

Commentary

The Role of a Historically Black University and the Black Church in Community-Based Health Initiatives: The Project DIRECT Experience

La Verne Reid, John Hatch, and Theodore Parrish

This work explores the role of North Carolina Central University (NCCU), a historically Black university, and local Black churches in serving as community resources in Project Diabetes Interventions Reaching and Educating Communities Together (Project DIRECT). Project DIRECT is a federally funded participatory research project sponsored by the Centers for Disease Control and Prevention. The rationale for involving NCCU is presented. The authors review how faith-centered strategies were used in local churches to create social and environmental changes to support diabetes prevention and control. Involving historically Black colleges and universities and Black churches in health promotion at the community level represents an excellent example of how local institutional resources can help eliminate health disparities.

KEY WORDS: faith-based health initiatives, health disparities, historically black colleges and universities, Project DIRECT

Because of the large burden that diabetes imposes on African American citizens of North Carolina and throughout the nation,¹ it is important to implement appropriate prevention and control strategies to help ameliorate this public health crisis. Since 1994, Project Diabetes Interventions Reaching and Educating Communities Together (Project DIRECT), a community-based intervention funded by the Centers for Disease Control and Prevention, has served as a demonstration project to identify culturally sensitive and efficacious approaches to reduce the burden of type 2 diabetes (hereafter referred to as diabetes).² Project DIRECT was implemented to increase awareness among Black residents of Southeast Raleigh, North Carolina, of the importance of complying with recommended guide-

lines for exercise, diet, and diabetes self-management. If guidelines were followed successfully and consistently, it was hoped that the disproportionate burden of diabetes would decline. The project is grounded in experiences that have helped facilitate changes in daily living among residents at highest risk for diabetes. Various community partnerships including local churches, businesses, health care providers, academic institutions collaborated on this project. This commentary focuses particularly on the role of local Black churches and a historically Black university in helping to improve the health of residents diagnosed with diabetes in a large community in southeast Raleigh.

Specifically, in this commentary, we examine the influence of North Carolina Central University (NCCU) faculty and students on the course of community involvement strategies. We also describe and discuss the effectiveness of conducting community-focused health promotion through partnerships with churches that serve the Black population. In 1996, the Department of Health Education at NCCU was contracted by the North Carolina Department of Health and Human Services to help define and develop the role of the community in Project DIRECT. NCCU believed that in the years ahead, the health promotion component of disease prevention and control would focus on obtain-

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ing a better understanding of underlying social and psychologically embedded attitudes and beliefs that influence behavior, particularly among certain population clusters.^{3,4} NCCU believed that work with Project DIRECT could facilitate the discovery and necessary testing of community intervention models better suited to meet the needs of various cultural and structural configurations within Black communities.

● Impact on Outreach

NCCU's first activity with Project DIRECT was to learn about how project staff and the community understood outreach and to find out the actions they were taking or hoped to take to facilitate their outreach goals. One-on-one conversations with key stakeholders facilitated the acquisition of this knowledge. The stakeholders included leaders of various community organizations, tenants' associations, civic leaders, Project DIRECT board and staff members, health professionals, and clergy. Two of the authors (LR and JH) were key members of the NCCU faculty dedicated to Project DIRECT. Project DIRECT staff and board members strongly supported the need for community outreach, but there was less agreement on what outreach was and the best ways to achieve it.

Early in the project, clarification of overall goals was necessary. Staff training was developed by NCCU faculty to promote understanding of theories associated with community outreach. Outreach to churches was considered an effective way to increase awareness and participation.⁵⁻⁷ NCCU thought the outreach mission should include all full-time professional DIRECT staff. Both NCCU and Project DIRECT staff agreed that there was a tremendous need to build trust and increase understanding of Project DIRECT'S mission through formal and informal networks throughout the community. Events that best enabled NCCU and Project DIRECT staff to build trust usually took place in the evenings, on weekends, and after normal work time. It was important to learn about ways to collaborate with other agencies with similar missions.

In addition, NCCU understood the need to demonstrate the competence of Project DIRECT staff to the medical community serving Southeast Raleigh. It was important to help the medical community understand the ways Project DIRECT could complement and reinforce patient care. NCCU also knew it was essential for Project DIRECT staff to understand how much time health care providers could give to patients and still remain in business. NCCU undertook interviews with providers to learn firsthand the challenges they saw and to understand ways to work more effectively with them. Doing so resulted in better insight into

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the motivation of providers and the strategies they used to help change patient behavior. We learned that many patients had more than one chronic condition, and yet providers in this setting had only about 15 minutes per patient to provide comprehensive care. In conversations with providers we cited literature that documented the value of provider education, and this seemed to ease stresses that providers felt. Moreover, they became more caring, motivated, and willing to do things proven beneficial in patient education. Referrals from providers to counseling services increased. Because patient care in Project DIRECT was performed by a nurse with experience in diabetes care, the role of this unit gained strong acceptance and support from health center staff.

