HEALTH PROMOTION: A COLLABORATIVE MODEL FOR

FAITH COMMUNITY NURSING

By

KRISTEN A. PALPANT

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the project of KRISTEN A. PALPANT find it satisfactory and recommend that it be accepted.

Kris Miller, DNS, RN

Tina Bayne, MN-APRN,

Margaret Jones, MN, ARNP, CS
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Abstract

By Kristen A. Palpant, MN
Washington State University
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Chair: Kris Miller

The Faith Community Nursing Health Promotion Model is proposed as a tool for the Faith Community Nurse (FCN) to improve the quality of health promotion program development and outcomes for the congregational community. Application to the planning of a health fair illustrates key features of the new model, including: emphasis on assessment of congregational population and subpopulation needs, partnership building and incorporation of a population-focused prevention typology to guide program development.
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Introduction

The purpose of this article is to propose a faith community nursing health promotion model that incorporates a three-tiered prevention framework (See Appendix B) developed by the Institute of Medicine (Mrazek & Haggerty, 1994), and includes expanded collaborative relationships. The model is designed to serve as a guide to the FCN in initiating collaborative and partnering relationships with community health agencies while developing services for tailored prevention and health promotion programs. These programs are designed to meet the needs of populations within the congregation and to establish a foundation for long-term community relationships that support the health of the congregation. Application of the Faith Community Nursing Health Promotion Model (FCNHPM) (See Figure 1 on page 6) will be illustrated with an example of planning a health fair for a congregation (See Appendix A).

Parish nursing began as a specialty practice in the early 1980's. In cooperation with six churches in the Chicago area, Lutheran Chaplain Granger Westberg (1988) designed a program to integrate faith and healing at the congregational level (Brudenell, 2003; Miskelly, 1995; Westberg, 1988). Today, over 140 sites in the United States and internationally offer parish nursing certification classes (Deaconess Parish Nurse Ministries, 2009), reflecting the burgeoning number of parish nurses prepared to promote health and wellness in their congregations.

In 1998 the American Nurses Association (ANA) collaborated with the Health Ministries Association to develop scope and standards of practice for the parish nurse. These standards described potential parish nurse roles; including, promoter of faith and health, counselor, educator, advocate, coordinator, and referral advisor. In 2005 the document was re-titled Faith Community Nursing Scope and Standards of Practice and revised to keep pace with the evolving specialty. The primary roles remained the same, but preferred minimum preparation became a baccalaureate or higher degree. Research, evidence-based practice, population-
specific programs, and multidisciplinary health promotion partnerships were included as part of FCN advanced practice.

Health Promotion Roles of the Faith Community Nurse

Faith community nursing roles embody integration of health promotion and holistic care. As an accepted and respected member of a congregation, the FCN engages in a ministry of presence (see background shading in Figure 1) to promote faith and health through active involvement and visibility within the faith community (Smucker & Weinberg, 2009). The ministry of presence deepens and extends connections and relationships with the congregation over time. Relationships open the door for the counseling role which includes listening and spiritual guidance from a holistic perspective that incorporates body, mind, and spirit. With this perspective, the FCN can convey to others that a sense of well-being can be encouraged, even when healing cannot be achieved (ANA, 2005).

The FCN is uniquely qualified to promote health not simply as the absence of disease, but as spiritual, physical, social, and psychological well-being, and as a sense of harmony with self, others, the environment, and God (ANA, 2005). Health promotion-focused roles are integral to FCN practice. In the role of educator, the FCN disseminates information that supports optimal health and decreases health risks (Wilson, Mood, Risk, & Kershaw, 2003). The caring church environment is ideal for both formal and informal health teaching, as well as opportunities for follow up teaching with church members (Wilson, et al., 2003).

Promoting health through advocacy, the FCN represents the congregation within the health care system and the community at-large. The advocate, coordinator, and referral advisor roles may all be engaged to promote health by bridging service gaps and helping individuals and families navigate through systems, institutions, and agencies for health care access. These roles are used to build strong, mutually supportive relationships between the health ministry and the community health resources needed to promote congregational health (Brudenell, 2003; Schweitzer, Norberg, & Larson, 2002; Wallace, Tuck, Boland, & Witucki. 2002). Health
promotion and prevention program planning are an extremely important part of the work of the FCN and depend heavily on the educator, coordinator, advocate, and counselor roles. The range and scope of the congregation’s health needs and the programs required to address those needs can be very broad. In addition to the roles used for prevention and health promotion, the FCN needs tools to help support systematic program planning and implementation.

