

# DEVELOPMENT OF A PARTICIPATORY CAPACITY-BUILDING PROGRAM FOR CONGREGATIONAL HEALTH LEADERS IN AFRICAN AMERICAN CHURCHES IN THE US SOUTH

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African Americans are disproportionately affected by diabetes and colorectal cancer. Although studies have shown the effectiveness of spiritually based health interventions delivered by community health workers to African Americans, few have described the development of the capacity-building component. This article describes this process. The development of the Healthy Congregations Healthy Communities Program (HCHC) was guided through a community-based participatory research lens and included: 1) establishment of a community coalition; 2) identification by coalition members of churches as the best venues for health promotion strategies among African Americans; 3) recruitment of churches; 4) development of a training manual; 5) recruitment and training of congregational health leaders (CHLs); and 6) "Passing of the torch" from the coalition to the CHLs who implemented the intervention in their congregations. We trained 35 CHLs to promote awareness about diabetes and colorectal cancer using a culturally relevant, spiritually based curriculum. Pre- and post-test paired t-tests showed significant increases in CHLs' knowledge of wellness ( $P < .001$ ), colorectal cancer ( $P < .002$ ), nutrition ( $P < .004$ ), and lifestyle changes ( $P < .005$ ). The community-academic partnership was successful in developing a culturally relevant, spiritually based capacity-building program for African American CHLs to implement health promotion strategies in their congregations and communities. *Ethn Dis.* 2018;28(1):11-18; doi:10.18865/ed.28.1.11.

**Key Words:** African Americans; Community Health Workers; Capacity-Building; Spiritually Based Intervention

## INTRODUCTION

African Americans are disproportionately affected by diabetes and colorectal cancer with prevalence and mortality rates that are significantly higher than their non-Hispanic White counterparts.<sup>1-6</sup> Timely screening and regular care can significantly improve colorectal cancer and diabetes-related health outcomes.<sup>1,4</sup> However, African Americans have lower colorectal cancer screening rates than their non-Hispanic White counterparts.<sup>7</sup> Additionally, African Americans with diabetes are significantly less likely to have a usual source of care compared with Whites.<sup>8</sup>

For decades, empirical studies have shown that community health worker (CHW) interventions, which recruit and train 'natural helpers' to provide health education and linkage to care to fellow community members, are effective at increasing health screenings and access to regular care among ethnic minority communities.<sup>9-11</sup>

Community-academic partnerships show great potential for increasing the development and implementation of CHW interventions toward the decrease of health disparities among

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disproportionately affected African Americans.<sup>12</sup> However, only a handful of studies have described the steps involved in developing participatory, capacity-building CHW programs through a community-academic partnership.<sup>12-15</sup> Therefore, the aims of this article are to address this gap in

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the literature by describing the step-by-step development of a culturally relevant, spiritually based, capacity-building program for CHWs in the US South and to provide a road-map for other researchers and community members interested in partnering to develop these types of interventions.

## **METHODS**

### **Development of Healthy Congregations Healthy Communities (HCHC) Program**

In 2003, a multidisciplinary team of investigators at the University of Alabama at Birmingham received a grant from the National Center for Minority Health and Health Disparities (NCMHD) to address health disparities. This was part of the NCMHD Centers of Excellence in Partnerships for Community Outreach, Research on Health Disparities and Training effort, also known as Project EXPORT.<sup>16</sup> Given the team's expertise in colorectal cancer and diabetes as well as the disparities associated with these diseases between Whites and African Americans, the team decided that the focus of the project would be on these two diseases. As part of the outreach component, academicians partnered with a community-based organization to accomplish three major goals: 1) establish a coalition that would lead to effective partnerships between the community at-large and academic institutions; 2) promote capacity-building in the targeted communities; and 3) explore culturally relevant and data-driven strategies for reducing

health disparities in diabetes and colorectal cancer based on feedback from targeted communities.

