nurse as opposed to a non-nurse.

Nursing Implications

Nurses have many different roles throughout the community and should be aware of the opportunities they have to share their expertise and knowledge. Through this Prezi, nurses may gain a new perspective on how they can make a difference in their community. Health education does not have to be limited to doctor office visits or hospitals. The key to preventive health is to reach people while they are still healthy and give them the education and resources to form or

maintain healthy behaviors. This would hopefully decrease the amount of individuals affected by chronic illnesses.

Conclusion

Faith communities can serve as an ideal setting for health education. Nurses involved in their faith community are in a unique position to use their knowledge and passion for health to stimulate a culture of wellness through education. The poor utilization of preventive services in the United States necessitates more than the traditional means of health education (CDC, 2017). The purpose of this project was to create awareness to the many ways and areas nurses can contribute to community health outside hospitals or clinics. Through this educational resource, it is my hope that nurses will feel more equipped to implement health programs in their faith community and any other organizations or groups they may be involved in.

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Appendix A

UMC Health Ministry Network Needs Assessment

Sample Health Ministry Needs Assessment for Congregations

1. Snapshot of the congregation:
   Your age: ❒ 1-12 ❒ 13-17 ❒ 18-30 ❒ 31-50 ❒ 51-68 ❒ 69-80 ❒ 81+
   Your gender: ❒ Male ❒ Female
2. Do you or a family member currently have health-related issues? ❒ Yes ❒ No
   If ***yes***, please explain: _____
   _____
   _____
3. Please check or circle the topics of interest to you:
   (Insert topics of interest specific to your community, such as health concerns, support groups, activities, etc.)
4. When is the most convenient time/day for you to participate in health-related activities *(please check one)*?
   ❒ Before 8:00 a.m. ❒ 8:00 a.m. – 1:00 p.m. ❒ 1:00-5:00 p.m. ❒ 5:00-7:00 p.m. ❒ Evening (after 7:00 p.m.)
   Indicate the day you prefer (Monday through Sunday) _____
   ❒ Prefer online or teleconference participation
   ❒ Home-bound; would need an alternative means of participation? ❒ Yes ❒ No
5. Are you interested in using your skills and talents to work in health ministry?
   If so, please describe your professional skills, personal interests and other ways you would like to participate.
   _____
   _____

[1] Commuter community: lives in one area, but stays in another area during the work week

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Appendix B

Evaluation Feedback Form

Dear Reviewer,

I look forward to receiving your feedback to enhance my presentation. Please review the presentation and respond to the following questions,

1. Is the content clear and logical?

2. Is the presentation appropriate for the targeted audience - nurses involved in their faith communities?

3. Are the facts presented accurate and up to date?

4. Is the writing persuasive and scholarly?

5. Is the format of the presentation appropriate and professional?

6. What are the overall strengths of the presentation?

7. What parts of the presentation could be strengthened?

8. Please provide any additional comments/suggestions.

I am thankful for your critical review. Please email your responses to me by October 15, 2018. If you have any questions or concerns or you cannot complete the review by this date, please contact me at kssheehan@ucdavis.edu or 916-803-7612.

