



**Issue Brief**

# **Faith-Based Health Services**

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**June 2004  
Revised August 2004**

**Prepared for:  
The Missouri Foundation for Health  
Program and Grants Committee  
and Project Review Committee**

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# **Issue Brief: Faith-Based Health Services**

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## **Introduction**

The Missouri Foundation for Health (MFH) has received a number of proposals from faith-based agencies. These applicants seek funding to implement health-related programs and activities that target members of their faith community. At a meeting of the MFH Program and Grants and Project Review Committees a request was made by a board member for an MFH issue brief on the topic of health promotion and prevention services in a faith-based setting. Based on that request, the MFH policy area has studied the topic and offers this paper which includes:

- Background information, history and assets of faith communities;
- A few preliminary provisions regarding health-related activities in a faith-based setting;
- Key elements for successful faith-based programming and
- Illustrations of faith-based programs.

## **Overview**

### **Health Promotion and Prevention Services**

Faith-based organizations provide a wide-range of health-related services. Religious denominations own and operate hospitals, clinics and non-profit agencies. These charities work in such health-related fields as primary care, mental health, substance abuse, homelessness, violence prevention and food outreach. However, for the purpose of this paper, the scope of study was limited to health promotion and prevention programs implemented within a specific faith community or house of worship. Examples of these types of activities include: parish nursing, exercise programs, screenings (e.g. mammography, blood pressure, diabetes), nutrition projects and health education.

The American Journal of Health Promotion has stated that “lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices.”<sup>1</sup>

## **History of the Faith Community's Role in Health Services**

Faith communities and health care services have been tied together from the earliest existence of the world's major religions. Historically, religious leaders and healers were the same individuals. In England, up until the middle of the eighteenth century, individuals wishing to practice medicine or surgery had to attain a license from the bishop. Furthermore, the first hospitals were founded by adherents to Christianity.<sup>2</sup>

However, during the twentieth century the field of medicine experienced a transformation in its understanding and treatment of disease. Before and during this revolution, the medical community began to push the boundaries of scientific investigation and explore ideas that many religions were reluctant to accept. In the process of modernizing the field of medicine, the medical community separated from the influence of religion and moved forward with an entirely mechanical and physical view of health. The U.S. health care system has become focused almost solely on treating and curing diseases.<sup>3</sup>

## **Holistic View of Health**

While the diagnosis, treatment and cure of disease remains a vital component of the health care system, the piece that was lost when science and religion divided paths was the faith community's holistic view of health. A holistic integration of faith and health takes into account not just physical aspects, but also mental, spiritual, emotional, social and cultural facets that contribute to the actual wellness of an individual. "As medical care evolved into the science-based discipline that we know today, churches and religious orders became less engaged in the health care delivery system, divesting themselves of hospitals and long-term care facilities that they had originally built to meet holistic health needs."<sup>4</sup> These domains, which interact to create the core of an individual's life, can be addressed when religious communities create programs to promote health and prevent disease.

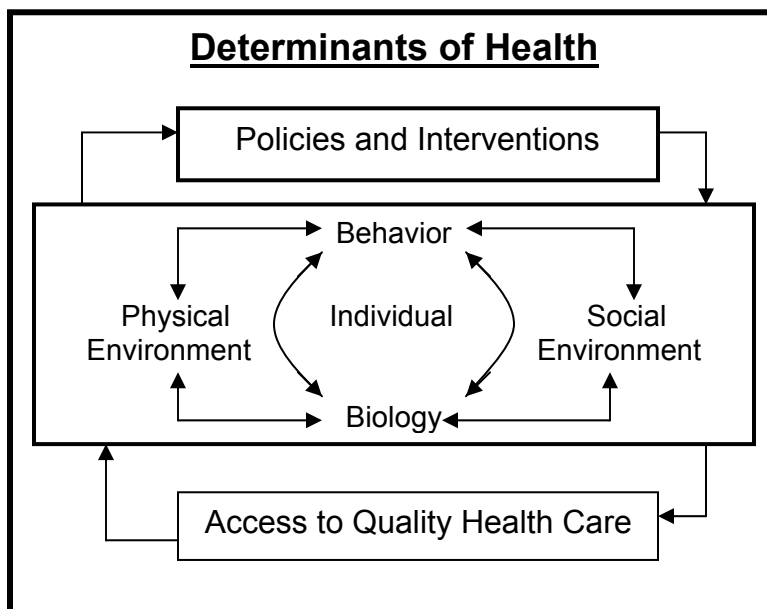
**"As medical care evolved into the science-based discipline that we know today, churches and religious orders became less engaged in the health care delivery system, divesting themselves of hospitals and long-term care facilities that they had originally built to meet holistic health needs."**