Parish /Faith Community Nursing Models and Prevention Frameworks

Parish and Faith Community Nursing Models

Limited research and lack of models designed for specific application to faith community nursing restrict the evidence base for FCN practice. However, there are other models, guidelines, and processes that could be adapted and incorporated for FCN practice. Tools can be used to improve and strengthen the practice and provide clear guidance for health promotion. According to Healthy People 2010: Understanding and Improving Health (USDHHS, 2000), community health nurses (CHN) and agencies are key players in providing prevention and health promotion programs and services. The FCN’s expanded scope of practice and integration into both the congregation and the community can be an important resource in achieving our national goals of eliminating disparities and improving health and wellness.

The roles defined by ANA (2005) and the Health Ministry Association along with a loosely structured parish community health nursing model described by Miskelly (1995), derived from the works of Stanhope and Lancaster (Shuster & Goeppinger, 2002), have served as a practice framework for faith community nursing. Miskelly’s parish nursing model includes the following steps: assessing needs, identifying aggregates, implementing plans and programs, coalition building, and process and outcome evaluation. The FCNHPM is based on the principles of Miskelly’s parish community health nursing model and the Institute of Medicine’s (IOM) prevention framework (Mrazek & Haggerty, 1994) (See Appendix B).
Current prevention and health promotion efforts must increase in scope, focus, and sophistication if they are to become a fundamental foundation for improving health in America. Weis, Matheus, and Schank (1997) emphasized that “New models must focus on health promotion and disease prevention and emphasize self-care and individual responsibility” (p. 368). The Faith Community Nursing Health Promotion Model (FCNHPM) proposed here (See Figure 1 on p. 6) is designed to help the FCN develop targeted health promotion and early prevention activities, using familiar roles and increasing the use of the community-focused collaborator role.

**Prevention Frameworks**

For decades, the traditional public health prevention classifications have been designated as primary, secondary, and tertiary prevention (Commission on Chronic Illness, 1957). The framework for prevention and health promotion within the Faith Community Nursing Health Promotion Model is provided by the population-focused, tiered approach introduced by the Institute of Medicine (IOM) (Mrazek & Haggerty, 1994). This framework, conceived by Gordon in 1983, was later defined and refined by the IOM in the publication titled *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* (Mrazek & Haggerty, 1994).

Based on population-focused prevention, the IOM framework identifies three types of programs for populations or subpopulations most likely to benefit from prevention programs (U.S. Public Health Service, n.d., Risk Factors and Protective Factors, para 3; Mrazek & Haggerty, 1994): *universal, selective, and indicated* (See Appendix B). Universal prevention programs are designed for total populations, often the general public. Selective prevention programs are appropriate for a population or subpopulation with elevated risk factors that can be reduced or eliminated through targeted programs. An indicated prevention program is directed at persons who manifest a risk factor or abnormality identified as being at especially high risk for the future development of a disease or health problem.
The IOM framework focuses on actual prevention: only those steps taken before health problems occur. Screening and rehabilitation are excluded, with the primary prevention and health promotion portion of the traditional public health model comprising the focus of the IOM framework. Significantly different in the IOM prevention framework is a program development focus and organizational structure centered on populations and their risk levels, rather than disease identification and management.

The Faith Community Nursing Health Promotion Model (FCNHPM)

The Faith Community Nursing Health Promotion Model (See Figure 1) consists of six phases, to assist the FCN in identifying populations within the congregation and their health risks and provide structure that can improve the relevance and effectiveness of prevention programs more effectively than broad, less focused programs. Throughout the model, collaboration and building partnerships are integrated into each phase.

