Working Across Faith and Science to Improve the Health of African Americans

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The 7th Episcopal District African Methodist Episcopal Church represents 23% of African Americans in South Carolina. We describe lessons learned when a large faith community and two research universities collaborate. In 2001, the bishop of the 7th Episcopal District and the president of the Medical University of South Carolina signed a memorandum of understanding on how to collaborate, including the principles of sharing resources, credit, and responsibility. Planning and research committees, with representatives from the church and university, designed and evaluated a website to reduce health disparities and encourage the use of the internet. In 2002, with the University of South Carolina as a new partner, we obtained a grant from the Centers for Disease Control and Prevention to promote physical activity. Open communications and trust are keys to a successful partnership. This partnership requires people who are dedicated to the principles in the memorandum of understanding, are open to new ideas, and have positive attitudes. Culture clashes present opportunities to strengthen partnerships and new activities to achieve mutual goals. (*Ethn Dis*. 2007;17[suppl 1]:S1-23–S1-26)

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Background

Health disparities result from complex interactions among sociocultural, economic, and political factors. To begin to address the complexity underlying these disparities, community-based organizations and academic institutions are working together to translate research theories and practice into the lives of the people who are affected.[1] The goal is to develop interventions that are more effective because they are culturally based and specific to the population in need. Achieving this goal requires sharing power and resources between community and academic groups, often a new experience for both.

This paper describes how a large faith community and two research-intensive universities worked through cultural differences to develop a partnership that addresses their missions and interests. The aim is to summarize the nature of the partnership, the lessons learned, and some of the unique products created to spur interest in forming community-academic partnerships. The partners met on two occasions to share perceptions of the relationship. Three questions structured those discussions: 1) How are the three groups involved alike? 2) How are they different? 3) What are some areas of tension and how to work through them?

Conceptual Basis

Academic Framework

The concepts of applied and action research have deep roots in academic theory and practice.[2] The disciplines of anthropology and public health, specifically, require field work in and with the community to understand the phenomenon in question from the perspective of the individuals affected—the real experts. Recently, some have taken this concept further to a true collaboration, with an emphasis on service learning.[3,4] Frameworks such as community campus partnerships and community-based participatory research (CBPR) share many traits, including equal power in decisions regarding all components of the research, from conceptual development and proposal writing to publishing, building on strengths of the partners to create a plan of action that involves setting priorities and including representatives of both groups. The aim is to promote an environment of open communication and trust.[5,6] We used the CBPR framework to guide our collaborative partnership.

Mission of the AME Church

The 7th Episcopal District African Methodist Episcopal Church (AME) has >600 churches throughout South Carolina, many in rural areas with congregations that include retirees in poor health. Church doctrine advocates ''access to health as a right not a privilege,'' and it ''seeks to make our denomination a healing faith community.''[7] To accomplish this, the district promotes a network of interrelationships characterized by trust, cooperation, concern for others, compassion for the poor and needy, and volunteerism. The Medical University of South Carolina (MUSC) and University of South Carolina (USC), two state-supported academic institutions, have missions that stress the importance of fostering the health of citizens of the state. The universities and church leadership encourage community-based work in the areas of practice, education, and research.

HISTORY OF THE PARTNERSHIP

Our partnership began in 1996 when MUSC funded an $11 million program of community-based work entitled the Healthy South Carolina Initiative (HSCI). This initiative required faculty to identify community partners for the purpose of submitting a joint proposal for funding an outreach program based on documented need and a plan to sustain the program's activities.[8] The AME and a faculty representative from the MUSC Hollings Cancer Center submitted a proposal to support a mobile van to bring cancer screening and education services to AME Churches throughout the state. That initial partnership also produced a cookbook of low-fat recipes from AME members and the expectation that MUSC would continue and expand the initial activities.

In 2000, the faculty member leading the program retired. A presiding elder from the AME approached the director of HSCI (ML) to explore how the partnership could continue. The episcopal director of health for the AME (RS) joined the discussion to determine how the organized health ministries could work with the university. As a first step, they crafted a memorandum of understanding between the AME and MUSC that outlined the nature and expected outcomes of the collaboration. The memorandum stated that both entities would share equally in all decisions made by and credit gleaned from the partnership. Further, they would share resources and jointly commit to sustaining programs after grant funding ended.