## Revisiting the Determinants of Health

In the MFH issue brief, “Health Promotion for Youth,” a model of six determinants of health was introduced to illustrate how different factors in an individual’s life interact to create a holistic picture of human wellness. (See Figure 1.)<sup>5</sup> One of these determinants, termed Social Environment, includes such components as family, culture, community, social institutions and religion. “Faith communities nurture and provide social support for the well-being of those that share their faith, and they reach out to those in need within their neighborhoods and throughout the world. Inequities that create disparity in the determinants of health for individuals, families, and populations capture the attention of faith organizations and public health.”<sup>6</sup>

Faith communities, while a factor in the Social Environment shown in Figure 1 below, can and do establish health programs and activities that address all of the determinants of an individual’s health. Moreover, faith communities provide an established base for the implementation of health promotion and prevention activities because they offer access to target populations (i.e. the underserved or uninsured) that may otherwise not be reached. Health-related programs within faith communities, which address these multiple facets of health, can effectively improve the health status of the target population and correspondingly reduce the rates of morbidity and mortality from preventable injuries and diseases.<sup>7</sup>

Figure 1.



## **Assets of Faith Communities**

Several advantages come with implementing a health-related program within a faith community. In general, as neighborhoods decline many businesses, including health care organizations, tend to migrate away from these communities. However, places of worship usually remain in these distressed neighborhoods and exist as ideal “agencies” to reach uninsured and underserved populations. “Beyond their involvement in existing health activities, churches and other faith-based institutions have much to offer to health promotion planners: They have credibility and roots in urban low-income communities. In many devastated neighborhoods, churches are among the most established community institutions, having served several generations of parishioners.”<sup>8</sup> Additionally, faith communities in the United States have other assets that can benefit health-related programming, including facilities, volunteers and an extended tradition of health ministry outreach and support.<sup>9</sup>

## **Initial Stipulations**

Before introducing the fundamental components of an effective faith-based health service, it is necessary to explore several preliminary items of interest. These concepts should be kept in mind when discussing proposals to MFH that relate to this topic.

## **Limited Research and Evaluation**

While the amount of research conducted on health programming based in places of worship continues to grow, currently only a limited amount exists. Furthermore, most of the studies that have been performed on this topic relate to parish nursing or to health programs in African American churches. There has been very little research into health-based activities in faith communities other than Christianity. Additionally, when programs have been implemented in faith-based settings, many times they have not been evaluated properly and therefore the outcomes of the program are unknown or vague.<sup>10</sup> Despite these limitations, initial research has shown that health promotion and prevention activities established in faith communities can be effective at addressing a range of health behaviors and diseases (e.g. hypertension, cardiovascular risk factors, cervical cancer, exercise, smoking cessation, cholesterol reduction and nutritional intake).<sup>11</sup>

## **Partnerships between Researchers and Faith Communities**

Partnerships between researchers and faith communities offer benefits for both sides of the collaboration. Religious institutions gain the technical expertise of having professional researchers operate a health promotion program within their congregation. Investigators secure the opportunity to work with a population that may otherwise not be accessible. Congregants look to faith leaders as a trusted and reliable source of information. To this day, certain populations remain wary of research studies and would not participate without an endorsement from the leader of their faith-community.

