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Faith Wellness Collaboration: A Community-Based Approach to Address Type II Diabetes Disparities in an African-American Community

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Abstract

Community-based participatory action research was utilized to form a collaboration that developed a Health Ministry program in four Northeastern urban Black Churches, in which they designed and implemented a culturally competent Type II Diabetes self management education program. Minister sponsorship and a program coordinator synchronized the four Health Ministries' development and diabetes program planning. A case study design, and participant observations and a focus group methodology were used to explore the faith-based community residents' collaboration development, and design and implementation of the health promotion program. The implementation process can be described as occurring in four essential elements: (1) the development of the health ministry in each of the four churches; (2) the process in which the four ministries coordinated their activities to create the diabetes education program; (3) the process of delivering the diabetes education program; and (4) the challenges in promoting the diabetes education program across the community. Practice implications, as well as cultural competency issues related to social work practice with faith-based organizations and African-American communities, are also presented.

Keywords

diabetes self-management; Black Church; collaboration; cultural competence; community based participatory research; African Americans

INTRODUCTION

African Americans are disproportionately diagnosed with diabetes, having the greatest incident of the disease and are 2.2 times more likely to die of diabetes than non-Hispanic Whites (CDC, 2007; USDHHS, 2009). Diabetes can result in heart disease, renal failure, and neuropathy. It is the leading cause of blindness and is the seventh leading cause of death (CDC, 2007). Estimated costs in the United States were $174 billion in 2007 (direct and indirect costs). Adopting self-care practices that include a healthy diet and exercise moderate the impact of diabetes and reduce the onset of the complications associated with diabetes (ADA, 2009; CDC, 2007).

Social workers and other health providers have long recognized the need to provide culturally sensitive health education programs to enhance the health awareness among ethnic groups (Altpeter, Earp, & Schopler, 1998; Brown, Jemmott, Mitchell, & Walton, 1998;

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Bullock & McGraw, 2006; DeCoster, 2001; Ka'opua, 2008). Consequently, appropriate programs have been developed for specific ethnic and cultural populations. Such programs attempting to reach African Americans identify the Black Churches as the appropriate community setting to reach the greatest number of African Americans. Black Churches hold a prominent role in African Americans' lives by offering an environment of social and psychological support and 80% of African Americans attend church regularly (Lincoln & Mamiya, 1996; Taylor, Lincoln, & Chatters 2005). Studies of health education programs in Black Churches have generally been experimental, randomized trials designed and implemented by health professionals that were time limited with minimal plans for sustainability beyond the research period (Campbell et al., 2000; DeHaven, Hunter, Wilder, Walton, & Berry, 2004). Positioning health education as a permanent function requires the infrastructure for consistent and culturally congruent programming. A Health Ministry (a committee of congregational members) operating within a Black Church was shown to successfully promote health awareness and advance medical service seeking behavior among congregational members (Austin & Harris, 2011). In this article, we present the development of a collaboration between social workers and four Black Churches that established Health Ministries and their implementation of a culturally congruent Type II Diabetes education program that improved participants' evidenced-based self-care practices and self efficacy.

THE COMMUNITY-BASED FAITH WELLNESS COLLABORATION

African American Clergy for Empowerment (ACCUE), a community-based organization consisting of 25 inter-denominational Black Churches in Albany, New York, sponsored the project. AACUE's health committee, Voices of Wellness (VOW), chairman was charged with the development and oversight of the Faith Wellness Collaboration. In 2008, four Baptist Ministers volunteered their churches for this pilot project, which spanned three communities. The Faith Wellness Collaboration was thus conceived and developed to supported VOW's philosophy and commitment to the spiritual and physical health of the congregants and the community. It was composed of the VOW chairman who was a minister of one of the churches, ministers of the remaining three churches, volunteer members of the four churches, the Capital Region American Diabetes Association, and two university-based social work researchers—one who was a member of a participating church.

The Faith Wellness Collaboration developed the infrastructure for church-based Health Ministries, planned and implemented a culturally congruent diabetes self-management education program, and conducted the case study. The collaboration adopted the Center for Disease Control and Prevention's (CDC) funded REACH model of community partnerships utilizing Community Based Participatory Research (CBPR) to reduce health disparities (Two Feathers et al., 2005).

