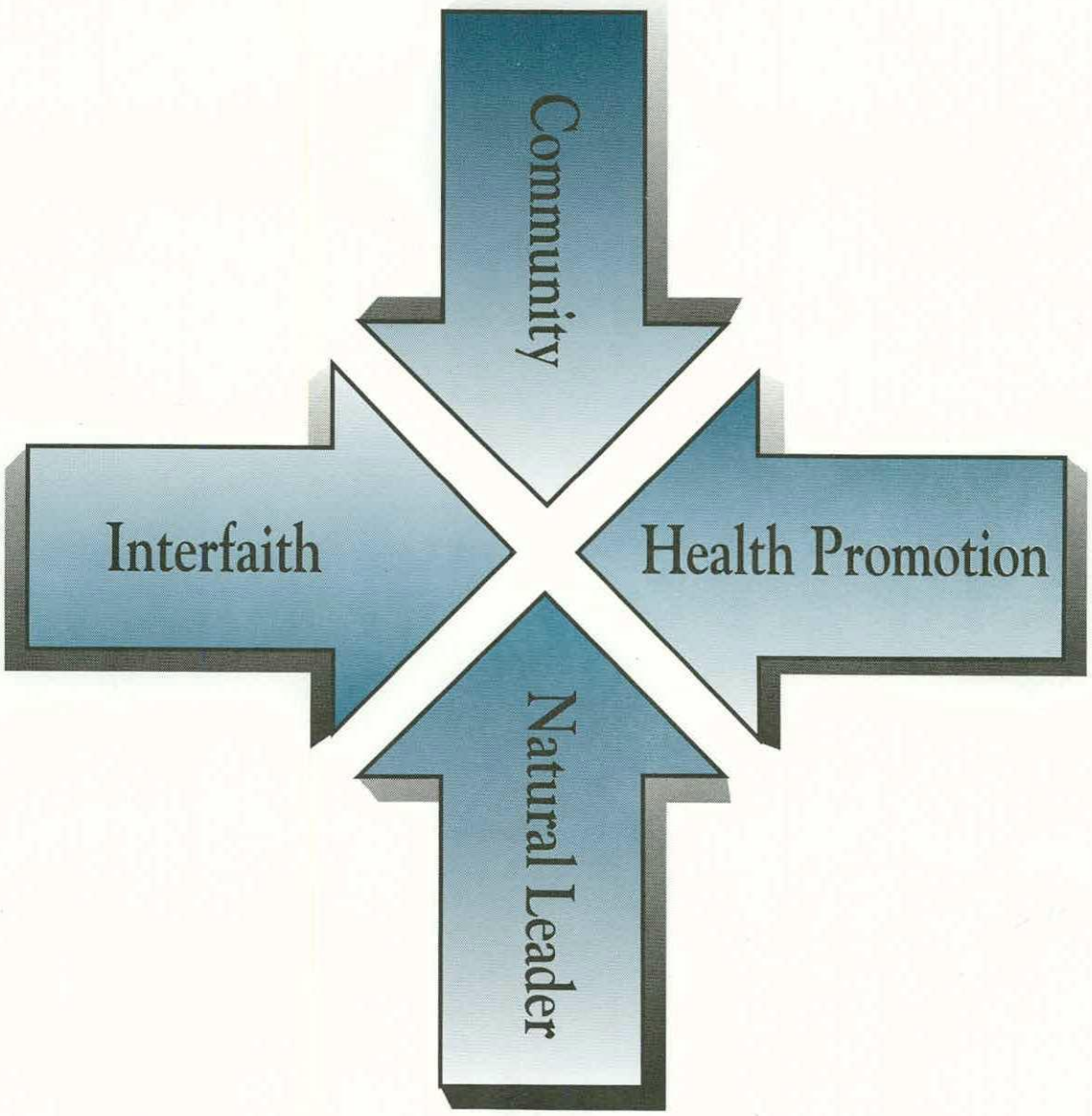
EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH | Interfaith Health Program
Hubert Department of Global Health

STARTING POINT

Empowering Communities to Improve Health



A Manual for Training Health Promoters
in Congregational Coalitions
1997

INTERFAITH HEALTH PROGRAM
The Carter Center

Foreword by President Carter

The Carter Center's Interfaith Health Program (IHP) was created to help faith communities nationwide prevent disease and promote wellness, especially in areas where residents may be at risk due to factors such economics or age. Through this program, religious groups across the country are building an impressive network of leaders, scholars, and community activists who share a common goal—to help people lead healthier lives. Through regional meetings, educational materials, and an informative Web site, the IHP teaches people across the country how to implement effective health ministries.

To further this effort, the Atlanta Interfaith Health Program, the local initiative of the IHP, created this manual. It is a step-by-step guide to help congregations teach lay volunteers to be "health promoters." In this role, trained volunteers first identify the health needs of their individual congregations and then work to find appropriate resources to meet them. This might mean conducting smoking cessation clinics with help from the American Cancer Society or providing free blood pressure screening through the local Red Cross. Simple services such as these are important because they not only improve the quality of lives, but they may even help save some.

I encourage leaders of all congregations to read this manual and discover how it might help them and members of their faith group. After all, the key to empowering any community, be it religious or otherwise, is team work and a strong spirit of collaboration.

President Carter and Buford Congregational Health Promoters, each representing a different nationality

Preface

Starting Point is intended for a wide audience. We hope you find it useful in implementing congregation-based efforts to improve health in your community. Churches, synagogues and mosques have always been resources for health. However, they have rarely thought of themselves as health agencies that can do as much for health improvement as other institutions. *Starting Point* is a manual for building a coalition of congregations to improve health by training lay volunteers as health promoters.

Starting Point is jointly produced by The Carter Center's Interfaith Health Program and the Nell Hodgson Woodruff School of Nursing, both of Emory University. Please share with us your reactions to this manual and information about similar faith/health practices. This is but one of many models that the Interfaith Health Program of The Carter Center seeks to identify and disseminate.

There is an on-line version of this manual on the World Wide Web at the addresses listed (in bold face type) below.

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Acknowledgments

Many people played important roles in the Atlanta Interfaith Health Program (AIHP), too many to mention on this page. For the most part, acknowledgments will be limited to those who were responsible for training congregational health promoters and for producing this manual.

Dr. Tom Droege (The Carter Center) and Dr. Gerald Durley (Morehouse School of Medicine) were co-directors of the AIHP and thus responsible for the project. Dr. Fran Wenger (School of Nursing at Emory University) had responsibility for the training component. Core members of the committee who planned and implemented the training, besides Dr. Wenger and Dr. Droege, were Dr. Joyce Murray and Prof. Ann Connor (School of Nursing at Emory University) and Ms. Mimi Kiser (The Carter Center). Ms. Kiser also coordinated the evaluation process.

Three instructors of Emory University's School of Nursing served as trainers of congregational health promoters. Ms. Lynne Meadows was the trainer for the Brown and McNair coalitions. She developed many of the training materials in this manual and served as a training consultant. Her experience was particularly helpful in planning the training for the Buford coalition. Ms. Elizabeth Downes and Ms. Connie Hannah were trainers for the Buford coalition.

The technical writer of this manual was Mr. Scott Proeschold. After completing his studies at the Rollins School of Public Health at Emory University, Mr. Proeschold spent the summer of 1996 as an intern in the Graduate Assistant Program at The Carter Center. During this time, he gathered materials, conducted interviews, and completed the first draft of this manual under the supervision of Dr. Droege and the committee coordinating the training. After completing his internship and moving to the Southwest, Mr. Proeschold volunteered to complete work on this project, including placing the on-line version of this manual on the World Wide Web: <http://www.interacess.com/ihpnet/>

The real heroes of the story that unfolds on these pages are the congregational health promoters who were trained and the 41 congregations they represent. These volunteers gave unstintingly of their time to complete the training, to use their skills in implementing health ministry programs in their congregations and community, and to meet regularly with their fellow health promoters after their training had been completed. The training was designed to empower them by means of participatory learning, and their record of achievement is a testimony to the success of this approach.

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What if every congregation. . . ?

In a video introducing The Carter Center's Interfaith Health Program (IHP), President Carter asks, "What if congregations, mosques, and temples cooperated with each other to improve the health of people in the communities where they are located?" The IHP was established to address this question.

The Carter Center's conviction that faith communities can play a primary role in improving health began in 1984 when the Center sponsored a national symposium entitled *Closing the Gap*. This symposium identified and focused on the "gap" between how to prevent disease and improve health and the practices based on this knowledge. In an effort to move from reflection to action, The Carter Center identified the religious community as an under-utilized resource group to narrow this gap.

In 1989, The Carter Center gathered religious leaders from major faith traditions to discuss the role of faith communities in health promotion. Challenged by members of this symposium to carry this process forward, the Carter Center established the Interfaith Health Program (IHP) in 1992. After visiting religious and health leaders in over 20 cities in the United States, the IHP developed a national strategy for improving health through faith communities. That strategy is based on closing five major gaps that keep faith groups from fulfilling their potential for improving health *(see chart below)*.

The Faith and Health Movement

So many creative and innovative programs are being implemented by faith communities throughout the nation, that we can begin to think in terms of a faith and health movement. The objective of the Interfaith Health Program is to nurture this movement, because health is central to the mission of every faith tradition.

The contributions of faith communities to health and healing have been relatively insignificant in this century. This was due largely to the scientific breakthroughs that gave modern medicine enormous prestige and power. However, concern for healing was never lost in faith communities. This concern was evident in prayers for the sick, the establishment of Jewish and Christian hospitals, medical missions, and the practice of faith healing. Until recently, however, both medical and faith groups have focused almost exclusively on the treatment of disease.

The emphasis in the last two decades has shifted from healing to health, from a narrow focus on physical ailments, to the health of the whole person. This shift of emphasis, as welcome as it is, still reflects a narrow individualism within our culture. The leading edge of the faith and health movement is focusing attention on the health of communities.

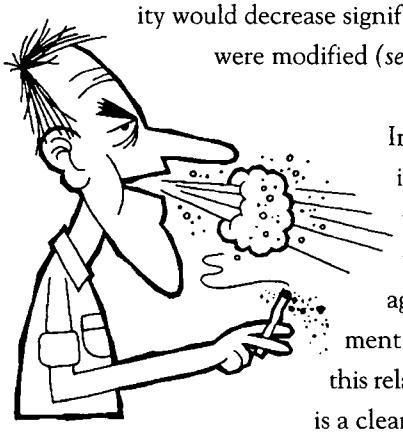
Promoting health is the challenge both religious and faith leaders face as we move into the next century. None of us wants to be without modern medical advances, but health

The Five Gaps That Keep Faith Groups From Fulfilling Their Potential

Gap 1	Having the knowledge but not applying it
Gap 2	What faith communities say about social justice and what they actually do
Gap 3	Failing to make successful practices widely available for replication
Gap 4	Faith communities operating in isolation from each other and health agencies
Gap 5	Current needs/wants vs future needs/wants

is more than the absence of disease. It involves mental and spiritual well-being as well as physical health. It involves the health of communities as well as the health of individuals. By reclaiming health as part of their mission, faith groups once again are partners with other community agencies in improving health.

Where do we need to focus our efforts? First, more than half of the leading causes of death in this country are preventable. Deaths due to alcohol, tobacco, and inactivity would decrease significantly if lifestyles were modified *(see charts below)*.



In addition to promoting lifestyle changes, faith groups share with public health agencies a commitment to social justice as this relates to health. There is a clear connection between socioeconomic status (SES) and health. No matter how SES is measured, persons who are impoverished, homeless, or vulnerable are likely to have negative health patterns. Health is a goal for everybody, but SES factors undermine it in spite of personal efforts. Because health is a goal for all, community members have a moral imperative to address SES.

Public health agencies and faith communities share social justice as a fundamental core value. This provides a basis for collaboration. Community-level systemic change in addressing problems like substance abuse and violence can best be achieved through partnership.

The Atlanta Interfaith Health Program

Convinced that it must practice locally what it promotes nationally, The Carter Center's Interfaith Health Program initiated a program for addressing health needs in underserved sections of Atlanta. The Atlanta Interfaith Health Program (AIHP) was a three-year project ending in December 1996 whose major funding came from the Pew Charitable Trusts. Wheat Ridge Ministries and the Dai Ichi Kangyo Bank provided additional support. The project's goal was to apply the national strategy of the IHP at the local level. This was done by building coalitions of congregations to improve

■ The Ways We Die

The 10 Leading Medical Causes of Death . . .	Deaths		. . and the Lifestyle Factors Leading to Half of Them	Deaths
Heart Disease	720,000		Tobacco	400,000
Cancer	505,000		Diet, Sedentary Lifestyle	300,000
Cerebrovascular Disease	144,000		Alcohol	100,000
Accidents	92,000		Infections	90,000
Chronic Pulmonary Disease	87,000		Toxic Agents	60,000
Pneumonia and Influenza	80,000		Firearms	35,000
Diabetes	48,000		Sexual Behavior	30,000
Suicide	31,000		Motor Vehicles	25,000
Liver Disease, Cirrhosis	26,000		Illicit Drug Use	20,000
AIDS	25,000			
TOTAL	**2,148,000**		**TOTAL**	**1,060,000**

Source: J. Michael McGinnis & William H. Foege, "Actual Causes of Death in the United States," Journal of the American Medical Association, November 10, 1993—Vol 270, No. 18, pp. 2207-2211.

health and training Congregational Health Promoters (CHPs) as agents to "close the gaps" *(see page 5)*.

CHPs help people apply knowledge they get from community health agencies. They remind their fellow congregants of their health mission and their commitment to social justice. They also adapt successful health ministry models used elsewhere. By joining with other CHPs and health agencies in the community, they overcome the isolationism that characterizes so much of congregational ministry. Finally, they are the voice of the needy in this and future generations.

"People from many different backgrounds coming together for a purpose—you couldn't ask for anything better."