One example of such mistrust lies within the African-American community whose negative experience of medical research stems in large part from such historical events as the Tuskegee syphilis study. This research project monitored 400 low-income African-American men, infected with syphilis, for 40 years and denied them treatment even though a proven cure (penicillin) became available in the 1950's. The study continued until 1972.<sup>12</sup> "A recent report suggests that African Americans are significantly more likely than their White counterparts to believe that medical research exposes them to unnecessary risks and that they do not receive a full explanation of the implications of research participation."<sup>13</sup> Researchers that wish to evaluate the effectiveness of a health-based program within a particular faith community must be aware of past events and take steps to secure the trust of participants through a strong partnership with faith leaders.

## **Research Motivated Proposals**

Since research relating to faith-based health services remains a growing field of study, MFH may wish to consider funding university studies in this area. Such research is outside the definition of "basic medical research" which MFH does not fund. Many of the crucial factors listed in the following section can be useful in evaluating research directed proposals. Nevertheless, research applications should contain the following elements to improve the likelihood of successful programming. At the request of the PGC/PRC this list can be expounded upon; however, the following constitutes a basic overview:

- Build Credibility and Trust with Faith Community<sup>14</sup>
- Empowerment vs. Expert Approach ("Do With" vs. "Do To" the Community)<sup>15</sup>
- Understand and Integrate the Strengths of the Faith Community<sup>16</sup>

- Honest and Complete Disclosure of Study Purpose and Requirements<sup>17</sup>
- Assistance in Continuation of Intervention Program<sup>18</sup>

### **Enhancing Faith-Based Capabilities**

“Community and religious groups are the backbone of civil society, nurturing America’s core values of active citizenship, community self-reliance and public spiritedness.”<sup>19</sup> Faith communities have the potential to make progress in improving the health of individuals and neighborhoods. However, in particular areas some may need technical assistance in order to successfully compete for funding or to manage the grants that they receive. Capacity building may be necessary on topics such as forming a 501(c)(3) organization, administrative functioning, writing and managing grants, data collection and evaluation. These types of activities would assist in strengthening and expanding the contribution that places of worship make in the field of health promotion and prevention.

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One way to provide these capacity building services is through the use of intermediaries. Essentially, intermediaries assist faith-based service providers to improve their skills and competence in areas such as those previously mentioned. Intermediaries could be individual consultants or non-profit organizations that specialize in this type of technical assistance. Many foundations remain wary of intermediaries because they may view them only as “middlemen” or may have policies against re-granting. However, these intermediaries act as bridge builders, connecting non-profits, government and philanthropy to faith-based organizations. A recent report by the Hudson Institute found that “intermediary organizations currently make enormous contributions to the scope, scale and effectiveness of grassroots, faith-based social service agencies, and often do so at low cost.”<sup>20</sup> Frequently, faith communities need some technical assistance before implementing health-related activities in their place of worship. Since March 2003 MFH has supported faith-based agencies that need technical assistance through its agency enhancement funds.

## **Key Elements of Success**

### **Community Needs Assessment**

The health problems of the faith community and the neighborhood that it resides in should be examined before deciding what health topic to address. This needs assessment should involve utilizing available data, talking to neighborhood residents and members of the faith community, as well as studying the types of outreach already being performed by other area congregations.<sup>21</sup>

The key to deciding on a health-based program lies in identifying the gaps in services that exist. “The challenge is not for each [faith community] to begin programs that deal with community health but to align assets with the plethora of organizations already engaged, experienced and committed.”<sup>22</sup>

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### **Model-Based Strategies**

Although research and evaluation of faith-based wellness services is limited, models of effective health promotion and prevention programs in a religious setting do exist. Examples of model programs can be found in locations such as scientific journals, the Centers for Disease Control, national and local health foundations, as well as faith collaborations. A recent literature review found that health-based programs of faith communities can affect health and health behavior. Additionally, the review showed that these types of projects have the potential to:

- increase knowledge of disease,
- improve screening behavior and readiness to change,
- reduce risk associated with disease and symptoms of disease,
- reduce unnecessary hospitalizations/emergency department visits and
- reduce potential costs.<sup>23</sup>