The Faith Wellness Collaboration explored the American Diabetes Association's (ADA) cultural specific education programs for Asians, Latinos, and African Americans as the curriculum for the diabetes educational program. The Albany Capital Region ADA and VOW agreed to utilize the ADA's faith-based African-American curriculum, Project Power®, (American Diabetes Association, n.d.). Project Power contains four modules that include an overview of diabetes, heart disease risk, healthy eating, and overview of good health care. The Collaboration modified Project Power curriculum to actively engage participants in healthy eating and exercising during the education sessions.

ADA trained all Faith Wellness Collaboration members in presenting the curriculum. In addition, the ADA provided each Health Ministry a library of ADA sponsored African-

American cookbooks and exercise books. The libraries were a resource for the group's preparation of the diabetes education program's healthy meals and the exercise activities.

METHODOLOGY

The main focus of this study was the implementation process of the community-based collaboration utilizing community based participatory research (CBPR) in providing a diabetes educational program in Black churches. Participant observations and a focus group explored the faith based community residents' collaboration development, and design and implementation of a community health promotion program. Such qualitative research permits participants to provide in depth complex explanations of experiences that might reveal new insight about social phenomena, and organizational processes (Lincoln & Guba, 1985; Marshall & Rossman, 2006).

Cultural Competence and Community-Based Participatory Research (CBPR)

The study is embedded in CBPR, which acknowledges that community participants are equal research partners who engage in knowledge and skill development for program implementation, and assist in assessing the effectiveness of the program (Alvarez & Gutierrez, 2001; Israel et al., 2003). The transfer of knowledge and expertise among the collaboration members builds new knowledge and empowers partners, which produces skill development that can be applied to future endeavors (Israel et al., 2003). The adoption of CBPR encouraged the Faith Wellness Collaboration to actively engage partners to identify areas of research they considered important to their needs and ensured cultural congruence in program planning and implementation. Thus, the CBPR approach empowered groups on the local level to address the specific health disparities within their communities, in this case Type II Diabetes.

Utilizing CBPR required the social workers to practice cultural competence for successful collaboration with members of the Black Churches. Cultural competence requires social workers to be aware of their own values while building knowledge of differences among racial, ethnic and cultural groups in order to develop intervention practices (NASW, 2007). The application of cultural values ensures that social workers are responsive to the views of community members. Fong (2001) proposes that cultural competence is a staged process evolving from cultural awareness to cultural sensitivity, and finally to cultural competence.

Analysis

An overt participant observation method was used to identify processes occurring during the collaboration development (Parker, 1974). It also enabled the researchers to understand the contextual meanings occurring in the planning meetings. These meetings included the development of the health ministries, coordination of the four health ministries, and the development and promotion of the diabetes education program. Such methodology makes available a quality and depth of information regarding unknown group behavior, as well as the pressures, influences, and group norms motivating these behaviors.

Data was collected and analyzed from the researchers' notes of each planning meeting. These narratives were analyzed by the social work researchers in consultation with health ministry coordinators. A case study was then conducted across the four health ministries. The case study narratives identified themes and patterns that were compared across the four workshops, producing a cross-case synthesis (Yin, 2003).

The researchers conducted a focus group after the collaboration implemented the diabetes health education program. The purpose was to capture the members' experiences in developing the collaboration and presenting a health education program. Focus groups are a

means for learning how people feel or think about an issue. It can be utilized as the primary data collection in a qualitative study or provide supplementary data in a quantitative study, as was the case in this study (Krueger & Casey, 2009). The question posed by the moderator to a group typically not larger than ten participants can lead to perceptions and opinions that generated from the group members' discussion (Morgan, 1997).

This study employed an unconventional method by including 23 individuals in one focus group. This unconventional focus group was at the insistence of the collaboration members, reasoning that this larger group would afford active cross-discussion, thus providing greater information. In keeping with participatory principles, we agreed to this format. The focus group consisted of two ministers, the Health Ministry chairpersons, the program coordinator and 16 workshop participants representing the four churches. The participants were asked their perspective of the program goals, what they learned, what they liked about the program, what aspects of the program worked well, and recommendations for improving the program. Members of the Health Ministries were also asked to provide their perspective of developing the Health Ministry and presenting the diabetes education program.

FINDINGS

The collaboration was formed by the following process. The Faith Wellness Collaboration was created by the VOW chairman who was a minister of one of the churches, and the two university-based social work researchers. The minister recruited ministers from the remaining three churches. Ministers recruited volunteers from each of the four Black Churches in the role of Health Ministry chairperson, who then recruited their ministry volunteer members. The Albany Capital Region American Diabetes Association joined the collaboration two months later. The implementation process can be described as occurring in four essential elements: (1) the development of the health ministry in each of the four churches; (2) the process in which the four ministries coordinated their activities to create the diabetes education programs; (3) the process of delivering the diabetes education program; and (4) the challenges in promoting the diabetes education program across the community.

