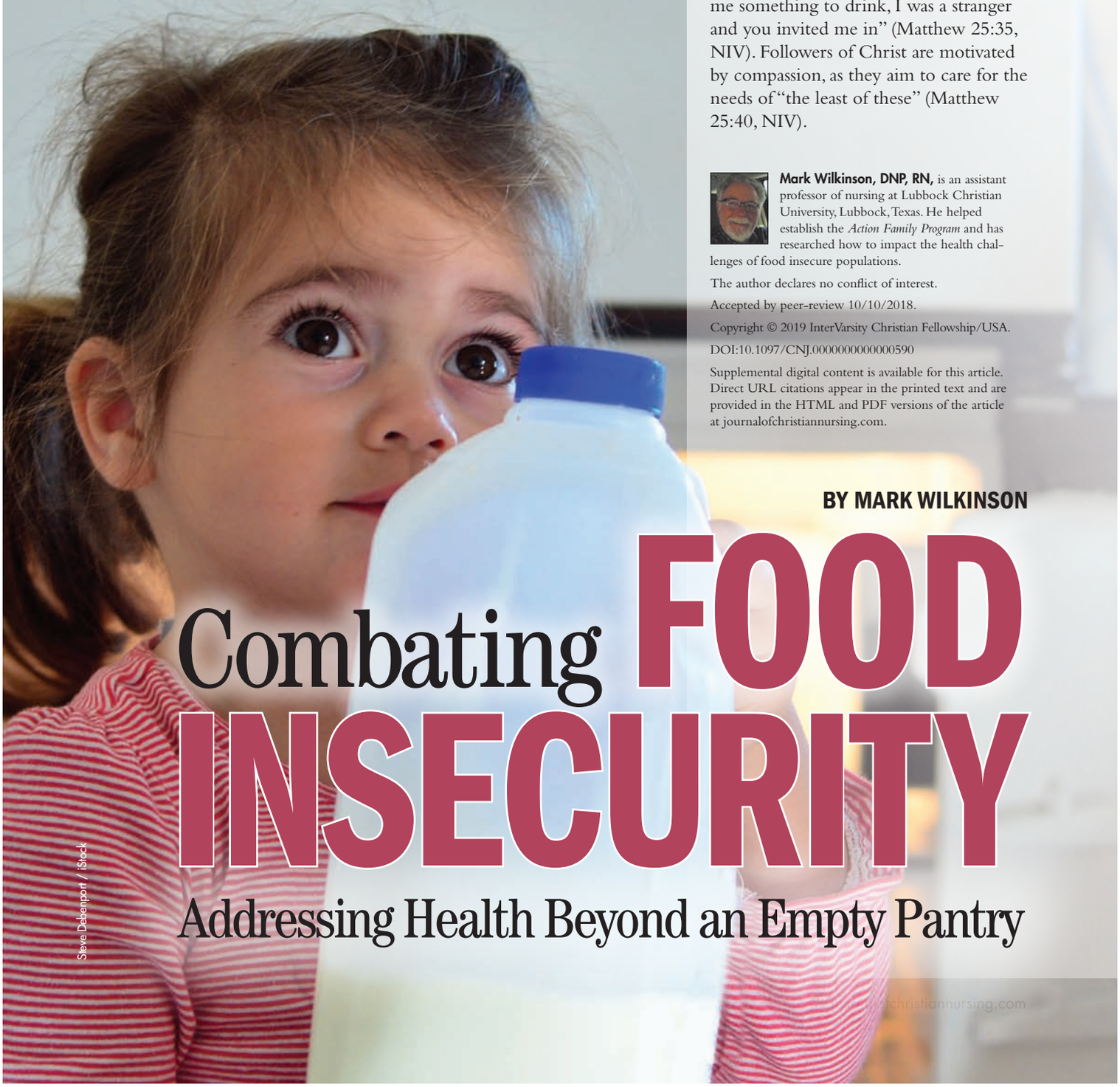
ABSTRACT: *Individuals and food-insecure households who rely on food banks have a higher likelihood of chronic health conditions. A study of the* Action Family Program *at a faith-based community center demonstrated how nurses can impact food bank recipients' health measures through health promotion interventions. Providing healthier food options with the weekly food distribution box, cooking demonstrations, health screenings, and health education resulted in reduced weight, and decreased systolic and diastolic blood pressure measurements.*