### **Gatekeepers/Influence Leaders**

Securing faith community acceptance of a health promotion program means the planning process must identify and involve the gatekeepers or influence leaders of the targeted population.<sup>24</sup> A gatekeeper is defined as “an individual or group that controls

access to somebody or something.”<sup>25</sup> For MFH purposes, we will define gatekeepers as the natural leaders who influence the thoughts and behavior of a community. In the case of houses of worship, commitment and participation from the clergy (i.e. pastor, priest, rabbi, imam, etc.) must occur to assure a successful health program. Part of the importance of having the faith leader involved in the project ties back to the trust issue discussed earlier. Individuals in the faith community will be more likely to accept and participate in a health program if they hear about it directly from a highly respected person in the organization.<sup>26</sup>

### **Steering Committees**

Often the clergy in a faith community have a substantial number of commitments and become pressed for time in terms of taking the leadership role in a new project. Although vitally important to obtain faith leaders’ support, a key to creating a successful program may involve the creation of a steering committee for the health promotion program. This working group can be constructed using other members of the faith community that have skills or knowledge on the health topic being addressed. Additional individuals that could comprise this committee include: neighborhood leaders, persons working in local health-related non-profits, individuals who plan on participating in the program, as well as medical professionals (e.g. nurses, doctors, dentists, health educators, etc.) that belong to the faith organization or live in the area.<sup>27</sup> Many of these persons involved on the steering committee should be seen as influence leaders or gatekeepers to the faith-community as a whole.

### **Synergistic Partnerships**

Faith-based health services can not effectively operate in a vacuum. For the greatest success, these programs need the support of collaborations with the surrounding community, such as other faith communities, neighborhood associations, non-profits, health service agencies, hospitals, clinics, etc. As mentioned above, involving individuals from organizations such as these on the project’s steering committee increases the likelihood that the

**“Neighborhoods to national systems work more efficiently and effectively when a critical mass of leaders appreciates the opportunities and pathways for collaboration. Everything moves more easily — services, resources and knowledge, which produces very tangible and concrete gains.”**

program will properly meet the needs of the community. “Neighborhoods to national systems work more efficiently and effectively when a critical mass of leaders appreciates the opportunities and pathways for collaboration. Everything moves more easily — services, resources and knowledge, which produces very tangible and concrete gains.”<sup>28</sup> Studies have shown that partnerships between faith communities and health care organizations have successfully implemented health promotion and prevention programs, particularly in underserved populations.<sup>29</sup>

### **Appropriate Linkages with Formal Systems of Care**

A strategic by-product of establishing collaborative health-based services is that the faith community can establish appropriate linkages with formal systems of care. When these health promotion and prevention projects identify individuals in need of formal treatment, the affiliation with identified health care organizations must already be established, especially for uninsured persons. Faith-based health programs should have formal agreements with treatment centers to provide follow-up services to individuals diagnosed through screenings or other health promotion activities. “Creative approaches to effectively link formal health providers with informal networks are essential to ensure appropriate, accessible, and effective health and mental health care.”<sup>30</sup>

### **Leader and Volunteer Trainings**

A faith-based health program should contain a strategy for providing training to clergy, influence leaders and volunteers regarding the specific project’s health topic (diabetes, fitness, nutrition, etc.). This training, provided by professionals in the health field, also educate the members of the faith community on such things as the program model, linkages with formal care organizations, social support functions, evaluation skills and cultural competency. Furthermore, the health professionals involved in the program, either as staff or consultants, should participate in continuing education opportunities as much as possible. For example, the International Parish Nurse Resource Center (IPNRC) offers a yearly seminar on parish nursing, along with program support and continuing education through parish nurse networks in specific cities or geographic regions.<sup>31</sup>

## Cultural Competency

Cultural competency has become a catchphrase in the last several years in the health and philanthropy communities. While an element that should generally be a part of any health program, its importance should not be overlooked or disregarded in the consideration of faith-based programs. All persons involved in the implementation and operation of a faith-based health service should be culturally competent to work with members of the given target population. Some faith-based health programs hire staff from outside of the faith community. These individuals should be knowledgeable in working with the diverse populations they will meet in working in the specific faith community. Understanding cultural differences relating to an individual's ethnicity, race, religion, gender, sexual orientation, national origin or age offers an opening to effectively address a health concern.