AIHP Congregational Health Promoter

About This Manual

This manual is one way by which the IHP seeks to build community capacity for health promotion in faith communities around the nation. This is not a traditional training manual in health education and skill development (CPR, blood pressure, etc.). Rather, it is a method for empowering change. Though this manual could be used to train people from congregations unrelated to each other, we think the approach presented here works best with a coalition of congregations in the same community. The manual is divided into five sections:

- Section One describes the development of the Atlanta Interfaith Health Program (AIHP).
- Section Two describes the participatory approach to learning in training CHPs.
- Section Three describes the development of the training program.
- Section Four addresses post-training issues, such as continuing education and support for CHPs and the training of new ones.
- Section Five is an appendix of training materials.

Like all programs that try to break new ground, there is much to learn from successes and mistakes. We hope those who read this manual will learn from both.

Purpose

The purpose of this manual is to broaden and deepen the faith and health movement by:

- Fostering the development of health ministry in congregations throughout the U.S.
- Stimulating interest in a faith-based model for improving personal, congregational and community health
- Describing how the Atlanta Interfaith Health Program trained Congregational Health Promoters (CHPs)
- Sharing successes and failures of the training process
- Highlighting the "participatory learning approach"

"I believe with this training we will be able to prevent a lot of health problems in our community."

Congregational Health Promoter

This manual can be a resource for:

- Congregations (churches, synagogues and mosques)
- Parish nurse programs
- National church associations
- Health agencies (private and public)
- Community development organizations
- Interfaith, ecumenical and denominational alliances
- Universities (Schools of Public Health, Nursing, Medicine, Theology) seminaries, and lay academies

This manual can be helpful in:

- Explaining how health workers can serve congregations as CHPs
- Developing congregational coalitions
- Training Congregational Health Promoters (CHPs)
- Building partnerships with organizations that share a common mission
- Accessing resources in the community

I. The Atlanta Model For Health Ministry

As previously noted, to practice locally what it promotes nationally, the IHP established the Atlanta Interfaith Health Program (AIHP), a congregation-based health promotion project using health workers/volunteers. A working group of 15 religious and health leaders in Atlanta were invited to participate in a six-month planning process to determine the most effective way to enlist faith communities in health promotion activities. This process was important not only to develop a coherent vision and strategy, but also to nurture a network of potential collaborators. The "working group" formulated a plan for building interfaith networks of congregations, the networks governed by a Health Ministry Council of representatives from each congregation, and staffed by a network coordinator (a half-time position paid from project funds). At the heart of the plan was the training of Congregational Health Promoters (CHPs), coordinated by the Nell Hodgson Woodruff School of Nursing of Emory University.

"I am honored to have the opportunity to be a participant in this training class."

"To be part of the Interfaith Health Ministry is wonderful and to share with my congregation as a CHP is a blessing."

Congregational Health Promoters

Faith Communities and Congregational Health Promoters (CHPs)

Training members of the congregation as CHPs is one way religious organizations (often in partnership with health agencies) prevent disease and premature death. Over 3,000 congregations use nurses, usually called parish nurses, as health ministers. Employing a health professional as a member of the ministerial team is beyond the capacity of many congregations, especially small ones. To help such congregations, this manual describes how to recruit and train lay volunteers as CHPs.

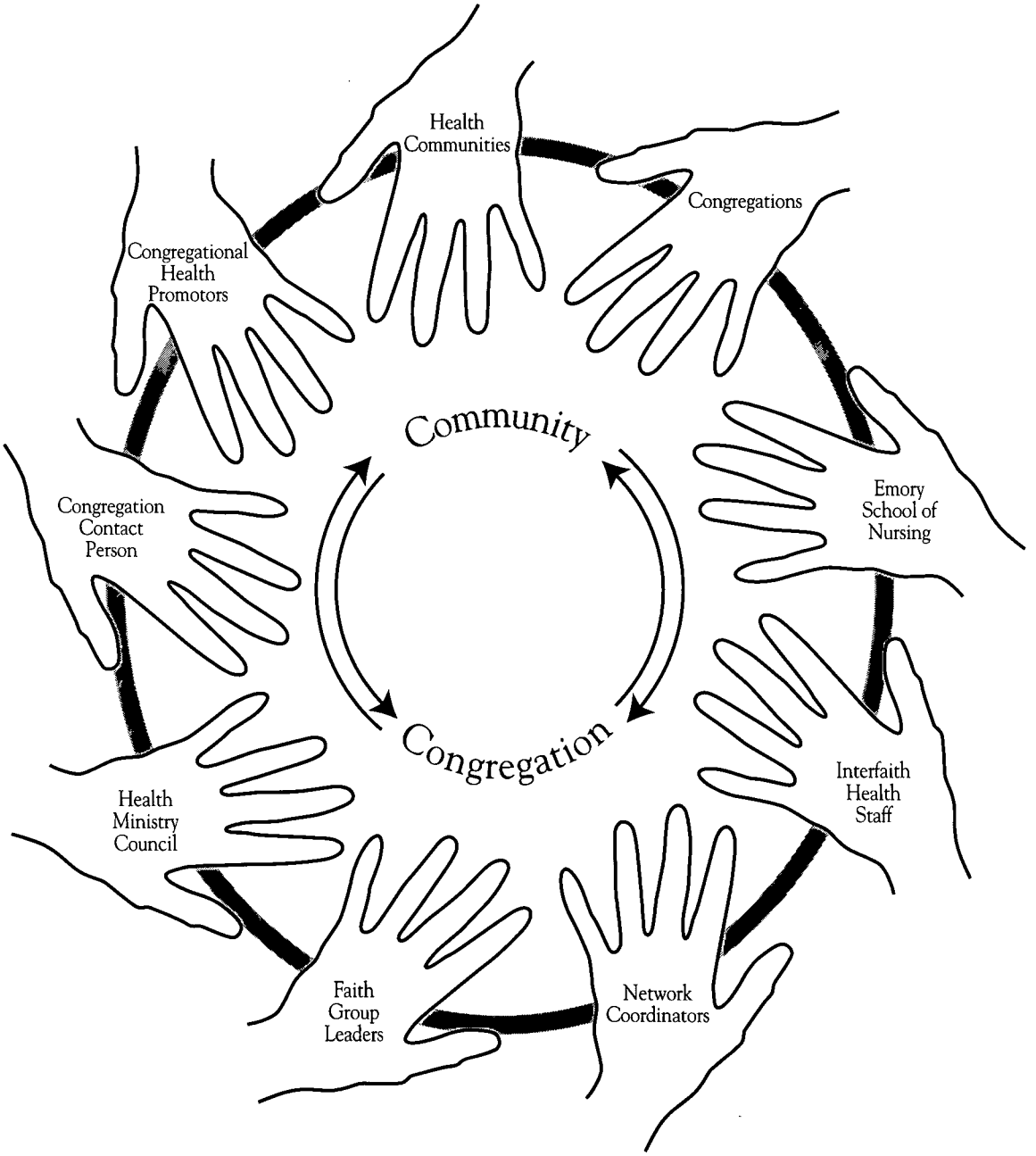
CHPs come from a variety of backgrounds. While some may have formal training, more important is that they are people who are respected and trusted by their community. CHPs are community "insiders," valued for their insight and concern. They understand the local cultural and ethnic values and beliefs that might be a barrier to an outside agent or organization. Using adult education principles, CHPs empower communities to act upon their health needs.

Impact of Congregational Health Promoters

As faith communities become increasingly aware of the strategic role they can play in improving health, health ministers (such as parish nurses and CHPs) will be as common as youth ministers are today. If every church, mosque or temple had Congregational Health Promoters:

- congregations would identify local health issues and work collectively to solve them
- individuals of all ages and races would be empowered to improve their spiritual, physical and mental health
- premature deaths from such factors as tobacco, stress and diet would decrease
- communities could be empowered to address health-related issues, such as poverty, violence, and substance abuse

Congregations Working Together to Promote Health: McNair Cluster Vision of Collaboration



Coalitions of Congregations with a Common Mission to Improve Health

If the criterion for inclusion is a "common mission to improve health," every coalition should be interfaith. Ecumenical means all Christian denominations. Interfaith means all faith traditions, including Judaism, Islam, Bahai's, and many others. Based on our experience, congregations from different faith traditions can work together without friction when their common mission is health.

Three locations within Atlanta, each with populations at risk for a wide variety of diseases and health care problems, were chosen as areas in which networks of congregations would be formed. Two coalitions were located in geographical regions of The Atlanta Project (TAP), The

Carter Center's urban revitalization project. Both coalitions were entirely African-American and Christian, except for one Muslim faith group. A third interfaith coalition, with considerable ethnic diversity, was formed in a region known as the International Village. This network of congregations consists of 19 faith communities comprised of 17 churches, plus one Baha'i and one Unitarian Universalist congregation. This multiethnic coalition consisted of Vietnamese, Korean, Chinese, Hispanic, recent Eastern European immigrants, African-Americans, and some dominant American-culture participants. The names of the two African-American coalitions come from the regions within TAP, Brown and McNair. The name of the multiethnic coalition, Buford, also comes from the region of Atlanta where it is located, the Buford Highway Corridor.

We strongly recommend that coalitions be both interfaith and multiethnic

Recruitment of Congregations

The AIHP model of training was designed for a coalition of congregations, and it's not likely to succeed apart from that structure. In this model, the basis of the coalition was the close proximity of congregations to each other. There are obvious advantages in beginning with a pre-existing alliance, such as denominational affiliation or a ministerial alliance. Coalitions will vary. Some are outgrowths of previous alliances; others are initiated by an external agency, such as The Carter Center or a public health department. Some are small, consisting of 3 or 4 congregations, others as large as 20 or more. Some coalitions have strong congregations, while others lack sufficient resources. These are critical factors that affect the recruitment and sustainability of a coalition. See *Resources for Training* in the appendix for information about building coalitions.

The co-directors of AIHP were responsible for the recruitment of congregations in the Brown and McNair coalitions. All congregations within the targeted region were contacted first by letter, then by phone, and then invited to a meeting or visited in person. One of the co-directors was well known in the Brown and McNair regions of TAP, and his contacts were invaluable in the formation of those two coalitions. In the Buford region, it was the network coordinator who was the primary agent in recruitment.

In all cases, the initial contact was with the minister or imam of the congregation. In African-American congregations, it is almost always the minister/imam who makes the final decision about the congregation's participation. Whether the decision is made by the minister or by a church council, the blessing of the minister and his or her continual support is essential for the success of this project.

The Organizational Structure of Congregational Coalitions

The Brown and McNair coalitions were formed at the same time. Representatives from each of the participating congregations constituted a Health Ministry Council (HMC) in each of the networks, consisting of clergy in one coalition and a combination of clergy and lay people in the other.

Their first task was to select a network coordinator - a half-time paid position. The role of the network coordinator is to stimulate interest in the project and strengthen relationships between congregations. The selection of a network coordinator was made by each HMC rather than the program directors of AIHP, a plus in an empowerment model. Since they were not involved in recruiting congregations, it was a challenge for them to establish a good working relationship with the HMC and each of the participating congregations.

The network coordinators in the Brown and McNair coalitions were resilient and inventive in meeting the challenges they faced. Rev. Edith Shokes, a long-time resident in the Brown community and a member of one of the coalition congregations, initially used office space in her church. Later she relocated her base of operations to the regional office of The Atlanta Project in the Brown community. A vibrant community organizer, her presence in the office of TAP ensured a steady flow of information between the coalition congregations and the community. Yolanda Nolton, network coordinator in the McNair coalition, used her home as an office. She was a member

of a small church in the coalition and could identify with the struggles of other small minority congregations who were doing their best to promote health in their congregations and the community in which the coalition was located.

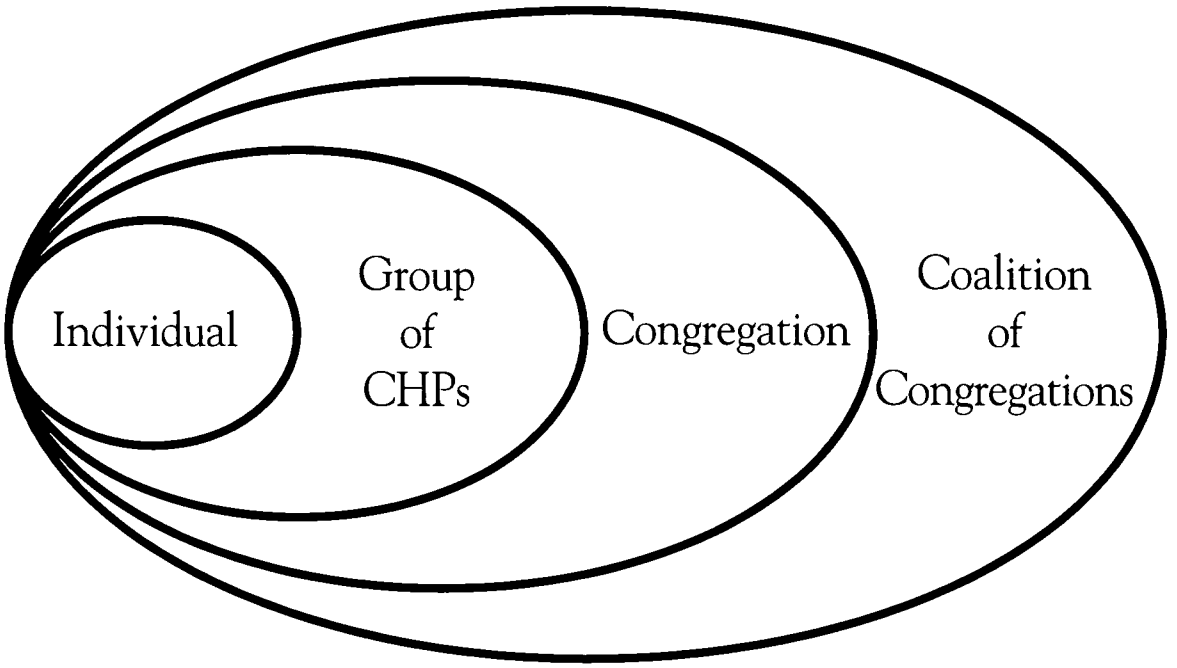
A different approach was used in the third coalition, which began approximately two years later. Rev. Sam Bandela, the director of a community ministry center located in the heart of this multiethnic community was recruited as the network coordinator. His knowledge of the community and prior contacts with many ethnic clergy in the region resulted in the recruitment of a highly diverse coalition of congregations. Following his suggestion, congregational leaders, both lay and ordained, were invited to The Carter Center for an inspirational program about the project. After the coalition was formed, it was a big advantage to have an office where people could come or call for information. The Chamblee-Doraville Ministry Center has decided to incorporate this health ministry into its ongoing operation, thus increasing its potential for sustainability.

