chapter 2

A 10-STEP APPROACH FOR HEALTH COMMUNICATIONS WITH COMMUNITY- AND FAITH-BASED ORGANIZATIONS DURING PUBLIC HEALTH EMERGENCIES*

Scott Santibañez, Amy Becker LaFrance, Anna DeBlois Buchanan, and Caroline Barnhill

Public health agencies have long recognized the value of collaborating with grassroots entities in health promotion efforts, but recent years have seen a growing recognition of the importance of collaboration with faith-based organizations. This is evidenced by the American Public Health Association's recent formation of a Caucus on Public Health and the Faith Community to encourage health and faith partnerships. Similarly, the White House Office of Faith-Based and Neighborhood Partnerships, originally instituted under the George W. Bush administration and reconstituted in 2009 under the Obama administration, works with states and local communities to assist them in engaging Community- and Faith-Based Organizations (CFBOs) and other grassroots organizations in addressing health needs. In addition, several states have established either offices or liaisons for CFBOs. Even some local governments now include offices dedicated to public health–FBO partnerships (Office of Faith-Based and Neighborhood Partnerships, 2009).

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Although there has been progress in collaboration between public health and CFBOs, CFBOs remain an underutilized resource in health communication efforts (Parrott, 2004), and little guidance is available to public health entities that would like to work alongside faith communities toward common health goals. This chapter grew out of the authors' experience of working with CFBOs in the At-Risk Populations Project (ARPP). The ARPP was developed on the basis of feedback from a series of public engagement meetings in 2008 in which the Centers for Disease Control and Prevention (CDC) partnered with the Association of State and Territorial Health Officials (ASTHO) to help state, territorial, tribal, and local public health officials prepare to protect at-risk people during a severe influenza pandemic and other public health emergencies. Project methods included a 2008–2009 literature review and meetings with academics, community organizations, and at-risk populations. CDC and ASTHO were assisted by the Center for Infectious Disease Research and Policy at the University of Minnesota, the National Association of County and City Health Officials (NACCHO), and The Keystone Center. Among the hallmarks of the project was a focus on CFBOs as a crucial link to at-risk populations and the provision of detailed recommendations for public health planners on methods to engage and partner with these groups (Association of State and Territorial Health Officials, 2008). An in-depth description of project methods and recommendations is available online at www.astho.org.

In this chapter, we propose 10 steps toward collaboration that can be taken by communications teams (see Box: 10-Step Approach to Health Communications With Community- and Faith-Based Organizations During Public Health Emergencies). Teams may be comprised solely of a public health agency employee or may include a multidisciplinary group of communications people and representatives from any number of other agencies. We illustrate the steps with our experiences in the ARPP, as well as from other effective public health–CFBO partnerships. We ask readers to consider the following caveats. First, while we describe the 10-Step Approach in step-wise fashion, some steps will occur simultaneously. Second, although the focus of the ARPP was pandemic preparedness, we do not discuss specifics about influenza. Because information about influenza can change rapidly, we encourage interested readers to visit www.flu.gov, www.cdc.gov, www.astho.org, and www.cidrap.umn.edu for the most up-to-date information. Third, this chapter is not intended to cover health communications theory, but rather to report experiences and lessons learned from public health practice that may be useful to others. Finally, the examples of working with and respecting religious value systems are not exhaustive; they serve as snapshots of the range of needs that may arise.

Box: 10-Step Approach to Health Communications With Community- and Faith-Based Organizations During Public Health Emergencies.

1. Incorporate health communications with CFBOs into an overarching public health strategy.
2. Assemble the appropriate health communications team.
3. Determine which factors place people at risk of disease.
4. Locate at-risk populations in the community.
5. Identify, engage, and collaborate with CFBOs that can help reach these at-risk populations.
6. Recognize and appreciate cultural beliefs and practices.
7. Work together to develop messages.
8. Use a variety of methods to convey and amplify messages.
9. Evaluate message impact and make improvements.
10. Maintain relationships with CFBOs.