One model of cultural sensitivity breaks down the concept into two dimensions: *surface structure* and *deep structure*.<sup>32</sup> Surface structure involves tying program materials and messages to discernible social and behavioral characteristics of the population. In other words, this involves identifying the channels and settings that will most effectively deliver the health messages and programs. "Surface structure reflects the extent to which interventions correspond to the needs and preferences of the target population, and how well interventions fit within the culture, experience, and behavioral patterns of the audience."<sup>33</sup>

Deep structure cultural sensitivity involves comprehending how cultural, social, psychological, environmental and historical factors influence health behaviors. "This includes understanding how members of the target population perceive the cause, course, and treatment of illnesses, as well as perceptions regarding the determinants of specific health behaviors."<sup>34</sup> Key elements to achieve both surface and deep structure sensitivity include cultural research, training and experience with the target population. Cultural sensitivity ties closely to trust issues discussed on page five in *Partnerships between Researchers and Faith Communities*.

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## **Thorough Evaluation of the Program**

Measurable objectives form the basis for a thorough evaluation of a faith-based health program. Evaluation monitors the progress, demonstrates impact and measures the effectiveness of the health services. Tracking outcomes and writing quantifiable objectives may be beyond the capacity of some faith-based agencies. In these instances, MFH should consider whether an intermediary agency or contractor could assist in demonstrating the value of the faith-based health project. While the complexity of evaluation can at times intimidate the staff and volunteers of an organization, training and support exist that could provide the methods and tools to properly assess the efficacy of a faith-based health promotion program.<sup>35</sup>

## **Faith-Based Health Services**

Faith communities have been concerned with the health problems of their congregants as well as their immediate neighborhoods for many years. This health ministry stems from the health-related tenets that can be found in every faith tradition. In the last decade, the United States has seen a resurgence of faith-based health activities,

including parish nursing programs, nutrition and exercise projects, and interfaith organizations working to provide health services. “So strong is the connection between faith and well-being that more than 30 medical schools in the United States now offer courses on spirituality and medicine.”<sup>36</sup> Through these faith-based projects, communities receive the benefits of health education, prevention, counseling, support services, as well as assistance in navigating the formal health care system.

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The following section provides two examples of faith-based health programs. They cover a range of target populations and health issues while demonstrating the key elements outlined in this paper. The first provides an example of a well-developed, highly-effective program that meets specific needs identified within the community. The second project illustrates a Missouri faith-based program that offers families a range of health-related services and assists them in navigating many different systems of care. This example also highlights the need for faith-based programs to obtain support in the form of both grants and agency enhancement services.

## **The Community Model Project (CMP)-The Archdiocese of Philadelphia**

CMP originated as a collaborative effort between the Archdiocese of Philadelphia and a national alliance called Supportive Care of the Dying (SCD): A Coalition for Compassionate Care. The SCD had released research that showed a gap in the continuum of care for those facing life-threatening illnesses. Starting as a pilot project in 1998, CMP has the following goal: “to keep people at the latter stages of life just a bit longer in their homes by assisting them in small ways; to make them feel safe and secure within their own environments; and to offer the gift of presence and acknowledgement.”<sup>37</sup> The program is comprised of the following three elements:

- outreach to the frail elderly and other homebound persons with serious or life-threatening illnesses via the volunteer program,
- parish education seminars on supportive care issues and
- parish resource boxes.<sup>38</sup>

Currently, the fully-developed program has been folded into the Archdiocesan Parish Nurse Program, which provided an established infrastructure of communication and collaboration to implement the program beyond the initial pilot phase. The CMP incorporates all of the essential elements discussed in this paper that contribute to a successful faith-based health program.