Another intervention we viewed to be especially enabling was to have convenient conversations with patients living with diabetes who visited a local health center. In general, these patients were told to come to the health center on a particular day and were not given exact appointments; wait times of 30 to 60 minutes were not unusual. We gained permission to carry out interviews with the objective of learning what and how the patients thought about diabetes. Rather than crafting a rigid protocol, we asked questions such as the following: Did the person, family member, or friends have diabetes? What did the patients consider the cause(s) of the disease? What action (if any) should be taken to prevent or control diabetes? What were they doing, if they had diabetes, manage this problem? We explained our role with Project DIRECT and asked if the person would be interested in attending sessions on diabetes education or health education. The insights gained provided knowledge of local beliefs and actions that enabled Project DIRECT to better focus its outreach and education efforts.

● Outreach with Churches

Historically, African American people have turned to the church for information about services of value and importance to them.⁷ Our challenge was to gain support from clergy and key leadership for community-based diabetes control. Communities of faith, regardless of denomination, generally receive numerous requests to participate in health-related intervention programs. Without systematic methods to prioritize their health needs, they often end up overwhelmed, and their

resources spread too thin. Achieving lifestyle change would require NCCU and Project DIRECT staff to understand that churches are discrete social organizations with unique demographic profiles, histories, and traditions. Based on Dr. Hatch's previous work with faith organizations, we were aware that demographics of the congregation were likely to be a stronger predictor of responses than denominational affiliation was. Although Project DIRECT staff could identify the location and faith affiliation of every church in Southeast Raleigh, we did not know the congregations' demographics, perceptions of health needs, or awareness of diabetes as a disease of particular importance to Blacks. Visits with pastors or key leaders would not necessarily provide solid information about people they served or ways to introduce change within their congregations.

NCCU faculty, graduate and undergraduate health education majors at NCCU, made visits to churches regularly. After service, when visitors are invited to introduce themselves, they identified themselves as workers with Project DIRECT. As time permitted they would describe services offered by the project. During the same time period, NCCU faculty designed the congregational needs assessment tool (CHAT) and the congregational health action plan (CHAP), both tailored to the needs of each congregation. NCCU believed that engaging the leadership in a needs assessment would be an effective way to increase knowledge of risk factors for diabetes and to understand what might be a good place to start. NCCU consultants and Project DIRECT staff presented church leaders with the results of the CHAT and CHAP. NCCU referred church leaderships to (or facilitated their contacts with) organizations and experts who could help their churches develop comprehensive responses to address health priorities, particularly diabetes. Several churches have reorganized their social or health ministries based on findings from the CHAT. It is important to note that several times visits to local churches were made before approaching the leadership to participate in the CHAT and CHAP. These visits included identifying the appropriate messenger or ambassador to deliver the menu of Project DIRECT activities. For leaders of church congregations, the CHAT and CHAP have succeeded in improving the leadership's knowledge of its organizational makeup by age, gender, and health needs.

● Implications for Public Health

It is important that NCCU students and practitioners understand that simply being Black does not qualify one as competent to deliver health education in Black

populations. In addition, it is essential that the students understand intra-group diversity and disparity. It is especially important that NCCU students learn to use theory from a critical perspective and to use practice to refine educational strategies to reach the multiple strata of people in African American communities. "One size fits all" thinking is grounded in ignorance.⁸ NCCU's involvement with Project DIRECT has provided a unique opportunity for a historically Black college or university to be on the cutting edge of strategies that must replace costly "after-the-damage intervention" in chronic disease. In addition, our experience with Project DIRECT has enhanced employment opportunities for our graduates.

Moreover, the NCCU Department of Health Education has designed an interdepartmental master's-level practice-based degree for health educators and for majors in human sciences, sociology, physical education, nursing, nutrition, and social work. NCCU students in these majors seek careers in community-building interventions and program evaluation. NCCU continues to provide traditional public health courses, such as epidemiology, health behavior for effective living, and community health, and the university now offers courses on social structure and organization of inner city populations, self-destructive social construction of health, and assets mapping. NCCU and Project DIRECT have benefited from each other's interaction. Historically Black colleges and universities and the Black church offer tremendous potential in reducing health disparities if given the opportunity to participate in the process.^{9,10} The African American community in Southeast Raleigh will be a healthier place as a result of Project DIRECT and the involvement of NCCU and local Black churches.

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