Phase 1: Assessment

According to Swinney, Anson-Wonkka, Maki, & Corneau (2001), a congregational community assessment must produce information that is (a) empirical, (b) systematic, and (c) appropriate for decision making and planning. Data collection tools for target population assessment have included community forums, surveys, interviews (Goldman & Schmalz, 2004; Hecker, 2000; Swinney et al., 2001; Wilson, 2000) and combinations of these tools. The tools should be adapted for use in a congregation needs assessment to assure that the data gathered is comprehensive enough to support targeted program development. An example of an especially thorough community assessment tool was developed and reported by Pallant (2002) in the *Health Needs Assessment Tool Kit*.

Health promotion experts recommend congregational community member involvement in conjunction with the assessment process (Pender, Murdaugh, & Parsons, 2006) as a means to ensure that health information and experiences the community wants will be included. In some congregations, the act of including community agency or health care organization...
representatives in planning and conducting the needs assessment could be beneficial, depending on the general characteristics of the congregation.

Faith Community Nursing
Health Promotion Model

*Phase 1: Needs Assessment

*Phase 2: Identification of Population Risks

*Phase 3: Program Planning

*Phase 4: Partnership Building

*Phase 5: Program Implementation

*Phase 6: Process and Health Outcome Evaluation

Community/Congregation Needs Assessment (NA)

**UNIVERSAL population

**SELECTIVE population

**INDICATED population

Community Church Board

Subgroup within church with identified need

Individual needing specific intervention because of high risk for disease

Health Education Articles/Classes

Support Groups

Follow-up Visits/Phone Calls

External/Internet Collaboration and Partnerships

Health Promotion Program

Universal Programs

Selective Programs (Follow-up referral if needed)

Indicated Programs (Follow-up referral if needed)

Evaluation

Ministry of Presence

*(Miskelly, 1995)

**(Mrazek & Haggerty, 1994)

Figure 1
Phase 2: Identification of Population Risks

Phase 2 of the FCNHP entails reviewing the needs assessment data and identifying the types and levels of health risks and risk factors shared by groups or populations within the congregation. The IOM framework can then be used to determine specific groups or subpopulations that could benefit from universal, selective, or indicated prevention interventions. The needs assessment should also reveal information about congregation members’ perceived needs and other factors that should be considered in developing relevant intervention and prevention programs. Congregation member participation can be helpful in this phase of the process for identification of cultural traditions and beliefs, education and literacy levels, language preferences (Aponte & Nickitas, 2007), and socio-economic status that will affect program planning.

Phase 3: Program Planning

Two types of planning are involved in health promotion programs for congregational communities: content and delivery methods. Content planning focuses on the perceived needs and risk levels of the populations identified within the congregation. The FCNHPM Phase 3 focused program planning utilizes the IOM prevention framework (Mrazek & Haggerty, 1994) as a guide for population-focused prevention program and intervention development. Health promotion and prevention activities and resources can be identified to address levels of specific risks of populations identified within the congregation. This focused approach is intended to bring together those at risk with the people, programs, and services best able to help reduce the risk and prevent problems before they occur.

The whole congregation is the target population for universal prevention because these programs are intended to benefit everyone. Seat belt use, safe food handling at home, and interpersonal communication and conflict resolution skills are examples of universal prevention programs. In many cases, this type of program may be easier to implement than those for populations with higher risk levels. “In many cases, universal preventive measures can be
applied without professional advice or assistance. The benefits outweigh the costs and risks for everyone” (Mrazek & Haggerty, 1994, p. 21).

Selective prevention programs are appropriate for an identified population or subpopulation with elevated risk factors that can be reduced or eliminated through programs targeted to that population. Examples include interactive social activities for isolated older adults and mentoring for children of single parents (Gordon, 1983; Mrazek & Haggerty, 1994).

An indicated prevention program is directed at persons who manifest a risk factor or abnormality identified as being at especially high risk for the future development of a disease or health problem. The IOM recommends implementation of indicated prevention measures to improve outcomes for smaller targeted populations, even when cost is involved (Mrazek & Haggerty, 1994). Examples of indicated measures include stress management courses for laid off workers, workshops on home safety modifications for families of individuals with physical disabilities, and support groups for family members of individuals with drug and alcohol problems.

