6-1-2018

Formative Research to Identify Community Partnerships and Foster Relationships for Health Promotion Research in South Mississippi

Jennifer Lemacks
University of Southern Mississippi

Alicia Landry
University of Southern Mississippi, alandry@uca.edu

Peyton Wenzler
University of Southern Mississippi, peyton.wenzler@cru.org

HHS Public Access

Author manuscript

Public Health. Author manuscript; available in PMC 2019 June 01.

Published in final edited form as:

Public Health. 2018 June ; 159: 58–62. doi:10.1016/j.puhe.2018.01.023.

Formative Research to Identify Community Partnerships and Foster Relationships for Health Promotion Research in South Mississippi

Jennifer Lemacks, Ph.D.[a,b], **Alicia Landry, Ph.D.**[a,c], and **Peyton Wenzler, M.S.**[a,d]

[a]The University of Southern Mississippi, Hattiesburg, Mississippi 118 College Drive, Hattiesburg, Mississippi, United State of America 39406-0001

Community-based participatory research is a proven method that includes the community in the research process as an equitable research partner.[1] However, it is a somewhat elusive process as most researchers are not formally trained to develop organic research partnerships with lay members of the community. Building trust and relationships with trusted community organizations (those which have a strong relationship in the community of interest) is one method that can facilitate and potentially accelerate community-academic relationships. For example, among several reviewed diet and physical activity intervention studies focused on chronic disease and African Americans, studies partnered with churches reported the most success recruiting and retaining participants (both church non-/members) and achieving positive health outcomes.[2] Thus, while CBPR is an ideal method to engage and intervene in underserved populations and those who historically mistrust institutions,[1] the church could be a valuable resource for reaching hard-to-reach populations.

This study describes three phases of research which built relationships and trust, and fostered collaboration between researchers and community members. Mississippi is infamous for having the poorest of health outcomes to include health care access/utilization, chronic disease and obesity prevalence, and uninsured populations in the US.[3] Mississippi has the largest rural and minority population of the southern US, both of which have a higher risk of obesity and poor health behaviors.[4] On a more positive note, the state also has a much higher weekly church attendance than the national average (60% vs. 39%),[5] indicating that the church is a valued community-based organization in this health disparate region. Thus, to identify potential collaborators and build a relationship with area churches (Phase 1) to address health disparities in the rural South, 136 churches were identified via directory/web

[b]Corresponding Author: 118 College Drive #5172, Hattiesburg, MS 39406-0001, Jennifer.Lemacks@usm.edu, Phone 601-266-6825, Fax 601-266-6364.

[c]Present Address: alandry@uca.edu, University of Central Arkansas, 201 Donaghey Avenue, Conway, Arkansas, United States of America 72035

[d]peyton.wenzler@cru.org

Ethical Approval

All human subjects research was reviewed and approved by the University of Southern Mississippi Institutional Review Board.

Competing interests: None declared

searches (in fall 2012) and a survey was mailed (in spring 2013) with attention to church leaders to determine health views (i.e., is church an appropriate place to discuss health-related topics and host health-related activities), existence of a health ministry (and if so, describe duration, leadership, and activity level), church demographics and attendance and interest in starting/strengthening a health ministry. Researchers had no pre-existing relationships and were not aware of any colleagues working in these areas; we hypothesized that any church that returned a survey could potentially be identified as a potential partner to develop a relationship. From our searches, we found churches were predominantly Methodist or Baptist and from available information 22 and 73 were identified as predominantly African American and Caucasian congregations, respectively, with 41 unknown.

Building Relationships and Trust

Phase I

Twelve churches returned completed surveys and the majority of respondents were senior pastors (83%), thought the church was an appropriate setting to discuss (91%) and host health-related topics (82%), and felt an individual had control over his/her health (100%). Most did not have health ministries established (91%) but were somewhat (45%) or very interested (18%) in starting a health ministry. Five churches did not view HIV/AIDS as an appropriate health concern to address in the church setting, followed by prostate and cervical cancer (n=3), breast cancer (n=2) and exercise/nutrition (n=1); all viewed diabetes and hypertension as appropriate health concerns. Reported average church attendance on Sundays was mostly greater than 100 people (101–150, n=4; 151–200, n=1; ≥201, n=3) and mostly white congregations (n=9; n=2 black).