KEY WORDS: *community health, faith community, food bank, food insecurity, health education, health promotion, nursing, Pender's Health Promotion Model*



Steve Debenport / iStock

CE **1.5 contact hours**

Jesus' ministry exemplified meeting the needs of the poor and broken. Today, we struggle to find balance between helping and enabling. Are we giving a handout or a hand up? Do those questions matter to Christ? The apostle Matthew wrote that, at the final judgment, Jesus will say to faithful followers, "For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in" (Matthew 25:35, NIV). Followers of Christ are motivated by compassion, as they aim to care for the needs of "the least of these" (Matthew 25:40, NIV).

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BY MARK WILKINSON

Combating FOOD INSECURITY

Addressing Health Beyond an Empty Pantry

One avenue through which nurses and community volunteers are demonstrating compassion for the needy is serving in food bank programs. Historically, food banks have been a valuable resource for individuals and families with various levels of food insecurity, to supplement their food supply (Loopstra & Tarasuk, 2012). However, health risks exist for people who rely on food banks as the major source of their diet. One consequence of providing free food is the inadvertent increase of health risks in the people receiving assistance. For example, people who regularly receive food from food banks have been shown to be at risk for obesity, hypertension, type 2 diabetes, and cardiac disease (Pérez-Escamilla, Villalpando, Shamah-Levy, & Méndez-Gómez Humarán, 2014; Tobin, Downer, Prendergast, & Marshall, 2016).

FOOD INSECURITY

One in seven Americans is food insecure. Among households with children, one in five homes experiences food insecurity, "meaning that at some time during the year they had difficulty providing enough food for all of their members due to a lack of resources" (Schanzenbach, Bauer, & Nantz, 2016, para 1) (sidebar, *What Is Food Insecurity?*).

Food banks and pantries have become primary nutrition sources for food-insecure populations. Significant challenges exist for providing healthy food choices for organizations that depend on food donations. Food-insecure individuals who are at risk for diabetes, obesity, or hypertension have an added burden in achieving a healthy lifestyle. Hispanics and African Americans both have higher levels of food insecurity than other groups (United States Department of Agriculture, 2018) and are more often impacted by diabetes, hypertension, and obesity (Cowart et al., 2010; Ickes & Sharma, 2012). Seeking successful interventions for food-insecure populations is important to promote improvements in health and health habits. Churches, community centers, and faith community nurses can play instrumental roles in providing interventions.

Interventions that include cultural preference seem to have more impact on health (Adams, Burns, Forehand, & Spurlock, 2015; Ickes & Sharma, 2012). Churches and community centers may already be serving specific cultural or socioeconomic groups, addressing cultural sensitivity in a more natural context. Furthermore, it takes time for a community to build trust with a healthcare team. Communities with a high number of food-insecure households have seen a lot of well-meaning people coming in to *do good deeds.* Typically, as Joseph and Rusmore (2014) describe, these programs are unsuccessful when insufficiently planned and executed. It takes time to gain the community's trust and get *buy-in* from local residents.

> We struggle to find balance between helping and enabling. Are we giving a handout or a hand up?

Nurses working in community centers and in faith communities located in underserved areas have an advantage in building sustainable programs with lasting impact. Why? Because nurses are able to build a sense of community and accountability—elements essential to lasting change (Ruggiero, Oros, & Choi, 2011; Tumiel-Berhalter, Kahn, Watkins, Goehle, & Meyer, 2011).

Faith-based organizations have a built-in volunteer base and can combine resources with other agencies. Programs can be adapted to meet specific needs within the community; there is no "one size fits all" at the community level (Tumiel-Berhalter et al., 2011; Vatcharavongvan, Hepworth, & Marley, 2013). Peterson, Atwood, and Yates (2002) conducted an outcome-based literature review for church-based health promotion programs and identified seven key elements of successful programs: (a) partnerships with other agencies, (b) positive health values, (c) availability of services, (d) access to church facilities, (e) community-focused interventions, (f) health behavior change, and (g) supportive social relationships. Faith-based organizations build their services around models of care that readily complement nursing interventions.

