Involving the Southern Rural Church and Students of the Health Professions in Health Education

JOHN W. HATCH, DrPH
KAY A. LOVELACE, MPH

A HEALTH EDUCATION AND COMMUNITY ORGANIZATION operating in a rural North Carolina county enables students in public health, medicine, and nursing to satisfy their desire to develop skills that will enable them to provide health care in underserved communities. The Community Health Education and Resources Utilization Program is a demonstration project of the Department of Health Education, School of Public Health, University of North Carolina at Chapel Hill, which is funded under title 1 of the Higher Education Act of 1965. Its objective is to increase the number of people in selected rural communities of 1,000 to 2,000 population who can provide correct information and appropriate counseling about the risks associated with hypertension, pregnancy, diabetes, and other health conditions that community residents identify as problems.

The population targeted for this program is composed of black people with low to modest incomes who have disproportionately experienced the stresses of a rapidly changing social and economic environment during the past two decades. Since 1960, the major source of this population's income has shifted from small farming operations to service jobs (for example, housekeeping and maintenance in hospitals and universities) and jobs in small manufacturing enterprises. Changes, such as the large increase in the percentage of women working outside of the home and neighborhood, have had a dramatic impact on the traditional patterns that these people have had for providing services and support to their family members as well as to their friends and neighbors. We suspect, too, that the perception of the term "community" is changing as significant elements of community identity, such as neighborhood schools, crossroads general stores, and resident professionals, disappear from the local environment. These social and environmental changes, along with the increase in industrialization, may have increased the number of problems experienced by rural black communities while at the same time may have weakened the patterns of managing them.

In rural North Carolina communities, the functions of black churches appear to have changed less than most of the other major elements that together form the community identity. Rural neighborhoods and thoroughfares are frequently identified by the name of the local church attended by most of the neighborhood people. Throughout the rural South are hundreds of Ephesus Church Roads, Mount Zion Church Roads, and Mount Olive Church Roads. Significant life events centering around the church, such as celebrations of birth, marriage, and death, continue with little change from earlier days. The church provides a setting for the exchange of news, social support, and resources. For instance, important social events in the community are announced at church, and after services the church members informally exchange various bits of information, give accounts of friends and family, and often arrange for the exchange of labor and other resources. The church continues to play a significant role as well in caring for the ill and giving support to families in times of crises.

These observations led us to the notion that by building on and expanding the support role these churches were already playing—that is, providing knowledge, advice, and other forms of help to friends, relatives, and neighbors—the level of sound health

Dr. Hatch, an associate professor, is the director, and Ms. Lovelace is the coordinator, of the Community Health Education and Resources Utilization Program, Department of Health Education, School of Public Health, University of North Carolina at Chapel Hill, N.C. 27514. Tearsheet requests to Ms. Lovelace.

knowledge and the effectiveness of advice-giving could be increased. Further, we hypothesized that the church would afford an effective and efficient means for intervention in certain selected health conditions that disproportionately affect people in these rural black communities.

Educational Program in the Churches

Health professions students visited ministers from eight churches located in one part of Chatham County, N.C., to discuss our health education program. The students explained that the program was designed to reinforce the functions that the churches were already carrying out, rather than to create new functions or discontinue old ones. These visits were usually followed by an invitation from the the church for a member of the program staff to present the program formally to the congregation during Sunday morning church services. Each church was asked to select three participants for the program who were already playing a key support role in giving advice or aid to people in need, who were involved in a range of community and church activities, who were respected by all generations in the church, who were likely to remain in the community for at least 2 years, and who were willing to volunteer at least one night of service a week for 12 weeks. In all, 18 participants—12 women and 6 men —were selected by the 8 churches.

The involvement of the selected community participants consisted of participation in 12 weekly training sessions. Each week, a different resource person, such as a local health professional or someone from the community, led a discussion with the selected community participants that focused on strategies, namely, (*a*) how preventive health behavior by church members might be promoted, (*b*) how people experiencing health needs could be matched with the appropriate resources, (*c*) how church members might be helped to follow through on actions recommended by the care-givers so as to improve their health status, and (*d*) how professionals might be provided with the input that could help them serve the community better.

The sessions also covered content. Hypertension, diabetes, and poor maternal and child health were selected by the program staff as the problems that disproportionately affected the black population in North Carolina. Because the community participants considered alcoholism and child abuse as problem areas in their communities, they also selected these conditions for discussion.

The skills covered in the training sessions were counseling, referral, use of audiovisual equipment, and ways of involving the entire church in health promotion.