The Unique Identity of Congregational Coalitions

The story of each of these coalitions needs to be told, but it would take a separate manual to do so. We made a decision to keep this manual formal, describing as accurately as we could the process of development and training in the formation of coalitions. What is sacrificed are the stories of the individuals and groups who made these coalitions living communities that brought changes in attitude, behavior and faith. The following paragraphs provide only a glimpse of the character of each of the coalitions.

The Brown coalition consists of 13 African-American churches located in the urban center of Atlanta. The congregations varied in size. The Health Ministry Council

■ Different Levels of Need



consisted solely of clergy. At its first meeting they elected as their chair Rev. Edith Shokes. Excited by this ministry of health, she campaigned vigorously and successfully to become the network coordinator. The HMC selected Rev. Otis Pickett, pastor of Capital View United Methodist Church, to replace her as chairperson. These two met regularly to nurture this coalition of congregations that had made a covenant to improve health in their congregations and community. Together they planned monthly HMC luncheons, each hosted by one of the congregations. In these meetings, the host pastor described the health ministries in his congregation, followed by sharing and presentation/s from community health agencies. At one memorable meeting, the pastors talked openly about their health habits and the importance of being role models in their congregations. A coalition will not survive, much less flourish, without strong leadership from people like Rev. Pickett and Rev. Shokes.

The McNair coalition consists of nine churches and one mosque, the most active of which are small minority congregations struggling to survive. Sitting in the back of the room at a breakfast meeting to recruit congregations for this coalition was an extended family that was the nucleus of a small Pentecostal church. Rev. Richard Ash was the pastor, and with him was his wife, parents and children. A gentle, soft-spoken man who has a passionate concern for the black youth who live within the shadows of his church, Rev. Ash was elected as a co-chair of the HMC. His wife was trained as a congregational health promoter. As a family unit, the Ashes developed a thriving health ministry in this tiny church that served not only its members, but its community. They talked about health in their worship services and sponsored a small Sunday-after-church health fair. They inspired youth to plan their futures by showing them what was available in Atlanta. They caught the vision of health ministry and lived it. In so doing, they demonstrated that it doesn't take a lot of money or people to develop a congregational health ministry.

Sister Ozzie Wattleton, 80-year old pastor of East Atlanta Church of God, has attended almost every HMC meeting for over two years. A source of inspiration to her congregation, the HMC, and the entire community, she spearheaded the development of a family health program. Teams of congregational members canvassed the community with information about monthly family health workshops. This is an example of how a congregation can implement and sustain programs without external support.

The Buford coalition is an interesting mix of 19 multiethnic congregations. Started two years after the Brown and McNair coalitions, it is in its early stages of development. The biggest story of health ministry in this international community is just beginning to unfold. The coalition is planning a huge health fair in the Spring of 1997. The event will be held in conjunction with a children's health fair being sponsored by Scottish Rite Children's Hospital. Each congregation will sponsor a booth and provide health information or screening for a wide variety of health needs. It will be an excellent example of what congregations can do when they work together for the health of the community.

More stories are needed to enliven the objective accounts of building coalitions and training congregational health promoters. In a narrative manual, the real heroes of this project would emerge as main characters, and those responsible for development, training, and manuals would fall appropriately into the background. The heroes are the volunteers who were empowered for health ministry by their faith and a participatory process of learning. They helped shape the coalitions, determined what should be done, and found the resources to do it. Although their stories get told within the coalitions, you only get a glimpse of them here.

Atlanta Interfaith Health Coalitions

Brown

African-American
Empowerment Zone area

Brown Coalition
13 churches
24 CHPs
Health Ministry Council
Network Coordinator

McNair

African-American
Empowerment Zone area

McNair Coalition
9 churches, 1 mosque
12 CHPs
Health Ministry Council
Network Coordinator

Buford

Multiethnic community
15% Hispanic, 25% African-American, 15% Korean,
8% Vietnamese, 8% Chinese, 10% Eastern European
Landing area for recent immigrants

Buford Coalition
17 churches, 1 Baha'i, 1 Unitarian Universalist
35 CHPs, 5 countries and 4 languages
2 parish nurses from the St. Joseph's Parish Nurse Program
Chamblee-Doraville Ministry Council
Network Coordinator

II. Training Congregational Health Promoters

After reading this section, the person or group planning the training should be able to:

- understand the participatory approach to learning and teaching
- incorporate the key concepts behind health promotion in planning a health ministry
- plan a program of successful training
- understand group process and how to provide information about health skills and topics
- articulate a philosophy for a faith-based approach to health promotion
- plan a series of learning experiences designed to raise awareness and develop skills for promoting health in their communities
- draw on resources in the community to assist in the training

The training process described in this section can be adapted according to community needs. In addition to the philosophy of training, you will find training session agendas and selected examples of particular training sessions.

What the CHPs said about training . . .

"It was great to see the churches in the community get together sharing ideas. This is a start. The coordinator carrying out the training sessions was excellent."

"The trainer was very well prepared and organized in a timely manner."

The Participatory Learning Approach

The philosophy of participatory learning is based on the work of the Brazilian educator, Paulo Freire *(see reference list for reading materials on the participatory learning approach)*. His adult education principles were successfully used in literacy programs in many developing countries. The basic principles of Freire's participatory learning are:

- Education is never neutral; it is either liberating or domesticating.
- People will act on issues that evoke strong feelings.
- People are creative, intelligent and have the capacity for action.
- Genuine dialogue is needed if communities are to share, listen and learn.

The participatory learning approach is suggested in training CHPs because its underlying principle is that the trainees are in a better position than the trainer to identify the health-related problems and assets within the community. The primary task of the trainer is to listen well to the trainees. This enables the trainees to listen well to each other and to the communities from which they come. Listening is perhaps the most important skill to be learned in participatory training.

Congregational health promoters learn to understand/elicit the general health issues of the community by listening for common themes/concerns. An identified concern is then posed back to the community to answer/resolve. For instance, CHPs in one coalition voiced concern about the death of young men in their community from handgun violence. Rather than citing studies or recruiting an expert to address the group, the trainer reflected this theme back to the CHPs and encouraged them to talk about it. The CHPs suggested that grim employment prospects for youth might be a primary cause. They then listed ways churches could persuade business leaders to hire more local youth.

Participatory learning is a way to mobilize the community's capacity to engage issues. Since the goal of this approach is to build the capacities of communities rather than fix problems, it can be applied in a variety of ways. This process works equally well with large or small groups.

Though simple in theory, participatory learning challenges traditional assumptions about the process of education. For example, people seeking health information in an educational setting expect a lecture from an expert rather than an invitation to participate in a process of assessing a problem and, in concert with others, seeking a solution. People become empowered when they see themselves as experts on the deficiencies and assets in their communities. By listening to each other, community members learn to identify health problems and access resources. This approach leads to both behavioral and systemic changes.

Though the emphasis in this manual is on the use of participatory learning in the training of CHPs, the ultimate goal is that the CHPs will use this approach in their congregations and surrounding community. The trainer needs to intentionally model the participatory learning approach in a manner that will make it easy and natural for those who are trained as CHPs to use it themselves.

Mixed Reactions by CHPs to Participatory Learning

It takes time and effort to use participatory learning approaches when conducting CHP training. The trainer needs to be committed to the process. She or he must sensitively and consistently assist the participants to "find their voice." From beginning to end, periodic feedback needs to be elicited from the group as they learn to understand and use participatory learning skills. Some participants will be enthusiastic about this style of learning while others, conditioned by traditional learning methods, will have reservations.

"There was too much time letting the group decide. When you have so many diverse people you will never reach a decision. Needed more rigid multiple choice selections, such as—these are the days of training—please select one."

"Group participation was a beneficial learning tool."

"to have a schedule and ideas of what to do during the meetings; not waste time in making decisions."

Congregational Health Promoters

Overcoming Resistance to Participatory Learning

Participatory learning proved to be a challenge for both trainers and CHPs. According to one of the trainers in the Buford coalition, "People who were more familiar caught on right away and were more successful." The trainer of the Brown and McNair coalitions felt that the CHPs were uncomfortable with the process and reluctant to decide what should be included in the training. Only after recognizing that they knew more about health in their communities than anyone else, did they overcome this resistance. It is important to allow time in the sessions for participants to arrive at this stage in their development.

The premise of participatory learning is that every group has skills, resources, capabilities and shared experiences that they bring to the process. They have the resources to solve their own problems.

For example, there were health professionals in the Brown coalition that made class presentations on various health topics. In the McNair coalition the participants sought outside resources for information about topics such as AIDS, TB, and diabetes. Thus, they focused on gaining the knowledge and skills needed to access resources and network with local health professionals. In the Buford coalition, one of the participants was a breast cancer survivor who, with the aid of her husband, started a support group called "Bosom Buddies." The group was for women recently diagnosed with cancer and in need of resources or support. By sharing their experiences, these CHPs gave their counterparts a lesson in how to implement successful health initiatives.

Participatory leaning is an experiential education process that CHPs can use in their congregations and communities. For example, a training session on planning a hypothetical health fair evolved later into a plan for a large-scale community health fair implemented by all congregations in the Buford coalition. The CHPs of the Brown coalition did something similar after being commissioned. They used several of their post-

training meetings to plan a community health fair at a local YMCA that made the facility available at no cost.

While participatory learning inevitably generates resistance if people expect to be passive recipients of expert information, in our experience, benefits of empowerment far out-weighed the difficulties. For example, one CHP was disappointed to learn that the function of the trainer was not to teach health skills like taking blood pressure and administering CPR. However, he was pleased to learn how to access resources in the health community that could provide such services. Trainers need to regularly emphasize that changing behaviors is a slow process of personal and community empowerment.

The Role of the Trainer/Facilitator

The Emory University School of Nursing coordinated the training program for AIHP in all three coalitions. Two faculty from the nursing school and two AIHP staff attended a week-long workshop on *"Training for Transformation"* (See "Resources for Training" in the appendix) to assist them in thinking through the type of training needed. The decision to use Friere's participatory learning approach can be traced to their involvement in this empowerment workshop. Though not a necessity, an experience of participatory learning can be enormously helpful in planning and implementing a training process employing its principles.

"So many great things happened that caused me to grow from the training."

"The coming together of different Faith groups for a good cause and training as one for the sake of the community."

"The involvement and persons of the Carter Center and Emory School of Nursing—The commitment of a faithful few to complete the training sessions—These were some very serious-minded persons."

Congregational Health Promoters

It was unfortunate that the opportunity to participate in the *Training for Transformation* workshop occurred before the selection of trainers. Only one of the three trainers was familiar with the method of participatory learning. Though all three trainers read the *Training for Transformation Handbook (see page 31, for information about this handbook and training workshops)* and other materials to familiarize themselves with the process, one trainer noted after the training, "Nothing could prepare me for this type of training except experiencing it."

Because the model is new and different, each trainer needed to make adjustments, particularly in the early stages. One suggested that more structure at the beginning could have created a better learning environment. Instead of the CHPs making all of the decisions right away, it would have been better to help them recognize the assets they brought to the learning process. Generally speaking, CHPs were slow to recognize their strengths and thus reluctant to make decisions even when they knew more than anyone else about their congregations and communities. The trainers agreed that their role was to empower the CHPs by focusing on goals and tasks the CHPs set for themselves.

Length, Spacing and Setting of Training Sessions

How much time is needed to adequately train CHPs? Based on the experience of the AIHP, 20 hours is a minimum. Anything less than 20 hours is insufficient for training based on participatory learning. More than 20 may be a burden for volunteers who have work and family responsibilities. However, the CHPs in the Brown and McNair coalitions asked for an additional four hours to complete the agenda they had set for themselves. Participants in all three AIHP coalitions decided for themselves the length of each session and the frequency of meetings. The training sessions in the Brown and McNair coalitions were scheduled every other week in two-hour sessions on Thursday evenings. Each coalition met for a total of 24 hours over a six-month period. Twenty hours of training in the Buford coalition were completed in six weeks in sessions ranging from two-four hours, some on Saturdays and some during weekday evenings.

Advantages of the six-month process included spreading out the time commitment and building relationships among participants. The additional time also made it possible for participants to become familiar with resources in the community and implement programs in their own congregations. While still in training, some CHPs used specific strategies, developed handouts, and conducted health programs in their congregations, using the trainer and the class to get feedback and suggestions. Disadvantages included the six months needed to complete the training and month between sessions especially if a CHP trainee missed one.

The advantage of the shorter program is the intensity of involvement in the six-week period and the sense of continuity between one session and the next. The disadvantages are insufficient time to absorb fully and put into practice what was learned, and the gap for trainees who miss any sessions. In summary, six months is too long and six weeks too short. Three months seems optimal, with CHP trainees deciding the length and number of sessions. This assumes, of course, that additional training is received in regular CHP meetings after the training program.

A safe, convenient and comfortable setting is also important. The space should be open and allow for different seating arrangements. Generally speaking, a circle is better than a row of chairs, though that arrangement may be appropriate for a presentation on a health topic. The space should be large enough to permit the formation of small groups—a vital part of participatory learning.

Building Trust and Community

Trust, self-esteem and personal ownership are the building blocks of participatory learning. A variety of exercises in the AIHP training, especially in the early stages, were designed to build trust and a sense of community. Simple strategies such as using name tags and get-acquainted exercises help participants feel welcomed and important *(the appendix contains a number of "ice-breaker" exercises for this purpose)*. Calling people by their preferred name and using a non-judgmental tone enhance a positive environment for learning. Using a flip chart to record what people say is a visual way to demonstrate that each person's response is valued.

If the trainer is flexible and sensitive to group process, group members will form into a community. Community-building is not only essential for successful training, but serves two additional purposes: (1) it models the process that CHPs are encouraged to use in their congregations and (2) heightens the likelihood that CHPs will continue to meet regularly after completing the training.