**Needs Assessment**—The CMP used “cluster planning” to choose the initial area in which to focus the pilot program. Cluster planning “uses the talents of both laity and clergy in assessing the strengths, weaknesses, resources, and needs of a cluster or group of geographically contiguous parishes.”<sup>39</sup> In this case, Cluster 16 (comprised of 12 parishes) was chosen as the pilot area for the CMP because an assessment of the area showed large numbers of elderly, as well as a diverse ethnic representation (German, Italian, Polish, Hispanic and Lithuanian) and a strong commitment to the faith community. Additionally, several resources already existed within the cluster, including parish groups, social services and parish nursing.<sup>40</sup>

**Model-Based Strategy**—While the CMP was a demonstration project, it was based on research that shows that a minimal amount of assistance can help the elderly and some persons with life-threatening illnesses safely stay in their homes (which they prefer) and avoid or delay institutionalization.<sup>41</sup> In-home care also saves tax-payers and families billions of dollars annually—“If institutionalization of individuals with Alzheimer’s disease

could be delayed even one month, it would mean a savings of \$1.2 billion annually.”<sup>42</sup> Furthermore, as stated in this paper, research shows that faith-based services can increase knowledge of end-of-life issues through health education activities.

**Steering Committee**—An initial leadership steering committee, formed with national representation, worked to develop resourceful ways to care for individuals with a life-threatening illness through the faith community. After the initial cluster group was chosen, representatives from the 12 parishes were chosen in order to form a cluster supportive care project leadership team.<sup>43</sup>

**Gatekeepers/Influence Leaders**—The existence of the CMP can be attributed to the influence and commitment of leadership from both the health and faith communities in Philadelphia. The project gained an initial opening when the Deputy Secretary for Catholic Health Care Services captured the ear of the Reverend Monsignor Timothy C. Senior who played an instrumental role in garnering support and enthusiasm for the project from the vicar responsible for the pilot cluster and the 12 parish ministers. Other influence leaders recruited for the project include national experts, parish nurses, lay parish leaders, Catholic healthcare providers, local Catholic university leaders and key gatekeepers of other Archdiocesan Offices.<sup>44</sup>

**Partnerships**—Relationships exist between the CMP and other health-related programs within the Archdiocese and the individual parishes. Additionally, the CMP has found partners in health providers, community groups, local universities, social service organizations and the Supportive Care of the Dying coalition.

**Linkages with Formal Systems of Care**—One component of the volunteer portion of the CMP includes developing lines of communication with health providers and, when appropriate, assisting families and caregivers in voicing their concerns to the care recipient’s doctors. Part of the volunteer training involves being a “first-alert system” to know when a client may be in trouble or seriously ill. The volunteers frequently communicate with CMP’s co-directors who can make referrals and recommendations. Having knowledge of and networking connections to community social service and health care organizations works as an invaluable asset of the Community Model Project.<sup>45</sup>

**Volunteer Training**—Formal volunteer training occurs in the CMP on topics which include:

- Understanding Your Role
- Making the Most of Visiting
- Utilizing Common Sense to Identify Problems
- Talking about Death
- Benefiting the Bereaved
- Spiritual Benefits of Volunteering
- Care Giver Respite<sup>46</sup>

**Cultural Competency**—CMP has tried to be aware of and address the needs of a program that has a vast amount of cultural diversity. When recruiting volunteers, a solicitation was mailed to 6,500 individuals. This mail-out was available in English, Polish and Spanish.<sup>47</sup> Many of the pieces of literature found in the parish resource boxes were also translated into Spanish to meet the needs of a growing Hispanic population. Additionally, several of the educational programs were provided in Spanish and were well received by the community. CMP also acknowledges diversity beyond the language barrier. For example, the volunteer program has activities targeting children and young adults, ranging from first graders making get-well cards to high school students helping with chores or small work projects.<sup>48</sup>

**Evaluation**—One of the goals of the CMP steering committee was that the project have benefits or outcomes that could be measured. While measuring such things as dollars saved due to prevented institutionalization may be beyond the scope of a program such as this, other aspects of the CMP can be tracked. Currently, CMP evaluates its activities by:

- documenting testimonials and case studies;
- utilizing evaluation forms for the educational seminars;
- tracking pieces of literature acquired from the parish resources boxes;
- acquiring pastor evaluations and
- measuring the individual parish's perception of the benefits of the education, volunteer and resource box components of the program.<sup>49</sup>

The Community Model Project represents a well-developed and effective faith-based health program that serves observed needs within the targeted community and promotes health education and prevention activities. The project has expanded into other cluster groups of parishes in the Philadelphia community and has been duplicated in other parts of the United States.

