EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH | Interfaith Health Program
Hubert Department of Global Health

Title	Final Report to the Pew Foundation on the Work of the Atlanta Interfaith Health Program
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Background	This report describes activities carried with funding from the Pew Foundation. This funding allowed for the creation of the Atlanta Interfaith Health Program, which brought together congregations in two neighborhoods in Atlanta to address inequity in health in relation to social factors and forces. The program endeavored to bring the distinctive resources of religious communities to the table to address these forces. This work carried out with this funding helped set the trajectory for IHP's work in subsequent years.

Narrative Report on the Atlanta Interfaith Health Program
Final Report of Three Year Project (12/1/93 - 6/30/97)

Planning Period (9/24/92 -- 6/30/93)
A planning grant from Pew Charitable Trusts enabled the Interfaith Health Program (IHP) to research the health and healing ministries of congregations in the urban center of Atlanta. This process allowed us to form a Working Group of religious and health leaders in Atlanta and to plan and establish the Atlanta Interfaith Health Program (AIHP).

Three part-time research assistants were recruited for the research process. They gathered information from 148 congregations (mostly by phone) in a region of urban Atlanta being served by The Atlanta Project (TAP) with a population of 550,000. (TAP is a program initiated by President Carter to empower communities to address the major social problems that are endemic to metropolitan urban populations.) The health-related ministries most frequently identified through the research process were: AIDS and substance abuse outreach, health fairs, shelters for homeless, feeding/clothing ministries. The challenge for researchers was in locating congregations (368 total), making contacts, and overcoming resistance to sharing information. The research was valuable in enabling IHP to identify the regions within TAP with the greatest health needs.

The Working Group consisted of the directors of Fulton and DeKalb County Boards of Health, prominent religious leaders, faculty from Atlanta universities, and activists involved in faith/health practices. In the course of five sessions, this group planned the AIHP strategy to form coalitions of congregations among at-risk populations for purposes of health promotion and disease prevention. Three of the coalitions were to be located in regions (clusters) of TAP and one in a region of Atlanta with a highly diverse immigrant population.

Phase 1: Forming Congregational Coalitions in Two Regions of TAP
A decision was made by the AIHP staff responsible for implementing the strategy recommended by the Working Group to begin with two of the four projected coalitions, both in regions of TAP. The reasons for starting with two rather than all four were: 1) to make the best use of available staff for the development of coalitions and 2) to apply what is learned in the first two coalitions to those that would follow.

The following process was used to recruit TAP clusters and congregations for the coalitions:

- Cluster coordinators and health committees of all twenty clusters of TAP were visited and invited to submit applications. Two were chosen (Brown and McNair clusters) on the basis of the following criteria: (1) limited health care resources in the cluster; (2) expressed interest on the part of faith communities; (3) support of cluster coordinator and health committee.
- All the congregations (Christian, Jewish, Muslim) within the boundaries of each cluster were contacted through a mailing, phone calls and personal visits. The congregation was asked to sign "A Covenant of Congregational Participation" (see attachment). Twelve congregations were recruited in one cluster and ten in the other. All of the congregations recruited in both coalitions were predominantly African-American and Christian (with the exception of one mosque), reflecting the population in both regions.

A Health Ministry Council (HMC), made up of representatives from each of the participating congregations, was formed in both coalitions. In the Brown coalition, consisting of mostly large and well-established congregations, HMC membership was completely clerical. In the McNair coalition, consisting of smaller congregations, the representatives were chiefly lay members.

Each HMC selected a network coordinator, a paid half-time position. The coordinators, both residents within their respective clusters and members of a faith community, were accountable to the HMC in their coalition and to the co-directors of the AIHP. Since there were no funds for the operation of a coalition office, one of the coordinators shared the cluster TAP office and the other operated out of her home. Sharing the TAP office worked well in coordinating the activities of TAP and the AIHP coalition of congregations. The home office was inadequate in that the coordinator was isolated from other community activity, and coalition members were hesitant to call at her home.