The Health Ministry Development

Minister sponsorship is essential for making community and Black Churches collaborations successful (Massaro & Claiborne, 2001). The VOW Ministers from the four participating churches played an integral role in the organizational development of the Faith Wellness Collaboration, the Health Ministries, and the success of the diabetes education program. Their leadership was invaluable for recruiting volunteers who created the Health Ministry in each church, actively supporting the diabetes education program, and sustaining the continuation of the church's Health Ministry.

The Health Ministries were the "engine" of the infrastructure development. This development was extensive in three churches that did not have a Health Ministry and was enhanced in the church where the existing activities included health fairs and screenings. Each Health Ministry consisted of a chairperson and four to five members. Each church was fortunate to have a chairperson from congregates possessing a health background of nursing, medical technician, or health social worker. The criteria for being a chairperson was being known in their church community, considered to have skill and expertise in health issues, and the ability to engage individuals with health needs.

A program coordinator was hired by the collaboration to synchronize the four Health Ministries' development and diabetes program planning. The program coordinator was a nurse who was a member of one of the participating churches and an original member of the

collaboration. She was known and respected by the ministers and the Health Ministry members. The program coordinator's modest salary, meals and incidental costs related to the program, and research costs were supported by a small health disparity grant.

Coordination of the Health Ministries

The program coordinator and Health Ministries met bi-monthly over a 5-month period of time. The VOW chairman minister attended these meetings in the beginning, and then only occasionally when requested by the group. The program coordinator and Health Ministry chairs agreed on individual roles and specific tasks they would assume for the Health Ministry development and diabetes education program coordination. The program coordinator was responsible for convening the meetings and acquiring diabetes health educators for the program workshops. The Health Ministry chairpersons were responsible for developing the Health Ministry in their church, as well as coordinating and engaging volunteers in program planning and implementation. The social work researchers made available resources from the ADA, identified the REACH model, detected specific issues for capacity building, and conducted the case study.

During the focus group, the ministers and Health Ministry chairperson confirmed that the program was valuable to their church and congregant. The Healthy Ministries were aware that many congregants struggled with the management of diabetes and believed the program would be valued. However, a major challenge was scheduling workshops to avoid conflict with the churches' calendar of local, regional and national meetings, and holidays, although difficult, was beneficial but time consuming. All agreed that scheduling such a program, especially coordinating with other churches, took one person at each site to be diligent in follow-up communications. The ministries conferred for several meetings to design the program's schedule as a seamless interface with the church calendars. Another challenge was scheduling the exercise classes at a time that ensures maximum attendance yet not compromising participants' mealtime requirements.

The regularly scheduled collaboration meetings provided a structure that enabled the Health Ministries to collectively problem solve issues that may impact their respective Health Ministry. All members of the collaboration were actively engaged in planning the details of the diabetes education program and identifying the components of diabetes self management curriculum that would be presented. The ministers and Health Ministry members, during the focus group, agreed that the CBPR approach permitted the collaboration to adapt the Health Ministry development and the diabetes education program in a manner that was meaningful to each church and their congregants. CPBR enabled the Health Ministries to own their engagement in program's design and implementation resulting in their belief that they had created needed services for residents.

Delivering the Diabetes Education Program

The Faith Wellness Collaboration diabetes education program consisted of a one-half day, all-community "kick-off" and a series of seven workshops. The "kick-off" served as a community educational promotional event and recruitment for the workshops. The key note speaker, a nationally renowned African-American physician-minister, presented health disparities information among African Americans and emphasized individuals must assume responsibility for their spiritual and physical health. Individuals with Type II Diabetes were then invited to enroll in the workshops series being offered at one of the four church locations. Participants were asked to complete an enrollment card and the health ministry chairperson conducted a follow-up call several weeks prior to the workshop start date.

Each church offered all seven workshops on different days and times in order to attract as many community participants as possible. Each workshop lasted approximately two and one-half hours and a different workshop was offered weekly, for seven consecutive weeks. All workshops presented information on diabetes care, details of which are: three workshops focused on healthy eating, three focused on exercise, and one focused on the role of family and friends in supporting individuals diagnosed with Type II Diabetes.