Congregation members’ involvement in the planning of faith-based programs increases the relevance and acceptance for those programs. Involving community agency representatives in the program planning process increases perspective, expertise, and community ownership in the project. These partnerships also provide a foundation for continuing relationships (Hecker, 2000). External experts and agency representatives also can provide helpful program information and prevention resources that may not previously have been available to the FCN and the congregation.

Phase 4: Partnerships

In Phase 4 of the FCNHPM, the FCN intensifies collaboration and partnership development begun with the relationships formed in earlier phases of the model. Partnerships for congregation health promotion and prevention programs should start within the faith community. Faith community nurses can continue to build and support partnership development
by involving congregation members in collaboration with external community agencies and organizations (Weis, Matheus, & Schank, 1997).

Brudenell (2003) asserts that community health must decrease the gap between community health agencies and resources and the faith-based community. One way this gap can be bridged is through partnerships. Collaborations established in the process of the needs assessment and program planning can provide a very good foundation for partnerships. Collaboration can benefit all parties or stakeholders involved by decreasing competition and placing focus on a common goal (Robertson & Baldwin, 2007). By working with individuals and agencies in the community in program planning, the FCN can learn which have goals, programs, or services that could be of benefit to the congregation. Shared goals and resources are important for effective partnerships; but, other characteristics are also needed, including mutual trust, equal power, and reciprocal contributions to achievement of the shared goals.

“Community partnerships, particularly when they reach out to nontraditional partners, can be among the most effective tools for improving health in communities” (USDHHS, 2000, p. 4). Strengthened connections within the congregation and with outside community agencies can support the community's ability to participate in the transformation of the environment of the targeted community, or empowerment (Pender, Murdaugh, & Parson, 2006).

**Phases 5 and 6: Program Implementation and Evaluation**

**Program Implementation.** The FCN may or may not be directly responsible for prevention program implementation. Often, other congregation members or community agencies or individuals can provide a program for a congregation that was developed in collaboration or partnership with the FCN. For some programs, the FCN may be instrumental in preparing other congregation members to lead or implement health promotion activities or programs. Regardless of the role played in implementation of a specific program, the FCN should be a resource, supporter, and facilitator for that program. “The church can provide the social and emotional reinforcement needed for health promotion programs to be effective”
(Wilson, 2000, p. 40). The FCN can provide, and encourage other members to provide, emotional reinforcement and support for health promotion and the potential for a sense of well being among all congregation members. Social support through partnerships with individuals, families, and communities can promote knowledge, skills, and confidence to successfully care for oneself and encourage people to “take responsibility for their own health” (Kane, 2008). “When community members are given the opportunity to be partners in their care and receive information and support, they are more apt to develop healthier lifestyles and stronger community resources” (Dillon & Sternas, 1997, p. 11).

Program Evaluation. The primary goal of the FCNHPM evaluation phase is to assess whether the objectives established for programs during planning phase were achieved. Some objectives focus on program outcomes for participants, including satisfaction with the program, changes in behavior or attitudes, or new skill development (Dillon & Sternas, 1997; Wilson, 2000). Surveys, focus groups, and short interviews and similar standard evaluation tools can be adapted for use with the FCNHPM. Evaluation of long term health status outcomes is more complex and may be difficult to achieve without help or consultation from collaborators or partners with sophisticated resources and expertise.

Some aspects of evaluation may address the program process, such as program attendance or utilization levels. Potential positive program process outcomes also can include successful partnerships, resource development, and program planning tools. Successful relationships and collaborations established during program planning and implementation can increase the visibility and acceptance of the health ministry and the importance of health promotion in congregational health (B. Kobbs, personal communication, January 17, 2009). Community agency evaluations also provide feedback about strengths and limitations of congregation health promotion programs in which they were involved.

The data collected through health promotion program evaluations should be analyzed and incorporated into the early phases of the Faith Community Nursing Health Promotion Model.
to clarify congregation health needs and risks, strengthen collaborations and partnerships and plan future universal, selective, and indicated prevention programs. Although identified as a single phase in the FCNHPM, evaluation should be a continuous part of the process depicted by the model.

