A Faith-Based Asset Approach to Cardiovascular Health Promoting Activities Within the African American Community

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Introduction

- Globally, stroke is the second leading cause of death.
- Stroke is fourth among all deaths in the United States.
- Annually, 750,000 individuals will suffer a new or repeated stroke.
- A single stroke costs $19,018.
- Annually, the US spent $34 billion on stroke related care and lost productivity.

PRAISE aims:

- To improve stroke outcomes among African Americans residing in Riverside County by strengthening cerebrovascular health promotion through increased knowledge, awareness, commitment for policy and environmental changes within the church and community via a faith-based asset approach.

Background

The need to increase stroke awareness, advocacy and cerebrovascular health promoting activities in the African American population is challenging, but it is a vital challenge that is essential in decreasing mortality, morbidity and inequalities in stroke.

Although African Americans only make up 6% of the total population in Riverside County, they made up the highest proportion of people suffering stroke morbidity and mortality. In 2010, African Americans had the highest rate of stroke, which was higher than the County rate of 40.5 per 100,000 populations. Stroke rates among Blacks were higher than the state average.

African Americans have a higher occurrence of stroke risks, incidence, as well as poorer outcomes. Some of the reasons are the result of genetics, environmental, social influences and the healthcare system, minorities are also less likely to seek emergency care and are less likely to be aware of stroke signs and symptoms.

Effective management of stroke requires the administration of recombinant tissue plasminogen activator (rPA) thrombolysis within three hours of suspected stroke. Therefore, it is necessary that symptoms be recognized in time. Effective management of stroke requires the administration of recombinant tissue plasminogen activator (rPA) thrombolysis within three hours of suspected stroke.

Methods/Project Description (n=85)

The proposed project utilized the theoretical framework of asset-based approach and the conceptual underpinnings of the faith-based approach to health promotion.

Project Logic Model

The project was delivered over 12-sessions. Each session delivered twice a week, lasting 2 hours. Pre-program health screening included: anthropometric, non-fasting blood glucose and lipid panel, weight and height, BMI, waist circumference, and body fat composition in order to provide for follow-up services with primary care providers (PCP) and coordinating by experts in the field. i.e., RN, Nutritionist and physical fitness trainer.

Participants were educated on the concept that “time is brain” and stroke (brain attack) is an emergency. The course presented the recognition of stroke, using knowledge of the face, arm, speech and time (FAST) scale, early management, post-stroke care and health promoting activities; navigating the healthcare system, pre-hospital care and management, coping and advocating, controlling of LDK, physical activity and nutrition. Teaching methods planned included lectures for new information, discussion sessions for sharing and clarification, story telling, demonstrations, interactive activities, i.e., physical training, cooking classes, incorporating faith-base teachings and principles.

Evaluation Strategy

Pre and post-program implementation evaluation:

Stroke assessment questionnaire (SAQ): stroke risk awareness survey; Sense of Coherence Scale (SOC); SF-36 Health Survey; Health Related Quality of Life (HRQoL); Nutrition Survey; General Health Related Survey; Clinical Screening Data: Weight, Height, Anthropometric, BMI, Lipids, Blood glucose, stroke knowledge and management; cholesterol knowledge, hidden sodium knowledge, Group interview questionnaire

Statistical analyses were performed with the Statistical Package for Social Sciences version 18.0 (SPSS) using descriptive analyses of the baseline characteristics. Clinically significant lifestyle changes, the SF-36 scores and their changes were computed, as well as the baseline SOC scores. A clinically significant lifestyle change was characterized as a weight reduction of 15%. Matched pairs tests were used to measure statistical significance between baseline and follow-up mean values.

Findings

Individual knowledge gains included stroke-symptom recognition 60.5% baseline to 94% at one week after program; and knowing to call 911 if stroke symptoms develop 47% baseline to 98% at one week. Assessment for knowledge of where in the body stroke occurs (8% baseline to 38% at one week), the warning signs of stroke 44% to 69% baseline to 78% to 100% at one week; varying percentage based on the warning sign, with severe headache being lowest and dizziness and loss of balance being the highest), and action that should be taken if you have any symptoms of stroke 46% at baseline to 100% at one week.

Sense of Coherence & Health Related Quality of Life (n=85)

Findings indicated that the program influenced participants’ abilities to make healthier choices with 33% made a lifestyle change, 49% saw a doctor for follow-up. Many participants made changes in their lifestyle based on their moderate risk factors for stroke; 64% changed to a low-fat and low-cholesterol diet, 45% had increased awareness and monitoring of their cholesterol; 31% of participants began exercising, 26% began weight loss measures, 18% improved blood pressure monitoring, and 57% of identified smokers were attempting to quit.

Nutritional Knowledge (n=85)

The average score for nutritional knowledge achievement was about 38, which concludes a very weak nutritional level. The nutritional knowledge level was statistically associated with participant’s age, educational level, occupation, marital status and obesity.

Discussion

The findings suggested some positive changes among participants in (a) access to resources, support and networking in cardiovascular health promoting activities, (b) increase in health related quality of life, (c) strong SOC, (d) increase knowledge, awareness and skills in managing stroke, (e) increase knowledge on nutrition and physical activities to promote health and decrease stroke risks and (f) improvements in major clinical indicators of stroke risks, anthropometric and weight. Health assets, whether internal or external, can influence and be utilized in difficult situations.

Conclusions

Participants applied the knowledge and skills acquired from the PRAISE program and the social support, networking, pastor involvement and encouragement provided for healthier options. Providing access to and additional resources within the community also provided for healthier choices among participants.

This strategy is in alignment with the asset-based theory that identifies the needs for health activities that will link individuals with access to health education, resources and support for empowerment and self-advocacy.

PRAISE proved to be a valuable intervention because it involved stakeholders both in the community and the church as well as providing for an all inclusive and ecological model of health promotion. PRAISE not only provided for stroke education but also provided a platform for advocacy and access to resources that enable the individual and the community in making healthier options.

Anecdotal evidence suggests that efforts to replicate best practices of the PRAISE program are being considered for other churches by Health Heritage Movement and the Health Ministry Alliance. There is a potential for the PRAISE project to align with participants’ primary care provider (PCP). The ability to collaborate with PCP as another link within the formal health care systems can further close the gap between the faith-based and community-based organizations of care and allow for follow-up services and resources to support their health.