A majority of the limited churches surveyed reported not having a health ministry in place, inconsistent with a survey of church pastors in another rural state that found nearly two thirds of their church sample reported established health ministries.[6] This discrepancy may be largely due to ten years of built and existing network infrastructure in that state.[6] The rural areas participating in this project have been untouched by research or community activism and that is an important consideration when setting outcome expectations for a new partnership or project.

Phase II: Church Leader Focus Groups

A ‘meet and greet’ event was held post Phase 1 to introduce church leaders to the research team and discuss the church’s role in public health. Phone calls were conducted and invitations sent to explain the purpose of and invite church leaders to participate in a focus group (held in fall 2013). Each focus group session (n=3) lasted approximately 1.5 hours, were moderated by two trained researchers and followed standard protocol to maintain participant confidentiality and data integrity. Audio recordings were transcribed and analyzed by two trained research assistants using thematic content analysis.[7]

Participants (n=13) who attended the focus groups were mostly pastors (n=7), all adults, and about half were female (n=7). Five participants were African American and eight

participants were Caucasian. Seven churches total were represented, three of which identified as having predominantly African American congregations (two from the same county) and three of the seven were from the same county. Key findings are described in table 1. Church leader participation was incentivized with gift cards and refreshments.

A unique consideration for future program planning is that pastors stated they would be ineffective as health promoters alone even though they do view themselves as role models. In contrast to our study's finding, pastors in rural communities have reported that they would be effective serving as health promoters and educators for their congregations.[8] Pastors participating in this study emphasized the importance of getting congregation members to take responsibility for programming and use university partners for more successful health programs. They have had previous successes using members to lead programs in their churches and feel that "new faces" with health-related credibility would help substantiate church health promotion efforts, especially when pastors do not necessarily view themselves as *health* role models. It would seem that churches welcome the help of the university to address health issues in their congregations.

Fostering Collaboration

A dissemination event was held (in spring 2014) to share and discuss focus group findings and implications with church leaders at a local venue. Thereafter, the research team organized monthly meetings (in the county with the most involved churches), as the Coalition for South MS Church Health, led by a researcher and church pastors to foster collaboration among researchers and church/community leaders around a mission "to build strength from within, improve the food environment of and reduce obesity and preventable chronic disease health disparities in South Mississippi communities." The mission was created and tailored by the group based on our collective areas of expertise and interests. The group collaboratively created a flyer to send out to county church leaders and raise awareness regarding diabetes, cardiovascular disease and obesity prevalence in the area; this was in addition to a brochure created to increase awareness of the group's mission and church health. As a result of the meetings, church pastors expressed the need to conduct focus groups among church congregation members to further identify health intervention interests and perceived needs; leaders were quite enthusiastic about the need to talk directly with congregation members rather than relying on the perception of needs from church leadership.

Phase 3: Church Member Focus Groups

A key church, who has a primary collaborator and the most accessible to researchers, was identified by church leader members (who at this point were predominantly African American) to conduct a focus group with congregation members. The same protocol and procedures as the church leader focus groups were implemented for the church member focus group. Refreshments were provided to congregation members participating in the focus group. Four men and three women voluntarily attended the focus group session. Key findings are also reported in table 1.

Ironically, church members do view pastors as integral role models which seems to support the need for self-esteem building in some church pastors. This may also be a difference of urban[8] versus rural communities. The theme of church members asserting a role as leaders in health programming does seem to echo across other African American churches where members (with pastoral approval) are comfortable making decisions for health programs to alleviate the challenge of competing demands/priorities that pastor's face.[6] African American pastors have also reported that the clergy themselves influence their own individual health, negatively or positively.[6] Beyond obtaining pastor approval and support, the intense involvement of the church pastor in program planning and implementation may not be necessary. In the experience of this project, pastors are more than willing to appoint a church member to serve as a health leader for the church.