STEP 1: INCORPORATE HEALTH COMMUNICATIONS WITH CFBOs INTO AN OVERARCHING PUBLIC HEALTH STRATEGY

From a public health perspective, health communications with CFBOs should ideally be one component of an integrated, overarching public health strategy that is based on sound science and well-defined health issues. For example, the New York City Department of Health and Mental Hygiene's *Take Care New York* is a multidisciplinary public health strategy that also includes other city agencies, health care providers, and businesses. This initiative recognizes CFBOs that serve New York City's diverse communities as one component of an overarching public health strategy (New York City Department of Health and Mental Hygiene, 2004). When a health communications initiative is developed independent of an overarching health strategy, it may become marginalized and difficult to sustain. Under-resourced and underexposed campaigns are unlikely to be effective (Institute of Medicine, 2002). Prior to the ARPP, there was no specific national guidance in place to direct the development of plans and procedures to ensure the health and safety of populations at risk of increased harm during an influenza pandemic. The ARPP provided guidance for public health agencies in their vital role of coordinating activities of multiple partners in a health emergency (Association of State and Territorial Health Officials, 2008).

STEP 2: ASSEMBLE THE APPROPRIATE HEALTH COMMUNICATIONS TEAM

In addition to constituting teams based on technical and subject area expertise, public health agencies that are considering working with CFBOs should think about including team personnel from religious or cultural traditions common in the target area. Health communications specialists familiar with their own religious traditions or community groups may help communications teams understand the culture, beliefs, and values of religious or community organizations (Sager, 2007). They may also understand communication channels in these communities. For example, staff familiar with Hindu and South Asian communities may recognize the important role of religious comic books in these communities. Esposito, Fasching, and Lewis (2005) note that the Amar Citra Katha series of more than 200 titles offers newly standardized versions of great stories of Hindu scripture in colorful illustrated formats written in English and various vernaculars. More than 280 million copies of *Amar Citra Katha* texts have been sold. Similarly, Public Health–Seattle and King County (2010) developed a 12-page comic book on pandemic flu in multiple languages entitled *No Ordinary Flu* (2009), which tells the story of a family's experience with the 1918 influenza pandemic, explains what to expect in a severe pandemic, and offers tips to help households prepare. It could be useful to make use of the *No Ordinary Flu* comic books in Hindu and South Asian communities.

Here we should clarify that while knowledge of one's own religious community or group can be beneficial, team members do not need to belong to a particular religion or ideology to collaborate with CFBOs. The essential point is that each team member should recognize the importance of beliefs and values in many communities and be able to treat others' beliefs with respect, regardless of whether they share those beliefs.

STEP 3: DETERMINE WHICH FACTORS PLACE PEOPLE AT RISK OF DISEASE

Communications teams should identify which factors place people at risk of *contracting* the disease or condition, or of the *consequences* of the effects of a disease they want to address (such as reduced availability of public assistance, for example). In the ARPP, we considered the following questions: Who is most at risk? What is the extent of the risk in the local community? What is the distribution of risk? What factors contribute to risk in this jurisdiction? How might the risk change over time? This factor-based definition avoids the use of labels and provides a more specific understanding of the populations that truly need *extra* assistance in an influenza pandemic, as well as the specific assistance they need and the barriers that render them more at risk (Association of State and Territorial Health Officials, 2008). With respect to pandemic influenza, such risk factors include economic disadvantage (e.g., not being able to afford to stay home from work, even briefly); absence of a support network (e.g., the homeless, people travelling, persons who are socially or geographically isolated); lack of support in daily activities because of physical or mental disabilities or other medical conditions; and inability to speak or understand English. Understanding who is at risk and how these subpopulations are distributed in a jurisdiction is a first step toward planning assistance in the case of emergencies. The characteristics of at-risk populations may shift in an emergency, depending on factors as variable as the location of a disaster to the epidemiology of a virus. Planners need to recognize the importance of reducing risk to the extent possible through strong planning while being prepared to narrow or broaden the definition of "at-risk" for emergency response activities.