THE ACTION FAMILY PROGRAM

In 2015, the *Action Family Program* (AFP) began as a health and wellness outreach at an established faith-based community center. The center is a distribution point for the local food bank. The AFP is an example of how food banks, faith communities, and community organizations can become effective partners with faith communities and nurses to improve the health and well-being of the people they serve.

Every Saturday, more than 100 people receive help from the AFP. At the community center, resources include a clothing closet, educational materials (such as Graduate Equivalent Degree and English as a Second Language instruction), and the AFP health promotion program. The AFP offers health screening, health education, and meal preparation demonstrations, aimed at empowering participants to adjust their daily living choices. The long-term objective is to improve health outcomes.

The AFP started by supplementing food bank offerings with healthier food options and providing a cooking demonstration, based on the weekly food box that is distributed to people at the center. Through a grant from a local health organization, options including proteins or fresh vegetables are purchased for the food boxes. The grant is reviewed and renewed yearly, based on the success of the program.

Although clients wait for their food box each Saturday, nurses and nursing students use the 2-hour clinic time to perform health screenings—checking weight, blood pressure, heart

Sidebar 1. What Is Food Insecurity?

Food insecurity is defined by the United States Department of Agriculture (USDA) as the limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways (USDA, 2018). The USDA considers a household to be food insecure when inhabitants are at times unable to acquire adequate food for one or more household members because of insufficient money and other resources for food.

An estimated 11.8% of households in the United States were food insecure at least some time during 2017 (Coleman-Jensen, 2018). Homes with children are more likely to confront food insecurity. In 2016, 13 million children under 18 (18%) lived in food-insecure households; of those, 1% were in households with very low food security.

In 2016, households dealing with food insecurity were almost twice as common among children in households headed by non-Hispanic Black or Hispanic parents than in those headed by non-Hispanic White parents. Also, children living in homes headed by single women were three times more likely than homes with married couples to be food insecure (Child Trends, n.d.).

Another group that is more vulnerable to food insecurity is seniors. Gundersen and Ziliak (2017) reported that food-insecure seniors are worse off in health outcomes compared with food-secure seniors. For example, they are 65% more likely to have diabetes and 19% more likely to have hypertension. Seniors with uncertain food supply are 2.3 times more likely to be depressed, 66% more likely to have experienced a heart attack, and 91% more likely to have asthma.

Although living in poverty is often a characteristic of families who are food insecure, it is not the defining factor. National surveys, such as Current Population Survey Food Security Supplement (CPS-FSS) and the Survey of Income and Program Participation (SIPP) have demonstrated that nearly half of families who are food insecure have incomes above the official poverty line. Various national surveys also document that close to half of all families reporting food insecurity have incomes above the official poverty line (Wight, Kaushal, Waldfogel, & Garfinkel, 2014). The same surveys, according to Gundersen, Kreider, and Pepper (2011), have found that people who are not considered food secure may be able to achieve a stable food supply because they are forfeiting other needs, such as prescription medications.

Situations other than income can result in food insecurity, such as loss of a job, divorce, or caring for a sick family member. Families may move in and out of periods where their food supply is stable and then unstable. **—Karen Schmidt, Contributing Editor, *JCN***

Child Trends. (n.d.). *Key facts about food insecurity.* Retrieved from https://www.childtrends.org/indicators/food-insecurity

Coleman-Jensen, A. (2018, November 5). United States Department of Agriculture, Economic Research Service. *Food pantries provide emergency food to more than one-quarter of food-insecure households*. Retrieved from https://www.ers.usda.gov/amber-waves/2018/november/food-pantries-provide-emergency-food-to-more-than-one-quarter-of-food-insecure-households/

Gundersen, C., Kreider, B., & Pepper, J. (2011). The economics of food insecurity in the United States. *Applied Economic Perspectives and Policy, 33*(3), 281–303. doi:10.1093/aepp/ppr022