Training Program for Congregational Health Promoters

The training of congregational health promoters (CHPs) from each of the participating congregations was at the center of the Atlanta Interfaith Health Program. A committee consisting of two AIHP staff, three faculty from the Emory University School of Nursing, and the chairpersons of the health committees from each of the TAP clusters was formed to plan the training of CHPs. The training module was based on the principles of empowerment and collaboration. Rather than the instructor constructing a curriculum, the CHPs determined the training agenda based on perceived needs in their congregations and communities. The instructor functioned more as a facilitator than instructor, assisting the participants to become responsible for their own learning. As the responsible agent for coordinating the training, the Emory University School of Nursing recruited an African-American nurse with skills in health education and knowledge of the communities being served as an adjunct member of the faculty to facilitate the training process.

Each congregation selected a male and a female as volunteers to participate in a 20-hour program to be trained as congregational health promoters. In most cases the faith leader (pastor, priest, imam) made that selection. The selection process was somewhat uneven, depending on the commitment of the faith leader to the project and the interest of persons that he or she selected. This was reflected in sporadic attendance at training sessions on the part of some CHPs.

There were two separate training sessions, one for each cluster. Each met every other week for two hours in a church building within the cluster. At the conclusion of the training process, a commissioning service was held in both networks. The service was planned by the HMC of each cluster as a recognition of the accomplishment of the CHPs and as an occasion for the participating congregations to express their solidarity in a common mission. Certificates were awarded by the Emory University School of Nursing to those who had completed the training.

The decision to include only one series of training sessions in the AIHP was wise in that a second series of training sessions by The Carter Center would have increased dependency on an outside agency to continue this program. However, by hindsight it is obvious that there was insufficient infrastructure in either coalition, or both together, to fully meet the challenge of planning and implementing a rigorous training program on their own.

The need for additional training became obvious at the end of the first year of the project and was even more evident at the close of the second year. Not all of the participating congregations had two persons trained as CHPs, some CHPs had moved or were no longer active, and congregations that joined the coalition did not have persons trained as CHPs.

The two coalitions of AIHP jointly planned a second series of training sessions for additional CHPs to serve in each of the coalitions. Two CHPs from one coalition and one CHP from the second coalition agreed to serve as trainers, with support from the nurse who facilitated the first training series. This plan was implemented in September, 1995, but was plagued by internal difficulties. Efforts by the two coalitions to raise funds for the training from local sources were not successful; as a result, there were no resources for supplies and no stipend for the trainers.

The attendance at the first two sessions was low, three persons from one cluster and one from the other. Changes in the position of network coordinator in both coalitions inhibited the recruitment process. The additional training was suspended and in spite of additional planning meetings has never been completed.

The AIHP Coalition of Congregations in the Brown Cluster

The Brown coalition fared better than its partner in McNair. One major factor is that the congregations in Brown are relatively large and well-established. The CHPs trained from these congregations are generally well-educated, many with a background in a health-related field. They met regularly once a month throughout the length of the project. They conducted a successful Family/Youth Festival at a local YMCA. Among the many activities that CHPs arranged for their congregations included: a smoking cessation clinic; Black Eyed Peas, a summer youth program; adult health education forums; blood pressure, diabetes and cholesterol screenings; AIDS awareness programs; substance abuse and violence prevention programs.

There were monthly meetings of the Health Ministry Council (HMC). Each month a different congregation hosted a luncheon for the HMC, at which time the pastor of the host congregation shared information about the health ministries in his congregation with the other ministers. In addition, presentations were made by area health leaders about materials and programs that would be useful in congregational and community health ministries.

The second network coordinator in the Brown Cluster (the first resigned after 18 months) spent much of his efforts organizing the coalition as a tax-exempt organization under the title of Atlanta Health Ministries in order to apply for grants that would sustain the coalition beyond the AIHP grant period. Though he was successful in this effort, he failed to provide sufficient support for the CHPs, and attendance at their meetings waned in the final six months of 1996.