AIHP Training Sessions

What follows is a description of the actual training sessions for CHPs in the Atlanta coalitions. First, you will find a complete outline in chart form of the training sessions in all three coalitions. Chart 1 is for both the Brown and McNair coalitions, and Chart 2 is for the Buford coalition. (Since the training sessions in the Brown and McNair coalitions were conducted by the same trainer every other week in one of two locations, the training session agendas were similar enough to combine in Chart 1). Following the charts are descriptions of key topics referenced by capital letters *(see the following pages)*.

For example, in the first block (Session 1) on Chart 1, "Hopes and Expectations" is followed "C" in parentheses. A description of this activity can be found in the next section, "Description of Agenda Items," under C.

Second, a complete lesson plan for some activities/exercises is included in the appendix. As will be obvious, some training sessions are oriented around process, others around content. That difference, as well as others, will be explored in a comparison of coalition training sessions.
Further information about each subject area can be found in the appendix or by consulting reference books listed in the appendix.

Generally, each of the training sessions outlined began and ended with one of the participants leading a spiritual exercise. Usually, this was a prayer in the Brown and McNair coalitions and generally a reading, poem, or song in the Buford coalition. This provided a spiritual grounding for each session that reflected the faith of the person leading the exercise. Housekeeping details were attended

to before the core topics of each session were addressed. The group determined break times, provision of refreshments, and opening and closing devotions. Generally two or three health topics or skills chosen by the CHPs were covered in each session.

Descriptions of Agenda Items from Training Sessions (See Charts 1 and 2)

• A: Qualifications for Certification (Chart 2, Session 1)

The idea of a commissioning service originated toward the latter part of the training sessions in the Brown and McNair coalitions. Because the question about who was qualified to receive a certificate was not considered earlier, the coordinating committee decided that all those attending at least one session would be eligible. In the first training session CHPs in the Buford Coalition determined the requirements for being commissioned as 16 of 20 hours.

• B: Composition of Workshop Groups (Chart 2, Session 1)

The facilitator describes the function of groups in training. Smaller groups gave CHPs a greater opportunity to participate in discussions and get to know each other. Group size and composition changed, depending on the topic and purpose of the exercise.

• C: Hopes & Expectations/Concerns (Chart 1, Sessions 1-4; Chart 2, Session 1)

During the first few training sessions, participants shared their hopes and concerns/expectations. The Brown and McNair coalitions devoted portions of the first four sessions to this exercise *(see appendix)*.

• D: Evaluation & Application (Each session)

Feedback in each training session was obtained through either written forms or group discussions. In all three AIHP coalitions, CHP input determined adjustments in the training process and topics covered. After evaluation forms were completed, it was useful for the group to discuss how the skills and topics covered could be utilized. *(See Evaluation forms in appendix)*.

Chart 1: Training Session Agendas—Brown and McNair Coalitions (Total—24 hours)

Session 1 (3 hr.)
Opening prayer
Introductions
Review purpose of the training session & history of project
Introduce participatory learning
Begin hopes & expectations **(C)**
Questions & answers
BREAK
Plan schedule for next meeting & establish house rules **(O)**
Evaluations **(D)**
Announcements/recap **(E, F)**
Closing prayer/adjournment

Session 2 (2 hr.)
Opening prayer
Introductions
- Ice breakers (see appendix)
- Recap **(E)**

Hopes and expectations **(C)**
BREAK
Questions and answers
Begin "tackling" activity **(P)**
Review schedule & house rules **(O)**
Evaluations **(D)**
Announcements/recap **(F)**
Closing prayer/adjournment

Session 3 (2 hr.)
Opening prayer
Introductions
- Ice breakers (see appendix)
- Recap **(E)**

Hopes & expectations **(C)**
BREAK
"Tackling" activity **(P)**
Questions & answers
Evaluations **(D)**
Announcements/recap **(F)**
Closing prayer/adjournment

Session 4 (2 hr.)
Opening prayer
- Ice breaker (see appendix)

CHP as role model (see appendix)
Finish hopes & expectations **(C)**
Complete "tackling" activity **(P)**
Questions & answers
Decide "What next"
Announcements/review schedule
Follow-up—CPR
Evaluation **(D)**
Closing prayer/adjournment

• E: Review/Recap (Each session)

After the opening, all three coalitions found it useful to review topics and skills covered in the previous session. This method was particularly useful for the Brown and McNair coalitions that met bi-weekly.

• F: Housekeeping (Each session)

Housekeeping covers all small items that must be attended to for successful training: attendance, filling out forms (such as CHP and congregational profiles), announcements (such as persons not attending due to illness or travel), and review of the session's agenda.

• G: Maslow's Hierarchy of Needs (Chart 2, Session 2)

This is a conceptual map to help CHPs understand needs of any given individual or congregation. An emphasis on community needs was used instead of the hierarchy's traditional focus on individual ones. (See appendix)

• H: Setting Goals (Chart 2, Sessions 2 and 4)

Utilizing a group process for goal setting and strategic planning, the Buford coalition used this process to plan a community health fair with other congregations. The process was so successful that participants agreed to implement the plan following the training.

• I: Listening Skills (Chart 2, Session 3)

Small-group process was used for learning listening skills. Such skills are needed to determine concerns, set goals and identify community issues. This is perhaps the most important skill to be learned in participatory training. (See appendix)

• J: Codes (Chart 2, Session 3)

Codes are drawings, poems, and stories which reflect health issues. They are used to spark discussion and identify common themes. Usually codes are chosen that strike an emotional chord within the community (see appendix).

• K: Nutrition Pyramid Profile (Chart 2, Session 3)

An activity focusing on daily nutrition and the use of food groups. Participants recall their last three meals and mark corresponding food groups. This leads to a discussion on

Session 5 (2 hr.)
Opening prayer
- Ice breaker (See appendix)

Stress reduction
Family affair **(Q, N)**
- Parenting • Child care
- City help • How you can help • Homelessness

BREAK
Announcements /recap **(F)**
Evaluation **(D)**
Review schedule **(E)**
Closing prayer/adjournment

Session 6 (2 hr.)
Opening Prayer
Recap **(E)**
Guest Presenters **(Q, N)**
- Drug abuse • Violence

Questions & answers
Distribute information
- Drug abuse & Violence

Evaluation **(D)**
Announcements & Review of Schedule
- Discuss teen forum

Closing prayer/adjournment

Session 7 (2 hr.)
Opening prayer
Recap **(E)**
Guest presenters **(Q,N)**
- Starting Healthy Congregations
- American Cancer Society
- Hypertension & diabetes

Announcements & review of schedule **(F)**
Closing prayer/adjournment

Session 8 (2 hr.)
Opening prayer
Recap **(E)**
Follow-up **(Q,N)**
- Cancer • Diabetes
- Hypertension

Teen issues
- General teen information • Smoking
- Pregnancy • School drop-out

Class discussion
Announcements & review of schedule **(F)**
Closing prayer/adjournment

Session 9 (2 hr.)
Opening prayer
Recap/announcements/schedule **(E)**
Guest speaker **(Q,N)**
- AIDS • Atlanta Interfaith AIDS Network

Questions & answers
Evaluations **(D)**
Closing prayer/adjournment

how to improve diets *(see appendix)*.

• L: Trust Building (Each session)

All coalitions used exercises to build trust, such as listening and sharing experiences—especially in small groups.

• M: Spirituality and Health (Chart 1, Session 11; Chart 2, Session 5)

This is a group exercise to link faith and health. Participants reflected on the role of spirituality in health and how they could use the resources of their faith tradition to improve health *(see appendix)*.

• N: Speakers/Micro Classes (Chart 1, Sessions 5-11; Chart 2, Sessions 4-6)

Outside resource persons were invited to present topics which CHPs identified as important to their community. In the Brown coalition, CHPs who were health professionals shared their expertise on health topics by making micro presentations and leading discussions. The McNair coalition chose to use several outside speakers.

• O: Establishing House Rules and Regulations (Chart 1, Session 2; Chart 2, Session 1)

Following the participatory process, each group established its own rules and regulations, including such matters as: beginning and ending on time, being respectful of the opinions of others, being non-judgmental, being open to new ideas and concepts, maintaining confidentiality and determining length and timing of breaks.

• P: Tackling Activity (Chart 1, Sessions 2-4; Chart 2, Session 2)

After hopes and expectations had been determined, a process was used to help participants identify what they wanted to achieve and how to accomplish it. Issues were prioritized and resources identified within or outside of the group. Each coalition fashioned its agenda according to its identification of needs and resources. In some cases, fellow CHPs presented micro-classes on various topics. In others, the trainer gathered information, made handouts, and/or invited guest speakers to make presentations.

• Q: Health Topics (Each session)

A variety of health topics were discussed in the training sessions:

Session 10 (2 hr.)
Opening prayer
Recap **(E)**
Guest presenter **(Q,N)**
- Family planning
- Sexually transmitted diseases

Questions & answers
Topic: TB **(Q,N)**
Announcements & review of schedule **(F)**
Closing prayer/adjournment

Session 11 (2 hr.)
Opening prayer
Recap **(E)**
Topic-TB **(Q,N)**
Review of United Way *Help Book*
Guest Presenter **(Q,N)**
- Spirituality & Health (p. 44)

Questions & answers
Discuss evaluation process **(D)**
Closing prayer/adjournment

This manual contains a comprehensive list of health agencies and resources throughout Atlanta. Each congregation was given a Help Book as a reference for CHP's and anyone else needing information about available resources.

Session 12 (2 hr.)
Opening prayer
Recap **(E)**
Evaluation of the training experience (all 12 sessions)
Evaluation of AIHP
Announcements **(F)**
Closing prayer/adjournment

■ Chart 2: Training Session Agendas—Buford Coalition (Total—20 hours)

Session 1 (4 hr.)
Introduction and Welcome
Group Exercises
Participatory Learning
Qualifications for Certification **(A)**
Composition of Workshop Groups **(B)**
LUNCH
Ice Breakers (see appendix)
Hopes and Concerns **(C)**
Evaluation/Application **(D)**

Session 2 (3 hr.)
Opening Exercise
Introductions
What is AIHP and CHP?
Review **(E)**
Rules and Regulations **(O)**
Housekeeping **(F)**
BREAK
Charting Ladder of Needs in Congregation/Community **(G)**
"Tackling" activity **(P)**
Closing

cancer awareness, exercise, AIDS, TB, violence prevention, substance abuse, hypertension, family health, diabetes, and adolescent issues. Discussions included relating lifestyle (smoking, stress, sexual behavior) to disease. Keeping with the participatory approach, it is important that the group decides topics to be covered and the resource persons to present them.

Comparison and Contrast in Training Styles

One major difference between the training sessions in Charts 1 and 2 is obvious. Presentation of health topics were more prominent on the agenda in the Brown and McNair coalitions (Chart 1) after the fourth session, while group process skill development played a more prominent role in the Buford coalition (Chart 2). Note that the pattern in Chart 1 after session 4 is the presentation of two or three health topics either by CHPs within the group or resource people from the community. The pattern in Chart 2 is the use of group process to learn skills such as strategic planning or listening skills. Other differences in the coalitions are noted in the chart below:

Two Examples of Process vs. Content

All three coalitions used the participatory approach in choosing health issues significant to their congregations. The difference, as noted above, is how those issues were addressed. Some learning needs, such as how to plan a health fair, can best be met through the use of group process. Other learning needs, such as health information, can best be met by accessing community resources, such as the American Cancer Society, for materials and speakers. *See the appendix, "Content and Process," for lesson plans that illustrate each approach.*

Session 3 (3 hr.)
Opening Exercise
Introductions
Listening Skills **(I)**
Codes **(J)**
Nutrition Pyramid Profile **(K)**
Evaluation **(D)**
Closing

Session 4 (3 hr.)
Opening Exercise
Trust Building **(L)**
Local Programs: **(O)**
- What Works: Pockets of Excellence
- Bosom Buddies

Parish Nurses: Supports in the Community
BREAK
Planning a Health Fair **(H)**
Evaluation **(D)**
Closing

Session 5 (3 hr.)
Opening Exercise
Housekeeping **(F)**
- Forms
- Commissioning

PERT (see appendix)
BREAK
Spirituality and Health (see appendix)
Evaluation **(D)**
Closing

Session 6 (4 hr.)
Opening Exercise
Speakers: **(Q, N)**
Local community agencies
- Right from the Start
- North DeKalb Community Health Center
- Egleston-Safe Kids
- Mercy Mobile Health
- Even Start
- Chamblee-Doraville Ministry Center

Evaluation **(D)**
Closing

Contrast in Training Between Atlanta Coalitions

Brown and McNair Coalitions	Buford Coalition
training during 6 month time period	training during 6 week time period
2 hours per training session x 12 = 24 hours	3-4 hours per training session x 5 = 20 hours
Focus: health topics	Focus: group participatory skills
1 facilitator, 15 CHPs each coalition	2 facilitators, 35 CHPs
small and large group sessions	2 groups, meeting both separately & jointly

III. Development of The CHP Training Program

Training people as congregational health promoters is at the heart of the Atlanta Interfaith Health Program and must be carefully planned. This section gives a brief history of development of the training program described in the earlier section.

Coordination of Training Program

A committee consisting of three faculty members of the School of Nursing, two AIHP staff, and two community representatives was formed to plan the training in the Brown and McNair coalitions. As noted earlier, four members of this committee attended a week-long workshop on participatory learning. Several people with experience in training multiethnic lay health workers were added to the coordination committee for the Buford coalition. In addition, the trainer should be included on the committee as soon as she or he is selected. Planning committee meetings were held before, during and after the training to discuss and evaluate the process.

> *"Thanks a lot for starting this program, I am excited about sharing with others all the information I received and very interested in helping my congregation & community."*
>
> Congregational Health Promoter

Based on our experience, the committee coordinating the training should include as many stakeholders as possible. Consensus on the role of a congregational health promoter and the kind of training needed is essential.