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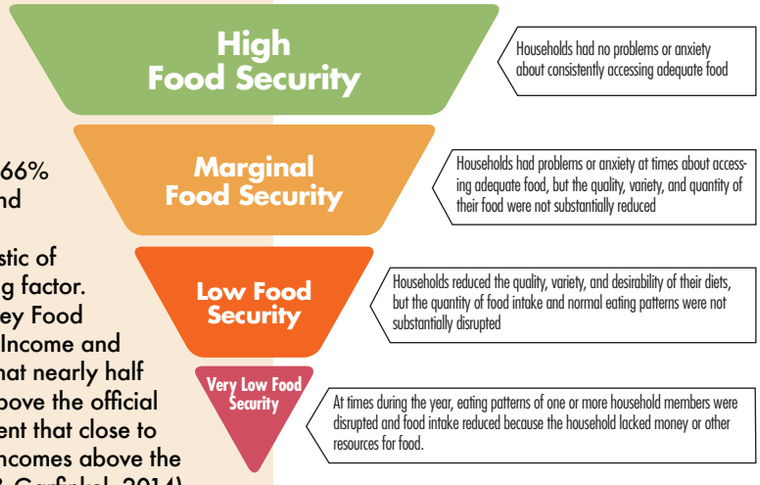
Wight, V., Kaushal, N., Waldfogel, J., & Garfinkel, I. (2014). Understanding the link between poverty and food insecurity among children: Does the definition of poverty matter? *Journal of Children & Poverty, 20*(1), 1–20. doi:10.1080/10796126.2014.891973

rate—and offer health education. The nurses spend one-on-one time with individuals to discuss their current medications and answer health-related questions. Checking blood pressure is useful, but human touch by connecting one-on-one and showing care are the most important acts the nurses perform. Each week, the nurses review medications, discuss treatment options, and provide nursing interventions to promote the health of the individuals they encounter.

Area nurses volunteer for the AFP. Many volunteers are students from area nursing schools, who satisfy their needed community health practicum hours. Sigma Theta Tau International nurses volunteer on the fifth Saturday of the month. Other nurses, who are members of the sponsoring church, volunteer from time to time.



Hunger + Health. (n.d.). *Understanding food insecurity.* Retrieved from https://hungerandhealth.feedingamerica.org/understand-food-insecurity/ Used with permission.

Through the AFP, health promotion interventions have been initiated. A walking club began meeting 4 days a week for exercise and fellowship, as described in the sidebar, *Stories of Transformation*. Area health experts began teaching monthly health and wellness classes. The education classes have expanded beyond disease management (i.e., diabetes, heart disease) to encompass a larger framework of wellness and health promotion. By including area experts, nurses have covered discussions on mental health, family issues, and the importance of exercise.