Sincerely,

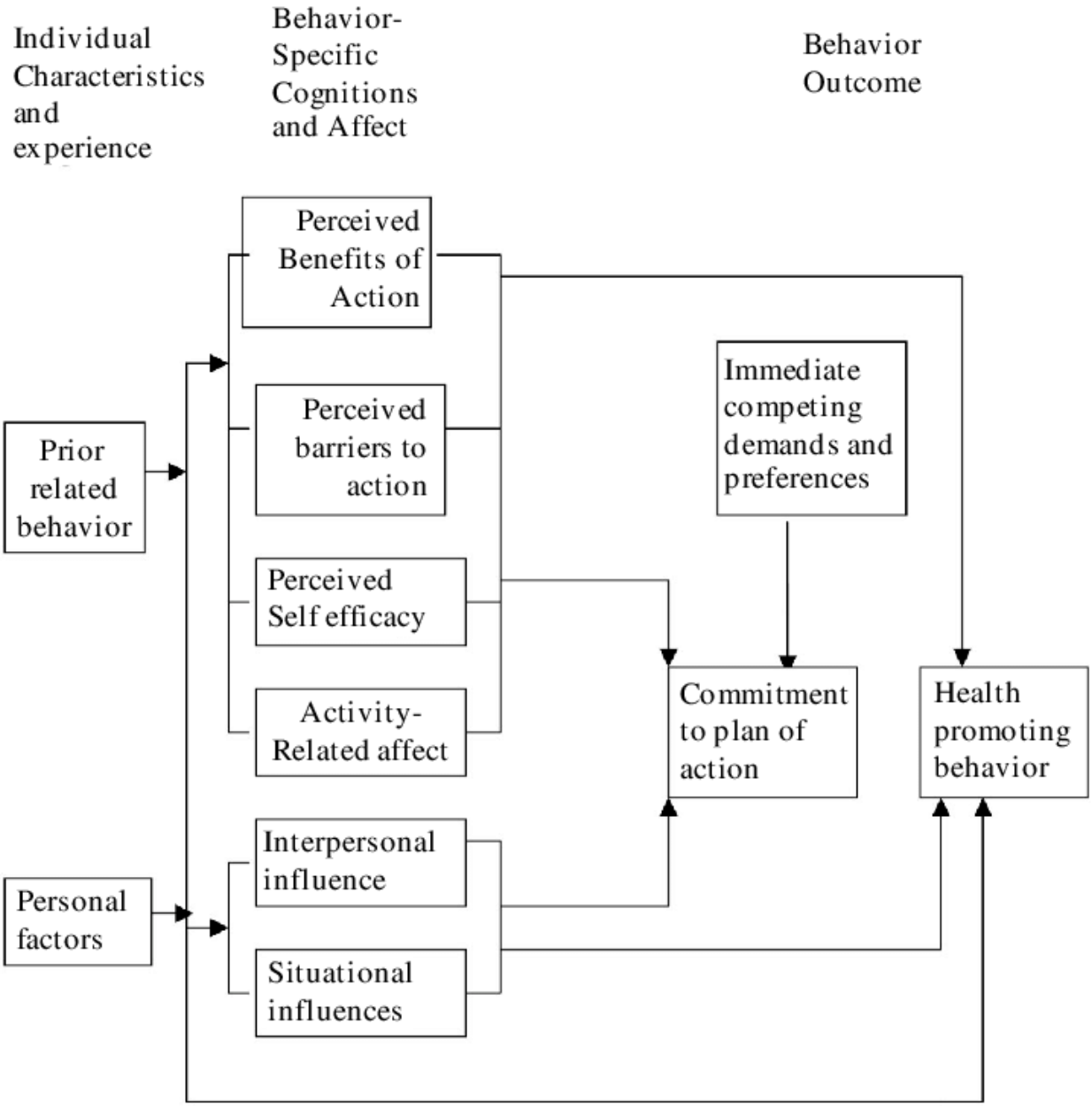
Kayla Sheehan, RN

Master's Leadership Student

Betty Irene Moore School of Nursing, UC Davis

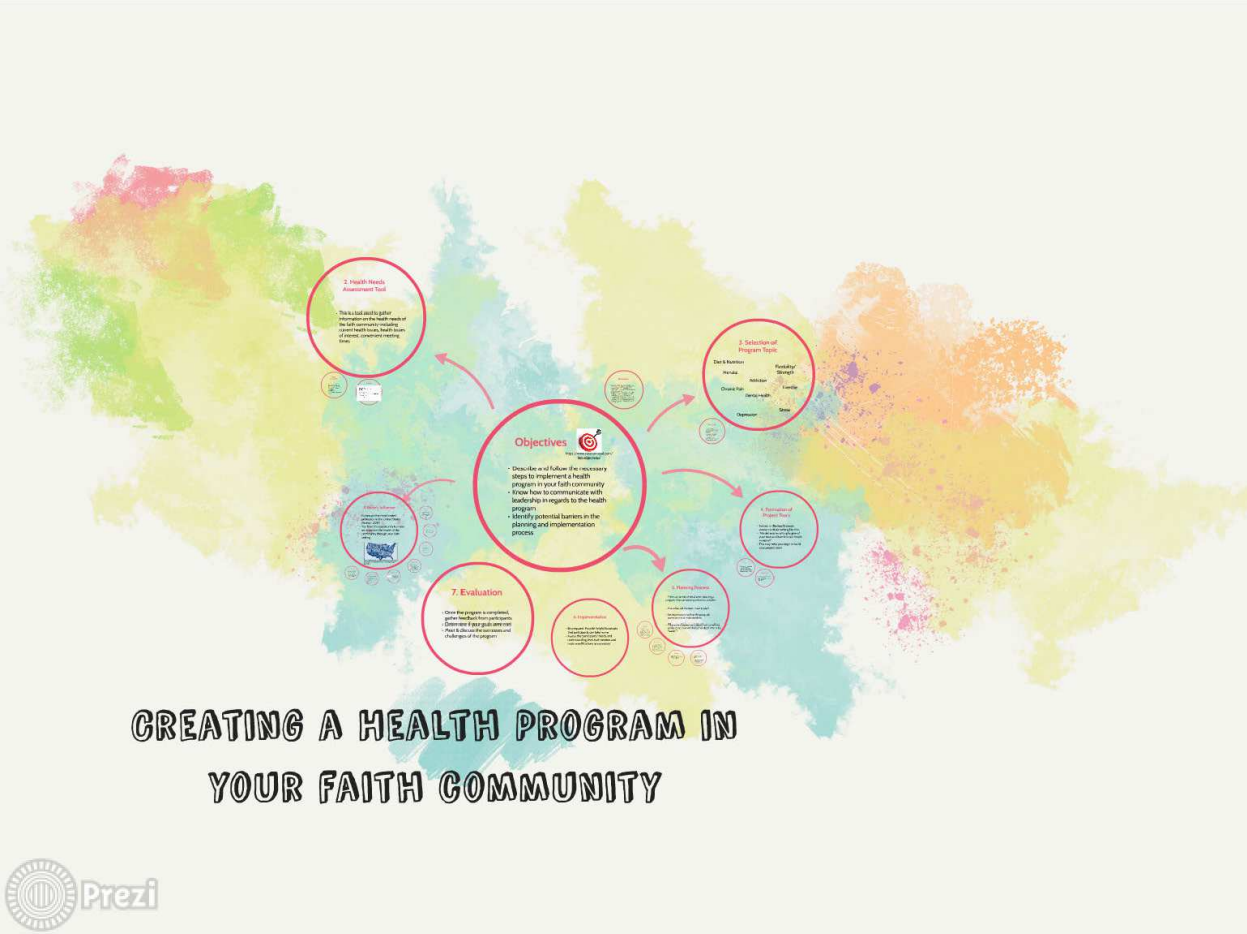
Appendix C

Pender's Health Promotion Model



Retrieved from https://www.researchgate.net/figure/Diagram-of-Penders-health-promotion-model_fig1_268983577