Both our study and previous studies revealed that church leaders and members view health programs as a means to reach out to the community.[6,9] It was seen that church leaders from our study thought collaboration with the university would give health programming more credibility. Literature does show that churches do view themselves as an integral partner in health disparities research[10] and thus, there exists an integral, reciprocal relationship between academia and the church.

While our team grew immensely through this process, we were not met without difficulty. First, it was very difficult with limited resources to engage three separate counties. Thus, the group made the decision to host meetings in one county (with the most active participants) and though others were invited to participate via phone conference, this eventually resulted in their non-participation; additionally, one predominantly white church that participated via phone did not feel that their congregation was interested in health promotion amongst themselves or their community and were more interested in service-related work, such as summer food or backpack programs. That brings light to the next issue which was that white churches did not seem to be as interested in health promotion as the African American churches. Despite no race/ethnicity exclusions, over time white church leaders that met face to face in the selected county eventually discontinued participation in the coalition meetings.

Additionally, it has been difficult for academic researchers to establish transparent, ongoing relationships with invested community members. Instead, academic researchers have been viewed as a monetary resource and since the coalition at the time lacked funding, some community members ceased participation after becoming aware of this fact. An example of this unfortunate reality is that academic researchers were requested to funnel funding to unrelated community programs and/or host meetings at local restaurants at researchers' personal expense. Lastly, church leaders are often eager to act and lack patience with the research process which requires informed and deliberate actions/steps based on sound technique/methodology. For example, it was difficult to translate the importance of preliminary focus group work and information gathering which seems to have little impact at the time to community members but is necessary preparation for sustainable and informed efforts.

Qualitative research methods were essential for this CBPR study and a way to meet academic requirements while also developing community relationships. The partnership that

was developed and described in this manuscript resulted in the design of a nutrition and physical activity program to reduce preventable chronic disease, grant application submission and federal funding (National Institutes of Minority Health and Health Disparities Grant #1R15MD010213-01) with a church leaders listed as a co-investigator. Results from this study provide valuable information for researchers who are considering the initiation of CBPR to develop effective and sustainable health interventions in their respective communities. The inherent servant role of the church in the community and the community trust of the church provides a successful formula for developing community-academic partnerships and solving public health disparities in Mississippi communities. These findings and principles provide an example that may be used to conceptualize and apply CBPR methods in other local settings and untouched communities, serving both research and community agendas. The following highlights the major lessons learned from this work:

- Needs assessment and survey research can initiate conversations and collaborations with community partners.
- The lack of infrastructure in target communities “untouched” by research is an important consideration in developing research proposals as more training and support may be required from researchers and more time for relationship and project development.
- Pastor approval of health initiatives and appreciation of academic expertise and resources is essential for researcher access to the church community.
- Motivation and interest among churches may vary based on demographics and warrant further exploration.
- Researchers should consider planning efforts and activities which produce small steps towards research proposal development that is understood, informed and appreciated by community partners.

Acknowledgments

Authors would like to recognize graduate students (Amir Alakaam, Davis Townsend and Leslie Windham) who were involved in parts of the data collection process and analysis which occurred over the two years of activities in this project. We would also like to acknowledge two church leaders (Pastor Elijah Mitchell and Reverend Robert James) who were particularly influential throughout this process.

Funding

The work described in this manuscript supported a grant proposal which was funded on July 9, 2015 by the National Institute On Minority Health And Health Disparities of the National Institutes of Health under Award Number R15MD010213. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

References

1. Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: Assessing partnership approaches to improve public health. Public Health. 1998; 19:173–202.
2. Lemacks J, Wells BA, Ilich JZ, Ralston PA. Interventions for improving nutrition and physical activity behaviors in adult African American populations: a systematic review, January 2000 through December 2011. Prev Chronic Dis. 2013:10.