These goals would be accomplished through the lens of the community-based participatory research (CBPR)<sup>17</sup> and the philosophical framework of the Empowerment Model.<sup>18</sup> CBPR uses a partnership approach to ensure equitable participation of all stakeholder groups (eg, community members, investigators, local health care providers etc.) in all aspects of the research process including research development, implementation and dissemination.<sup>17</sup> The Empowerment Model, as proposed by Freire,<sup>18</sup> is based on the concept that communities must first be organized and empowered to address issues within their community, before they can address particular social change goals introduced from the outside. As the community needs, strengths and responsibilities are recognized, common goals are formed allowing the group to work together for a common purpose.<sup>18</sup>

This study received the appropriate approvals by the Institutional Review Board of the University of Alabama at Birmingham. All participants gave their informed, written consent prior to inclusion in the study.

### **Coalition Establishment**

In order for the activities to be community-driven, the two initial partners (an academic center and a community-based organization with an established long-term working relationship on several other projects) identified and recruited coalition members from different segments of the community (ie, schools, health

care, etc.). At the first coalition meeting, members generated ideas on the problems contributing to, and potential solutions for, colorectal cancer and diabetes health disparities between African Americans and Whites in Jefferson County. Coalition members identified the following problems: 1) unhealthy lifestyles; 2) lack of health knowledge; 3) mistrust of the health care system; and 4) lack of health care access. After lengthy discussion over several meetings, coalition members identified training of lay individuals in churches to disseminate health information and facilitate health care access as the solution for the identified problems. Coalition members and academic partners agreed to developing a spiritually based program that could be implemented in local congregations by CHWs who would be called congregational health leaders (CHLs). They also felt that pastors should be engaged early in the intervention development process and that the program should be spiritually based (ie, incorporate spiritual messaging throughout the intervention programming) to be successful. This process took approximately one year.

### **Recruitment of Churches and Development of the HCHC Training Manual for CHLs**

Coalition members divided themselves into two workgroups. The first worked on recruiting pastors and churches while a second started work on curriculum development. Pastors of approximately 10 congregations were invited to a face-to-face meeting to learn about the program. Based on the available

resources, the coalition decided that four churches would be selected to participate in the project. After discussion with the pastors, particularly about their commitment to the program, four pastors agreed to support the HCHC program by incorporating health messages in their church sermons (monthly), supporting the activities of the CHLs and participating in at least two health-related events (eg, health fairs) in their churches per year.

Simultaneously, the second coalition member workgroup developed the HCHC training program manuals for the training of congregational health leaders. As part of the coalition capacity building, members had the opportunity to share their expertise with the group and volunteer for specific tasks. For example, one of the coalition members was a registered dietitian who worked in the public health system. Therefore, she led the section on nutrition. Others with expertise in divinity incorporated the spiritual messages throughout the manual. Each session had corresponding spiritual messages. For example, in the nutrition section, the importance of eating grains was connected to Genesis 1:29-30 and Psalm 104:13-15. Wellness was discussed in the context of the John 3:2 – “*Dear Friends, I pray (SPIRIT) that you may enjoy good health (BODY) and that may go well with you, even as your soul (SOUL/MIND) is getting along well.*” Once finalized, specific sections were revised by a content expert who was part of the academic team or coalition. The appropriateness and relevance of the spiritual messages were revised by a pastor

who had not been involved in the development of the manual. This process took approximately six months.

#### *CHL Recruitment*

Each pastor was asked to nominate congregation members who: 1) would commit one year to the program; 2) would attend eight two-hour training sessions; 3) expressed an interest in learning about health issues; 4) had good communication skills; 5) were respected role models and engaging in health behaviors/health ministries themselves.<sup>19</sup> The size of the churches varied. Two churches had approximately 100 members and the other two churches had more than 2,000 congregants. Therefore, the pastors of the larger churches nominated more CHLs.