Atlanta Health Ministries is currently the umbrella for three different aspects of a continuing health promotion program in the Brown cluster. Six of the original twelve congregations in the coalition are still active. The three components of Atlanta Health Ministries are:

- A caregiving program to support and enhance respite care and visitation ministries has been established.
- Under the leadership of a public health nurse who participated in the AIHP training, a core group of about ten CHPs have begun to meet regularly after a period of about six months with little activity. Now regular meetings are held each month, a health calendar has been adopted, and increased congregational activities have resulted.
- In collaboration with Scottish Rite Hospital, three of the largest congregations are planning convocations centered around the health of families and children.

The AIHP Coalition of Congregations in the McNair Cluster

The McNair coalition consisted of mainly small congregations with limited leadership potential and material resources to develop the kind of internal organization and external support to enable this coalition to sustain itself after the grant period was completed. On a positive note, there

continues to be health promotion activities in the congregations of this coalition, but the coalition itself has not become self-sustaining. Sporadic attendance at CHP meetings in the second year of the project was not improved when the HMC and CHPs decided to meet jointly. A major renewal effort to establish a stronger organizational structure for the network of ten participating congregations had limited success. Large attendance at a meeting to renew commitment to the AIHP dwindled in subsequent months.

What we learned from the failure of this coalition to sustain itself beyond the grant period is the need for collaboration with other community agencies that share the same mission to improve personal and community health and who recognize faith groups as natural partners in accomplishing that mission. Even the collaboration with TAP was weak in this cluster because of community conflict about TAP, in which some of the clergy in the coalition were deeply enmeshed. Collaboration with TAP was strong in the Brown cluster, and this contributed somewhat to its sustainability, but a major weakness in both coalitions was the lack of partnership with like-minded community agencies.

The AIHP Coalition of Congregations along the Buford Highway Corridor
A third coalition of congregations was formed in the latter half of the second year of the project. Located along the Buford Highway Corridor of Atlanta and called the International Village, this region contains a richly diverse population of Hispanics, Southeast Asians, African-Americans and European-Americans. Rather than building an additional coalition in TAP, as was originally planned, it was decided to concentrate AIHP resources in the formation of a third coalition of congregations that was much larger than the previous two (21) and multiethnic.

There are two reasons why the building of a third coalition was important for evaluating the success of the AIHP:

- It provided a basis for comparison between a multiethnic coalition and homogeneous coalitions of African-American congregations, and
- There was an opportunity to make adjustments in program planning and implementation after two years of experience with two coalitions.

Though there were unique challenges in creating a multiethnic coalition, the culture and language differences were not major impediments. The adjustments made in building the third coalition contributed significantly to the greater success that the third coalition has had in achieving the original vision and purpose of the project. The two major adjustments were in locating the coalition in an already established ministry center and collaborating with community agencies in fulfilling the goals and objectives of the project.

A different organizational strategy was used to build this coalition of congregations. Rather than AIHP staff recruiting congregations for the coalition and giving them the responsibility of selecting their network coordinator, The Carter Center negotiated with the Chamblee-Doraville Ministry Center (CDMC) Board for the services of its director as the coordinator for a coalition not yet formed. This had two advantages:

- There was already a solid organization in place that could serve as a partner in this project and offer greater assurance of long-term sustainability.
- As the director of a thriving ministry center, the network coordinator already had many contacts with congregations and agencies in the community.

The strategy was successful. Through a variety of informational meetings and personal contacts with Korean, Hispanic, and Vietnamese pastors, 21 congregations were recruited for this coalition.

The training program for congregational health promoters was coordinated as before by the Emory University College of Nursing and patterned after the previous training. However, there were several important differences:

- Two trainers were recruited, both with experience in international health, because of the large number of persons to be trained as CHPs (42).
- Instead of two separate classes, as in the previous training, there was a combination of sessions in which the entire group met and sessions in which two groups met separately.
- Instead of six months of training (2 hour sessions every other week), the training was completed in six weeks of sessions varying in length from two to four hours.
- Better attendance was achieved by letting the trainees decide how many hours of training were necessary to be commissioned (16).

Thirty-five congregational health promoters from 21 congregations were commissioned in an interfaith service of worship in June, 1996. They have met once a month since that time for continuing education and mutual support. They have been active in their congregations with a wide variety of programs, such as: immunizations, chronic illness and grief groups, blood pressure screening, health education programs, cancer screening, congregational health fairs, CPR training, healing circles, nutrition classes, and a variety of other health promotion initiatives. They have adopted a name by which they are known in the community, the Interfaith Health Promoters.

