

Churches, Academic Institutions, and Public Health: Partnerships to Eliminate Health Disparities

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Introduction

The disproportionate burden of preventable illness and death suffered by racial and ethnic minorities and/or other persons from low-socio-economic status backgrounds—health disparities—came into focus with the release of the 1986 landmark document titled the Report of the United States Secretary's Task Force on Black and Minority Health (the Heckler Report). This report, along with *Healthy People 2000 and 2010*, has spurred a number of research, education, and service initiatives aimed at eliminating health disparities. Despite many efforts to address these disparities, health professionals continue to experience difficulty reaching minority populations with sustainable research, education, and service initiatives. Obstacles include, but are not limited to, mistrust due to past misuse and abuse, culturally insensitive methods and materials, and one-way research and intervention efforts that benefit academic and public health institutions, but fail to provide tangible benefits to church and community members.¹ These obstacles hinder progress in addressing health disparities.

African American and other racial and ethnic minority populations continue to suffer a disproportionate burden of preventable disease and death.²

Broad partnerships between community-based, academic and public health institutions have emerged as a plausible solution to overcoming the obstacles to engaging hard-to-reach populations in efforts to eliminate health disparities. Interdisciplinary and/or inter-institutional partnerships (involving pastors, physicians, parish nurses, lay health advisors, chaplains,

community leaders, theological educators, health educators, researchers, and other stakeholders) engage a diverse group of people in the discovery and transfer of new knowledge that could provide solutions to the complex issues that cause health disparities. More specifically, research suggests that engaging the black church in health disparities partnerships is an effective way to develop sustainable culturally-appropriate research, education, and service projects that are acceptable to African Americans.^{3,4,5}

Drawing upon current literature and our experiences as pastors, health and theological educators, and practitioner-researchers⁶ who are actively engaged in several health disparities partnerships, this commentary explores the development of sustainable partnerships between African American churches and academic and public health institutions.

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Why Churches?

Community members, universities, and government agencies see churches as institutions that should be included in public health partnerships.^{7,8,9,10} Reasons include: (1) churches share a mutual concern with public health institutions about the issues that

impact the health knowledge, attitudes, behavior, access, and outcomes of racial and ethnic minority, low-income, and other underserved populations, (2) the faith tenets of most churches encourage the promotion of holistic health, healing, and living, (3) churches are the historical center of comfort, guidance, and inspiration, particularly in African American communities, (4) churches offer a variety of resources (human, intellectual, capital, social, and spiritual), and (5) churches are uniquely situated to facilitate participation of people from hard-to-reach populations.

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Increasing Emphasis on Church Involvement in Health Initiatives

Recently, the number of health research, education, and service initiatives implemented by or including churches has increased. For example, the number of “faith and health” initiatives in North Carolina that have some connection to the North Carolina Office of Minority Health and Health Disparities has increased by 78% (from 11 to 48 over the past five years).¹¹ Health disparities partnerships that include churches are encouraged and participated in by state and local governments, universities, corporations, hospitals, professional associations, and community groups.^{1,7,12,13,14,15}

The increased emphasis on partnerships in general, and the engagement of churches specifically, as a mechanism to effectively address health disparities is encouraging. However, concerns about the difficulty associated with effectively engaging and sustaining African American churches has been expressed by church, community, university, public health, and government representatives. These concerns highlight the need for a strategic approach to the development of broad partnerships that include churches. Below is a set of principles that could help to address these concerns.

Principles for Engaging African American Churches in Health Disparities Partnershipsⁱ

These principles are informed by the current literature and our experiences as pastors, health and theological educators, and practitioner-researchers.^{10,16,17,18,19,20}

Principle Number 1: Identify and Prioritize Potential Partner Churches

Identification of churches begins with a deliberate choice to prioritize churches that will comprise a pool of *potential* participants. A common mistake associated with efforts to engage the “the church” is a failure to recognize the diversity that exists among churches. This diversity stems from the fundamental beliefs that people of faith have about “their god” and the corresponding doctrine, polity, and denominational structure

employed to guide their understanding, devotion, worship, and service. There is also a great deal of diversity within and among churches that share the same doctrine and to a lesser degree polity and denominational affiliation. For example, there are eight different *historical* denominations categorized as African American Protestant churches.ⁱⁱ In recent years, we have also experienced a boom in the growth of other denominations as well as “Non-Denominational” Protestant Churches. A working understanding of the basic doctrinal beliefs, polity, and organizational structures of the various churches that are potential partners is a pre-requisite to recruiting and forming trusting relationships with churches.

Principle Number 2: Develop Trusting Relationships that Lead to Sustainable Partnerships

Sustainable or “true partnerships” include trusting relationships, mutually beneficial collaborations, participatory processes and shared governance. The people who are sent to interact with representatives of the potential partners are key to establishing trusting relationships. Identifying the “right representative(s)” is not merely a matter of race and ethnicity. The primary factor is a willingness to understand and develop an appreciation for the perspectives of others. When seeking to engage churches, it helps to have a translator—persons with knowledge of and experience working with both churches and public health institutions.