STEP 4: LOCATE AT-RISK POPULATIONS IN THE COMMUNITY

Geographic data allow planners to spatially locate at-risk populations in areas where they live, work, and receive services (African Religious Health Assets Programme, 2009). Several U.S. jurisdictions use Geographic Information Systems (GIS) to merge data from different sources (Campbell, 2006; Enders & Brandt, 2007; ESRI, 2008). This allows planners to determine where at-risk individuals live or receive services within a jurisdiction. By viewing regional maps of at-risk populations, disparate partners can integrate their responses (Enders & Brandt, 2007).

A single data source cannot address all aspects of complex social problems. Data triangulation, which involves getting information from multiple sources, often using different methods, is potentially more rigorous, reliable, and valid than using a single research method or data source (Santibañez et al., 2005; World Health Organization, 1998). Readers are referred to the ASTHO Planning Guide for references to resources on specific data collection methods. CFBOs may have detailed knowledge of specific subpopulations and may be able to help identify community members with functional needs. Common types of partnerships between public health agencies and CFBOs have been in the areas of assessment of community health needs and community assets.

STEP 5: IDENTIFY, ENGAGE, AND COLLABORATE WITH CFBOs THAT CAN HELP REACH THESE AT-RISK POPULATIONS

It is important for communications teams to consider various CFBOs as potential partners, recognize the strengths and limitations of each organization involved, and decide how a partnership could improve community health. CFBOs vary widely in organizational structure. Some serve a specific cultural group, whereas others address a specific functional need. Organizational size does not necessarily correlate with ability to reach at-risk individuals. Large CFBOs may have infrastructure and resources, whereas smaller congregations can be important in reaching some of the most marginalized people (Whiters, Santibañez, Dennison, & Clark, 2010).

Communication teams should identify groups already involved in community work. For example, in the aftermath of the December 2004 tsunami that struck the Indian Ocean, small groups of Buddhist householders gathered medicines, bandages, clothes, and food for compassionate assistance. Those interviewed said they were motivated by their Buddhist tradition's teachings that acting compassionately is a central duty (Esposito et al., 2005). Such a group, already having participated in past relief efforts, may be mobilized for involvement in preparedness for health emergencies. Neighborhood networks in Jones, Smith, Wayne, and Jasper Counties in Mississippi were developed through local fire departments and churches. These networks are designed to offer support to communities during a pandemic by ensuring that fire departments provide resources to churches. Every household in each fire department jurisdiction is assigned to a church. Churches visit each household to identify special needs or at-risk individuals and monitor specific neighborhoods and roads (Promising Practices, 2010).

Given the often urgent nature of their missions, CFBOs may not immediately recognize the benefits of networking with public health planners. Although public health agencies may want to focus on one health issue, they need to realize that partner organizations may need to address multiple health or community concerns. In the case of the ARPP, we found that many groups benefited immensely from understanding that pandemic preparedness could strengthen their ability to continue their work in the face of many kinds of emergencies. It was helpful to emphasize that emergency preparedness would allow community organizations to fulfill their mission (Association of State and Territorial Health Officials, 2008). For example, we partnered with a Christian national disaster relief organization that focuses on mass feeding after disasters. In looking for points of overlap with our project, we pointed out how it could be useful to provide meals to people who have to stay at home because they are sick with the flu. We also

talked about the idea that it might be necessary to avoid mass feedings if there was a severe pandemic because of the risk of virus transmission at mass gatherings. Furthermore, some CFBOs collaborate with nonprofits in their communities and neighborhoods; others are part of national networks with ties to the private sector. Local religious leadership may be part of ecumenical or interreligious groups, local ministerial associations, or hospital chaplains groups (Santibañez, 2007). It may be helpful to work with these existing networks before considering developing new ones.