PROGRAM IMPACT

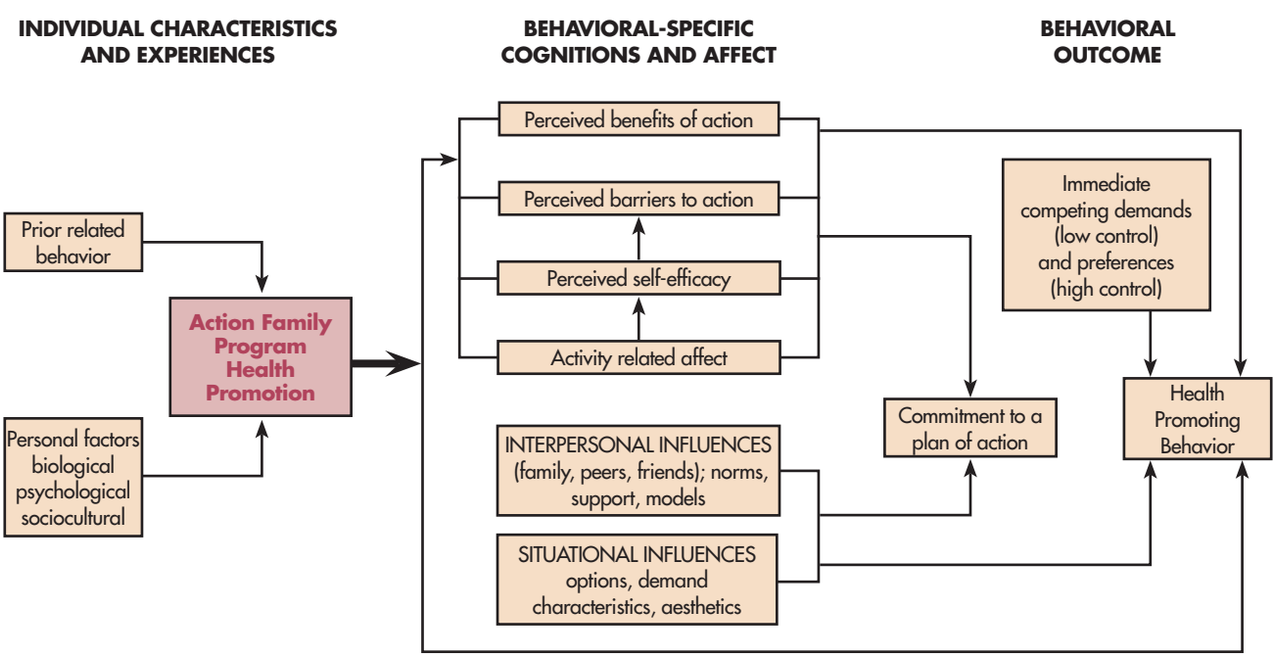
A study was conducted to determine the impact of the AFP on select health indices of food-insecure individuals coming to the community center to receive food. Pender's Health Promotion Model (HPM) guided this study. The HPM is rooted in the expectancy value theory that individuals engage or participate in activities to achieve goals they believe to be possible (Pender, Murdaugh, & Parsons, 2015). The model identifies background factors that influence health behavior. Making lasting change in individual behavior involves changing the mindset of the person's perceived barriers. People do what they think they can do. Making unhealthy choices can be the result of thinking there are no other choices. Eating healthily, for example, requires changing generations of dietary habits. "This is how we have always cooked" or "this is what we have always eaten" are common expressions voiced by AFP participants. The HPM brings the idea of making change because one can. People are motivated to change when they believe specific goals are attainable.

Once trust is established, the opportunity to change behaviors becomes more attainable, and people are better equipped to commit to change. In the AFP, 6 months passed before the participants freely talked with the nurses on a meaningful level, which indicated trust was established.

Pender et al. (2015) stated that making incremental changes increases the awareness of the desired outcomes people want and can build from success to success. The AFP introduces positive outcomes that are attainable, increasing the potential for individual improvement in health choices. For example, providing food and, as needed, clothing, has built trust between the recipients and the AFP and created positive, attainable outcomes. Figure 1 shows how Pender's Health Promotion Model was used in the Action Family Program.

The community center records and maintains the participants' health promotion records with a signed consent for participation. A community action committee composed of participants gives input and guides the decisions about offering interventions. To measure the impact of the AFP, 50

FIGURE 1.
Pender's Health Promotion Model (2014) with Action Family Program Health Promotion Intervention



Source: Pender et al. (2015). Reprinted and adapted by permission of Pearson Education, Inc., New York, New York.

records were chosen for review from the 100 registered AFP participants. Records were chosen based on individuals' participation in at least 50% of the AFP clinics over the previous 12 months. Five records were eliminated because of missing data, resulting in 45 participants ($N = 45$). Institutional Review Board approval was obtained from Lubbock Christian University and Samford University.

Participant demographics were representative of the community coming to the center. The 45 participants who met inclusion criteria included 30 Hispanics, 10 whites, and 5 African Americans. Of these, 30 were female, and 15 were male. Age ranged from 24 to 76 years, with a mean age of 60.

STUDY RESULTS

Review of participants' records ($N = 45$) revealed that after 12 months of program participation, average systolic blood pressure decreased from the beginning reading of 136 mmHg to an ending reading of 129 mmHg. The average diastolic measurement decreased from 79 mmHg to 75 mmHg in the same period. Overall, 95% of the participants experienced an improvement in their blood pressure. One person in particular had a blood pressure change from 196/98 to 152/79. Two participants had no change in their systolic or diastolic readings. Figures 2 and 3 show how average systolic and diastolic blood pressure decreased over the 12-month period. The heart rate of participants remained unchanged at 75 to 79 beats per minutes.