### **The Positive Family Enterprise-St. Paul Parish<sup>50</sup>**

The Positive Family Enterprise operates in south St. Louis City and works to build strong families through parenting and child classes. This prevention and education program is its own 501(c)(3) organization and receives funding and support through both St. Paul United Church of Christ and the Deaconess Foundation's parish nurse initiative. The staff consists of a parish nurse, a chaplain, several part-time social work students and an large volunteer base. The organization receives referrals from the courts, Department of Family Services, police, neighborhood stabilization officers, as well as former clients.

The staff of the Positive Family Enterprise conducts home visits, runs classes and assists families in navigating systems. The program does not attempt to duplicate services that exist, but works to support families struggling with issues relating to:

- Housing,
- Health Care (including Substance Abuse and Mental Health),
- Education (i.e. truancy and GED),
- Employment,
- Financial Management,
- Child Care and
- Transportation.

St. Paul provides space for the classes which occur on Sundays for two hours and run for 16 weeks. The program focuses on a different topic each week and while parents and children have separate classes, they work on similar topics (i.e. anger management, interpersonal relationships, family support systems, clear instructions and belief in self and others). On average, fifteen families graduate from the program each semester.

**Needs Assessment**—The Positive Family Enterprise was established by the parish nurse working at St. Paul, who saw this type of program as a great need among families

in the community. While not conducting a formal needs assessment, the parish nurse, at the time the organization was founded, had over 20 years of experience. At the program level, each family receives an assessment and completes a family history. A Goal Attainment Scale, used for each family, marks their progress in meeting family defined objectives.

**Model-Based Strategy**—The program was established partially on a model out of Ames, Iowa which showed the effectiveness of long-term, relationship-based family interventions.

**Gatekeepers/Influence Leaders**—Positive Family Enterprise has support and buy-in from the pastor of St. Paul, the Deaconess Foundation, referral agency leaders, as well as former clients.

**Steering Committee**—The Board consists of nurses, a pastor, a congregation member, volunteers, clients and a social worker. While still learning and developing, they represent a diverse background that properly reflects the community and the goals of the organization.

**Partnerships**—The parish nurse now has thirty years of experience working within this community. In helping families navigate systems, the staff of Positive Family Enterprise has established relationships with social service organizations, medical providers and clinics. Additionally, volunteers and social work students come through established relationships with St. Paul, Ursuline Academy (high school) and Saint Louis University.

**Linkages with Formal Systems of Care**—The staff of the organization acts as advocates for the families within the formal systems of care, steering them within these structures and helping them properly utilize the resources that exist.

**Volunteer Training**—The volunteers receive an initial two hour training in which they learn about their role related to such activities as child supervision, mentoring and transportation.

**Cultural Competency**—While no formal cultural competency training component exists for the organization; great diversity exists within the board, staff, volunteers and host

parish. The social work students receive some schooling in cultural competency at Saint Louis University School of Social Service.

**Evaluation**—The Positive Family Enterprise has a desire to effectively track outcomes; however they have found it difficult to find the time with a limited number of staff and within their small operating budget.

This program illustrates a small, grassroots faith-based organization that functions in the field of health promotion, prevention and education. The program provides an example of an agency that provides essential gap-filling services, but lacks expertise in certain core skill areas such as operating, leading or evaluating the components of an organization. The example provided may not meet all of the essential elements outlined in this paper, but MFH may wish to consider similar programs for core support funding or agency enhancement services.

## **Conclusion**

Faith-based health programs work as a valuable tool to reach underserved, uninsured or underinsured populations. Research shows that these types of services can be effective in delivering health promotion, prevention and education activities. Faith-based programs can benefit a diverse population of individuals and neighborhoods, and can reach groups of persons that other types of non-profit agencies and health care organizations may not be able to engage. Additionally, faith-based programs have the ability to focus on a wide-range of health issues. These projects, when properly constructed, help individuals and families adopt healthier behaviors and attitudes, as well as assist persons in navigating health systems or obtaining appropriate referrals for care.

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