#### *CHL Training*

CHLs were then invited to an 8-week training. Instructors included the principal investigator, coalition members, health providers, and other experts. Each of the eight two-hour sessions consisted of a knowledge component and an intervention implementation skill-building component. The knowledge components included evidence-based informational lectures on the following topics: 1) The Wellness Model (covered a holistic understanding of health and the dimensions of wellness including physical and spiritual aspects;<sup>20</sup> 2) health care access (included information on eligibility for federal programs such as Medicare and patients’ rights); 3) diabetes (included information on type 1 and 2 diabetes and how to manage them); 3) colorectal cancer (included information on who

should be screened and at what age); 4) nutrition (discussed dietary guidelines and healthy food consumption); 5) physical activity (included information on recommended levels of physical activity); and 6) lifestyle self-assessments/stress management (discussed how to identify, assess and cope with every day stressors). The skills-based portions of the sessions included lectures and exercises on: 1) team building; 2) problem solving; 3) listening and communication skills; 4) stages of change (ie, understanding congregation members’ readiness to engage in health seeking behaviors and tailoring health promotion strategies accordingly);<sup>21</sup> 5) self-responsibility and goal-setting; 6) identifying community assets; and 7) developing plans of action. The last session provided training on how to develop plans of action for church-based health promotion activities as a team (for all four churches together) and for their congregations. Plans of action usually addressed a particular behavior (eg, promote colorectal cancer screening), specific objectives to be met, planned activities, location(s) and a timeline. CHLs were provided with tools (eg, evaluation template form) and support by the research team to evaluate their objectives.

Following the eight-week training, CHLs co-signed a contract with their pastor, principal investigator, and coalition representative outlining the roles and responsibilities of each party. For example, some of the responsibilities of the academic institution/community-based organization and coalition included: design and implement the eight-week training session at no cost to the participants; to support

the congregational health leaders in the implementation of their activities in their congregations. Some of the pastors' responsibilities included: support the activities of the congregation health leaders in their congregations; be familiar with the congregational health leaders' responsibilities. Some of the congregational health leaders' responsibilities included: attend all eight training sessions and monthly booster sessions; share the information learned with other people in the church/community; do not give talks or lectures without professional expertise in a particular topic. At the end of the training, each participant was provided with a \$50 gift card and presented with certificates of completion at a ceremony in their church worship services. This phase took approximately six months.

*“Passing the Torch”: Development of Community Action Plans*

After the completion of CHL training, the coalition “passed the torch” and handed further planning to the CHLs. Post-training, CHLs met as a group for monthly booster sessions as they developed and implemented their participatory action plans. CHLs received a \$10 gift card at each of these booster sessions. Although several coalition members and investigators attended these meetings for support, the primary drivers of the intervention implementation were the CHLs. During the meetings CHLs: 1) created joint action plans (eg, community-wide health fair); 2) updated each other on individual church action plans and successes; and 3) discussed budget allocations. For example, CHLs decided as a group, that all church-

**Table 1. CHL characteristics, n=35**

Demographics	n (%)
Sex	
Male	5 (14)
Female	30 (86)
Age, mean (SD), range	51.8 (12.2), 27-77
Education	
High school	3 (9)
Some college	11 (31)
College degree	11 (31)
Post-college	10 (29)
Employment	
Employed	27 (77)
Unemployed	1 (3)
Marital Status	
Married	19 (54)
Divorced	9 (26)
Widowed	4 (11)
Single	3 (9)
Household income	
< \$20,000	5 (14)
\$20,000-29,000	6 (17)
\$30,000-39,000	4(11)
\$40,000-49,000	6 (17)
\$50,000 and over	14 (40)
Perceived health	
Excellent	5 (14)
Very good	16 (46)
Good	13 (37)
Fair	1 (3)
Regular medical care	
Yes	31 (89)
No	4 (11)
In terms of weight, do you think you are?	
Overweight	24 (69)
Underweight	1 (2)
Just right	10 (29)
Health behaviors	
Exercise; days per week with 30 min. physical activity	
0	6 (17)
1-3 days	18 (51)
4-6	9 (26)
Daily	2 (6)
Tobacco use; how often do you smoke cigarettes?	
Never	28 (80)
100 in lifetime but quit	4 (11)

es would have the same maximum amount of funds available to them (up to \$2,500) for the implementation of action plans. The implementation of activities in the churches took place over a period of three years.