As partners begin to collaborate, it is essential to have buy-in from key leaders. The dedication and commitment of a religious leader to a health issue can strongly influence a congregation (Association of State and Territorial Health Officials, 2008). There may also be unofficial leaders who do not occupy obvious or formal roles but can still be influential. Because a message's acceptability is highly dependent on who delivers it, trusted messengers are key for conveying messages to at-risk populations. The ARPP advocated for "trusted messengers," people who are known to the population for being a leader and a source of accurate information, stating that, "When people view sources to be similar to themselves, they may be more likely to trust the source, underscoring the importance of using messengers that communities identify with" (Association of State and Territorial Health Officials, 2008, p. 47). For example, the value of engaging Muslim community leaders in pandemic planning was affirmed by the former president of an organization of Islamic physicians who noted, "The push is to get the local communities thinking about flu pandemic planning. By presenting to [Muslim community leaders] first and letting us take the message back to our communities, we are able to get across to our communities that this can be a very serious problem and we need to prepare for it." It may be helpful to create a database or directory of trusted sources to deliver messages and update it regularly. Trusted messengers may be found among advocacy groups, neighborhood associations, schools, workplaces, public health, social service, or emergency preparedness agencies, assisted-living facilities, caregivers, senior centers, and literacy groups (Center for Minority Health, University of Pittsburgh, 2008).

Communications teams must take care to seek those to whom others look for direction and who command respect from their peers. Informal leadership may be more difficult to discern without deep familiarity of a particular cultural context. Moreover, leadership roles may be dynamic and ever more so in an emergency situation. Gaining entree into a community can be difficult. Persons who first or most ardently reach out to outsiders may not be typical of the majority of the group or may have limited ability to broker needed relationships. Informal and formal leaders alike may encounter controversy and other challenges to their credibility in brokering between external and internal partners.

Through the course of the ARPP, it became clear that partnerships might not occur in some instances because of a lack of understanding of organizational structure and norms of potential partners. For instance, CFBOs and even public health staff may have limited resources, few paid staff, and multiple competing needs. Because groups and individuals have different constraints, collaborators may need to schedule meetings at times and in locations that allow partners to participate more easily. Planners in the ARPP effort, for instance, met with personnel from one Hindu nonprofit organization on a Saturday afternoon because this was when people came to the Hindu temple. Respect for religious traditions may require working with religious groups outside of the usual 9 to 5 business hours. Partners can also foster good working relationships through the powerful step of acknowledging when they have made mistakes and apologizing, or even by simply responding to voice messages and emails in a timely fashion.

It is useful to be explicit about what partners can and cannot provide. This is particularly crucial with issues of resources and funding because misunderstandings or unwarranted expectations can easily occur. In some cases involving an informal partnership, where there is enough time and effort available to learn about the other agency, simply discussing expectations may be enough. In other cases, partners may need to formalize activities through a Memorandum of Understanding (MOU) to outline each partner's roles and responsibilities, define expectations, provide accountability, and clarify how to collaborate, including the principles of sharing resources, credit, and responsibility (Laken, Wilcox, & Swinton, 2007). For example, the San Mateo County Health Department developed a partnership with CFBOs that have existing relationships with special populations. The partnership included MOUs with these organizations, articulating expectations for all parties named in the MOU and providing a way to update CFBOs quickly during emergencies.

In some cases, partnership may not be the best way to address a public health issue. Agencies and CFBOs should recognize that mutually agreeing to not partner is acceptable and on occasion may be the best option. The two groups can continue to work toward the same goal but do so independently of one another.

STEP 6: RECOGNIZE AND APPRECIATE CULTURAL BELIEFS AND PRACTICES

Religious beliefs are part of a broad range of cultural beliefs about the causes of and appropriate responses to illness. Collaboration with community