Conclusion

The faith community nurse is an integral part of the congregational community. The FCN’s ministry of presence facilitates role development and opportunities for health resource improvement on behalf of the congregation. Through the health ministry and leadership ability, the FCN can elevate holistic prevention and health promotion to a central focus for congregational communities. The Faith Community Nursing Health Promotion Model, an expanded version of the community health parish nursing model, is proposed as a means of improving the quality and specificity of health promotion and prevention within the congregational community. The effectiveness of the model’s use in the practice of individual FCNs, as well as the health of their congregations must be tested, along with its effect on increasing and strengthening community ties with the congregation.

The Faith Community Nursing Health Promotion Model synthesizes principles of community health nursing, tiered prevention, and partnering into a framework for population-focused prevention and health promotion program planning. The model directs assessment, planning, partnership building, implementation, and evaluation while focusing on prevention and health promotion for specific populations. The emphasis on partnerships encouraged by the model reflects the expanding role of the FCN and extends the nurse’s ability to impact the health of the congregational community and the community at large.
Appendix A

Model Application: Congregation Health Fair and Partnership Development

Health fairs have been used often in other contexts but are a relatively new tool for FCNs. They provide an opportunity for significant numbers of congregation members to have direct, face-to-face contact with community agencies or program staff and volunteers. Congregation members can evaluate the potential usefulness of what an agency or program has to offer and begin developing a relationship with them. The Faith Community Nursing Health Promotion Model can be especially useful for FCNs while planning health fairs that provide targeted universal, selective, and indicated prevention activities. Following are some examples of how the FCNHPM can guide that process.

Congregation Needs Assessment

Most church communities are composed of subgroups with separate needs and health risks that should be addressed at the health fair through activities specific to their needs. The FCNHPM encourages thorough and detailed data collection for identification of populations and their risk levels. Knowing how the data will be used can help the FCN create or modify existing needs assessment tools to gather the population information needed for a successful health fair.

Another important element of the assessment phase of the FCNHPM is establishing new relationships and partnership building. Congregational community members' involvement in the needs assessment process can provide access to information about groups in the congregation that may be especially difficult to reach through traditional approaches. Informal interviews, talking with key informants, and small group discussions can be led by appropriately prepared congregation volunteers from difficult to reach groups. These techniques could provide not only better assessment information about risks and needs, but could also create opportunities for relationship building for both volunteer leaders and members of the group. This congregation-as-partner approach to needs assessment helps builds internal relationships and connections.
for the FCN and assures congregation members that the information and experiences at the health fair will be relevant and appropriate for their needs.

**Identification of Population Risks**

Needs assessment data should be analyzed and grouped by risk factors, population and subpopulation characteristics, and health concerns or needs specifically identified by members. Carefully designed needs assessments also can identify potential resources for relevant intervention and prevention programs (Swinney, et al., 2001). The availability of specific population needs assessment data provides direction for developing each type of prevention activity or program during the health fair planning phase.

Congregations can vary considerably in size and composition and that must be taken into consideration when the FCN and planning group identify populations and risk levels for health fair program development. Universal prevention is always appropriate because its target is the general population, that is, the congregation as a whole. The size of some groups that need selective or indicated prevention may be so small that devoting significant health fair space and resources to meeting those needs may not be realistic. For these groups, locating resources outside the congregation may be an alternative for the FCN.

**Program Planning**

With populations and their risk levels identified within the congregation, the FCNHPM guides the FCN to the program planning phase of the health fair. Collaboration and partnership development increases in importance as specific community agencies, activities, and programs that will be included in the health fair are determined. Finding the resources for universal, selective, and indicated prevention among congregation resources and in the outside community requires creativity and successful collaboration.

Information, services, and programs that address risks or potential risks that everyone in the congregation faces would comprise universal prevention at the health fair. For example, the risk for excess weight, lack of physical activity, and/or inadequate nutrition exists for nearly
everyone to some extent. Creative, innovative, or entertaining activities or programs to address these universal risks are appropriate for the entire congregation, especially those that teach new skills and behaviors. The FCN could develop a relationship with the county extension service or the county health department that provide a wide variety of resources and expertise appropriate for each level of prevention.

Populations or subpopulations at increased risk in these same areas could benefit from selective interventions. For example, adolescents who are at higher risk for inactivity or eating inappropriate snack foods could have the opportunity at the health fair to try out new electronic media games designed to engage them in vigorous physical activity to play. If resources are available, this same group could be involved in creative nutritious snack making and tasting.