**Measures**

CHLs completed a baseline questionnaire which gathered data on demographic characteristics, perceived health, health care utilization, health behaviors, reasons to participate in

the program, and community experience with health care leadership. They also completed a 24-item (true and false) pre- and post-test to assess increased knowledge. The assessment included items on 7 training topics: 1) wellness (two items, including “The way we feel mentally affects our physical health.”); 2) health care access (six items, including “Anyone diagnosed with a disabling chronic illness is eligible for Medicaid.”); 3) diabetes (five items, including “There is a cure for diabetes.”); 4) colorectal cancer (three items, including “Colorectal cancer screening should begin at the age of 50.”); 5) nutrition (four items, including “Meat is the healthiest form of protein.”); 6) physical activity (two items, including “The Centers for Disease Control recommends that adults engage in at least 15 minutes of moderate physical activity per day.”); and 7) lifestyle (two items including “Joyful life events can be a source of stress.”).

**Statistics**

The mean score changes between pre- and post-tests in CHL health knowledge were analyzed using paired t-tests. Statistical significance was set at P<.05. Analyses were performed with SAS v9.3.<sup>22</sup>

**RESULTS**

Twelve members consented to be part of the coalition representing different segments of society. Their level of involvement varied from providing input when needed to being actively engaged in the development of CHL training. Thirty-nine CHLs were recruited and consented to be trained

**Table 2. CHL’s reasons to participate in program**

Reason	n (%)
To help people	25 (71)
To help my community/congregation	32 (91)
I have friends who have joined the program	3 (9)
To make friends	5 (14)
To get involved in health issues	17 (49)
To learn more about health topics	8 (23)
To help my friends who have health problems	1 (3)

and 35 completed the training (Table 1). Eighty-six percent of participants were females (n=30). Most participants had “some college education” (n=31). The mean age was 51.8 years (SD=12.2). Most CHLs were currently employed (77%). Fifty-four percent were married (n=19) and 40% (n=14) had an annual household income of >\$50,000. All but one participant rated their health “good,” “very good,” or “excellent” and 89% reported obtaining “regular medical care” (Table 1). Eighty-three percent reported that they engaged in physical activity (30 minutes minimum) 1-3 days a week or more. Most had never used tobacco products (80%).

The most commonly reported reason to participate in the program was “to help my community/congregation” (91%) (Table 2). Fifty-seven percent reported that they had “ex-

perience in a health care setting” and most had provided health information to their family members (94%) or congregation (n=80%) (data not shown). Paired t-tests showed significant increases in CHLs’ knowledge of wellness (P<.001), colorectal cancer (P<.002), nutrition (P<.004), and lifestyle (P<.005). No significant differences in knowledge were found on health care access, diabetes, or physical activity (Table 3).

**DISCUSSION**

This community-academic partnership successfully developed a culturally relevant, spiritually based capacity-building program for African American CHLs to conduct health promotion strategies in their congregations in Alabama. The pro-

**Table 3. Pre- and post-CHL training knowledge assessments, n=35**

Knowledge <sup>a</sup>	Pre-training <sup>b</sup>	Post-test <sup>b</sup>	P <sup>c</sup>
Overall <sup>d</sup>	14.4 (3.2)	16.7 (2.9)	.001 <sup>k</sup>
Wellness <sup>e</sup>	2.0 (.2)	1.7 (.6)	.044 <sup>j</sup>
Health care access <sup>f</sup>	4.4 (1.2)	4.7 (.8)	.178
Diabetes <sup>g</sup>	3.2 (1.2)	3.4 (.9)	.468
Colorectal cancer <sup>h</sup>	1.3 (.7)	1.9 (.7)	.002 <sup>k</sup>
Nutrition <sup>i</sup>	2.0 (1.0)	2.7 (.9)	.004 <sup>k</sup>
Physical activity <sup>e</sup>	.7 (.7)	1.0 (.7)	.119
Lifestyle <sup>e</sup>	.9 (.8)	1.3 (.7)	.005 <sup>k</sup>

a. Correct answers scored as 1. b. Reported as mean (SD). c. Paired t-test. d. Average of all 24 survey items. e. 2 items. f. 6 items. g. 5 items. h. 3 items. i. 4 items. j. P<.05. k. P<.01.