Selecting a Trainer/Facilitator

Perhaps the most important decision that the coordinating committee will make, other than the type of training to provide, is the selection of a trainer/facilitator. Foremost in the minds of the AIHP coordinating committee was that the trainer/facilitator be culturally sensitive and committed to the empowerment principle. Respect for the broad spectrum of faith traditions was another important criterion. Though commitment to a faith tradition was not a criterion, it perhaps should be. Since all those trained are strongly motivated by their faith, it is an advantage if the trainer is also. A third criterion of selection was knowledge about health education and community resources. Some traits of a good trainer/facilitator:

- Familiarity with "participatory learning" for health promotion
- Sensitivity to requests for specific health topics
- Commitment to faith-based health promotion
- Listening skills (reflecting/summarizing viewpoints, seeking clarification through open- ended questions, posing new questions)
- Personal qualities (creativity and open-mindedness; membership in a faith community; cultural competence; and small and large group facilitation skills)
- Knowledge about health education and community resources

The facilitator/trainer should be part of the planning process. This was the case with both the Brown/McNair and Buford training. A close working relationship between the coordinating committee and the trainer/facilitator during planning, training and evaluation will provide the support and guidance needed.

Recruitment of Lay Volunteers for Training as CHPs

After an AIHP congregation signed "a Covenant of Congregational Participation" *(sample copy in the appendix)*, two persons (where possible, one male and one female) were recruited for training as congregational

health promoters. In African-American congregations, the minister was the key decision-maker in determining this selection. Though project leaders stressed the lay character of CHPs, nurses often volunteered or were asked to serve in this role (7 of 23 in one coalition).

The CHPs that have been most successful have the following qualities:

- Committed to the principle that people and communities should be responsible for their health
- Self-motivated and able to inspire others to act
- Able to listen well to the needs of others and assist them in meeting those needs
- Trusted and respected by other congregational members
- Spiritually grounded and committed to the faith basis of health promotion
- Role model for others in making lifestyle changes in physical, mental, social and spiritual health

It is important that the volunteers who are recruited for the training know exactly what is expected of them. We found that a meeting with the CHP trainees in the Buford coalition prior to the beginning of training was very useful in establishing a clear understanding of expectations.

Location of Training

In addition to finding adequate meeting facilities, the geographical location is important. The coordinating committee decided that the training should happen in the community where the coalition of congregations had been formed. This enhances the training and reinforces the sense that it is community-based.

The coordinating committee considered the selection of a neutral facility, such as a public library or YMCA, to avoid the impression that the training was a Baptist, Methodist or Roman Catholic program. These options did not prove feasible in the Brown and McNair coalitions, so each training session was held in the same church building. The idea of rotating the meeting locations among all the congregations was rejected to avoid confusion. The fear that the program would be linked to the congregation where the training was being conducted proved groundless for the following reasons: 1) The Carter Center was viewed as the primary agent in recruiting congregations and implementing the training; 2) During their first session together, the CHPs decided among themselves where to meet. This group decision helped to establish the participatory process.

Training Budget

- Fee for a trainer (In-kind service may be available from health agency or area university)
- Providing snack food (All of the food for the training in AIHP was provided by the participants)
- Office supplies: Flip-chart, paper, photocopying, markers, pens, tape, etc.
- Loose-leaf notebooks for handouts, agendas, personal notes
- Health resource guide for each congregation. (In Atlanta the United Way produces a Help Book listing all heath resources available in the community)
- Secretarial support: letters to churches, CHPs, handouts, etc.
- Meeting place (Likely available free of charge from health agency or church)
- Access to audio-visual equipment: overhead projector, slide projector, VCR, TV, etc.
- Training materials, such as Training for Transformation manuals (see "Resources for Training" in the appendix)

Planning a Commissioning Service

A commissioning service at the conclusion of the training served as a celebratory event marking the first milestone in the development of each coalition. The idea of a commissioning service came from one of the Health Ministry Councils. It is hard to overemphasize its importance. Called a commissioning service rather than a graduation, the event emphasized the challenge ahead rather than the training just completed. The service accomplished a number of related goals:

- Gave public recognition to congregational health promoters
- Gave visibility to the coalition within the community
- Served as an occasion for congregations to publicly declare their solidarity as a coalition of congregations committed to health ministry
- Provided an opportunity for an interfaith service of worship

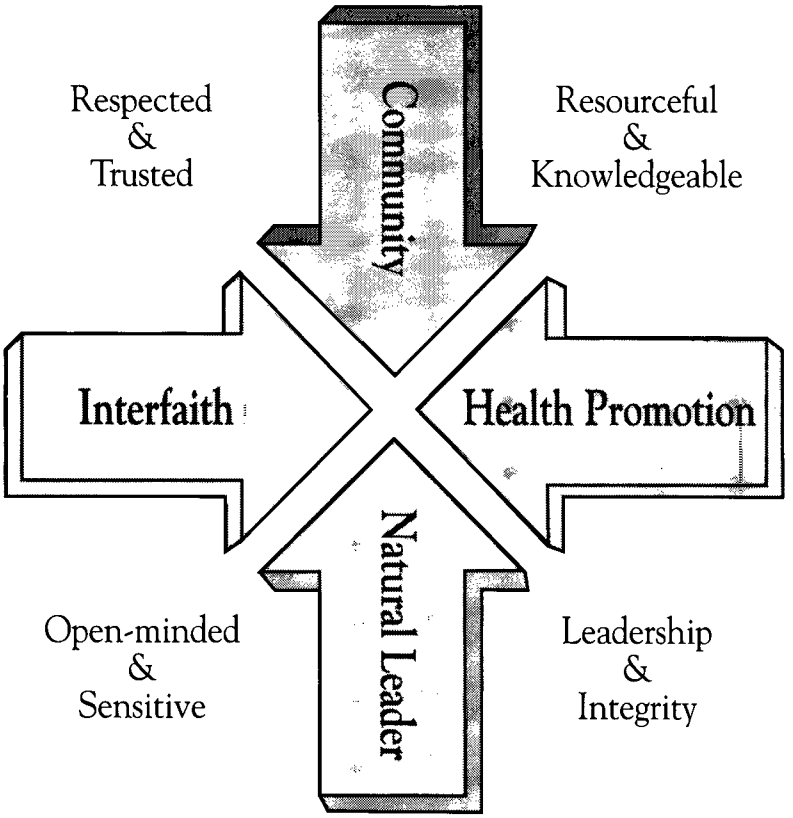
- Marked the end of recruitment and training and the beginning of implementation

The commissioning service was the first success for each coalition. Though not all congregations felt comfortable with the idea of interfaith worship, every effort was made to enable them to participate with integrity. A number of different choirs sang in each of the three commissioning services. To ensure their participation, clergy served not only as readers and speakers, but accompanied the CHPs from their congregation in procession and as they received their certificates.

At the heart of each of the services was the actual commissioning of the CHPs, each of whom received a certificate from the Emory University School of Nursing and a personal note of congratulations from President Jimmy Carter. One of the CHPs in the Buford coalition suggested an additional ritual. Each of the CHPs received a candle in a jar with the inscription of The Carter Center logo, the words "Congregational Health Promoter," and their name. Each CHP lit his/her candle from a common flame symbolizing their commitment to carrying forward the work begun during the training session.

A reception followed all three commissioning services. For each, the meeting hall was festively decorated with crepe paper and balloons. Food was prepared by participating congregations, including a large cake decorated with appropriate words of congratulations.

Traits of Successful Congregational Health Promoters

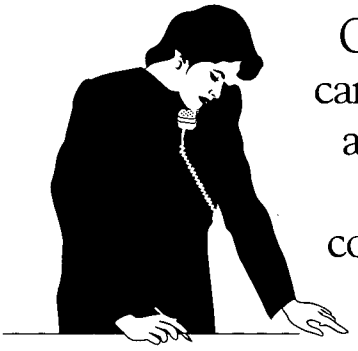


Anyone can be a CHP

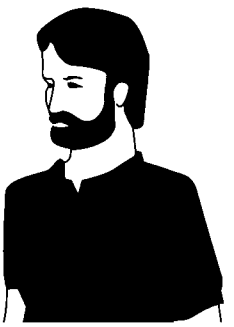
Because health is more than treatment of disease

Selecting Congregational Health Promoters

- Ability to Listen to community
- Natural leader
- Respected by Community
- Actively Participates in Collective Solution Process
- Concern for the Health and Well-being of Others
- Understanding Health as more than Medical



CHPs are leaders who can empower individuals and communities and have the vision of collectively working on shared problems



Working with the Community to Promote Health

IV. After The Training: Follow Through

Support System for Congregational Health Promoters

Support for the CHPs who have been trained and commissioned is essential. At a minimum, this means monthly meetings. Coordination of those meetings became the responsibility of the network coordinator in the Brown and McNair coalitions, though the Brown coalition later elected one of the CHPs as chairperson.

Two parish nurses at the Chamblee-Doraville Ministry Center assumed the responsibility for coordinating CHP meetings in the Buford coalition. A Parish Nurse Program at St. Joseph's Hospital in Atlanta was in the early stages of formation when congregations were being recruited for the Buford coalition. Since its manager, Sharon Stanton, wished to develop innovative models for parish nursing, two parish nurses were assigned to support CHPs in the Buford coalition, one with primary responsibility for Hispanic congregations and the other, a Korean nurse, with primary responsibility for Korean congregations. This was facilitated by Samuel Bandela, the network coordinator of the coalition and the director of the Chamblee-Doraville Ministry Center.

In all three coalitions, the agenda of these sessions was:

- Sharing information about activities in each congregation
- Participatory learning around a topic of group interest, with or without an outside expert
- Planning activities in the community jointly sponsored by all congregations in the coalition

Training of Additional Congregational Health Promoters

There was provision in the grant proposal to the PEW Charitable Trusts to fund only one series of training sessions in each of the coalitions. An assumption was made that additional training could and should be done by the coalitions, with AIHP providing consultation and technical support. There is a strong correlation between additional training and sustainability of a health ministry project dependent on lay volunteers.

The need for additional CHPs in the first two coalitions was evident fairly soon after completion of the training. Both CHPs in one congregation moved within months of being commissioned. Some became inactive after six months or more, and some coalition congregations had only one person trained. Congregations interested in joining one of the coalitions needed CHP training for their members. How might this need be met?

A committee of CHPs from each of the coalitions was formed to consider this question. This committee met several times with the trainer of the two coalitions, members of the coordinating committee, and several of the pastors from participating congregations. They decided to plan a series of training sessions similar in process and content to what they had experienced. They also selected three commissioned CHPs (two from one coalition and one from the other) to serve as trainers. With their trainer serving as a consultant, an agenda for the first few sessions was planned. A modest grant was submitted to a local foundation to support the process.

This carefully conceived plan had a promising beginning but was not fully implemented. Two sessions were held, but with limited attendance. A decision was made to postpone future sessions in order to recruit additional people. As of this writing, no more training sessions have been held.

Why was this excellent plan and a truly participatory process not enough? First, the grant proposal was not funded. Even with volunteers who were ready and able to help, this project called for collaboration among 24 congregations in two separate coalitions. With modest funding, a coordinator of training could have organized efforts to market the training by: 1) contacting clergy and

CHPs in coalition congregations about the need for additional CHPs, and 2) making contact with other congregations that showed interest in the program.

The part-time network coordinators of the coalitions were not in a position to assume the additional responsibility of coordinating additional training. It is easy to understand why the volunteer trainers were discouraged by the lack of support needed to sustain their efforts. The lesson learned from this experience is that it takes organization and collaboration, with community agencies and congregations, to build a sustainable coalition.

Therefore, AIHP sought out a reliable infrastructure in the multiethnic community where it established a third coalition. What we learned is that a coalition needs a "home" and promise of continuity. The Chamblee-Doraville Ministry Center, located at the very heart of the community being served, provides that home. Its director is the network coordinator for the coalition. Its board is supportive of this project, so much so that it contracted with the Parish Nurse Program of St. Joseph's Hospital for the services of two parish nurses whose primary responsibility is to support CHPs. The parish nurses work out of the ministry center. They convene monthly CHP meetings and will train future volunteers. The AIHP coordinating committee provides consultation and technical support. A county community health center being built to serve this multiethnic community is committed to a close collaborative relationship with the coalition. Collaboration and sufficient resources will help to ensure success and sustainability.

V. Evaluation

Evaluation of the Atlanta Interfaith Health Program (Currently in Process)

The overall purpose of the evaluation of this project is to learn and share with others information that will be useful in implementing congregation-based health promotion. Primarily, this is an internal evaluation describing the development and implementation of an interfaith-coalition- structured model of health promotion in an urban setting.

Data collection is focused on documenting the start-up and implementation process in the following general areas:

- Congregational recruitment
- Congregation-based health promotion (implemented by Congregational Health Promoters, CHPs)
- Community health promotion (through collaboration among congregations and between the congregations and community)

This is being accomplished by the following record keeping process: letters, meeting handouts, proposals, information gathered in minutes, meeting sign-in sheets, a Network Coordinator Activity Log, and CHP Monthly Reports *(see forms in appendix)*.

The Emory University School of Nursing had responsibility for the training of the CHPs. At the conclusion of each initial training, participants completed an evaluation. A summary of their responses will be included in the analysis and final evaluation report. Likewise, evaluations of all subsequent training will be reported.

In addition to written reports, the sharing of verbal information in meetings is a vital component of the evaluation process. Both in the CHP and Health Ministry Council meetings, there is encouragement for participants to share what is happening in their congregations. This encourages recording keeping and the motivating of participants. Formally, written summaries will be shared with all participating stakeholders for their review and comments at designated times throughout the project.

Evaluation of Congregational Health Promoter Training Program (Currently in process)

Evaluation is an important component of any program. It is needed to show the community, congregations, and individuals successes and concerns as the program is implemented. Evaluation data also demonstrate to other communities and funding sources the worth and value of such projects as a workable model for improving health through faith communities. Evaluation tools and processes were developed early on to help answer selected evaluation questions. With a little forethought, data can be made readily accessible. It can be used to show improvements, provide direction for change, share general information about the impact of the program with a variety of interested audiences.

The evaluation format for CHP training groups was based on a set of evaluation questions:

- Who was involved?
- What were the goal/desired outcomes?
- What processes were most effective?
- What changes actually occurred? What and how were resources utilized?
- Were the CHP participants satisfied?
- What were the experiences of the facilitator/trainer?