Health fairs have been the primary means by which this coalition of congregations has reached out to the surrounding community. Two small health fairs were conducted in apartment complexes. There was little need for marketing, since these fairs were done for people living in the apartments, and the attendance was good. A very large health fair was held in April, 1997, and this was a huge success. Collaboration was the key to success. The DeKalb County Board of Health was one of two community health partners in this project. The other was Scottish Rite Hospital. They focused on children and the AIHP coalition focused on adults. There were between 700-800 people who attended on a rainy, cool day. Six months of planning on the part of congregational health promoters contributed significantly the success of this project, which is likely to be an annual event.

The major reason why the CHPs in this coalition of congregations have functioned much more cohesively as a group is the support they have received from two community health nurses from

the Parish Nurse Program of St. Joseph's Hospital, a hospital with a mission to serve at-risk populations. They contracted with the CDMC to provide the services of a Korean and Spanish-speaking nurse to support CHPs in Hispanic and Korean congregations. It would be hard to overestimate the difference it makes to have community health parish nurses available to support the congregational and community-based programs that have been developed.

Major Obstacles Encountered in the AIHP Buford Coalition
Though a Health Ministry Council was not planned for this coalition, pastors of participating congregations were invited to meet regularly to share information and discuss their roles in supporting congregational health ministries and providing leadership in promoting community health ministries. Overall, this was not successful. Several luncheon meetings were scheduled but not well attended. One successful event was a full morning workshop on the congregation's role in community health followed by a luncheon. We know pastors are pleased with this program, but they have not claimed ownership for it. They see it as something The Carter Center, CDMC, and St. Joseph's are doing for them. Efforts to get congregations to make monthly contributions to the program have not produced results.

A second obstacle has been the difficulty in incorporating Korean congregations as full participants in the coalition. This was evident already in the training process. Because of the discomfort they felt in the large training group, partly because of language limitations, the Korean CHPs completed their training with a Korean nurse in the Korean language. Inclusion continues to be a challenge and is complicated further by the departure of the Korean providing support to these congregations.

Starting Point, A Manual for Building Congregational Coalitions and Training CHPs
With the aid of a graduate assistant in the summer of 1996 who served as a technical writer, a manual was produced that describes the building of congregational coalitions and the AIHP training for CHPs (see attachment). 1,000 copies of *Starting Point: Empowering Communities to Improve Health* were published and have been widely distributed throughout the US. There has been keen interest in this manual, and several sites are considering an adaptation of the model in their communities. The San Mateo Country Board of Health is collaborating with Bay Area Health Ministries in planning a similar project there, and staff from the IHP will provide on-site consulting and training.

Conclusion
One of the major goals of the Atlanta Interfaith Health Program was to develop a model for organizing congregations serving at-risk populations for ministries of health promotion and disease prevention. Information about this model could then be disseminated through the Interfaith Health Program's national network of communication. This goal was achieved beyond the original expectations. As anticipated, information about this model was shared through: 1) *Faith and Health*, the national publication of IHP; 2) speaking engagements; 3) professional meetings; 4) telephone consultations with interested parties; and 5) newspaper accounts. The publication of *Starting Point*, the manual which describes the process of forming coalitions and

training CHPs, was not anticipated. Not only has that generated further inquiries, but it provides a blueprint that can serve as a guide to those who wish to replicate or adapt the model for their locality.

Another major goal of this project was that the AIHP coalitions would be self-sustaining without the support and direction provided by The Carter Center. The transition process from dependency on external support to an autonomous and self-sufficient operation has not be easy. This was especially so for the Brown coalition, which did not have the benefit of the infrastructure provided to the Buford coalition by their affiliation with CDMC. A small grant for caregiving and collaboration with Scottish Rite Hospital has given this coalition greater stability. Both coalitions will benefit from the remaining AIHP matching funds that Pew Charitable Trusts has graciously agreed to provide them as an incentive to seek additional funds for the continued operation of these vital ministries in congregational and community health.