Two committees were formed composed of AME members and MUSC faculty. A planning committee approved all new proposals for joint activities. The research committee approved all research proposals including the methods and wording of surveys and consent forms. Together the partners developed a plan to move the educational materials and the cookbook from hard copy to a unique website, www.health-e-ame.com. Grant funding was obtained to support the design of the website and conduct a needs assessment from a stratified sample of adult members of AME churches to assess their use of the internet, health status, and health behaviors related to diet and physical activity.[9] Results of that survey were shared with the planning committee. The committee members wanted to implement a statewide program to encourage more physical activity as a strategy to reduce weight and ultimately reduce diabetes and hypertension. The partners sought expertise in physical activity research from USC (SW), and a second university joined the collaboration and the committees. Several joint meetings and focus groups were held in preparation for a successful joint proposal to the Centers for Disease Control and Prevention under their initial CBPR initiative.

Two areas highlight differences in approach to the new proposal between AME and the universities. The universities wanted to use a clinical trial in which churches were randomly assigned to intervention and control groups to test the physical activity intervention. The AME viewed clinical trials with this kind of random assignment as unfair to the control group. A compromise was proposed for a delayed intervention random assignment in which churches in the delayed-intervention group would get the "improved version" of the intervention one year after the initial intervention churches. The second difference involved managing funds. The partners discussed the need to distribute funding equitably in the form of subcontracts. The AME was concerned about managing federal funds and audits of church records. Therefore, the partners agreed that while funds would flow directly through the two universities, the church would benefit equally through salaries and incentives to participants in physical activity training programs.

Culture of AME and Universities that Promote and Inhibit CBPR

An organized religious organization and two public universities have different cultures that promote and inhibit partnership and CBPR. Both are hierarchical with a clear structure. Both value ongoing evaluation, with annual evaluation of faculty, pastors, and presiding elders, and rewards for productivity. For example, faculty is evaluated, in part, on scholarly research including obtaining extramural grants, and pastors are evaluated on the number of members they attract to their church. Most importantly, all partners value education, community service, and activities that eliminate health and economic disparities. The partners recognize these characteristics about each other and have discussed at length their effectiveness in forging common goals and developing collaborative programs.

However, differences can create tension in the partnership and need to be acknowledged and addressed. For example, many church members who volunteer to staff church programs are only available in the evening and on weekends, while faculty and research staff work during the week. Faculty and staff learned to be flexible in their schedules to accommodate the church members. The church values gospel, science, and viewing people from a community and a more holistic and inclusive perspective. Faculty value science within an ethical domain and are more narrowly focused on their area of expertise. This focus can result in differences of opinion about what to include in a program of research. For example, universities prefer focused, evidence-based activities, whereas the church may be more influenced by previous experiences and their sense of what will work in their congregations. Universities prefer strict random assign-

ment to produce greater control, whereas the church would prefer all members to have access to the program.

Other more subtle cultural differences continue to be problematic. For example, faculty members are firmly committed to academic freedom and time management to achieve scholarly pursuits. They seldom check with university officials as they conduct their activities. Church members are part of a hierarchical organization that requires permission and active buy-in from those in leadership, such as pastors, presiding elders, and the bishop. Church activities are often planned at a time close to their implementation with less attention to precise start times. This may reflect the fact that faculty and staff are paid for their time and view their participation as work, while church members volunteer their time and value social interaction along with program activities. Faculty and staff receive extrinsic rewards (salary) for their participation (along with intrinsic rewards of contributing to the health of church members), while church members are motivated to volunteer primarily by intrinsic rewards. Cultural differences require adjustments by everyone. Church members have learned to tolerate detailed minutes of meetings and pressure from faculty to implement activities at a scheduled pace. Faculty have learned that every major decision will take longer than grant timelines indicate because church leaders must be consulted, and attendance at scheduled activities may change as new priorities arise.

Finally, the partners view each other differently. For example, faculty view the church as being more in touch with its members and more attuned to their needs and resources. They also believe that while the grant authorizes planned activities and provides budgeted items, church members have the authority to commit their own resources to a program. Church members often view the university as having tremendous resources through well-funded grants and political connections. These cultural differences are more difficult to address because they continue to arise when new church members, faculty, and staff are introduced to the partnership. This difficulty is particularly problematic with a CBPR grant, as budgets are not flexible enough to adjust to needs that were unknown when the proposal was written, which can foster distrust in those who dispense grant funds if new expectations are not met.