Evaluation tools were designed from the beginning of the program to collect needed data. The following is a list of data collection tools utilized in the CHP training programs. These tools are only examples of what might be utilized to collect needed data. However, there are many other effective tools and methods.

- **Personal Sketch Forms** *(see appendix)*. These forms provided demographic data, including name, address,

occupation, church/faith affiliation. Other information included experience in health education, health interests, special skills and talents, reason for participating in the program, and participation in other church/faith/community activities.

- **Training Sessions Attendance Roster** (see appendix). Such information is useful in determining the number of active participants and CHP retention rates. This information was useful in planning the certificate ceremony and in determining how absenteeism affected performances of CHPs.

- **Evaluation of Training Sessions** (See appendix). Each training session was evaluated using questions related to process activities. Three different approaches were used to collect this information. The first approach consisted of open-ended questions to the group at the end of the session and responses being taped, or recorded on newsprint. The second approach was to meet with 2-3 members of the group. The third approach was the development of a rating scale for each session to be used at the end of the program.

- **Class Training Session Book and Materials.** Training materials for each class were filed. Materials are available for review along with individual session evaluations and the journal of the facilitator. A complete evaluation of each session is possible with such materials.

- **Trainer's Journal**. Trainers were asked to keep a journal of reflections on the training process and their experience in this leadership role. The journal helps the trainer be aware of her or his journey in promoting participatory learning. It also provides important evaluation data.

VI. Appendix

1. Resources for Training

Training and Development Resources

■ *Training for Transformation: a handbook for community workers*
Anne Hope and Sally Timmel
Mambo Press, Zimbabwe
Available through Grailville Bookstore
Loveland, Ohio 45140
513-683-0202

■ *Helping Health Workers Learn*
David Werner and Bill Bower
The Hesperian Foundation
2796 Middlefield Rd.
Palo Alto, CA 94306
415-325-9017

■ *From the Ground Up! A Workbook on Coalition Building and Community Development*
Tom Wolff and Gillian Kaye
AHEC/Community Partners
24 South Prospect Street
Amherst, MA 01002

■ *Community Health Education: The Lay Advisor Approach*
Connie Service and Eva Salber (eds)
From: Ethel Jackson
University of North Carolina, School of Public Health
Rosenau Hall
Chapel Hill, NC 27599
919-966-3910

■ *Community Health Advisors: Vol. I, Models, Research, and Practice. Vol. II, Programs in the United States*. Sept. 1994
Technical Information Services Branch
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
4770 Buford Hwy, NE, Mailstop K-13
Atlanta, GA 30341
770-488-5080
[This information can also be found on CHID, Combined Health Information Database through a Medline search at any medical library.]

■ *Health Promoter's and Trainer's Manuals*
English/Spanish
Providence Holy Cross Medical Center
Parish Nurse Partnership, Latino Health Promoters Program
15031 Rinaldi Street
Mission Hills, CA 91345
818-898-4683

■ *The Technology of Prevention Workbook: A Leadership Development Program*
William Lofquist
Associates for Youth Development, Inc.
P.O. Box 36748
Tucson, AZ 85740
602-297-1056

■ *Called to Care: A Notebook for Lay Care givers*
United Church Press
700 Prospect Avenue
Cleveland, OH 44115
800-325-7061

■ *The Health Promotion Resource Catalog*
Stanford Center for Research in Disease Prevention
1000 Welch Road
Palo Alto, CA 94304-1885
415-723-0003

■ *The Lafiyia Guide: A Congregational Handbook for the Whole-Person Health Ministry*
Association of Brethren Caregivers
145 Dundee Avenue
Elgin, IL 60120
800-323-8039

■ *Beginning a Health Ministry: A "How-To" Manual*
Health Ministries Association
PO Box 7853
Huntington Beach, CA 92646
800-852-5613

■ *The Community Health Advisor Network*
Agnes Hinton, Director
206 West Pearl Street, Suite 1010
Standard Life Building #822
Jackson, MS 39201
601-354-4225

Consultants for Training Faith-based Health Workers

■ David Hilton, MD
Ecumenical Health Ministries
(Training for Transformation workshop facilitator)
4162 Cimarron Dr.
Clarkston, GA 30021
404-508-2255

■ Mimi Kiser RN, MPH
Interfaith Health Program
(Training for Transformation workshop facilitator)
The Carter Center
450 Freedom Parkway, One Copenhill
Atlanta, GA 30307
404-420-3848

■ Global Health Action
(Train the trainer, community health worker training)
1712 Clifton Rd.
Atlanta, GA 30329
404-634-5748

■ Grace Tazelaar
Community Health Programs Director
The Luke Society, Inc.
1121 Grove Street, PO Box 349
Vicksburg, MS 39181
601-638-1629

2. Covenant of Congregational Participation

Atlanta Interfaith Health Buford Highway Corridor

Atlanta Interfaith Health is a three-year project of The Interfaith Health Program at The Carter Center. The purpose of this project is to build interfaith coalitions to promote congregational/ community health.

A Covenant of Congregational Participation

We the members of _____,
under the leadership of _____,
believe that God calls us to be a community that promotes health and well-being. We affirm our desire to explore more deeply the possibilities of improving health and encouraging wholeness in our lives. To this end, we commit ourselves to faithful participation in this program. We will promote healthy lifestyles and join with other congregations in programs to promote health in our community.

We have appointed _____

_____

(name, address, phone) to serve as our congregational representative to the Interfaith Health Council.

Responsibilities of the congregation:

- Form a health committee or assign responsibility to an existing committee to promote health in the congregation and its surrounding community.
- Select two persons (preferably a male and a female) to serve as congregational health promoters upon completion of a training program.
- Appoint a member of the congregation (plus an alternate) to the Interfaith Health Council.
- Collaborate with other congregations in the Interfaith Health Council in formulating and implementing a Health Ministry Plan for congregational and community-based health ministries in the Buford Highway Corridor.

Responsibilities of Health Ministry Council (HHC):

- Develop an organizational structure that will ensure long-term sustainability.
- Define the role and responsibilities of the network coordinator and provide necessary resources to support his activities.
- Work closely with other community agencies in program development.
- Formulate and implement a Health Ministry Plan for congregational and community- based health ministries in the Buford Highway Corridor.

Responsibilities of Congregational Health Promoters (CHP):

- Meet regularly with congregational health promoters from other congregations to share information and plan health ministries programs.
- Meet regularly with the pastor (rabbi, imam) and health committee of the congregation to coordinate the congregation's health program.
- Have CHPs from all congregations jointly plan and implement a yearly calendar of health emphases.

Responsibilities of The Carter Center (Atlanta Interfaith Health):

- Assist in planning and implementing ongoing training for congregational health promoters.
- Support a part-time network coordinator for congregational/community health.
- Assist the congregations and the Interfaith Health Council in locating resources to address identified needs in congregations and the community.
- Coordinate an evaluation of the project.

We are fully committed to participate in a coalition of faith groups which promotes healthier behavior in congregations, and to support community programs of health promotion.

_____ Signature: _____
(date) (pastor, rabbi, imam)

Two congregational members (preferably one male and one female) are to be trained as congregational health promoters. These persons should be natural helpers who are trusted and respected members of the community. They do not need to be health professionals. They will receive 20+ hours of training. Please note the names and addresses below.

Name: _____
Address: _____

_____
Phone: (H)_____ (O) _____

Name: _____
Address: _____

_____
Phone: (H)_____ (O) _____

Please send to: Samuel Bandela, Director
Chamblee-Doraville Ministry Center
5935 New Peachtree Road
Doraville, BA 30340

3. Introduction/Ice Breakers

Stand Up If...

People are usually curious to know something about the background and experience of others who are participating in a workshop. An easy way to get everyone familiar with one another, especially in a large group, is to prepare a list of characteristics that participants are likely to have in common, like being from another country. The facilitator asks all those who share a particular characteristic to stand. After naming several characteristics, the facilitator urges others to name characteristics, such as everybody who has a cat. Participants soon get a sense of the varied backgrounds of persons in the group. In the Buford coalition, one person stood up and said, "Survivors of Cancer." Several people stood up as everyone in the group applauded.

The list of characteristics needs to be tailor-made for each group. It is important to ensure that everybody has an opportunity to stand up several times. Those preparing the list need to be sensitive to the feelings of participants, and make sure that they do not hurt or embarrass anybody, especially as the first few characteristics are mentioned. The aim is to help the group recognize and respect a variety of experiences. As trust builds, one can introduce characteristics that would be inappropriate in another setting. For instance, in a workshop dealing with unemployment, one might ask people to stand up if they have ever experienced unemployment themselves. This experience, painful though it may have been, can be seen as an asset, enabling one to understand more deeply the people the group hopes to help, rather than as something of which to be ashamed.

Experience and skills which relate to faith and health can be highlighted, such as all those belonging to a particular faith tradition, or those with a nursing or a public health background. One can suggest that people watch carefully who stands up, in order to spot people they would like to meet, either formally or informally, in between sessions.

It is best if two facilitators alternate in naming different characteristics, as the change of voices adds more vitality to the process. It is also important to intersperse some characteristics which will raise a laugh to lighten the atmosphere in the group, e.g. "Stand up if you are afraid of spiders."

Procedure

- Introduce the exercise as a way of building trust in the group
- Ask the participants to stand if the statement applies to them, giving them enough time to see the others who are standing.
- A sample list might begin with the following questions:

"Stand up if...
you were born within 50 miles of this place
in another state
in another country
you grew up on a farm
you grew up in a small town
you grew up in a big city
your native language is . . .
you speak a second . . . third . . . fourth . . . fifth language
you have ever been a teacher . . . social worker . . .
farmer . . . nurse
planted a vegetable garden . . . had a dog . . .
a cat . . . gone fishing

Other questions may concern family, occupation, education, group memberships, favorite recreation activities, hobbies, books, films, fears or worries, functions within an organization, and so on.

Type Introduction/Ice Breaker

Time 10 - 15 minutes

Materials List of topics

Source Adapted from *Training for Transformation*

Guess Who

Based on the information given in the Personal Sketch, a fun game can be developed using the skills and interests of the group. After the first class, have the CHPs fill out the Personal Sketch form. Use the information to make a fun introductory game which can be used to re-introduce CHPs after the first break.

Procedure

Scan the personal-sketch forms for interesting or fun characteristics about the group. For example, if one of the CHPs is interested in music ministry, jot it down. If another member is part of a youth group, jot it down. Try to find several interests which overlap. For example, if several CHPs mention that they are involved in a choir, note how many. Once all of the forms have been scanned and a list of interests created, you can make a fun introductory game. Start a sentence with "Find a person who...(fill in this space with interests from list). A sample copy, used in the AIHP, is found on the following page.

This might be a fun exercise to use the second or third meeting when first names are known. This exercise allows people to interact and move about the room. This may be a good exercise to use after CHPs have been sitting for a long time.

Type Introduction/Ice Breaker

Time 15-20 minutes

Material Personal sketches from CHPs (filled out after first session) and handouts for each CHP to complete, based on personal sketches (look at Getting to Know You). Note italicized words in Getting to Know You are derived from the personal sketch forms.

Source Adapted from *Technology of Prevention Workbook* (see Resources)

Getting to Know You

Objective: Find a person for each (just one blank per person). Ask him or her to initial.

1. Find someone who speaks (Spanish, Portuguese, French). _____
2. Find someone who teaches CPR, children, adults. _____
3. Find a nursing student who volunteers for Meals-on-Wheels. _____
4. Find someone who drives an American made car. _____
5. Find someone who is the eldest/youngest child in her/his family. _____
6. Find someone who sails. _____
7. Find someone who loves gardening/home improvements. _____
8. Find someone who works in a bowling alley. _____
9. Find someone who plays in a handbell choir. _____
10. Find someone who knows what kimchee is. _____
11. Find someone who survived cancer. _____
12. Find a boy scout troop leader. _____
13. Find someone who hikes. _____
14. Find someone in a music ministry. _____
15. Find someone who is vegetarian. _____

4. Learning Activities

The Process of Learning

People often tend to think their primary source of knowledge is books and classroom instruction. This exercise is to help people broaden their understanding of what they have learned and how they learned it. By examining one's own way of learning and comparing it to the way of others, one can see what learning conditions are important.

Procedure

Explain the purpose of the session. Then give each person a piece of paper and ask them to answer the following questions:

- List three things that you learned outside of school, things that are important to you, that affect your daily life.
- Choose one and think through the process of how you learned it.

The following questions are written on newsprint or a blackboard:

- Why did you learn it?
- Who helped you?
- What was the relationship between you and the person who helped you?
- What was the situation in which you learned it?
- In what way did you learn it?
- Can you remember anything that made your learning easier or more difficult?

Each person writes for 5-10 minutes.
Ask them to share these points in groups of three.
Have the group brainstorm the following on separate pieces of newsprint:

_____ Content	_____ What they learned
_____ Situation	_____ What helped them to learn
_____ Method	_____ How they learned
_____ People	_____ Who helped them

Summary

The facilitator summarizes the points made by the group and includes the following four major points about adult learning from Malcolm Knowles, a pioneer of the new methods of adult learning.

Adult Learning Psychology

1. Adults have a wide experience and have learned much from life. They learn most from their peers. Facilitators help them share their dialogue with one another. The best seating arrangement is a circle where they can see each other's faces.
2. Adults are interested in and learn quickly about those things that are relevant to their lives. Therefore, the facilitator needs to create a situation in which they can share in the planning, choose the topics, and participate in regular evaluation.
3. Adults have a sense of personal dignity. They must be treated with respect and never be humiliated or laughed at in front of others.
4. As adults grow older, powers of observation and reasoning may grow stronger as memories get weaker.

Type Adult learning process

Time About 1 1/2 hours

Materials Paper (or questions already duplicated on papers,) pencils, newsprint, tape, markers and 'How People Learn" handout

Source Adapted from *Training for Transformation*

How People Learn

Tests have shown that:

People remember 20% of what they hear, (imagine an ear)
40% of what they hear and see, (imagine an ear and an eye)
and 80% of what they discover for themselves (imagine a person examining some object)

Education should stress learning over teaching. Where possible, facilitators should create a learning situation where adults can discover answers and solutions for themselves. People remember best the things that they have said themselves, so teachers should not speak too much. They need to give participants a chance to find solutions, before adding important points not mentioned.