groups will be most effective when communications teams learn about the cultural and social values and health beliefs of other partners, including CFBOs and the at-risk populations they serve. The Institute of Medicine (2002) has advocated for qualitative, ethnographic research that examines historical, social, and cultural contexts of diverse communities' health behavior. Ethnography is a set of social science methods originating in anthropology that uses predominantly qualitative research methods to learn about a culture or social group from the perspective of its members. Key methods in ethnography include a variety of types and combinations of observation and interviews. An additional strength of ethnography is that the ethnographer takes into account how his or her own life experiences and cultural values may affect his interpretations and recommendations. While communications teams may not include trained ethnographers and emergency situations may not allow for the extensive use of ethnographic techniques, it is still useful for partners to attend community events and meet at-risk individuals in people's neighborhoods when invited to gain a better appreciation of culture and values. It is also important that partners step back and assess how their own beliefs and experiences affect how they see and react to what may be unfamiliar contexts. Working with religious leaders and talking with community members about their health beliefs can help partners develop messages about healing and health care consistent with people's experiences and expectations. This may require some investment of time. For instance, in preparation for working with a Buddhist nonprofit organization in the ARPP, one of the authors of this paper took an intensive graduate school course to learn more about Buddhist history and culture and read several books by the dharma master. It is better for those who are not familiar with a particular culture or faith to be honest about that, to express interest in learning, and to ask questions respectfully than to make generalizations across groups and risk misunderstanding and ineffectiveness.

STEP 7: WORK TOGETHER TO DEVELOP MESSAGES THAT TARGET AT-RISK POPULATIONS

Effective engagement demands two-way learning. Communications teams may know their health topic very well, but they must also understand their audience. In the ARPP, we recognized that target communities might have a great deal to learn about pandemic preparedness; but we as preparedness planners also had a great deal to learn about perceptions of preparedness, disease, and disaster in these same communities (Association of State and Territorial Health Officials, 2008). Collaborating with CFBOs who were

insiders in the community was a key step in enabling communications teams to develop culturally appropriate messages.

One specific means of accomplishing this that was employed in the ARPP is public engagement meetings, which can help identify audience members' perspectives and concerns. "Community engagement" means "structured dialogue, joint problem-solving, and collaborative action among formal authorities, citizens at-large, and local opinion leaders around a pressing public matter" (Schoch-Spana, Franco, Nuzzo, & Usenza, 2007).

Separate public engagement meetings with both CFBOs and at-risk populations about pandemic preparedness as part of the ARPP helped us to understand underlying beliefs and, in some cases, misperceptions. Some participants, for instance, anticipated being immobilized with fear during an emergency. People also expressed concern about the threat of community-wide panic and riots, events that are actually rare. Understanding such feelings can help communicators tailor health messages (Association of State and Territorial Health Officials, 2008). Public engagement meetings also helped us understand some pressing concerns for at-risk populations. For example, the idea of falling ill during an influenza pandemic was inextricably tied to other social issues. Where could uninsured people obtain free or affordable health care in case of illness? How could people with jobs but limited or no paid sick time stay home while ill or care for sick family members if that meant they risked losing their jobs? How might a pandemic affect ongoing treatment for people with chronic medical conditions? Hearing such concerns helped us better identify important messages to share during a pandemic.

Once data are gathered regarding public concerns about the issue, a number of characteristics should be kept in mind as messages are developed. A growing body of information is available on structuring health messages so as to maximize understanding. Here we simply list some of the common general guidelines. Readers are referred to the list of resources in the ASTHO Planning Guide (pp. 60–64). Messages must be:

- simple, clear, and direct, using the fewest words needed to convey key information—one to three points at most;
- free of jargon and aimed at approximately a sixth-grade reading level (guidelines on simplifying messages can be found at the U.S. government's Plain Language Action and Information Network quick reference guide at http://www.plainlanguage.gov/howto/quickreference/checklist.cfm);
- focused on what to do as opposed to what not to do;
- conveyed in the most accessible ways. For example, low-literacy community members may find pictures, drawings, and cartoons more accessible than text-heavy documents (Jackson, 1998, p. 63);

- constructed using appropriate colors, images, and fonts. All of these can have social and cultural implications that communicators need to be aware of (Kreuter & McClure, 2004);
- built on persons' previous experience responding to emergencies and disasters, such as living without basic services or rationing food or other supplies (Santibañez, 2007).