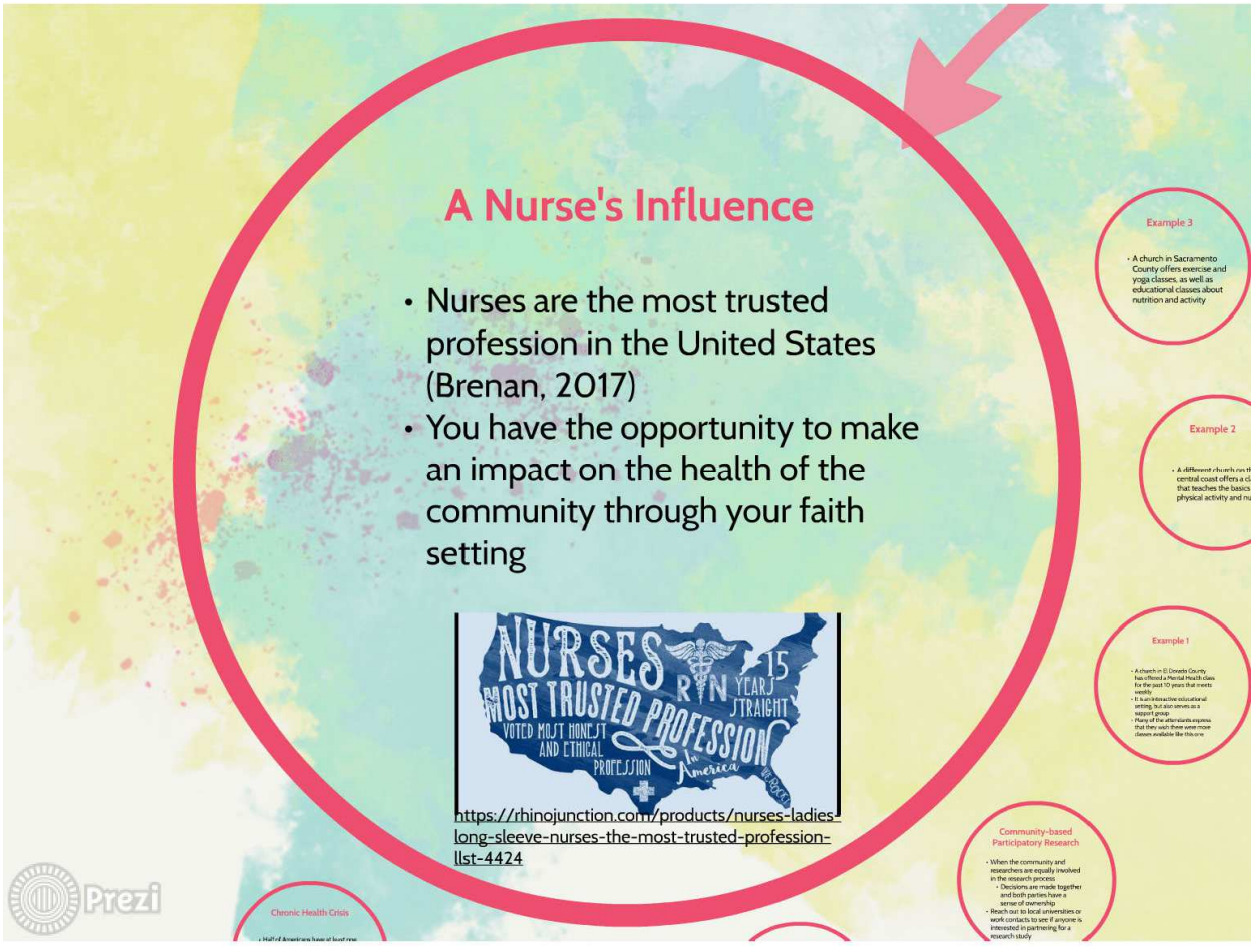
Appendix D

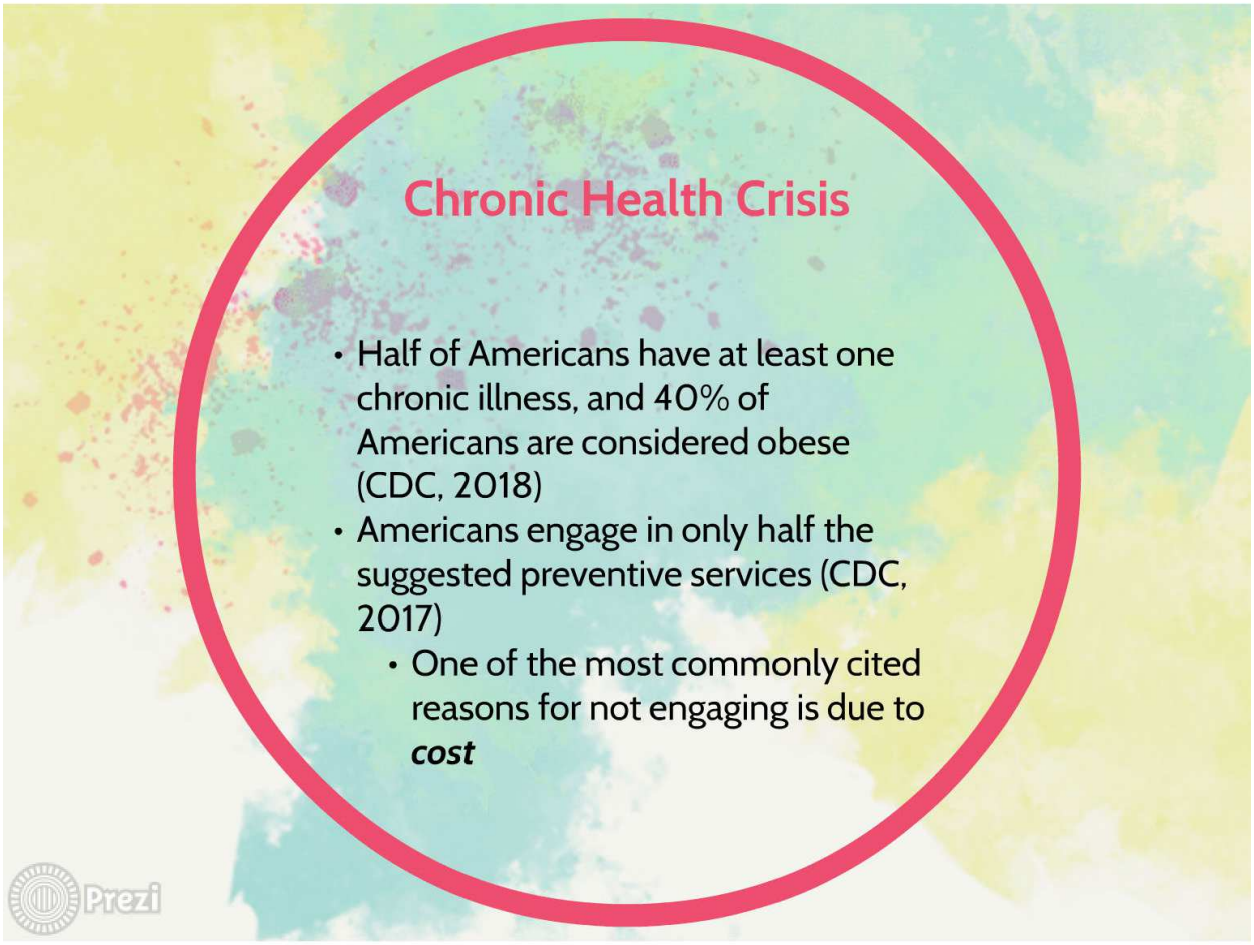

Objectives
7. Evaluation
CREATING A HEALTH PROGRAM IN
YOUR FAITH COMMUNITY
Prezi

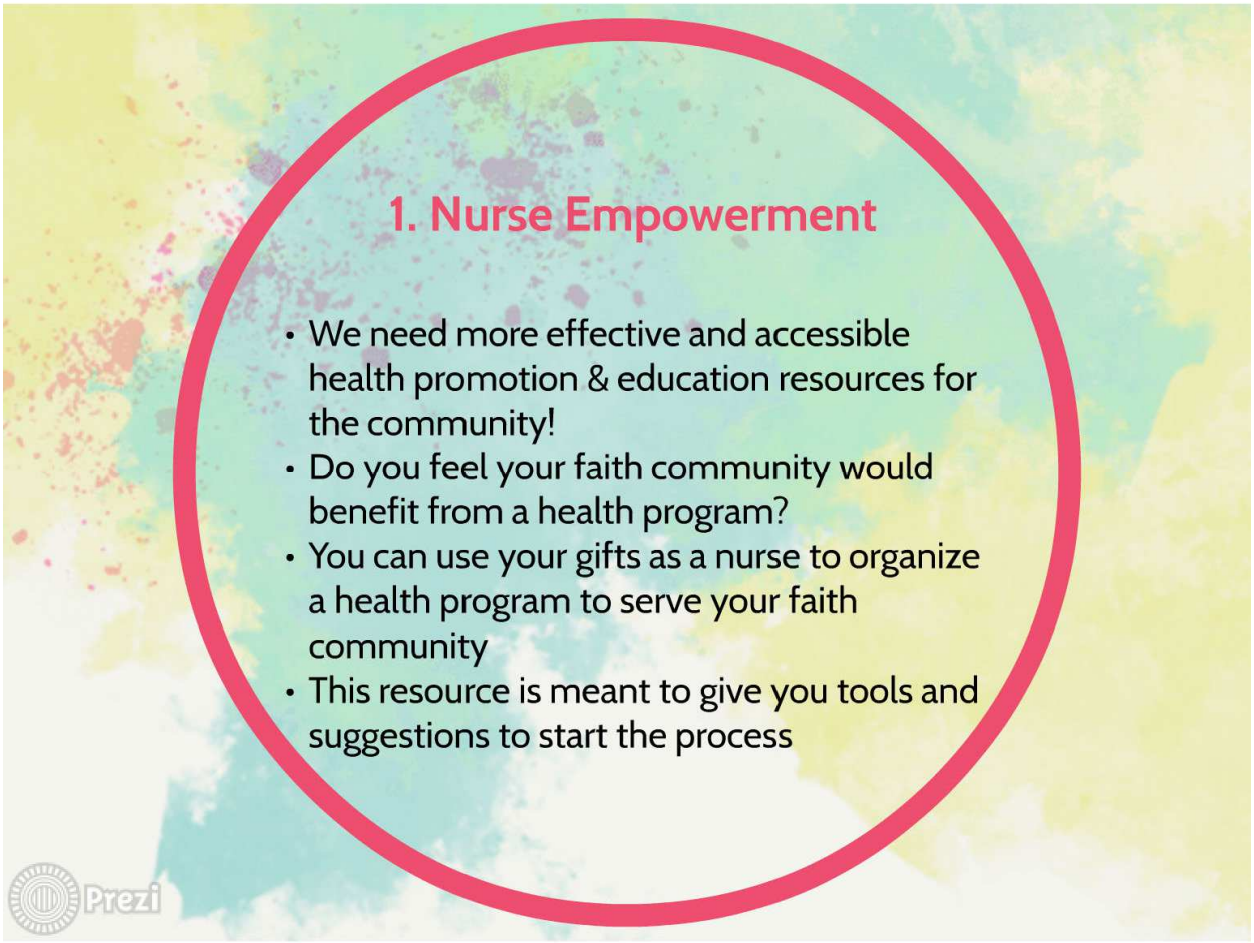
Objectives

https://www.caravannepal.com/key-objectives/

- Describe and follow the necessary steps to implement a health program in your faith community
- Know how to communicate with leadership in regards to the health program
- Identify potential barriers in the planning and implementation process


A Nurse's Influence
• Nurses are the most trusted profession in the United States (Brenan, 2017)
• You have the opportunity to make an impact on the health of the community through your faith setting
NURSES
RN
15 YEARS STRAIGHT
MOST TRUSTED PROFESSION
VOTED MOST HONEST AND ETHICAL PROFESSION
In America
https://rhinojunction.com/products/nurses-ladies-long-sleeve-nurses-the-most-trusted-profession-llst-4424
Example 3
• A church in Sacramento County offers exercise and yoga classes, as well as educational classes about nutrition and activity
Example 2
Example 1
Community-based Participatory Research
• When the community and researchers are equally involved in the research process
• Decisions are made together and both parties have a sense of ownership
• Reach out to local universities or work contacts to see if anyone is interested in partnering for a research study
Chronic Health Crisis
Prezi


Chronic Health Crisis
• Half of Americans have at least one chronic illness, and 40% of Americans are considered obese (CDC, 2018)
• Americans engage in only half the suggested preventive services (CDC, 2017)
• One of the most commonly cited reasons for not engaging is due to *cost*
Prezi


1. Nurse Empowerment
• We need more effective and accessible health promotion & education resources for the community!
• Do you feel your faith community would benefit from a health program?
• You can use your gifts as a nurse to organize a health program to serve your faith community
• This resource is meant to give you tools and suggestions to start the process
Prezi