gram significantly increased CHLs' knowledge of colorectal cancer, nutrition, and healthy lifestyle; however, significant changes to health care access, diabetes, and physical activity knowledge were not found. Pre-test physical activity scores were very high across the group of CHLs (most of whom exercised regularly). It is likely that CHLs already had significant knowledge about this topic. It is

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less clear why changes in health care access and diabetes were not noted. Consistent with other research (ie, non-spiritually based, CHW studies with African Americans), most CHLs in our study were women and had some experience with health promotion in their communities.<sup>23,24</sup> Similar to one other study, CHLs' main reasons for participating were to "help people" and to "help their community/congregation."<sup>25</sup>

In regard to the development of

the training program, the coalition members took the lead on the first phase by: 1) identifying the main challenges relating to colorectal cancer and diabetes among their communities; 2) identifying the church as a promising intervention venue; 3) involving pastors in program development; and 4) expanding a spiritually based intervention.<sup>26</sup> These steps were conceived and enacted by coalition members. However, once the CHLs had been recruited, these members took a step back and the newly trained CHLs took over the development of health promotion action plans. This seamless transition from the coalition members to the CHLs is a testament to the effectiveness of a CBPR lens, selection of natural community leaders to head up the program, and collaborative academic-community partnership. All members had ownership over the work and collaboratively brought it to fruition.

We learned several important lessons from this academic-community partnership. First, the team was able to collaboratively develop this training program, thanks to a consistent, respectful and open dialogue between the community and academic partners. This open dialogue was largely rooted in longstanding and positive relationships between the academic and community partners. Teal and colleagues have described the importance of continuous and open communication in academic partnerships aimed at developing culturally sensitive, evidence based interventions and the importance of long-term commitments from both sides.<sup>12</sup>

Second, aligned with other research,<sup>19,26</sup> we found that the early involvement of the church pastors was crucial to the success of the project. As leaders, pastors are deeply influential and crucial partners in faith-based interventions.<sup>26</sup> In this project, the partnerships with the pastors made the recruitment and training of true "natural leaders" possible.

Third, the setting of clear expectations and roles on both sides of the partnership, including the signing of agreements that clearly delineated these roles, facilitated all aspects of the project including the seamless "handing off" of responsibilities from coalition members to CHLs. In their descriptions of the development of faith-based CHW programs, Teal and colleagues also discuss the importance of clearly defined roles<sup>12</sup> and Dodani and colleagues point to the process of handing off responsibilities as an important attribute of successful partnerships.<sup>15</sup>

Despite evidence that church and spiritually based CHW programs are effective at promoting health among African Americans,<sup>9-11,15</sup> only a handful of published articles include detailed step-by-step descriptions of how academic-community partners can work together to develop these curricula.<sup>13,15</sup> Our study contributes to the literature by providing a detailed roadmap of the steps involved (ie, coalition building, church recruitment, development of the CHW curriculum, CHW recruitment and CHW training) in developing a participatory, culturally relevant, spiritually based CHL training through a CBPR community-academic partnership approach.

## Limitations

It is important to acknowledge the limitations of this work. First, randomized trials are needed to fully examine the impact of the intervention and longitudinal assessments will be necessary to understand the short, mid- and long-term effects of the program. Additionally, the research may not be generalizable, given that it was developed specifically for this subpopulation of church-going African Americans in the US South.

## CONCLUSION

This study illustrates the use of a CBPR and community-academic partnerships to develop and implement a capacity-building program for CHLs. Given the disproportionate burden of colorectal cancer and diabetes among African Americans, particularly in the US South, it is important that these efforts be replicated toward decreasing these health disparities.

## ACKNOWLEDGEMENTS

We express our appreciation to the dedicated pastors and congregational health leaders who volunteered their time to this program. This study was funded by the National Center on Minority Health and Health Disparities, Grant P60MD000502.

## CONFLICT OF INTEREST

No conflicts of interest to report.

## AUTHOR CONTRIBUTIONS

Research concept and design: Scarinci; Acquisition of data: Moore, Scarinci; Data analysis and interpretation: Morales-Alemán; Manuscript draft: Morales-Alemán; Statistical expertise: Morales-Alemán, Moore, Scarinci; Acquisition of funding: Scarinci; Administrative: Moore.

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