Despite these cultural differences, our partnership has flourished. We view our differences with a sense of humor and use them to reflect on how this diversity has strengthened our partnership and improved our common mission.

Products of the Partnership

Several products have resulted from the nine years of this partnership. The cookbook and educational materials that were integrated into the www.health-e-ame.com website continue to be updated. According to our annual telephone surveys of adult AME members, use of the website increased from 1% in 2001 to 16% in 2005.

Other products include those developed as the result of the three-year statewide physical activity initiative that began in September 2002 (funded by the Centers for Disease Control and Prevention). Lay leaders within churches were recruited and trained and were expected to return to their churches to deliver the programs they selected to be most appropriate for members of their congregation. These individuals received training in three action-oriented programs that were intended to reach those in early stages of readiness for change (praise aerobics, chair exercises, and walking programs). To reach church members in the early-to-intermediate stages of change, lay leaders learned how to deliver an eight-week program titled "8 Steps to Fitness." This program emphasizes the behavior change skills needed to become more active and eat healthier (eg, self-regulation, problem solving, and stimulus control). Finally, to reach individuals who might not seek out physical activity programs due to their lack of readiness for change, and to build physical activity into existing church activities, churches were trained in how to incorporate physical activity messages in sermons, church bulletin boards, bulletin inserts, health fairs, and announcements and to use a 10-minute exercise CD during meeting breaks or in conjunction with services.

Many churches have congregations with a high percentage of older adults, and programs were tailored to this population. For example, chair exercise is desired for older frail and overweight older adults, whereas walking programs are deemed more appropriate for adults of all ages, including healthy older adults. Slightly more than 300 AME churches across South Carolina have been trained to implement the program. All of the products and programs developed for this initiative are in the hands of the church's health ministry and are posted on the website, thus enhancing the likelihood of sustainability. A newly funded National Institutes of Health grant will fund components of the program deemed successful by the partners. This time, AME is participating as a full partner with its own subcontract to support some church activities.

Finally, we made joint presentations at several national meetings and with the local press and published together in professional journals. The physical activity program won a state award. Our goal is to always have AME and university representatives visible when we present our work and our partnership.

DISCUSSION AND CONCLUSION

Community-based participatory research (CBPR) requires equal power in

making decisions and implementing all phases of a program, shared responsibility and credit, and open communication and trust as a hallmark of the partnership. We learned that engaging people who are willing to work together for a common goal under CBPR principles can enable an ambitious program that reaches a substantial number of AME churches in our state. Differences in power as seen in control over the budget, group cultural differences, and expectations of key individuals act as ongoing threats and opportunities to true collaboration.

We learned four key lessons. First, all partners must share power through controlling a portion of the budget. Our new grant includes subcontracts to all partners. Having multiple subcontracts requires additional meetings to decide who has funds for what items and to review federal guidelines for budgets. We anticipate that after the grant begins, there will be a healthy ongoing dialogue about what is needed and who will cover the expense. This may create a more businesslike atmosphere in our meetings, and we are interested in how it will change our social exchange as well. Second, the partners have worked hard to address ongoing differences in expectation and culture. We have acknowledged and discussed our cultural differences and agree that we will use the differences to strengthen our partnership. Third, we learned to share all products of the partnership on the website, including results of telephone surveys, so that everyone is aware of our activities. This approach has promoted more openness in our activities and encouraged members to email us with their questions and comments. Fourth, the partners define their relationship by the principles of CBPR and those included in the memorandum of understanding. We are careful to include members of the church and the university in all decisions regarding our activities. We host meetings in churches and at the universities. We stress equal representation on publications and with the media. The fact that the leaders of both partners, the bishop and the university president, signed the memorandum of understanding gives credence to the principles for all partners. We established an ongoing process to orient new members to the objectives of our program, our joint activities, and how we reach consensus on the basis of the principles of CBPR. The leaders of both entities meet periodically to review the progress of the partnership and explore new avenues for collaboration. We look forward to including new partners as one strategy to orienting others to CBPR and to sustaining and expanding our programs.

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