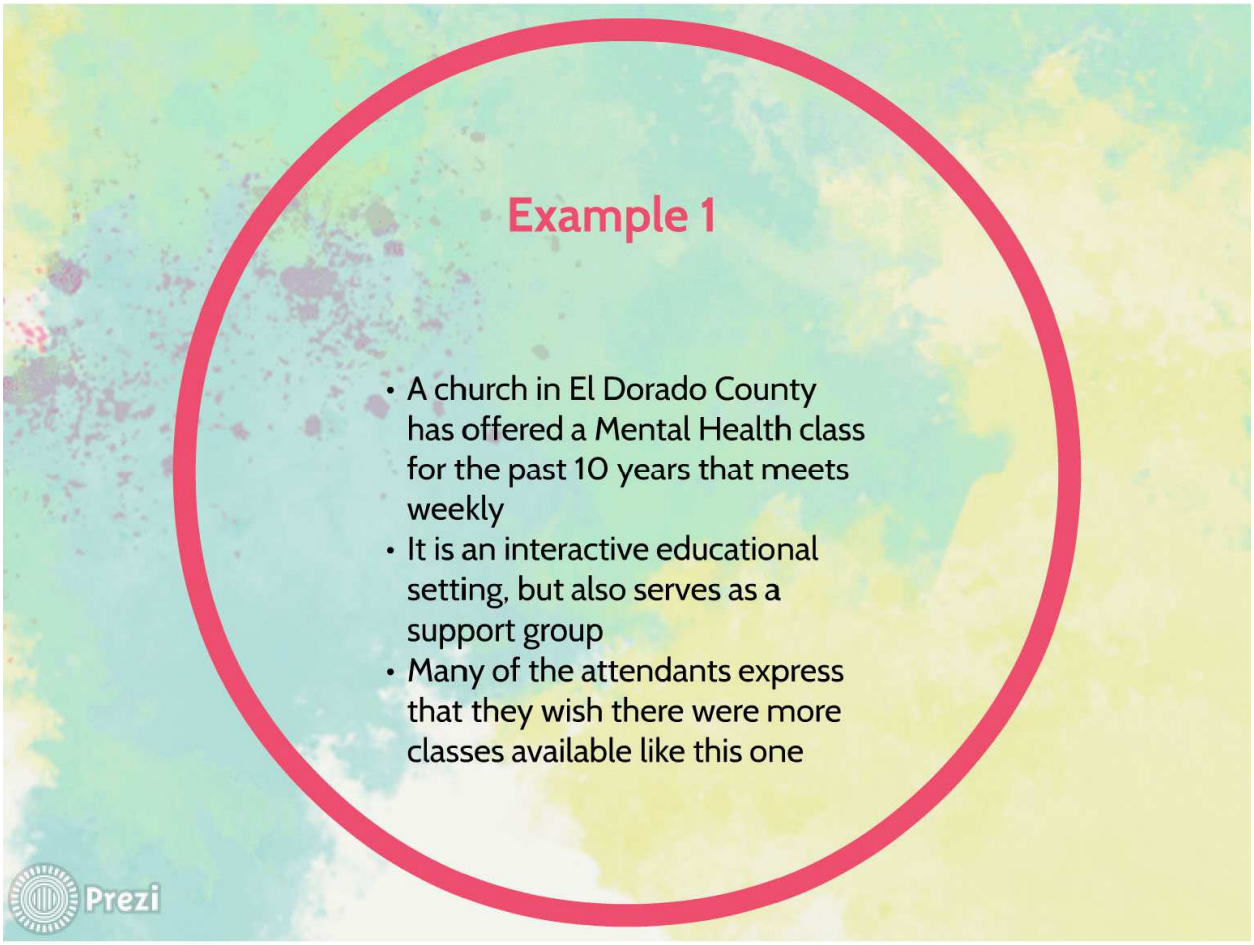
Nurse Empowerment in Action

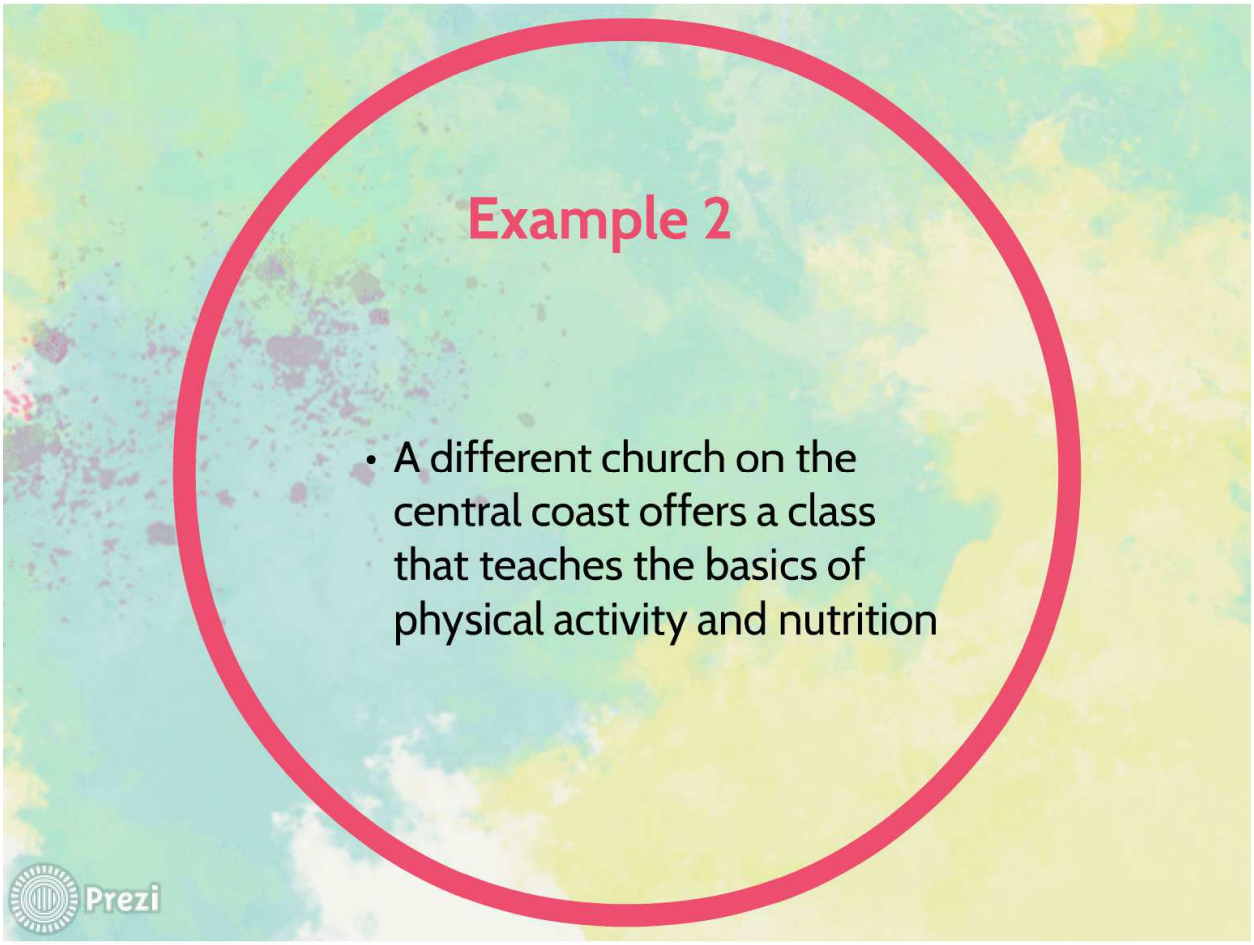
https://www.peakgrantmaking.org/blog/using-data-collaborate-actionable-steps-true-community-partners/

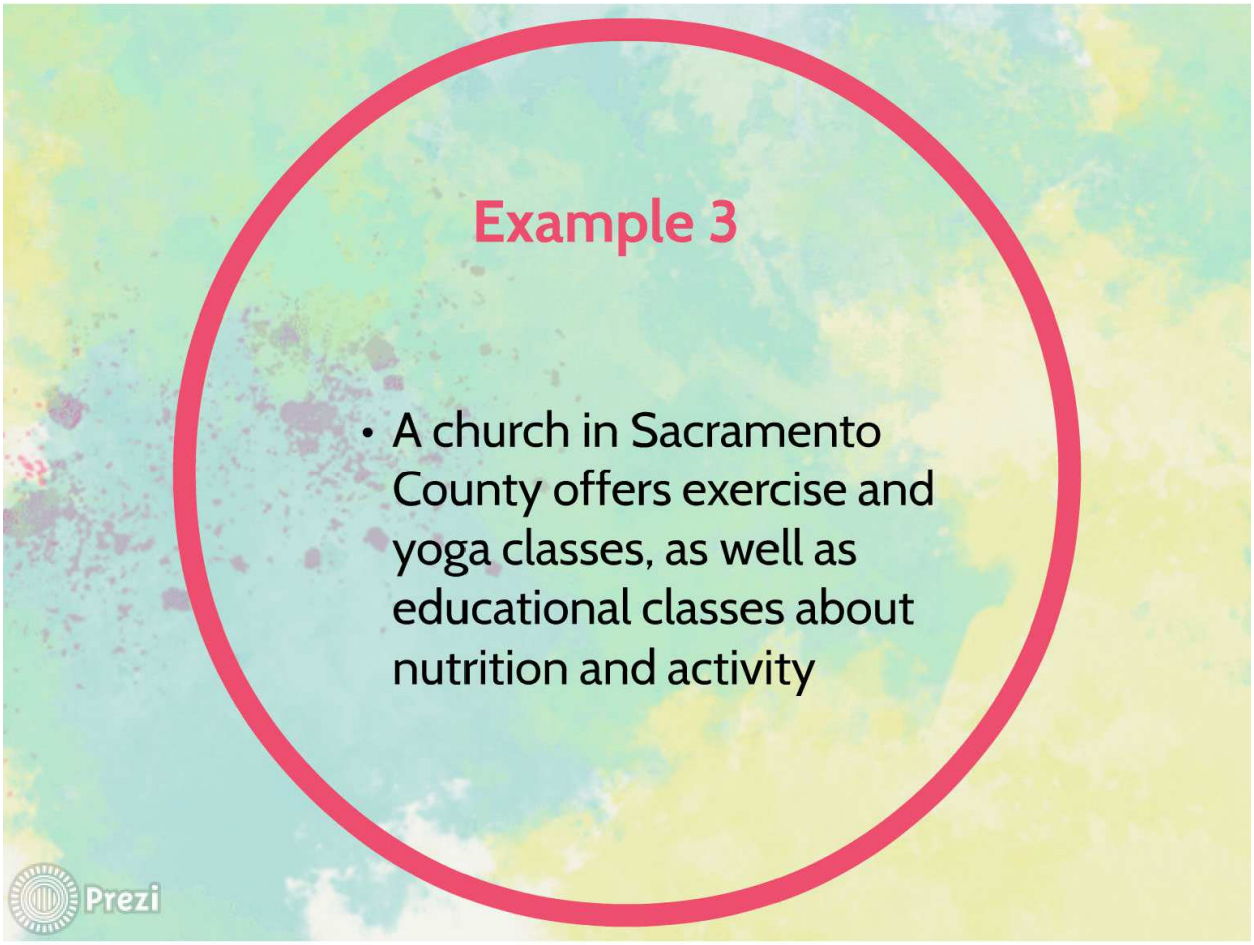
- Collaborate with your senior pastor and other faith leaders to determine whether implementing a health program within the church would be acceptable

Prezi


Community-based Participatory Research
• When the community and researchers are equally involved in the research process
• Decisions are made together and both parties have a sense of ownership
• Reach out to local universities or work contacts to see if anyone is interested in partnering for a research study
Prezi