Key principles of participatory learning:
- No education is ever neutral; it is either domesticating or liberating.
- People will act on issues on which they have strong feelings.

This can be contrasted to the old "banking approach" to learning:
- Teacher knows all
- Pupils seen as empty vessels needing to be filled with knowledge
- Teacher talks
- Pupils listen

Problem-Posing Approach
- Facilitator encourages creative thinking around a common problem
- Facilitator raises questions: why, how, who?
- Participants describe, analyze, decide, plan

The role of the facilitator is to help participants identify the aspects of their lives which they wish to change; to identify the problem; to find the root causes of these problem, and to work out practical ways in which they can create change.

Source Adapted from *Training for Transformation*

■ Making Codes

Codes are depictions of community situations about which people feel strongly. For example, a code in a community where violence is a problem, could be a drawing of a gun and young men. Or it could be a play which features guns and violence. A code is a concrete expression of a problem that encourages meaningful conversations about what is depicted in the code. Codes are open-ended; their purpose is to spark discussion, not solve a problem. When successfully used, codes promote critical thinking and action. Codes can be represented in the form of a drawing, play, song or story.

Procedure

In this exercise, CHPs will develop their own codes. Typically, codes are drawings, but each group can decide the type of code they prefer. Break the CHPs into groups of four. Explain codes and encourage a discussion about their meaning and use. Distribute a code to each of the groups and have them discuss. Some leading questions:
- What do you see in this? What are the problems?
- What's really happening? How do the characters in the code feel? How do you feel about them?
- How is this similar to our lives? How is it different? How do we feel about it?
- Why is this a problem? What are the root social/cultural/economic causes?
- What can we do about this problem?

After a few minutes, ask each group for a brief summary of their observations. Remember that no one answer is right or wrong; each response should be respected. Next, have each group make their own code about the role of CHPs in their community. After 20 minutes, bring the groups together and have one person from each group share his or her code depicting the role of CHPs. Follow-up by summarizing each group's perspective.

Type Key Activity: Process to determine which problem to address

Time 40 - 50 minutes

Material Large sheets of drawing paper, pens, colored markers and pencils and other supplies

Source Adapted from *Training for Transformation*
Questions developed by Dr. Nina Wallerstein

5. Organization and Listening Activities

Listening Activity

The ability to listen carefully to a wide range of people is one of the most important skills that a CHP must develop. Many activities should be geared toward improving skills. The objective is to train CHPs to listen carefully to those seeking help without being judgmental.

Procedure

Divide into groups of three. Review the listening techniques handout. In each group, have each person play all three parts: listener, speaker and observer. Give the group a topic to discuss about which people are likely to have strong feelings. One of the three persons in the group shares his or her feelings and ideas about a particular topic, such as discrimination. One of the other group members acts as the listener, while the third acts as observer. After five minutes, have the observer comment on what he or she observed in the listener, including nonverbal clues like body posture and facial expression. Did the listener ask for clarification? What was the listener's body position? Did the person who shared feel listened to? Next change roles and repeat until each CHP has had the opportunity to do each role.

Type Listening Skills

Time 30 minutes

Material Listening Techniques handout

Source Adapted from *Training for Transformation*

Listening Techniques

Types	Purpose	Possible Responses
1. Clarification	1. To get additional facts 2. To help the person explore all sides of a problem	1. "Can you clarify this?" 2. "Do you mean this?" 3. "Is this the problem as you see it now?"
2. Restatement	1. To check our meaning and interpretation with the other. 2. To show you are listening and that you understand what the other has said.	1. "As I understand it, your plan is . . ." 2. "Is this what you have decided to do . . . and the reasons are . . ."
3. Neutral	1. To convey that you are interested and listening. 2. To encourage the person to continue talking.	1. "I see." 2. "I understand." 3. "Yes, I can see your point."
4. Reflective	1. To show that you care about what the other is feeling or saying. 2. To make sure you understand what the other person is saying.	1. "You feel that . . ." 2. "It was shocking as you saw it." 3. "You felt you didn't get a fair hearing."
5. Summarizing	1. To show that you understand all that was said and not just individual points. 2. To serve as a springboard to discussion of new aspects of the problem.	1. "These are the key ideas you have expressed . . ." 2. "If I understand how you feel about the situation . . ."

Source: *Training for Transformation*

Content and Process

There are two important aspects of every discussion:
1. How the group talks about the subject (process)
2. What the group is talking about (content)

Process is a means of discussing content or learning a skill in the most fruitful way possible. The role of the facilitator is to help the group reflect on an issue and decide appropriate actions.

A group leader needs to understand how process skills enable a group to meaningfully discuss content and then strengthen commitment to carrying out decisions.

A more traditional classroom approach is the presentation of a topic from a person with knowledge and experience. This is usually followed by a question and answer period to get more information, or directions on how to apply the knowledge. For example, in the AIHP coalitions, several speakers were brought into the sessions to lead discussions around such topics as AIDS, TB, violence, homelessness, etc. The format for most of these sessions was similar to that of a classroom, where the teacher/expert stood in the front and the CHPs/students sat quietly and listened. There are many ways to learn. As is obvious from CHP comments throughout this manual, some preferred a process approach and others a stronger emphasis on content. Participatory learning emphasizes the development of process skills that will enable CHPs to actively seek and address issues important to the congregation or community.

Examples of AIHP Activities that were Process Oriented

Listening Activity	Organization Skills
Hopes and Concerns	Drawing Codes
Daily Food Guide Pyramid Activity	Maslow's Ladder

Examples of AIHP Activities that were Content Oriented

HIV/AIDS	Violence	Cancer
Hypertension	TB	Diabetes
Drug Abuse	Parenting	

Note: Many of the sessions that were content-oriented were occasions when community resource people made presentations to CHPs. In these sessions, discussion was usually limited to questions and answers.

Source Adapted from *Training for Transformation*

Hopes and Concerns For CHP Training

A session on *Hopes and Concerns* should come early in the training. Its purpose is to discover what each CHP wants to accomplish in the training sessions. Since the training agenda is to be determined by the CHPs' goals and objectives, a list of the CHPs' top concerns is needed. This can be done in a variety of ways. One approach is to brainstorm as a group. This can be followed by the next exercise to determine expectations.

Procedure

If the group is larger than ten, divide into groups of five or six. Begin by asking everybody to write down their hopes and concerns on separate slips of post-it paper and then invite them to share their answers. This process allows time to reflect. Keeping groups small makes it more likely that shy people will participate.

Reassemble as a large group and invite members to discuss why they are attending these sessions and what they hope to gain from this experience. Have each person place his or her post-it on a flip-chart. This gives visibility to each contribution. Try to get full participation by asking what others think, either by commenting on previous contributions or adding new ones. Let the CHPs have ample time to think out the reasons that they are attending the training sessions. This information will be critically important to the trainers as they summarize and categorize responses and incorporate them into the sessions.

Type Key Activity: Process to determine hopes and concerns of the group

Time 30 minutes

Material Chalkboard and chalk or flip-chart and markers, post-its and pencils

Source Lynne Meadows, AIHP trainer

Expectations For This Workshop

This exercise can follow a brainstorming session to determine CHPs' hopes and concerns. This helps the group clarify its expectations and assume responsibility for how time should be spent during the workshop.

Procedure

a. The facilitator introduces the purpose of this session as an attempt to narrow down the concerns and to see how the group wants to spend time during the workshop.
b. The facilitator then asks one of the following questions:
   What do you hope to accomplish during our time together?
   What do you hope we will achieve by the end of this workshop?
   What do you hope to learn in this workshop?
c. Ask people to form groups of three. Give them about 15 minutes to discuss.
d. Reassemble as one group and brainstorm the list of their expectations.
e. When this is finished, the facilitator summarizes the main expectations given by the group.
f. If there are more topics than can be dealt with in the time available, the participants can be asked to write down their three top priorities. This helps the planning group prioritize issues.

Type Key Activity: Process to determine expectations of the group

Time This exercise takes about 45 minutes.

Materials Newsprint, tape, felt pens.

Source Adapted from *Training for Transformation*

6. Health Related Activities

■ Maslow's Ladder of Needs

This exercise is one way to consider the needs of the community on a deeper level.

Procedure

1. The facilitator explains the purpose of the session.
2. A short explanation of Maslow's Ladder of Human Needs is given to the group.
3. The handout on Maslow is then given to each participant.
4. Ask the participants to form groups of 5 or 6 people to discuss the main needs of their community in the light of Maslow's hierarchy.
5. They should write their views on the left side of the paper.
6. Then pose the second question: "If you were a man/woman/youth living in poverty in the community, what needs do you imagine would be most important?" Write these on the right-side of the ladder. "Do these two lists coincide? If not, why not?"
7. Bring the whole group back together and share both questions, one at a time.

Purpose

The purpose of this session is to examine community needs by using a hierarchical conceptual scheme developed by an American psychologist exclusively for individuals. Maslow's ladder, beginning at the top and moving to the bottom:

- Curiosity and the need to understand
- Self-fulfillment
- Competence, prestige, and esteem
- Love and feelings of belonging
- Security and safety
- Physical needs

Explanation of Maslow's Ladder of Human Needs

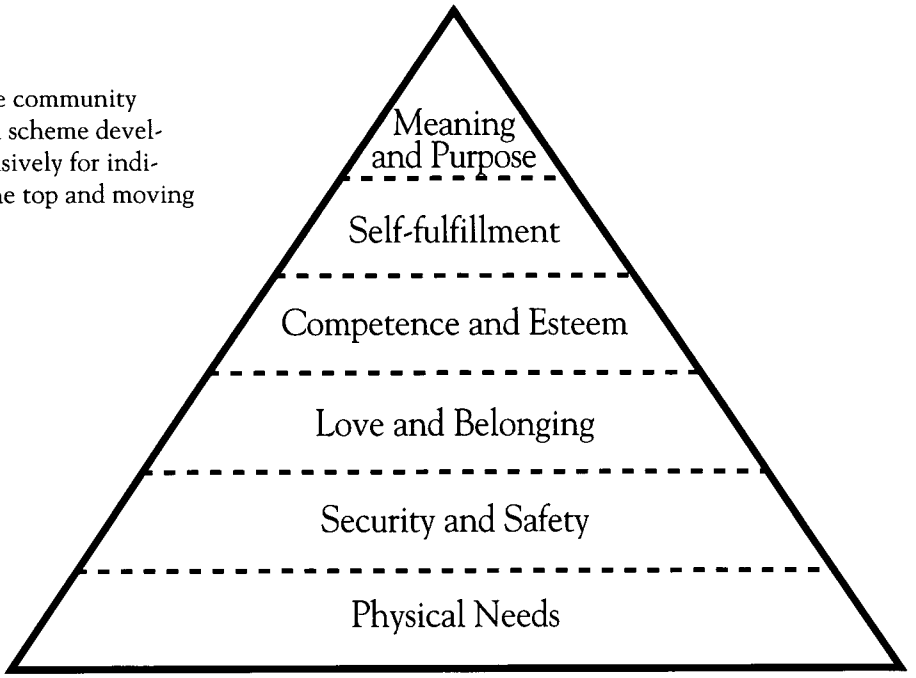
Maslow's Ladder is a way of looking at a community and assessing what problems or needs it has. The tendency is that communities with less resources are positioned on a lower rung of the ladder. The conceptual scheme provides a different way of looking at a community and seeing how others may perceive it.

If the group is doing a survey of community needs, it is useful to let them fill in the needs they expect to hear on the left. After the survey, fill in the needs people actually talked about on the right side of the ladder. The facilitator can then summarize the points made by the group.

Time About 1 to 1 1/2 hours.

Materials Copies of the Ladder for each Participant, newsprint, tape, felt pens.

Source Adapted from *Training for Transformation*



PERT: Program Evaluation and Review Technique

After a group has decided on a goal, action steps are necessary to help them achieve it. For local groups, it can be easier to use the planning kit explained in the next exercise. For larger programs, it can be very helpful to do a PERT as a visual chart.

This can be important to a team because:
- It shows how simple or complex the plan is
- It leads to realistic planning
- It organizes activities so that the goal can be reached
- It helps motivate and helps the team meet deadlines
- It provides immediate information for self-evaluation

How to do a PERT

As an example, let's assume that a coalition needs to hire a new network coordinator. The following tasks will have to be done:

1. Hire a new network coordinator
2. Form a selection committee
3. Develop a job description
4. Recruit candidates
5. Interview candidates
6. Make final selection

In this example, one can see that each activity must follow the other.

Decision to hire coordinator ➔ Committee formed ➔ Job Description ➔ Recruit ➔ Interviews ➔ Final selection

If the group has a deadline, it is important to plan backwards. For example, if you want to have the final selection of the candidate made by August 1, all of the candidates might have to be interviewed before July 15, etc.

1	2	3	4	5	6
April 1 ➔	May 20 ➔	May 25 ➔	June 1 ➔	July 15 ➔	August 1

Sometimes tasks can be done at the same time and do not have to follow one another. For example, these might be some of the tasks if you were organizing a dinner for your church: plan dinner menu, invite the guest speaker, invite the guests, buy the food, decorate the hall, cook the food, prepare the platform, begin the dinner, clean the hall.

In this example, a number of the activities (decorate the hall, cook the food, and prepare platform) will have to happen at the same time. On the other hand, the amount of time needed before the dinner would depend on how many people are involved and the availability of the guest speaker. If the group hopes to have a "famous" person to speak, they may well have to plan the event six months in advance. If the guest speaker is a local person, a one-month time frame may be adequate.

PERT is a common sense tool which helps remind people of the preparation work needed before an event and helps them check if the tasks will be completed on schedule.

Procedure

Read over PERT chart explanation. Describe the PERT chart idea to CHPs and use the above example for an illustration

Exercises

1. Use a PERT chart to organize a church reception
2. Use a PERT chart to plan a health fair with another church

Type Organization Skills

Time 30-40 minutes

Materials Paper for CHPs to plan exercise activity

Source Adapted from *Training for Transformation*

■ Daily Food Guide Pyramid Activity

The Daily Food Guide Pyramid is an activity which helps participants break down their meals into the five food groups. This allows them to be more conscious of what they eat and where their diet can be improved. The pyramid shows what foods are most important for a healthy life.

