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# Church-based Health Education: Topics of Interest

## **Cover Page Footnote**

I would like to acknowledge the Pastor, Parish Council, and Members of St. Mary Catholic Church for their assistance with this project.

Granger Westberg played a key role in the conceptualization of parish nursing in the 1970s and piloted the parish nurse role in the 1980s (Church Health Center, 2014). The name parish nursing has since changed to faith community nursing and much growth has occurred in the position. One can even look back many centuries prior to parish nursing or faith community nursing and note health ministry being evident in churches. There is a long history of deaconesses, sisters, and others providing services to aide in meeting physical and spiritual needs of others in their church community (Zersen, 1994). Today, seventy-seven percent of American adults identify with a specific church affiliation (Pew Research Center, 2015). This gives support for the development of health ministry programs in church settings as a venue to offer a variety of health services in a convenient, comfortable location in the community. Serving those with chronic medical conditions is a frequent part of health ministries (McGinnis & Zoske, 2016; Monay, Mangione, Sorrell-Thompson, & Baig, 2010). One important service that can be offered to members of a church community to aid in prevention and management of many chronic diseases is health education.

When thinking of implementing a health ministry program it is important to spend time on planning which should include getting input from members of the congregation. As noted by O'Brien (2011), listening to the needs of the community is essential. As discussion regarding the implementation of a health ministry program was occurring at St. Mary Catholic Church, input from the parishioners was recognized as being important. Interest of health topics by parish members has been noted to facilitate programs' success (Bopp & Fallon, 2013). The purpose of this descriptive correlational research study was to examine Parish members' interest of various health education topics.

## **Research Questions**

The research questions posed were:

1. Do church members believe offering health education on-site would be beneficial?
2. What do church members view as the most convenient time to offer health education on-site?
3. What health education topics would be of interest to the church members?
4. Is there a correlation between age or gender and topics of interest?

## **Methodology**

### **Design and Sample**

Approval for this descriptive correlational study was obtained from the institutional review board at the university where the researcher was employed. A convenience sample of adults, 18 years of age or older, attending weekend Mass (not including Hispanic Mass) at a Catholic church in South Central Kentucky was utilized for the study. At the end of Mass on Saturday evening and Sunday morning, during announcements, the researcher read the consent form to those in attendance. The researcher was then available in the Parish Hall to answer any questions and collect data. Those willing to participate were given a questionnaire to complete, which took approximately 10 minutes. Completion of the questionnaire was taken as implied consent. Data were collected anonymously with no names or identifying codes placed on the questionnaires. To encourage participation, snacks were provided following each Mass and each person completing a questionnaire had the opportunity to put their name in a drawing for a \$25.00 gift card to a retail store.

Forty-three adults were in attendance at the Saturday evening Mass and sixty-seven were in attendance at the Sunday morning Mass. If an individual was present at both Masses, they were included in only one of the attendance counts. Thirteen (30.2 % response rate) and twenty-five (37.3% response rate) questionnaires were received from the Saturday evening and Sunday morning Masses respectively. Combined, a total of 38 questionnaires out of a possible 110 (34.5% response rate) were received. The sample consisted of 11 males and 27 females. The age ranged from 19 to 80 years with a mean age of 54.31 (SD 16.4).

### **Instrument**

A researcher developed questionnaire was utilized. The questionnaire was designed to examine if the members of this specific Parish thought providing health education on-site at the Church would be beneficial, what times they believed would be best to offer the education, and what topics they perceived as being of interest. To enhance participation, the questionnaire was brief consisting of three demographic questions, one question regarding choice of times, and a list of sixteen health topics to examine perceived interest.

### **Results**

All data were entered and cleaned by the researcher. Data analysis was conducted using Statistical Package for Social Sciences (SPSS) version 23.0 (IBM, 2015). Descriptive and correlational statistics were employed.

To answer the first research question subjects were asked to respond *yes* or *no* if they believed offering health education on-site at church would be beneficial. Thirty-seven respondents indicated *yes* and one indicated *no*. Potential times were listed for subjects to select what they perceived would be the best time to offer the educational sessions on-site. Results were utilized to answer research

question number two: “What do church members view as the most convenient time to offer health education on-site?” Fifteen (39.5%) selected after the 8:00 a.m. first Saturday Mass and 10 (26.3%) selected prior to the 6:00 p.m. Wednesday Mass as the preferred times. The third most selected choice was after the noon Mass on Tuesday with five (13.2%) indicating this as the best time.

The third research question was “What health education topics would be of interest to the church members?” Subjects were asked to indicate if certain health related topics, which were listed in alphabetical order, would be of interest. A five-point Likert-like scale (1 = *strongly disagree*, 2 = *disagree*, 3 = *neither agree nor disagree*, 4 = *agree*, and 5 = *strongly agree*) was used. Table 1 indicates the means and standard deviations for each topic.

Table 1

*Means and Standard Deviations of Health Topics*

<b>Health Topics</b>	<b>Mean (SD)</b>
Healthy Heart	4.51 (.56)
CPR Training	4.47 (.56)
Nutrition	4.43 (.69)
Diabetes	4.40 (.64)
High Blood Pressure	4.30 (.78)
Healthy Lungs	4.28 (.77)
Prevention of Infection	4.24 (.63)
Medicare	4.22 (.85)
Sun Safety	4.11 (.66)
Vison Care	4.11 (.61)

Palliative Care	4.03 (.77)
Hospice	4.03 (.86)
Colon Cancer	4.00 (.68)
Dental Care	3.95 (.78)
Prostate Cancer	3.89 (.76)
Preparing for Doctor's Visit	3.79 (.86)

For research question number four: "Is there a correlation between age or gender and perception of topics of interest?" only one correlation was noted. Pearson product moment correlation coefficient (Pearson's  $r$ ) was used to examine the relationship between age and interest of each topic. A statistically significant correlation was noted between age and the health topic related to healthy lungs ( $r = .400, p < .05$ ) indicating as age increases this topic becomes of more interest. Using Spearman rank order correlation coefficient ( $r_s$ ), no statistically significant correlations were noted between gender and interest of any specific health promotion topics.

### Discussion

Findings indicate a positive reaction to the implementation of a health ministry program in a church setting. Additionally, results support an interest in all topics listed. Based on a five-point scale with five being *strongly agree*, four being *agree*, and three being *neither agree nor disagree* that the topic would be of interest, thirteen of the sixteen topics listed had a mean of greater than 4.0. The other three topics had means greater than 3.5. The top three means as shown in Table 1 were noted for the topics of healthy heart, CPR training, and nutrition.

### **Limitations**

The researcher notes limitations of the study which affect the ability to generalize the findings. These limitations include the descriptive correlational design, researcher developed instrument, and the convenience sample from one parish. A descriptive correlational design does not imply causation; however, it was appropriate for answering research questions of this particular study. Also, the instrument was developed to assess items for a specific parish such as times and health promotion topics of interest.

### **Recommendations**

Recommendations include replication of the study in other churches where larger, more heterogeneous populations may be available. Also, as noted by Callaghan (2016), following implementation of programs, ongoing data collection would be valuable to examine long-term effects. The researcher would suggest including a brief definition of palliative care as some subjects inquired about the meaning of this topic. Other churches may find different times being of interest as those listed on the questionnaire took into consideration other events occurring at this Church.

### **Conclusion**

With the growth of health ministry programs, it is imperative that input from potential participants is obtained during the planning phase. Ongoing assessment of needs and evaluation as the program is implemented and maintained will also be valuable. For this project, looking back at the end of the first year of implementation will be of interest. Dissemination of lessons learned could aid others as they embrace the beginning of a health ministry program.



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