The 12-session training cycle for the first group of participants was held between September 1978 and February 1979. A second cycle was carried on in another area of the county between February and August 1979, and a third cycle began in October 1979. The health education program appears to have won the support and confidence of people in the communities, since attendance has averaged about 80 percent of the selected participants.

Involvement of Health Professions Students

Although the primary purpose of our program was not the education of students of the health professions, we viewed it as providing an environment in which students could experience the range of activities typically performed by health educators in community settings. We also knew that students from the University of North Carolina Schools of Public Health, of Medicine, and of Nursing were placed in Chatham County as part of their field or preceptorship training. At the beginning of the health education program, two graduate assistants were hired as staff members. They eventually assumed major responsibility for its planning and coordination and also personally recruited most of the other seven students who served in the program as volunteers. These seven student volunteers—from the fields of nursing, medicine, health education, and nutrition—participated in the program to satisfy their desire to learn techniques for working with underserved populations while completing their field, technical assistance, or preceptorship requirements in their respective professional schools.

The students assumed responsibility for selection of community participants, curriculum design, coordination of the weekly training sessions, selected presentations to the community participants, followup with these participants, and evaluation of the program. Among the issues they faced were three that confront almost all professionals working with underserved populations:

1. To what extent do health professionals have the right to make decisions based upon their own beliefs and values about the design of a community health program?

2. How can health professionals and members of the community together determine which needs are most important and which can be addressed within a program?

3. How does the health professional gain and show respect for a different and unfamiliar culture?

As the students visited the churches, they began to examine their own ideas of the extent to which decisions should be reserved to professionals or left to

the community. And although they had very definite ideas about how they would like to see participants selected, they agreed that these ideas should be presented in the form of suggestions, and that the selection process should be left completely to each congregation. In this way church members accepted responsibility for the decisions that were important to them and began to accept ownership of the educational program. Assuming additional control, the community participants also decided which additional content areas should be addressed in the educational program, and they selected and invited speakers for it. Many of these methods were new to the health professions students, who were more familiar with professionally controlled service delivery.

Specific training to prepare the health professions students for a different kind of professional-community relationship was provided. The students were asked to play roles both as themselves and as community participants in many different situations and afterwards to examine their feelings both as professionals and as community members and then decide how they would like to see the encounters changed. In this way, the students were able to experience in a laboratory setting the exasperation that professionals often feel when they do not receive the response that they expect from members of a community.

The issue of how to determine the needs of the community arose as students began to question the role in, and the qualifications of community residents for, deciding about curriculum content and the style of their training program. For example, the students asked: "Will four hours be enough for the participants to learn all they need to know about hypertension? How can we assume that the necessary points will be covered if the community members participate in deciding on the session content?" An evening session devoted to hypertension helped answer their questions. The evening began with a short explanation by a local health professional of what it means to have hypertension. The professional then asked the community participants to form three groups around the subjects of interest, (*a*) diet and exercise, (*b*) medicines, and (*c*) side effects, and to decide which questions they thought people from their community would want answered. After listing the questions, the groups reconvened, and all of the questions were discussed together. As well as covering the topics of hypertension in depth in a way that responded to the expressed community concerns, the discussion revealed many of the local beliefs about hypertension, beliefs with which the health professions students had not been familiar.

The health professions students began to gain respect for a culture different from their own as the program progressed. By visiting peoples' homes and churches, they became interested in the community life. They began to see the people as individuals, apart from the stereotype of low-income and underserved populations. They learned that in a rural black community with low to modest incomes, people can be found who are willing and able to take action to improve their own health and that of their relatives and friends. This new understanding and respect will undoubtedly influence the future interactions of these students with the underserved.

Conclusion

The type of health education program described here can enable students of the health professions to promote better health behavior among the underserved, since such a program provides them with an opportunity to meet and work with people from a different culture in a comfortable setting. The educational benefits for the students include:

1. Learning the health educator's approach to community diagnosis and to the planning of strategies for health promotion. This knowledge is especially valuable to students who are not health education students, such as medical, nursing, and nutrition students. Through contact with members of the community, health professions students learn that the introduction of changes into the social fabric itself is often more effective in promoting health than treating the individual or the family.

2. Learning how a strong existing institution can be used in working with a community. Both theoretically and in practice, students come to see the need for considering and using institutions like the church that are already in existence in communities—institutions that support the individual and the family, promote health, provide the major social focus for the community, and will remain long after the professionals leave.

3. Learning how to relate to people from a different culture. Students increase their ability to communicate comfortably as equals with people whose lives and backgrounds are different from their own.

The satisfaction and confidence that the students gained in our program, whose aim was to reach underserved populations, suggests that such programs may offer a practical strategy for reducing the class, educational, and geographic barriers that often exist between young health professionals in training and the less well-served members of our society.