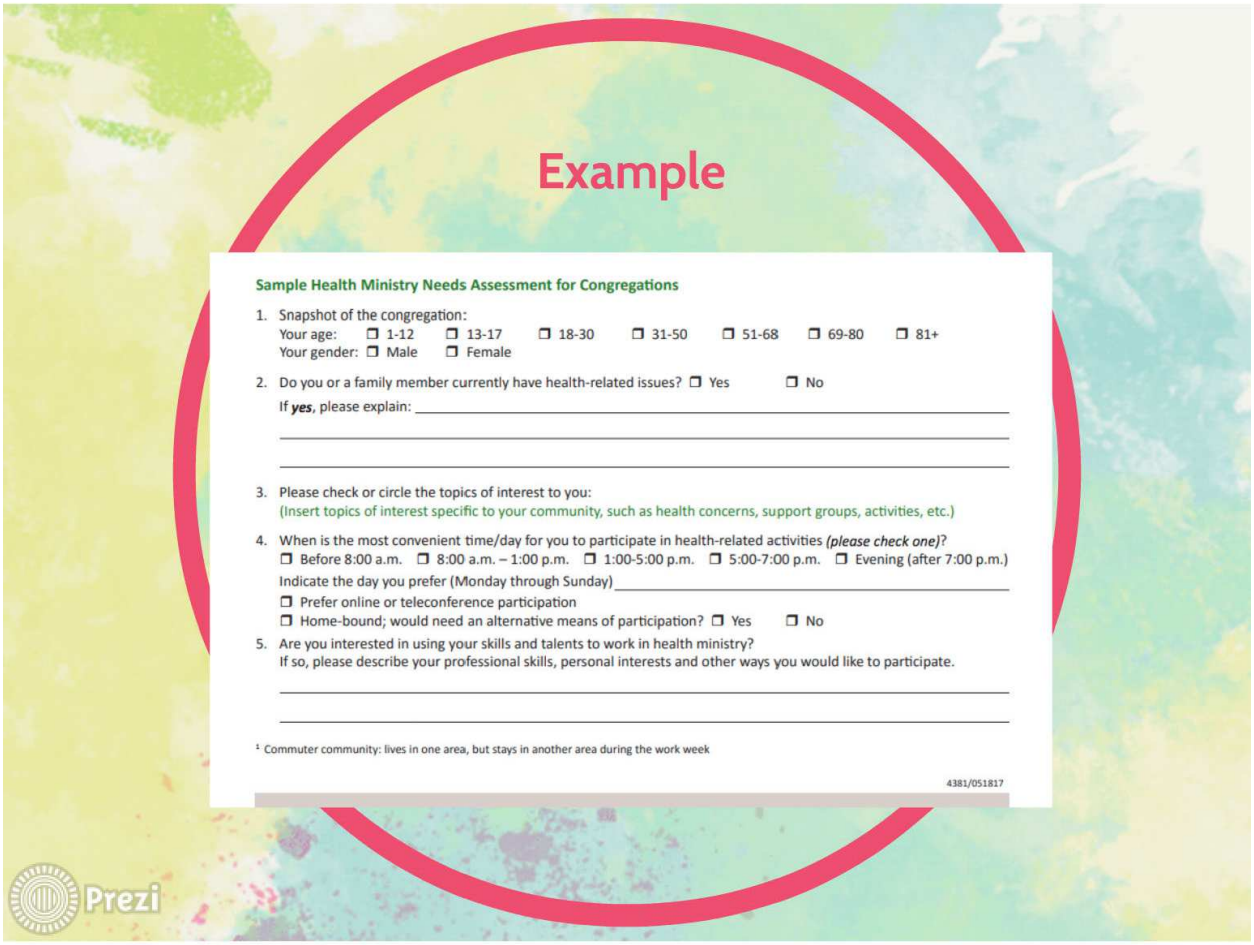

Example 1
• A church in El Dorado County has offered a Mental Health class for the past 10 years that meets weekly
• It is an interactive educational setting, but also serves as a support group
• Many of the attendants express that they wish there were more classes available like this one
Prezi


Example 2
• A different church on the central coast offers a class that teaches the basics of physical activity and nutrition
Prezi


Example 3
• A church in Sacramento County offers exercise and yoga classes, as well as educational classes about nutrition and activity
Prezi


2. Health Needs Assessment Tool
• This is a tool used to gather information on the health needs of the faith community-including current health issues, health issues of interest, convenient meeting times
Prezi
Needs Assessment


Needs
Assessment
• You can create your own or use one that has already been created and modify to make relevant to your community
• Distribute to the congregation to fill out and return
Prezi


Example
Sample Health Ministry Needs Assessment for Congregations
1. Snapshot of the congregation:
Your age: ❒ 1-12 ❒ 13-17 ❒ 18-30 ❒ 31-50 ❒ 51-68 ❒ 69-80 ❒ 81+
Your gender: ❒ Male ❒ Female
2. Do you or a family member currently have health-related issues? ❒ Yes ❒ No
If yes, please explain: _____
3. Please check or circle the topics of interest to you:
(Insert topics of interest specific to your community, such as health concerns, support groups, activities, etc.)
4. When is the most convenient time/day for you to participate in health-related activities (please check one)?
❒ Before 8:00 a.m. ❒ 8:00 a.m. – 1:00 p.m. ❒ 1:00-5:00 p.m. ❒ 5:00-7:00 p.m. ❒ Evening (after 7:00 p.m.)
Indicate the day you prefer (Monday through Sunday) _____
❒ Prefer online or teleconference participation
❒ Home-bound; would need an alternative means of participation? ❒ Yes ❒ No
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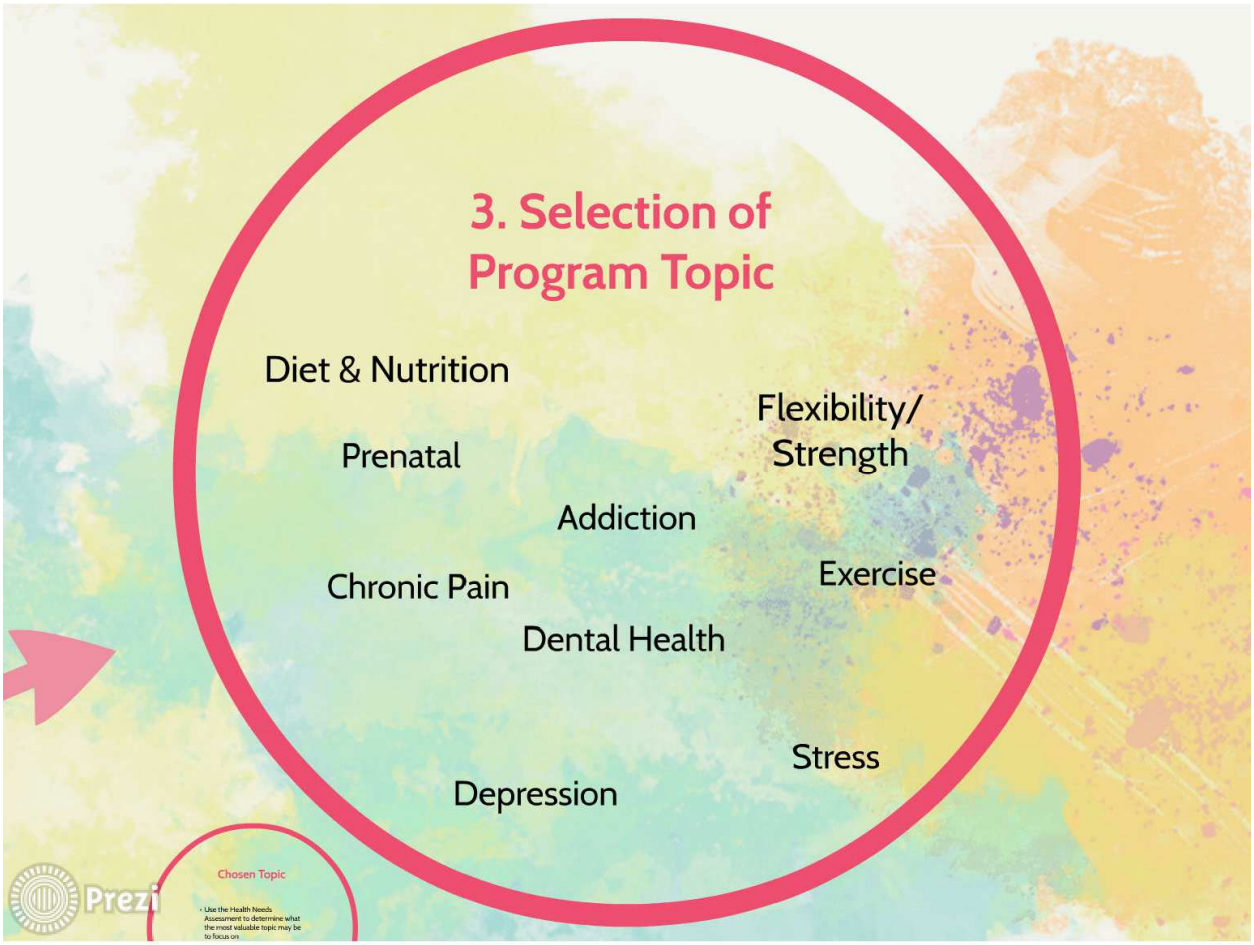
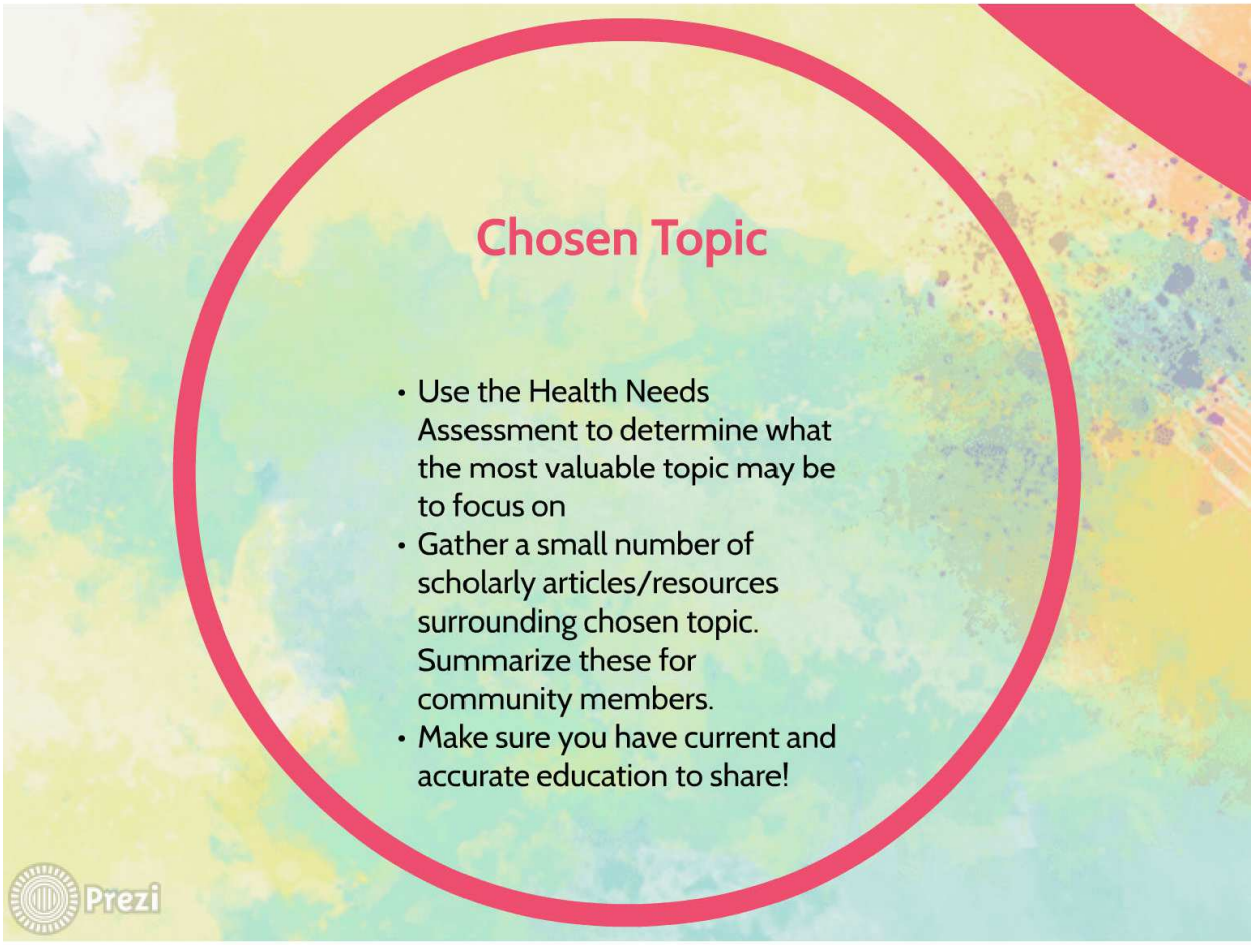
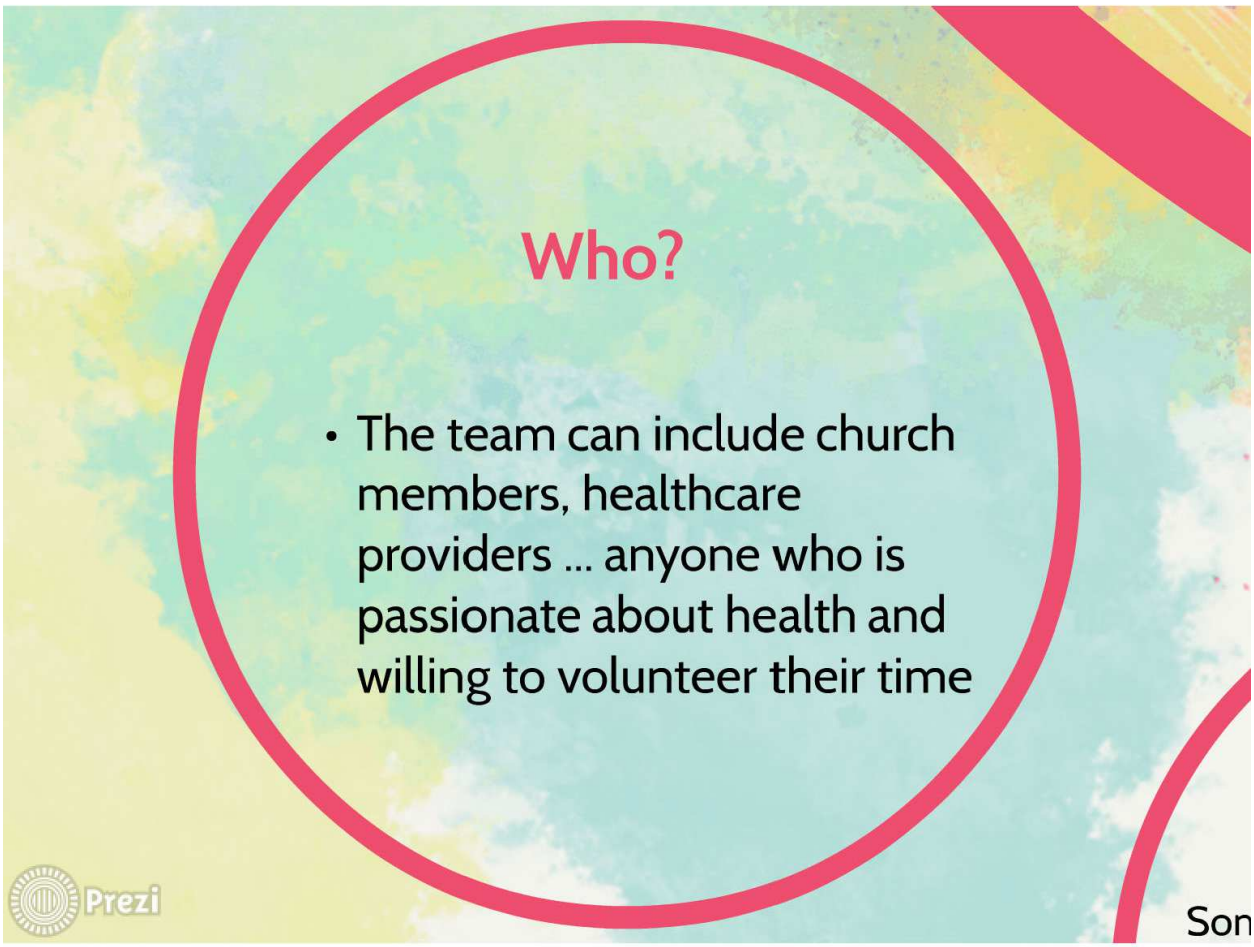
Prezi