Participants also experienced weight loss. Four participants asked that their weight not be recorded and were not included in the results. The remaining participants ($n = 41$) lost a total of 286 lb in the 12-month period. The average weight loss was 6.35 lb per person (Figure 4). Weight loss ranged from 0.4 to 30 lb (2 participants), whereas 6 participants had no weight change. Eight participants gained weight, ranging from 1.2 to 21 lb. Considering the average age of participants was 60, the weight loss is a significant achievement. Body mass index (BMI) calculations were consistent with the recorded weight loss. Average BMI decreased from 31 to 30 over the 12-month period.

A statistically significant difference between mean preintervention and postintervention scores supports improvement in overall weight loss ($p = .005$), BMI ($p = .001$), and lowering of systolic ($p = .007$) and diastolic blood pressure ($p = .039$). Cohen's d was calculated based on the average Standard Deviation (SD) from two means. For Cohen's d 0.2 = small effect, 0.5 = medium effect, and 0.8 = large effect. The effect size for this intervention was in the medium to large effect range, with the exception of heart rate. Paired sample t tests and Cohen's d for weight, systolic and diastolic blood pressure, BMI, and heart rate pre and post means are reported as supplemental digital content (SDC) at http://links.lww.com/NCF-JCN/A62.

This study is limited by the small sample size. Limiting the research to 45 participants meant that the ability to accurately see the full effect on all participants may have been diminished.

FIGURE 2. Average Systolic Blood Pressure Changes Over 12-Month Period ($N = 45$)

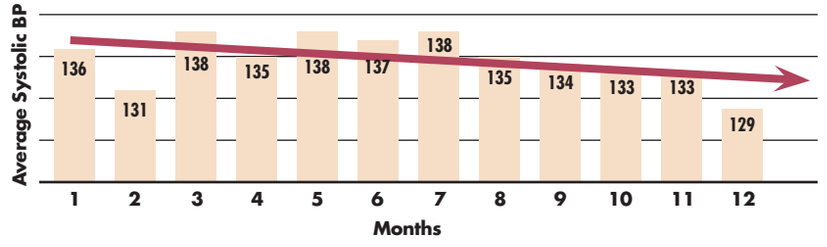


FIGURE 3. Average Diastolic Blood Pressure Changes Over 12-Month Period ($N = 45$)

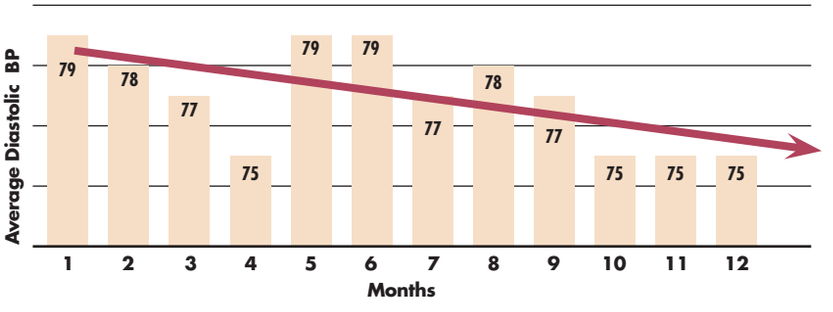
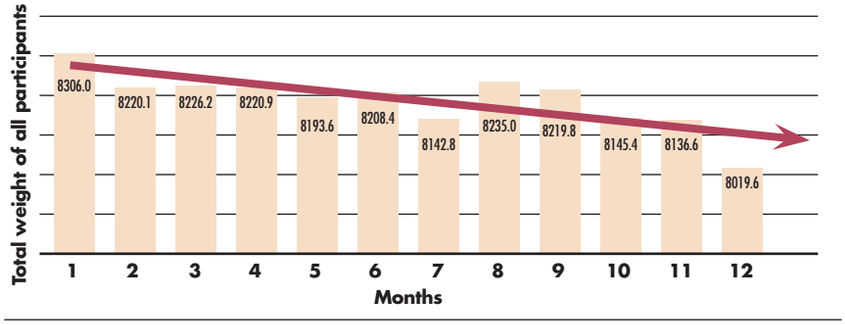


FIGURE 4. Total Weight Loss Over 12 Months ($N = 45$)[a]



[a]Total weight loss combined for all participants over 12 months was 286 lb.