Previously, we mentioned the doctrinal, political, and denominational diversity within “the black church.” Attempts to establish partnerships with churches without an appreciation for these fundamental tenets increase the risk that something might breach church polity. Such activities, although often unspoken, tend to deepen the mistrust that pastors and other church leaders have of “secular organizations.” Mistrust stifles the reflective dialog that is essential for sorting through the inter-institutional (churches, universities, healthcare and government agencies) and interdisciplinary (public health, medicine, theology, and religion) differences and similarities. Identifying the similarities coupled with efforts to understand and appreciate the differences precede the identification and

i (a) The principles are designed to assist public health representatives as they engage faith-based organizations in sustainable health disparities research, education, and service partnerships. While the premise of the principles discussed in this commentary represent a framework for engaging “the faith community,” they are most applicable to collaborations that include historically African American Protestant churches. The emphasis on African American Protestant churches does not insinuate that this or any other particular faith tradition is inherently more applicable for involvement in health disparities partnerships than others. However, since our knowledge and experiences are centered in African American Protestant church and theological education traditions, we are most qualified to adequately represent this perspective.

(b) We use the term “faith community” to refer to a diverse group of people who believe and trust in a god or a religious system whose existence cannot necessarily be proven with tangible evidence. Further, we emphasize our view that African American churches are part of the larger “faith community.” Similarly, we use the term churches generically to refer to organized religious fellowships. The term is inclusive of synagogues, mosques, and parishes and other fellowships.

(c) While this discussion is limited to broad principles, we distinguish *principles* from *practices*. Principles are fundamental presuppositions designed to guide the process of identifying, recruiting, and selecting churches (as well as church leaders) as partner participants. Principles are used to promote reflective dialog among a diverse group of partner participants that will lead to the establishment of mutually beneficial practices. Thus, practices are mutually agreed upon activities derived by the principles.

ii African Methodist Episcopal (AME); African Methodist Episcopal Zion (AMEZ); Christian Methodist Episcopal (CME); Church of God in Christ (COGIC) National Baptist Convention of America, Inc. (NBCA); National Baptist Convention, USA, Inc (NBCUSA); National Missionary Baptist Convention of America (NMBCA); and the Progressive National Baptist Convention, Inc. (PNBC)

prioritization of areas of mutual concern, which enable partnerships to build upon the strengths and minimize the weaknesses of each partner organization. Partnerships established without cultivating trusting relationships and mutually agreed upon policies and practices simply transfer traditional models of health disparities research and interventions from academic, government, and healthcare settings to churches.

Sustainable partnerships founded on trusting relationships reduce the likelihood that this will occur by ensuring that pastors and other church leaders are engaged as equal partners with other professionals.²¹ This provides pastors and other church representatives an opportunity to influence and be influenced by the policy and practices of public health institutions and vice versa. Ultimately, true partnerships produce changes in the policy and procedures of all participating institutions that will lead to culturally relevant health disparities research, education, information dissemination, and service/ministries.

When engaging churches in partnerships, it is important to involve pastors from the outset. Pastor “buy in” legitimizes church and community involvement in a manner that facilitates adoption, participant recruitment, and decision-making.²² As respected leaders in the community, pastors can help to: (1) design and plan culturally-appropriate research and interventions; (2) serve as advocates that will bridge the communication gap between health professionals, church, and community members; (3) develop comprehensive sustainable ministries of health; and (4) help to ensure a more culturally diverse healthcare workforce by encouraging church and community youth to pursue careers in the health professions.

Principle Number 3: Identify and Respect Institutional Priorities, Traditions, and Boundaries

Churches and public health institutions, particularly research-intensive universities, have divergent perspectives of how to effectively address an issue of mutual concern—health disparities. These perspectives grow out of the priorities, traditions, and boundaries (professional, intellectual, and ethical) of the respective institutions. They are rooted in the central differences between theology and science, particularly epidemiology.

Epidemiology is *the systematic, objective study of the natural history of disease within populations and the factors that determine its spread.*²³ *The core functions of public health agencies... are assessment, policy development and assurance.*²⁴ These functions are carried out in order to promote health and prevent disease. Theology is the science of God, and of the relations between God, [humans], and the universe.²⁵ In African American churches, theological constructs are applied in ways that are sensitive to the language, concepts, and issues of the folk [in the African American community] in a manner that leads to edification and liberation.²⁶ An emphasis is placed on ministry (the provision of service) that liberates destitute, oppressed, and marginalized people.