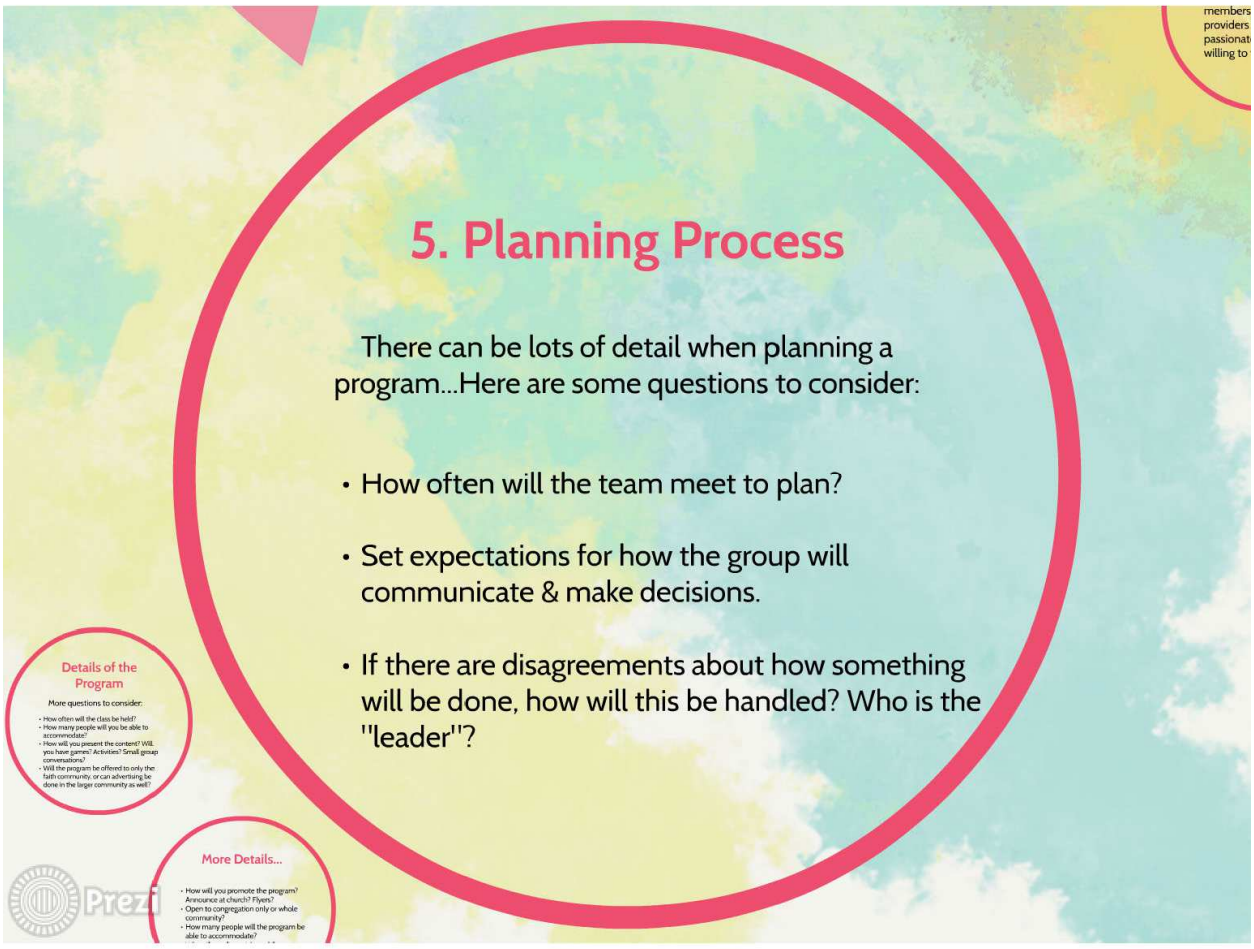

3. Selection of Program Topic
Diet & Nutrition
Prenatal
Flexibility/ Strength
Addiction
Exercise
Chronic Pain
Dental Health
Stress
Depression
Chosen Topic
Use the Health Needs Assessment to determine what the most valuable topic may be to focus on
Prezi