3. United Health Foundation. American's Health Rankings Annual 2016 Report [Internet]. 2016. Available from: http://assets.americashealthrankings.org/app/uploads/ahr16-complete-v2.pdf

4. Patterson PD, Moore CG, Probst JC, Shinogle JA. Obesity and physical inactivity in rural America. J Rural Heal. 2004; 20(2):151–9.

5. Religious. Washington, D.C: Pew Forum on Religion and Public Life; 2007. Religious Composition of the U.S. [Internet]. Available from: http://religions.pewforum.org/pdf/report-religious-landscape-study-full.pdf

6. Carter-Edwards L, Jallah YB, Goldmon MV, Roberson JT, Hoyo C. Key attributes of health ministries in African American churches: an exploratory surveyTitle. North Caroline Med J. 2006; 67(5):345–50.

7. Boyatzis, RE. Transforming qualitative information: Thematic analysis and code development. Sage; 1998.

8. Matthews AK, Berrios N, Darnell JS, Calhoun E. A qualitative evaluation of a faith-based breast and cervical cancer screening intervention for African American women. Health Educ Behav. 2006 Oct; 33(5):643–63. [PubMed: 16861590]

9. Markens S, Fox SA, Taub B, Gilbert ML. Role of Black churches in health promotion programs: lessons from the Los Angeles Mammography Promotion in Churches Program. Am J Public Health. 2002 May; 92(5):805–10. [PubMed: 11988451]

10. Odulana AA, Kim MM, Isler MR, Green MA, Taylor YJ, Howard DL, Godley PA, Corbie-Smith G. Examining characteristics of congregation members willing to attend health promotion in African American churches. Health Promot Pract. 2014; 15(1):125–33. [PubMed: 23493800]

HIGHLIGHTS

- Quantitative and qualitative research may guide relationship building, and fostering trust and collaboration in community-based research.
- Church members are valuable for health programming in church settings.
- Reaching out to broader communities (beyond congregation members) aligns with both church member and health program goals.
- Working with non-academic community members requires patience and persistence from the researcher to promote health programs and activities.

Table 1

Summary of Key Qualitative Findings

Theme	Qualitative Findings
Phase 2: Church Leaders Focus Groups	
Infrastructure of CSMCH	• Churches have advantageous resources for health programs. • The partnership creates more credibility with university backing and greater intervention power by working with multiple churches. • Pastors serve as a role model to many congregation members and it is important that they demonstrate healthy behaviors. • Church leaders expressed mixed opinions in regard to amending church food policies.
Barriers to church involvement	• Getting people to improve their health who don't care about changing is a concern. • Resource needs such as time, money and people are needed to produce successful health interventions.
Benefits to church involvement	• The opportunity to connect spirituality with health is a benefit to working with church populations. • Standing together with other church leaders to encourage healthy behaviors, sharing resources, and channeling available resources is advantageous for a greater impact.
Health Ministries	• Church leaders heavily emphasized their interest in reaching out to the underserved populations in their communities. • Church leaders had many ideas for exercise ideas at their churches. • Church leaders expressed concern pertaining to congregations' food choices. They had many ideas for nutrition education and nutrition programming. • Many church leaders viewed children's and youth programs as an opportunity to form habits earlier in life. • Many ideas were contributed for health program design.
Phase 3: Congregation Members Focus Group	
Perceptions of Health	• Health is related to your relationship with God and the Church. • Congregation members can be role models for their community. • Pastor's attitudes about diet may influence church members. • Lifestyle, food choices/access/cost, cultural (African American), and social (being from Mississippi) factors influence eating behaviors and contribute to health problems. • Time and lack of education also contribute to diabetes and hypertension.
Role of Church in Health Intervention Suggestions and Barriers	• Churches can make policies to role model health behaviors. • Churches can be a source of health information and provide support groups, exercise groups and nutrition education. • Competition would motivate churches. • Public and social events would mobilize the community. • Barriers to church intervention and involvement includes financial resources, church policies and unmotivated members.