Interestingly, the desired outcomes of both institutions focus on eradicating *dis-ease*. However, the priorities and traditions that undergird the practices appear disparate. For example, churches tend to measure the success of projects by how they helped to

provide immediate solutions to “felt needs.” To this end, churches desire the provision of tangible and sustainable service. Unlike the scientific process, the measures employed to determine success are sometimes “discernable,” but not necessarily quantifiable. On the other hand, public health institutions (particularly research-intensive universities) often measure success by the discovery of new knowledge, theories, models, policies, and/or procedures that may not necessarily help the participants of an existing study, but will be of benefit to others in the future. Therefore, efforts can be considered successful in the public health arena without the provision of direct service that provides “immediate” solutions to the felt needs of the prioritized populations.

These divergent perspectives must be reconciled if sustainable partnerships are to be developed. A failure to recognize or respect the institutional priorities, traditions, and professional boundaries of other partnership participants hinders reconciliation. For example, health disparities research, education, and service interventions that involve churches often focus on assessment and planning. Many pastors and church leaders have often expressed concern, if not frustration, over the fact that their involvement in health projects has resulted in their “being assessed to death.” However, both assessment and service are necessary if innovative ways to reduce health disparities are to be developed and sustained.

Principle Number 4: Promote the Transfer and Local Control of Tangible Power

Power refers to the knowledge, privilege, force, influence, authority and strength to accomplish a desired action. Power comes in various forms including social, mental, physical, spiritual, moral, political, and economic. These forms can be categorized as tangible and intangible. Tangible power is easy to recognize and measure, while intangible power is often invisible and difficult to measure. However, both forms are essential to the elimination of health disparities. Generally those possessing tangible power (money, budgetary authority, decision-making—particularly with respect to personnel and project goals, facilities, fund-raising ability, organized networks, the ability to determine legitimate and valid forms of knowledge, etc.) exert the greatest influence on the policies and practices that govern partnerships. In order to overcome the barriers to sustainability and to foster participation of persons from hard-to-reach populations, some tangible power should be transferred to church and community leaders where feasible.

Summary and Conclusion

The four principles represent a framework for improving the process of establishing sustainable partnerships between research, public health, and faith-based institutions that seek to eliminate health disparities. To improve the efficacy of partnerships with churches identification of potential partner churches must be deliberate, trusting relationships must be built, divergent perspectives must be communicated and reconciled, and some tangible power should be transferred to church and community leaders where feasible.

We applaud the National Institutes of Health, through the National Center on Minority Health and Health Disparities', efforts to "promote coordination and collaboration among the agencies conducting or supporting minority health or other health disparities research."¹⁵ We recommend that the North Carolina Office of Minority Health and Health Disparities be charged with and provided adequate resources to facilitate this

type of coordination and collaboration among North Carolina Department of Health and Human Services agencies that are conducting or supporting minority health and health disparities research. A special emphasis should be placed on partnerships that seek to engage communities of faith.

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The Data Collection/Data Distribution Center (DC)² Model of Engagement

The Data Collection/Data Distribution Center (DC)² is a network of 25 churches located in five prioritized regions of North Carolina. The regions and associated counties are: Northeast (Warren, Vance, Granville, and Franklin Counties); Eastern (Northampton, Bertie, Halifax, and Hertford Counties); Central (Wake, Durham, Orange, Chatham, and Johnston Counties); South Central (Duplin, Sampson, Cumberland, Bladen, and Robeson Counties) and Southwest (Mecklenburg, Gaston, Anson, and Scotland Counties). The network includes pastors and other church leaders, educators, researchers, and healthcare administrators representing various disciplines. Academic and governmental partners include Shaw University (a historically black liberal arts university), the University of North Carolina at Chapel Hill (a research-intensive majority institution), and the North Carolina Office of Minority Health and Health Disparities (established by the NC General Assembly to promote and advocate for the elimination of health disparities).

Spearheaded by the Shaw University Divinity School, (DC)² engages African American churches as an integral part of the Excellence in Partnerships for Community Outreach and Research on Health Disparities and Training (EXPORT) partnership. Funded by the National Center for Minority Health and Health Disparities, (grant #R24/P20/P60), the Carolina-Shaw Partnership seeks to eliminate health disparities between racial-ethnic minority and majority populations in a variety of ways. (DC)² is the hub of the partnerships community outreach activities. The primary goal is to investigate whether church-based information technology is an effective way for educators and researchers to communicate health issues to and receive feedback from communities about their health that could help make research, education, and service/ministry efforts more relevant. The network emphasizes a two-way flow of information where: (1) the health concerns and priorities of African American church and community members are communicated to educators, researchers, health policy makers, funding agencies, and healthcare providers to inform and influence their practices; and (2) practically useful health information is developed and disseminated to church and community members. The network also provides a mechanism for recruiting church and community members into health disparities research studies as partner-participants rather than as mere subjects. This ensures that a voice representing African American churches is included in academic research, education, information dissemination, and service projects that seek to identify solutions to African American health disparities in North Carolina.

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