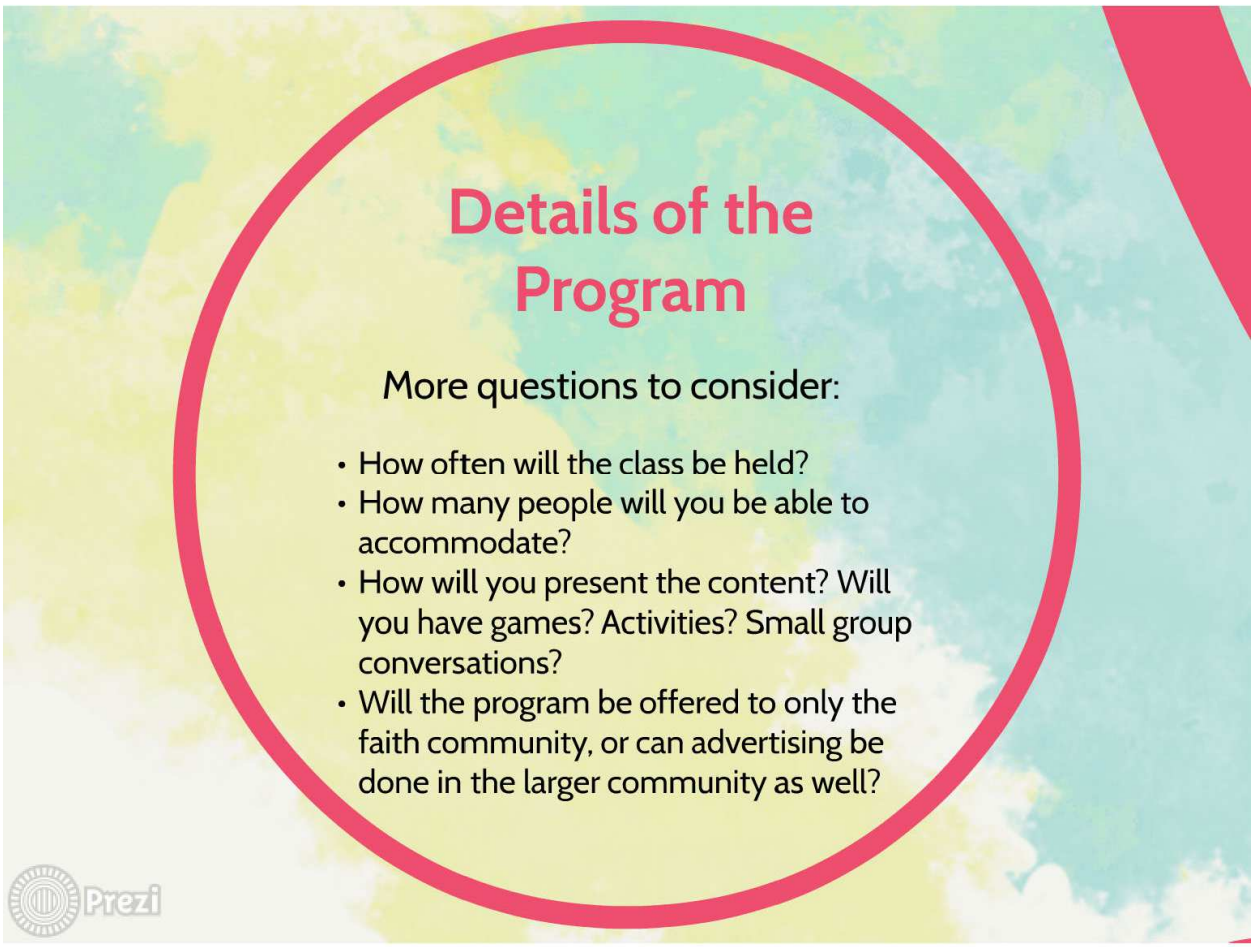

Chosen Topic
• Use the Health Needs Assessment to determine what the most valuable topic may be to focus on
• Gather a small number of scholarly articles/resources surrounding chosen topic. Summarize these for community members.
• Make sure you have current and accurate education to share!
Prezi


4. Formation of Project Team
• Include in the health needs assessment something like this:
• "Would you be willing to give of your time and talent to our health ministry?"
• This may help you begin to build your project team
Who?
• The team can include church members, healthcare providers ... anyone who is
Prezi


Who?
• The team can include church members, healthcare providers ... anyone who is passionate about health and willing to volunteer their time
Prezi
Son


Potential Roles
Some examples of roles members can play:
• Leading/teaching classes
• Gathering articles/information on topic
• Graphic designing
• Advertising
Prezi


members
providers
passionat
willing to
5. Planning Process
There can be lots of detail when planning a program...Here are some questions to consider:
• How often will the team meet to plan?
• Set expectations for how the group will communicate & make decisions.
• If there are disagreements about how something will be done, how will this be handled? Who is the "leader"?
Details of the Program
More questions to consider:
• How often will the class be held?
• How many people will you be able to accommodate?
• How will you present the content? Will you have games? Activities? Small group conversations?
• Will the program be offered to only the faith community, or can advertising be done in the larger community as well?
More Details...
• How will you promote the program? Announce at church? Flyers?
• Open to congregation only or whole community?
• How many people will the program be able to accommodate?
Prezi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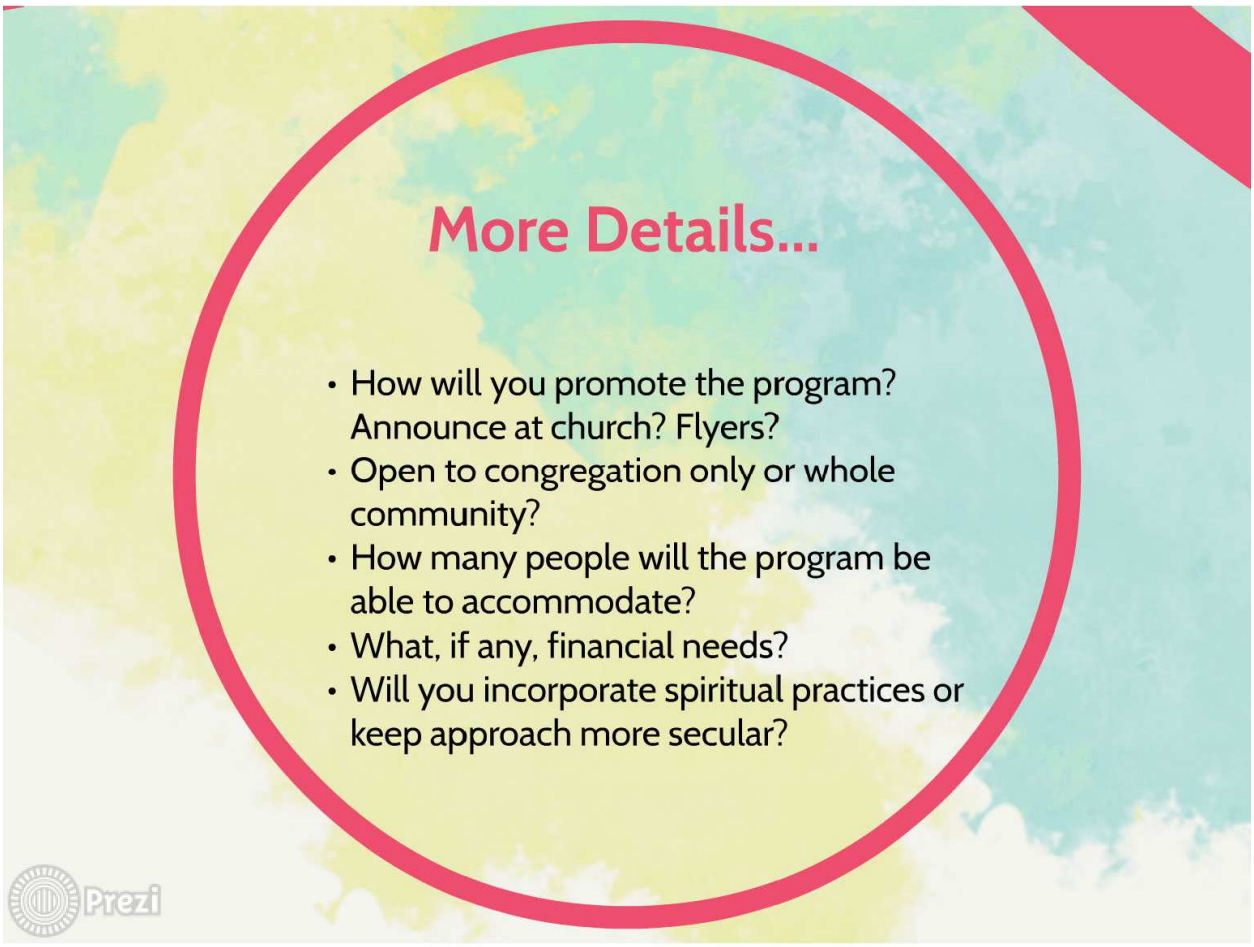
Prezi