Steve Debenport / iStock

Another limitation was the use of anonymous records, which eliminated any qualitative information that might have been gained. Personal interviews on the effectiveness of the AFP could offer additional valuable information. Further research is needed to understand the health needs of food-insecure individuals and build effective interventions and health promotion programs.

Another limitation discovered during the study was monitoring blood glucose of AFP clients. While reviewing participants' records, it became evident that people with elevated glucose readings quit getting checked. One participant was asked why he stopped getting his sugar checked. He stated, "I got tired of the lectures." That response warranted a look at our education process. Nurses can use negative messages when teaching patients, saying things such as, "You're going to go blind" or "We'll have to amputate your feet if you don't get this under control." Nurses can do a good job teaching at the cognitive and psychomotor levels but do very little teaching at the affect level. Change takes place most often at the affect level because that is where values are made and strengthened. The good news is this gentleman was worked with individually and his blood sugar lowered from a 250 average to around 140. Further research needs to be done on using principles from the Pender's Health Promotion Model and conducting effective patient education.

NURSING IMPLICATIONS

Any nurse, but especially community health and faith community nurses, can identify individuals and households experiencing or at risk for food insecurity using the two-question Hunger Vital Sign™ tool (Children's HealthWatch, 2018). Here are two statements that persons might be asked to rate in order to assess for food insecurity:

1. "Within the past 12 months, we worried whether our food would run out before we got money to buy more."
2. "Within the past 12 months, the food we bought just didn't last, and we didn't have money to get more."

Those whose reply to one or both questions is "sometimes true" or "often true" can be considered food insecure and referred to federal resources—Supplemental Nutrition Assistance Program and the Special Supplemental Assistance Program for Women, Infants and Children, and state opportunities such as the Child and Adult Care Food Program. Provide details about local

Sidebar 2. Stories of Transformation

The Walking Club has been one of the best offerings we have started as part of the Action Family Program. The club has made it possible for those who attend to develop a greater sense of community. The walkers have built, and continue to build, relationships with one another.

Gaining New Purpose

The impact of the Walking Club on the Action Family community is evident in changes among participants. One morning last year, Jenny* came out to walk with the group for the first time. Someone had mentioned the walking program, and she realized this was a change she needed.

For many years, Jenny had been a caregiver for an elderly man, but he had passed away recently. Caring for this man had given purpose to her life for many years; with his death, she felt heartbroken and alone.

Having lost her sense of purpose, Jenny had become increasingly depressed. She rarely left her house and had given up socializing. She was unhappy, lonely, and unhealthy. That first day at the Walking Club, walking with the other members was an epiphany for Jenny, as the members welcomed her. She cried as she was leaving—happy tears, she said, explaining that this group and this activity were what she had been missing. As she became a regular walker, other participants embraced, accepted, and loved her.

In time, as Jenny walked faithfully with the group, we witnessed her attitude and her perspective on life turning from negative to positive. Jenny said she knew that God had brought her to the Dream Center, the sponsor organization of the AFP. Soon she was mak-

ing friends and had invited a new acquaintance to join the Walking Club. Through Jenny's involvement with walking, and then in the AFP education programs, she started attending church, and a transformation became evident. Jenny tells us how she loves Jesus and gives him glory for bringing her to the Dream Center. She's happy again, is working on her health issues, making friends, and enjoying life: She feels she once again has purpose.

Notable Health Improvements

Other individuals have expressed similar narratives of transformation. One man who has been part of the Walking Club for more than a year has diabetes. He was pleased to see his hemoglobin A1C (HbA1C) drop from a high of 11 to a much healthier 7, due to his participation that has resulted in weight loss. Others have experienced similar results in their HbA1C levels and reductions in weight.

One lady who started walking with the group had been a heavy smoker. Because of the encouragement from participants who attend the Walking Club and other education classes, she decided to quit smoking. Support from her new friends at the AFP has helped her accomplish this feat. When she announced at one of the classes that she had not smoked in 2 weeks, the room erupted in applause. Her accomplishment was a touching moment for all of us.

Transformation Through Compassion

Sometimes, change and acceptance are slow in coming. An elderly man, Joe*, and his wife, Evie*, have come for several years to the community center to receive food. Many times, Joe has behaved rudely and hatefully. His attitude was one of entitlement, and he never had anything positive to say. Three years ago, when the AFP started, we changed the way we conduct our food outreach. Any time change happens, people's reactions are unpredictable; how would Joe and Evie perceive a new routine at the community center?