Subpopulations at especially high risk for development of health problems due to inactivity and/or poor nutrition require indicated prevention programs or activities. Individuals with chronic illnesses that limit their mobility are an example of a population that could benefit from specialized adaptive group activity sessions along with support groups. While this type of indicated prevention program may not be available within the congregation, the health fair could provide onsite information and person-to-person access to help these individuals connect with programs that are available in the community. The health fair setting also has the advantage of creating an informal, interactive environment in which congregants can identify solutions, not just problems.

Program Implementation and Evaluation

The final two phases of the FCNHPM test the effectiveness of the model, the FCN, and the health fair in providing universal, selective, and indicated prevention and developing collaborative and partnership relationships for health promotion. The goal of emphasizing health promotion at a congregational health fair is to help participants increase their control over and improve their physical, social, and emotional health and their sense of well-being (Loveland-Cherry, 2002; World Health Organization, 1986). The health fair is designed to help
the participants find resources and support for prevention of health problems and maintain healthy behaviors. The environment and atmosphere during the health fair should promote these overall goals and the delivery methods or strategies for prevention activities should be supportive, positive, and empowering. In addition to careful advanced planning, achieving this type of health fair environment is dependent upon excellent organization and delivery.

A smoothly run health fair requires the help of collaborators and partners who will consistently contribute on the health fair committee and help secure volunteers for the day of the event. Some of the specifics for planning a health fair include the timeline, location, and budget. Starting well in advance of the fair date is a common recommendation, with some authors recommending at least 4 months advance preparation (Aponte & Nickitas, 2007; Berry, 2002; Dillon and Sternas, 1997). Location within the church determines access for participants and the potential layout of booths/tables and activities (B. Hula, personal communication, January 15, 2009; P. Mercer, personal communication, January 15, 2009; M. Stoops, personal communication, January 15, 2009). Other planning areas to consider include clear objectives, advertisement, and responsibilities of volunteers and representatives from community agencies. (B. Hula, personal communication, January 15, 2009; P. Mercer, personal communication, January 15, 2009). Each of these details contributes to creating an atmosphere that reflects the safe and supportive environment that a church health fair can provide while addressing risks to health.

Evaluation of the health fair is very important for the FCN health ministry and the community agencies involved. Participants' and participating community agencies' evaluative feedback helps the FCN design future health promotion activities and interventions at universal, selective, and indicated levels. The FCN will consider all evaluation data from a health fair to assess the congregation members' responses and opinions about the programs and use the information to adjust the programs to meet each subpopulation's focused needs.
Some of the strategies that can be used for health fair evaluation include personal calls, community agency evaluations, and referral system development. The FCN could make personal calls to individuals, based on health fair documentation. The FCN can determine whether participants went to see their health care provider for their pre-hypertension, mammograms, or medication, etc. as recommended.

Community agency health fair participants may be willing to share their experiences of participating in the health fair. Their responses may provide strengths and limitations of the health fair from their perspective. The FCN might also enquire whether the community agencies are willing to participate again next year (Blanchfield, 2003). This information can provide the FCN resources for building a portfolio of valuable and reachable community resources for future health fairs or other health promotion programs.

Another health fair outcome might be the FCN’s development of a referral system for the attendees and the entire congregation community. The referral system may have long term implications for education and screenings for future health fairs.

"With a basis in sound nursing and program planning theory, church-based health fairs can be an effective means for reaching large numbers of individuals and improving a community’s level of wellness" (Wilson, 2000). Effective health fair outcomes should result from a cycle of congregation health needs assessment, partnerships with providers, and tailored health promotion programs for congregation members. The aim of these programs is to meet the needs and health concerns of the congregation population and subpopulations in a way that makes health promotion and prevention accessible and relevant to congregants and strengthens relations within the congregation and with the outside community.
Appendix B

IOM Prevention Framework

Figure 2 (Mrazek & Haggerty, 1994, p. 23)

Figure 3 (Adapted from the IOM framework description, Mrazek & Haggerty, 1994)
References