In some cases, health agency partners in the ARPP took the lead in developing drafts of messages and shared them with CFBO partners for feedback. In other cases, CFBOs developed the messages based on health information we provided or adapted information from our website to make it culturally appropriate for their audiences. They then shared the final products with us to check for accuracy.

STEP 8: USE A VARIETY OF METHODS TO CONVEY AND AMPLIFY MESSAGES

Communications teams should be willing at times to disseminate health messages through existing communication infrastructure and established community networks, such as community relationships and ethnic media outlets rather than trying to create new channels. This may better meet partners' needs and contribute to overall sustainability. Effective communications can involve different levels of engagement: low engagement, in which indirect methods such as traditional advertisements, web sites, flyers, and press releases are employed; medium engagement, in which there is a mix of indirect and semi-direct communication pathways (e.g., prerecorded widely distributed phone messages); and high engagement, which relies on face-to-face, direct communication (Association of State and Territorial Health Officials, 2008). In our work toward pandemic influenza preparedness, CFBOs were encouraged to engage in a range of activities to support local health departments' educational and vaccination efforts—from supplying information to their members about preventing and treating flu to providing facilities for vaccination sites to developing a "buddy" system to help ensure vulnerable and hard-to-reach community members stayed connected to flu-related news and services. Local hospitals and community health workers also play key roles in sharing health information and can be an important link for communications teams. The public often views local providers, hospitals, and health care centers as trusted sources of information (Kentucky Cabinet for Health and Family Services & Jane Mobley and Associates, 2007). In many communities, however, the most trusted sources

are CFBOs. A study conducted in Texas, for instance, found that hard-to-reach Hispanic and African-American populations were likely to rely on family and community networks for information, and the best messengers included neighbors and faith leaders, especially in rural communities (Texas Department of State Health Services, 2004).

Messengers should be trained to deliver risk-communication messages and provide appropriate materials, such as brochures, pamphlets, posters, videos or audio, PowerPoint slides, and information cards. Using train-the-trainer strategies, communications teams can equip a wide range of community members to disseminate messages. For example, under the Illinois Faith-Based Emergency Preparedness Initiative, each of 65 faith-based organizations committed to select two to four Training Ambassadors who would be trained and equipped to reach at least 10 other faith-based organizations in their communities. The ambassadors provided information on pandemic flu symptoms, healthy habits, and preparedness resources.

During the ARPP, we considered how factors that put people at risk can complicate effective communications (Association of State and Territorial Health Officials, 2008). For example, economically disadvantaged populations may not have access to televisions, the Internet, or a telephone. One study showed that while many emergency resources for minorities are available on the Internet, these groups did not benefit from them due to limited Internet access or an inability to navigate complex web pages that are primarily in English (Andrulis, Siddiqui, & Gantner, 2007). Written materials may be ineffective with low-literacy populations.

Health materials may also be inaccessible to those in remote areas or those unable to travel to where materials are available. Undocumented workers or immigrants may be reluctant to seek official sources of information or assistance for fear of deportation or other repercussions. On the other hand, persons with certain disabilities may not be geographically isolated, but health materials may still be difficult for them to access. For example, unless video phones and text messaging devices are available for the deaf, and computer reading programs, audio files, or print materials in Braille are developed for the blind, these populations may be unable to access emergency information (New York State Department of Health, 2008). Finally, some at-risk individuals may not know where to go for health information, especially if they do not receive regular health care. In partnering with CFBOs, public health agencies should recognize that such considerations are not only issues that CFBOs can help to address, but they are also concerns with which members of CFBOs may struggle.

Given all of this, it is evident that effective communications requires both high- and low-technology approaches. We found partnership with CFBOs to be especially useful in implementing personnel-intensive low-technology communication—that is, the "push" as opposed to the "pull"

media. Mailed newsletters, prerecorded messages from trusted CFBO leaders on a designated call-in phone number, and printed copies of daily teaching guides from trusted leaders were useful ways to communicate with people who do not have Internet access. Designated CFBO members can also put together phone trees—well-organized systems for activating a group of people by telephone. It is important to note that if phone trees are used, they need to be tested regularly. The use of multiple methods can help compensate for differences among audience members. Participants at public engagement meetings, for instance, said that, although mailings might provide good information, some people ignore them.