The implementation of the AFP included the addition of a weekly health check for participants. Compassionate nursing students measure vital signs, check weight, and assess other health markers. Joe and Evie, who had been coming to the center for many years, started receiving regular health checks. Every Saturday they sit one-on-one with a caring nursing student, who not only checks their vitals, but, for those brief 5 minutes or so, talks with them, listens, and simply touches them with the love of Christ.

This change in their weekly visit has clearly impacted this couple. Joe no longer arrives at the center as a grumpy old man, but as a person realizing he has needs. He has commented on numerous occasions that it's not just the food he and Evie need or want; they love coming to the center because this community feels like family to them. They love the changes that have been made and have become appreciative of what the AFP is doing to promote healthy living in their spirits, minds, and bodies. Joe has stated that they love being part of something—their involvement is not about receiving the food, but coming to be with family.

In addition to their active, positive participation in the AFP, Joe and Evie have begun attending the weekly Saturday worship service for those who come to the food outreach. Though they had not attended in the past, as a result of the contact and relationships with the volunteers, nurses, students, and staff, who simply love people with the love of Christ, this couple is now attending services and hearing the gospel.

*Name changed to protect privacy.

> Making lasting change in individual behavior involves changing the mindset of the person's perceived barriers.

Web Resources

- **American Nurse Today Guide to Food Banks, Food Pantries and Soup Kitchens**—https://www.americannursetoday.com/nurses-guide-food-banks-food-pantries-soup-kitchens/
- **Feeding America**—https://hungerandhealth.feedingamerica.org/explore-our-work/community-health-care-partnerships/
- **Food Insecurity and Health, A Toolkit for Physicians and Health Care Organizations**—http://populationhealth.humana.com/documents/Food-Insecurity-Toolkit.pdf
- **Food Research & Action Center**—http://frac.org
- **Food Insecurity and the Role of Hospitals**—http://www.hpoe.org/Reports-HPOE/2017/determinants-health-food-insecurity-role-of-hospitals.pdf
- **Lubbock Dream Center, Action Family Program**—http://lubbockdreamcenter.org

food banks, pantries, and backpack programs, such as any requirements, open hours, and locations. Make connections for transportation if needed.

Nurses can collaborate with food distribution outlets to provide nutrition education and health promotion interventions. Posters, food samples, recipes, and basic written information about a healthful diet can be offered. By regularly staffing an information table at the food bank to answer health questions, take blood pressures, measure weight, and provide referrals to community health services, the faith community nurse can build relationships with community residents. Through educational partnerships, food distribution sites can become clinical opportunities for nursing students and other healthcare learners.

Food insecurity is a daily experience for many households; these households have the added burden of increased risk for obesity, hypertension, cardiac disease, and diabetes. Together, those in churches, community organizations, and nurses have considerable potential to positively alter the food supply, while also providing health screening and promotion. Once residents understand their health risks and engage in the process of change, interventions, such as those implemented by the AFP, can empower community residents to improve their health outcomes. The success of such a program is more than the good interventions implemented. The effectiveness of the interventions is closely tied to the atmosphere of trust and compassionate care demonstrated by the nurses while providing care. The importance of Pender's Health Promotion Model cannot be overlooked. Helping people to believe in different health options is critical in developing successful interventions.

Nurses and other volunteers who want to become involved in improving food security and health habits can contact a community outreach program or a local food bank to investigate possibilities for involvement. Health promotion takes time to be effective. The AFP, now into the third year, has had measurable

success on the individuals who have participated. The base of volunteers and donations from the community continue to increase. Both local businesses and volunteers are looking for opportunities where their time and products make a tangible difference.

As Christian nurses work in community services for the needy and develop relationships, spiritual needs may be revealed and addressed. The humble service of Christ-followers authentically demonstrates the mercy of God, speaking silently and convincingly to those in need. In this way, Isaiah 58:10 is made real: "If you pour yourself out for the hungry and satisfy the desire of the afflicted, then shall your light rise in the darkness and your gloom be as the noonday" (ESV).

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