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Short Communication

Formative research to identify community partnerships and foster relationships for health promotion research in South Mississippi

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ABSTRACT

Objectives: The purpose of this short communication is to describe the trust building and collaboration, fostering phases of a community-academic partnership between churches and academic researchers using a community-based participatory research approach.
Study design and methods: An academic-community partnership with church leaders was initiated using survey administration and was further developed using focus groups. A coalition was developed, and it guided a subsequent focus group with church members.
Results: Most churches surveyed did not have a health ministry in place but were agreeable that a variety of health topics were appropriate for the church setting. Church leaders felt that church members were key to engage in health programs in the church, whereas church members viewed pastoral support as important. Church leaders felt that working with a university brings credibility to their own health programs.
Conclusion: This early work provides a valuable example of how community collaborations may be initiated and developed using formative research methods, serving both community and research agendas.

Formative research to establish community partnerships and foster relationships for health promotion research

Community-based participatory research (CBPR) 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 in recruiting and retaining participants (both church members/non-members) and achieving positive health outcomes.[2] Therefore, while CBPR is an ideal method to engage and intervene in underserved populations and those who historically mistrust institutions,[1] the church

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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 including healthcare access/utilization, chronic disease and obesity prevalence, and uninsured populations in the United States.[3] Mississippi has the largest rural and minority population of the southern United States, 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. Therefore, 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 searches (in autumn 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 most respondents, who were senior pastors (83%), thought that the church was an appropriate setting to discuss (91%) and host health-related topics (82%) and felt that 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 10 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 after 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 were sent to explain the purpose of and invite church leaders to participate in a focus group (held in autumn 2013). Each focus group session ($n = 3$) lasted approximately 1.5 h and was 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 totally were represented, three of which were 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

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