Groups whose written languages are relatively young, such as Somali, Mien, and Hmong populations, or groups such as the Mixteco, whose languages have no written form, may need to be reached via oral communication. Partners may need to work closely with interpreters with such populations. Interpreters can range from trained individuals and bilingual staff to community members or family members. Considering the challenges of explaining medical and health terminology in another language, it is vital that CFBO members and others who serve as interpreters receive adequate training and education so messages are communicated accurately and effectively. Interpreters should also be trained on ethical and technical aspects of health interpretation, such as impartiality in delivering messages, maintaining confidentiality, and managing cultural differences (National Council on Interpreters in Health Care, 2009). In-language phone lines with interpreters can be important resources for populations with limited English proficiency.

STEP 9: EVALUATE THE IMPACT OF MESSAGES AND MAKE IMPROVEMENTS

It is useful to evaluate the impact of messages because knowledge, attitudes, and behaviors affect individual preparedness levels. Evaluation is important to health communications programs in other ways. It helps communications teams justify the program, provides evidence of success or demonstrates the need for additional resources, increases organizational and individual understanding, and even encourages ongoing collaborations with CFBOs and other organizations (National Cancer Institute, 2004).

Evaluating the effectiveness of health communications messages can be done a number of ways. It is not within the scope of this chapter to summarize the wide range of techniques available; readers are referred to the list provided in the ASTHO Planning Guide (2008) (pp. 88–94) for specific evaluation tools. What is important to note with respect to CFBOs is that many

such organizations lack the staff and financial resources to commit to long-term evaluation. Furthermore, they may be so focused on the community needs around them that evaluation may seem a distant second priority to them. Nevertheless, it is important to include them in the evaluation process so as to improve implementation of the project, ensure buy-in for project activities, and pave the way for future collaborations.

STEP 10: MAINTAIN RELATIONSHIPS WITH CFBOs

Successful collaboration should be the foundation for strong and enduring partnerships. Communications teams must be willing to make concerted efforts to maintain relationships with CFBOs once projects are complete. At the most basic level, this requires mutually respectful relationships. Public health personnel should never talk about public health "*using* faith-based and community organizations *as vehicles* to promote health." Such statements convey a manipulative, even paternalistic attitude. In truth, public health must *work with* these organizations so that together they can promote the health of their communities. Respect also means acknowledging the contributions of CFBOs and other community members who are giving their time. Volunteers at CFBOs accomplish enormous feats of care and concern for their fellow citizens. Public health professionals should give credit to community members who give of their time in this way, whether through press releases, events, or other methods of recognition. For example, local governmental leaders in the Gulf Coast region issued proclamations commending charity relief efforts after Hurricane Katrina.

Maintaining relationships can be difficult when priorities or funding changes or when the people who forged connections change jobs. It can help to designate a health agency staff member to build and maintain partnerships as a formal job duty. For example, a departing employee may introduce the incoming employee to key partners in a network or at least notify network members of the staff change. This can help to ensure that collaborative efforts are sustained and serve as a foundation for future work. Sustaining such relationships in the face of financial difficulties and organizational change requires long-term commitment of public health leadership and dedication to fostering and maintaining these important community relationships.

CONCLUSION

CFBOs can play a key role in reaching the most at-risk or vulnerable people in our communities, but they remain an underdeveloped resource in public health communication. Through the course of the ARPP, we found that both public health and CFBOs were ready and willing to collaborate, the question just became how best to do it. If collaboration activities are effectively initiated, such as before a pandemic in the case of the ARPP, health departments can activate networks and convey timely health information to at-risk populations when health emergencies do occur. It is our hope that lessons learned about working with CFBOs from the At-Risk Populations Project described in this chapter will be useful to other health communications teams.

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