Procedure

Start by asking the group how healthy they think their diet is. Answers will surely represent a broad spectrum. Have CHPs write on post-its what they have eaten in the last 24 hours. Each individual food goes on a separate post-it. After they have competed the 24-hour recall, hand out the Daily Food Guide Pyramid. Ask them to place their post-its in the corresponding food group. Remember to tell them that foods like pizza fall into many categories, and can be considered "healthy" when broken down into separate food groups. Include all snack items. The pyramid's shape is an important feature. A healthy diet has most of the servings coming from the base of the pyramid and the fewest from the tip. However, many diets are the opposite. This is illustrated visually by using the food pyramid. Copies of the Daily Food Guide Pyramid can be obtained by contacting the national or local Dairy Council. Discuss individual diets. Be aware that many people are uncomfortable talking about their diet. Are the CHPs surprised, or did they already have a good understanding of their dietary needs?

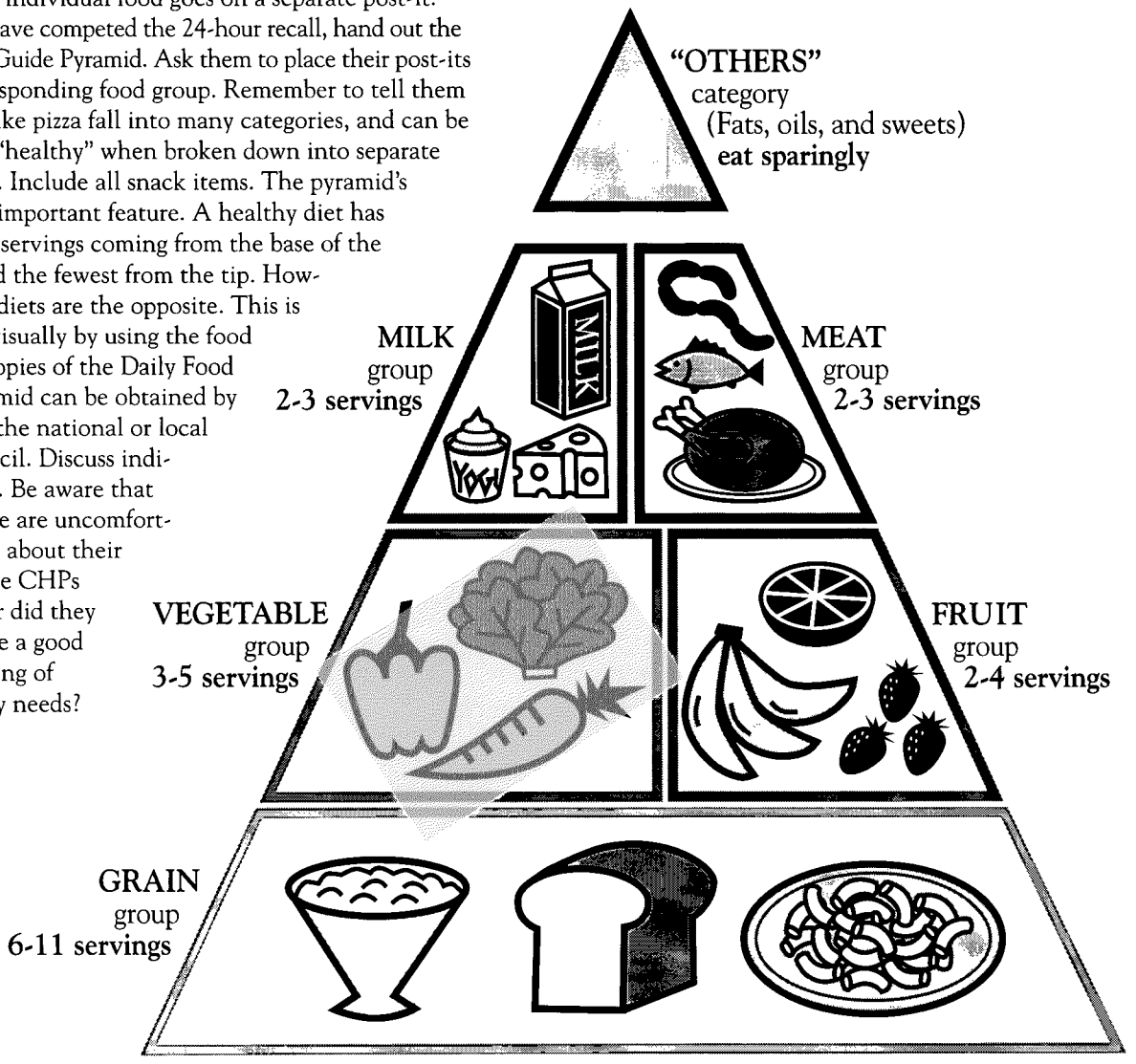
Discuss how they can use this activity in their congregations.

Type Health Related Activity

Time 15-20 minutes

Material Pens or pencils, Daily Food Guide Pyramid and yellow post-its

Source Elizabeth Downes and Connie Hannah, AIHP trainers



*Preteens, teens, and young adults (age 11 to 24) and pregnant and lactating women need 4 servings from the Milk group to meet their increased calcium needs.

Need more information on serving sizes or the variety of foods in each food group? Ask for a copy of Dairy Council's **GUIDE to GOOD EATING.**

Group Exercise in Exploring the Relationship Between Spirituality and Health

Introduction

The leader briefly introduces the exercise by commenting on recent studies showing that spirituality (a sense of meaning and purpose, hope, self-esteem, relatedness to others) is a positive indicator of good health. Health is enhanced even more if there is evidence of religious commitment and behavior. Christianity, as almost every other religion, highlights faith as a factor in health and healing. For example, Jesus said on one occasion: "Your faith has made you well." The purpose of this exercise is to explore the relationship between faith (spirituality) and health.

Exercise 1:

Divide into groups of three or four and share with others your understanding of how faith and health are related.

- Ask each person to write the words faith and health on a piece of paper, followed by words, phrases, or sentences that serve as definitions. Example:
  faith: trust, commitment, being able to count on someone
  health: being well in body, mind and spirit
- Encourage members of each group to share their definitions of faith and health, followed by a discussion about how the two are related. For example, someone might say that having a reason to live is important in maintaining your health or getting well.
- Write the following questions on a flip chart and encourage group discussion:
  - Can you be healthy without faith?
  - Can you be faithful (full of faith) but not healthy?
- Reassemble as a group and listen to reports from smaller groups.

Exercise 2:

Divide into the same small groups as in Exercise 1. Ask each person to share a story that shows how faith and health are related. A personal story is the best, but it can be one about someone they know or read about in their sacred scripture. This will likely generate tales of remarkable recoveries and stories about courageous coping with chronic illness.

Source Tom Droege, AIHP Co-Director

Healthy Lifestyles/Being a Healthy Role Model

As a Congregational Health Promoter, be a Good Role Model

Your congregation will notice your habits as well as spoken and unspoken attitudes about lifestyle practice.

People tend to follow the leader's example.

You will be your Congregation's Health Leader

so

BE a HEALTHY LEADER!

Living a Healthier Life!

Healthy Eating Habits

1. Eat regular meals, including breakfast.
2. Eat lots of fruits and vegetables.
3. Don't snack between meals.
4. Eat whole grain products every day (bread, cereal, pasta, and rice).
5. Substitute poultry and fish for red meat and use eggs sparingly.
6. Use fats and oils sparingly (butter, margarine, mayonnaise, and salad dressings).
7. Limit alcoholic beverages (drink in moderation or not at all).

Source Lynne Meadows, AIHP trainer

7. Evaluation Tools

■ Congregational Health Promoter—Personal Sketch Form

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____

Occupation: _____

Church/Faith Affiliation: _____

Pastor/Reverend/Minister(s): _____

Experience in Health Education: _____

_____

_____

Health Interest(s): _____

_____

_____

Special Skills/Talents/Abilities: _____

_____

_____

How have you helped others with their health/sickness? _____

_____

_____

What kinds of questions do others ask you about health? _____

_____

_____

In what other church/faith/community activities are you involved? _____

_____

_____

Please share any other information you would like us to know.

Comments: _____

_____

_____

What would you like to know about each other? _____

_____

_____

Source Lynne Meadows, AIHP Trainer

Training Sessions Attendance Roster

Name: _____

Date: _____

Class #: _____

Topic: _____

Name	Church/Congregation/Faith Group

Source Lynne Meadows, AIHP Trainer

■ Congregational Health Promoter Monthly Report Form "Sharing Your Current Health Ministries"

Month: _____

Congregation: _____ Name: _____

Date: _____

Health Activities:

1. Describe the health activity or activities that happened in your congregation this month.

a. Type (class, seminar, presentation, sermon, screening, etc.):

b. Health subject(s) covered:

c. Number of congregation members participated in each event:
Event (1) # (portion of congregation, 1/2,1/4,3/4, etc.) .

Event (2) # (portion of congregation) .

d. Number of community members participated in each event:
Event (1) # Event (2) #

e. Describe how each of these events was promoted in your congregation and in the community (flyers, bulletin, special announcements—include the number and who did it).

Health Information Distributed:

2. Describe what health information was distributed to your congregation this month.

a. Form (brochure, bulletin, flyer, newsletter, etc.):

b. How or where (at an event, mailing, set out at a resource area, etc.):

c. Health topic(s):

d. Number of people reached with each:
with .

with .

Referrals:

3. Referrals you made to a health service or resource this month.
   Total # _____ Organizations or resources: _____

Contacts with Atlanta Interfaith Health participants:

4. Describe contacts that you made this month with other CHPs, Parish Nurses, or the Network Coordinator. Describe the nature of each contact.

_____
_____
_____
_____
_____

Community Contacts:

5. What interactions have you had by phone or in-person with community health or service agency representatives this month? List names and organizations along with the nature of your interaction.

Describe contact: _____
_____
_____

Contact person _____ Organization _____

Support Needed:

6. How could your Network Coordinator or the Atlanta Interfaith Health staff or clergy leadership assist you in your ministry?

_____
_____
_____
_____
_____

Faith Group Leader Contact:

7. Have you spent time this month talking to your pastor/imam about health ministry?
   ❑ Yes ❑ No Describe what happened. _____
_____
_____
_____
_____

Congregational Support:

8. For this month, describe the activities of, and your interactions with, the health committee or group in your congrega tion that functions in that capacity.

_____
_____
_____
_____

Source Mimi Kiser, AIHP Coordinator of Evaluation

■ Essential Elements of Evaluation for Faith-based Program Activities

The Lincoln Community Health Center of Durham, North Carolina suggests you should consider the following when developing program activities for churches:

- The program should carefully outline what is to be accomplished. Goals and objective should be firmly stated, as well as why this program is important and should be implemented.
- Desired outcome data should be simple, relatively easy to measure, and easy to collect.
- If possible, obtain the services of a biostatistician and or someone with research and evaluation skills to assist with developing and monitoring the proposed program.
- The following is a list of suggested data collection tools. The program should try and develop tools prior to implementation. However, it should be expected that modification of measurement tools may be necessary as the program develops.

  - **Participant Registration Forms or Personal Sketches.**—Should obtain demographic data on program participants. Other information one might want to collect is whether or not participant is a youth, parent, interested adult or minister; church name and affiliation; health background, race/ethnicity and reason for participating in the program.

  - **Assessment/Evaluation Forms**—Useful for obtaining feedback about the program from the participants. Will also enable the provider to determine how active program participants are. Information can be used to improve or modify the program.

  - **Participation Log Sheets/Attendance Sheets**—Information gathered will help the program determine the number of active participants and CHP retention rates.

  - **Pre and Post Surveys**—For use when implementing health education classes/training that occur over a period of time. This is helpful in determining if program participants' knowledge levels have increased as a result of taking the class/training.

  - **Develop Yearly or Bi-yearly Reports**—This information will provide the program developer with a detailed log of the program's activities, progress, and what is needed to improve it.

- Develop a descriptive log of the process of the program's development over a period of time. The process of program development is very important because it provides others with information about how the program progressed from the conceptual through the developmental and implementation stages.

Adapted from: *The Church Connection*, Lincoln Community Health Center, Durham, NC.

Evaluation of Training Session (1)

Please help us evaluate our training. Your opinions are important to us. No names please.

1. How beneficial was the trust-building exercise?

1	2	3	4	5	6	7	8	9	10
not at all				beneficial					extremely

2. Why or why not?

3 How beneficial was information provided by Bosom Buddies?

1	2	3	4	5	6	7	8	9	10
not at all				beneficial					extremely

4. Why or why not?

5. How beneficial was information provided by parish nurses?

1	2	3	4	5	6	7	8	9	10
not at all				beneficial					extremely

6. Why or why not?

7. How beneficial was organizing a health fair activity?

1	2	3	4	5	6	7	8	9	10
not at all				beneficial					extremely

8. Why or why not?

Thank you!

Source Elizabeth Downes and Connie Hannah, AIHP Trainers

■ Evaluation of Training Session (2)

1. What was most helpful about today's session?

2. What was least helpful about today's session?

3. What are your suggestions for future topics?

4. Other comments:

Source Lynne Meadows, AIHP Trainer

Evaluation of Training Session (3)

Class #: _____ Date: _____

Key: 1 = Poor
2 = Fair
3 = Average
4 = Good
5 = Excellent

Please rate the following:

• **The method of presentation**	1	2	3	4	5
• **The effectiveness and organization of the presentation**	1	2	3	4	5
• **The appropriateness of information**	1	2	3	4	5
• **The helpfulness of the handouts and other teaching aids**	1	2	3	4	5
• **The amount of interest stimulated by the facilitator**	1	2	3	4	5
• **The helpfulness and appropriateness of group activities**	1	2	3	4	5

Comments/Suggestions:

_____
_____
_____
_____
_____
_____
_____

Source Lynne Meadows, AIHP Trainer

STARTING POINT: *Empowering Communities to Improve Health*

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