More Details...
• How will you promote the program? Announce at church? Flyers?
• Open to congregation only or whole community?
• How many people will the program be able to accommodate?
• What, if any, financial needs?
• Will you incorporate spiritual practices or keep approach more secular?
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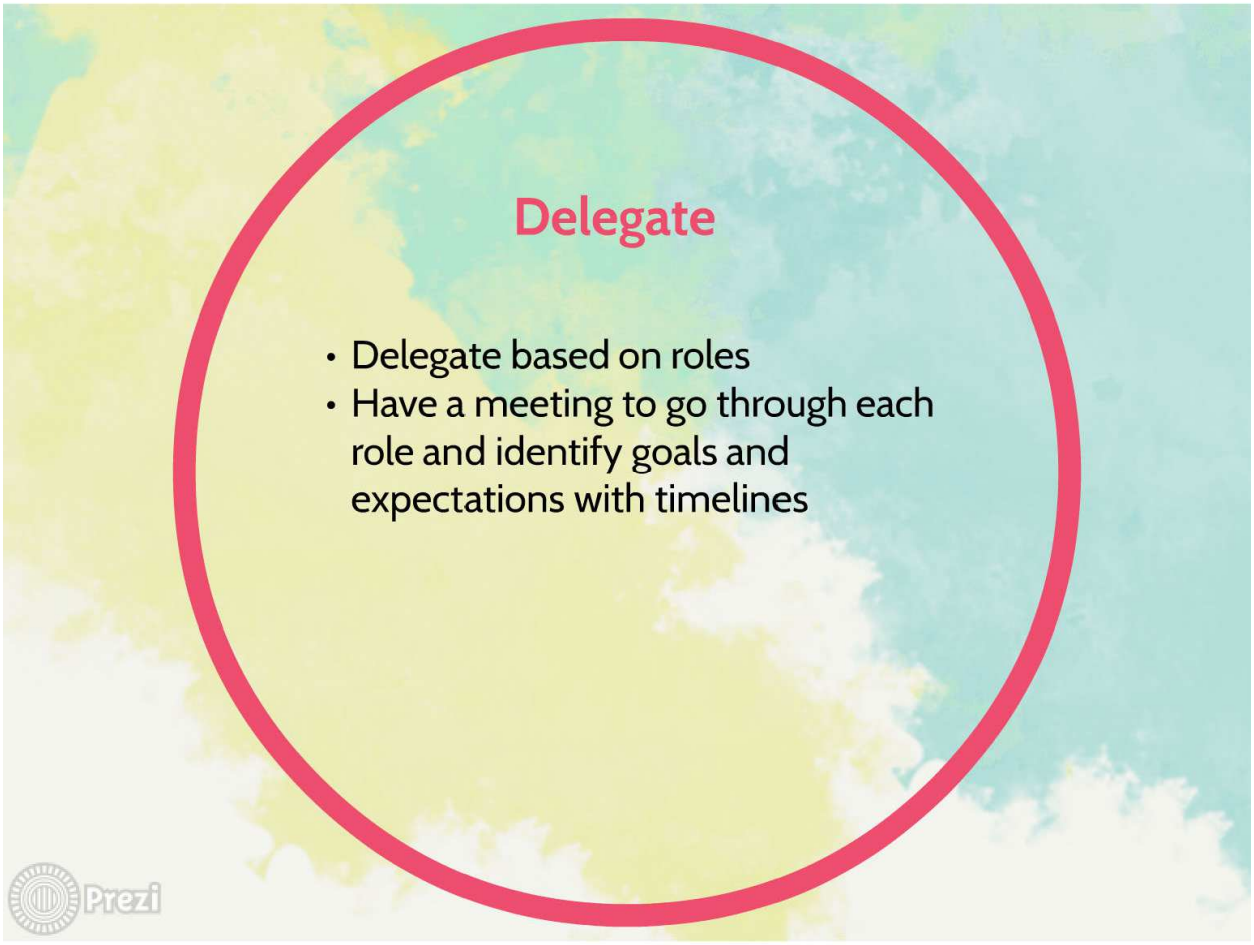
Delegate
• Delegate based on roles
• Have a meeting to go through each role and identify goals and expectations with timelines
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Goals
• Create specific, measurable goals to reach by the end of the program.
• Examples:
• 90% of participants will report eating 3 or more servings of vegetables daily.
• 90% of participants will lose 5% of their body weight.
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6. Implementation
• Be prepared. Provide helpful handouts that participants can take home
• Assess the participants' needs and understanding level each session and make modifications as necessary
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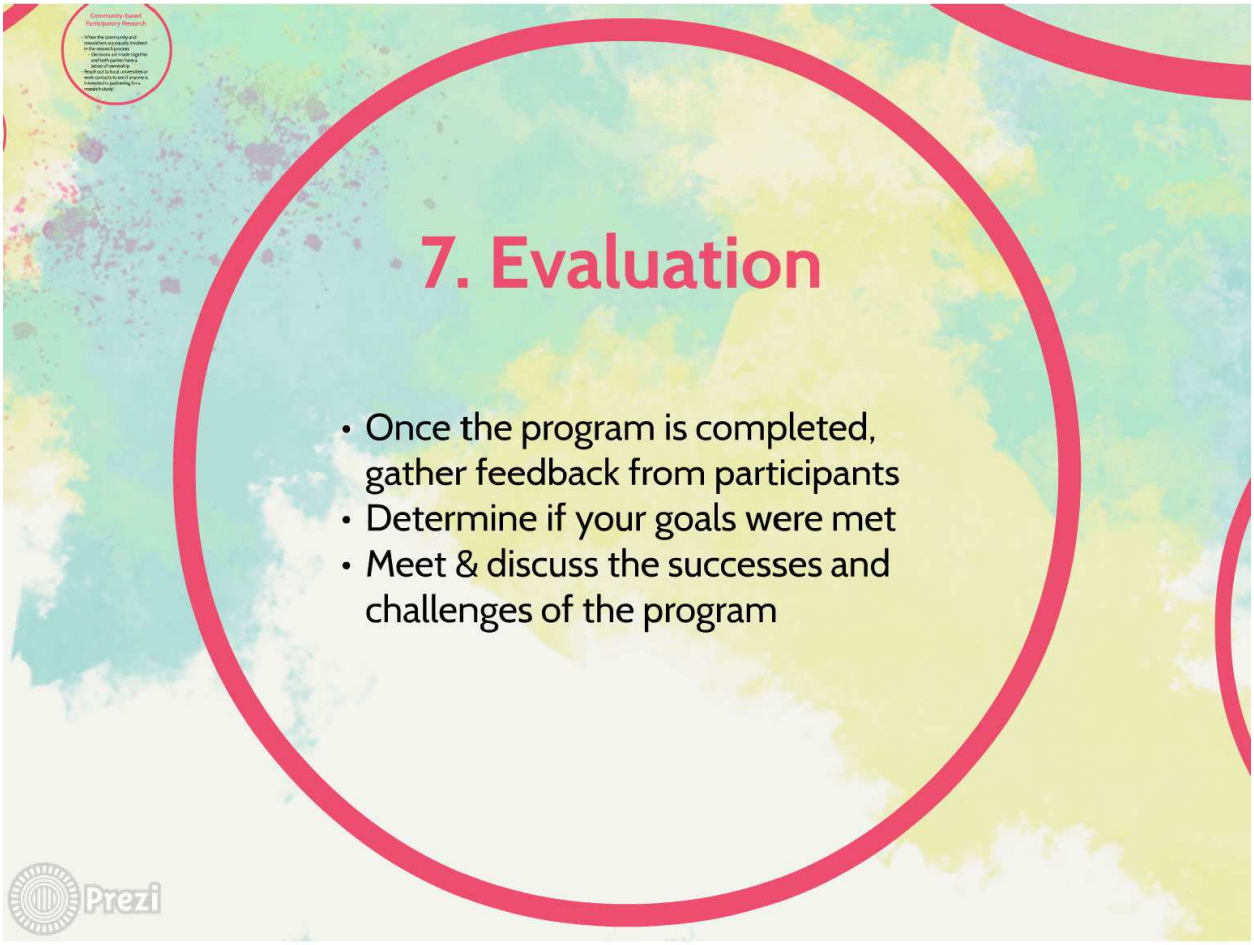
7. Evaluation
• Once the program is completed, gather feedback from participants
• Determine if your goals were met
• Meet & discuss the successes and challenges of the program
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References
• Brenan, M. (2017). Nurses keep healthy lead as most honest, ethical profession. Gallup Economy. Retrieved from http://news.gallup.com/poll/224639/nurses-keep-healthy-lead-honest-ethical-profession.aspx.
• Pender, N., Murdaugh, C., & Parsons, M. (2015). Health promotion in nursing practice. Upper Saddle River, NJ: Pearson Education Inc.
• Viswanathan, M., Ammerman, A., Eng, E., et al. (2004). Community-based participatory research: Assessing the evidence: Summary. Agency for Healthcare Research and Quality, Rockville, MD. (Report No. 99)
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