Project Power is designed for individuals with limited diabetes knowledge to lead workshops in an overview of diabetes, the importance of exercise and diet, and the impact of exercise and diet on heart disease. The curriculum was modified by the collaboration and presented by members of the Health Ministry. The modification included active diet and exercise workshops, departing from ADA's lecture alone format. The modification also involved extensive discussion among the collaboration members related to the churches culture associated with meals, church members' expectations for meals and type of food, and collaboration member strategies for introducing healthy meals to church cooks, workshop attendees, and congregants. Health Ministry members who planned the diet and exercise workshops were well known and respected by community residents for adopting and teaching healthy eating and exercising regimens. The four churches had an existing structure in which designated volunteer cooks provide food for all church events. Thus, each Health Ministry worked closely with church cooks regarding the diet workshops' goals and made the ADA cookbooks available to them. Subsequently, the cooks provided healthy meals, information as to the composition of each dish, and recipe copies during the healthy eating workshops. The modification of these three healthy eating workshops consisted of participants eating a healthy breakfast, lunch, or dinner (not just discussing a healthy diet).

A subcommittee of exercise experts designed and taught the three exercise workshops. This subcommittee, with the approval of the collaboration, designed the workshops mainly for African-American women over 50 years old who do not maintain a daily exercise regimen. The exercises presented were low impact and easily adopted for any lifestyle. These experts provided information and lead participants in exercises during the workshops. Adjustments for participants who did not "fit" the standard program design and suggested exercise regimens were made at individual requests.

The curriculum was further enhanced by the program coordinator and Health Ministries who enlisted guest speakers. Speakers included diabetes educators, nutritionist, pharmaceutical representatives, and physicians who presented specialized topics of nutrition, foot care, self-management with blood glucose meters, diabetes medications and navigating the health care system. Professional guest speakers were not standardized. For example, two nutritionists may speak at different churches. A representative from a pharmaceutical company provided free glucometers and instruction for their use to participants at each church.

Focus group participants who attended the education program identified the goal of the workshops as providing information for managing diabetes with exercise, diet and information. They identified a number of themes as having an important impact in their lives. These were: awareness of being in denial related to diabetes, improved self-care practices leading to a greater sense of controlling diabetes, being able to discuss diabetes risks among family members, and awareness that self-care practices may diminish the risk of diabetes related complications. The majority of the participants discussed becoming aware of behaviors and thought processes that permitted them to ignore self-care practices. A typical example was expressed by the following participants:

> I was in denial and came to terms with having diabetes. I can now face the possibility of my family members being at risk—I am more aware of this possibility. I am more conscious of what I eat. When I was in denial, I didn't care

> what I ate. Now having diabetes is in the forefront of my mind and I care-I hope to better manage the diabetes.
>
> This program was the beginning of the road to good health. I too was in denial. I had a strong propensity of diabetes in my family. My mother dealt with it for many years and then because I wasn't taking a shot, I felt like I didn't have it. Currently I try to be more conscious of what I put in my mouth.

Others conveyed angry feelings about having diabetes, as expressed by a participant who was diagnosed with diabetes for several decades:

> I wasn't so much in denial but angry. I resented having the disease-it was a battle between me and the disease for control of me. I felt anger would overcome it. I could eat and do what I want and my furious anger would overcome it.

Participants stated the knowledge they acquired enabled them to become proactive in addressing their diabetes. The interactive workshops were crucial in changing behavior in that they were now exercising, losing weight, eating healthy meals, and generally feeling better due to adopting practices learned during the workshops. One person stated: "I now exercise, watch my diet and do glucose checks." Another participant said, "I learned how to control my diabetes, now it is controlled where it was not before the workshops. I was eating wrong foods, now I eat right foods. Now I know what I need to do and I am in control."

In addition, the workshops enabled some participants to adopt healthy behaviors to manage their diabetes while overcoming experiences with family members who had struggled with the disease. Witnessing family and friends developing diabetes related complications was especially difficult and assumptions were made that these complications were an inevitable aspect of having diabetes. The workshops were attributed for reducing the fear and sense of hopelessness associated with confronting these risks:

> The workshops made a difference. I can feel better now and I have tools to avoid complications. I have knowledge that makes a difference from my mother, who died of diabetes complications. The information from the workshops helped me find a balance. I have information and tools that my mother didn't for avoiding diabetes complications.

Promoting Diabetes Education Program

The capacity for each workshop was 20 people for a possible total of 80 participants. Participation was limited to individuals diagnosed with Type II Diabetes. Family members were not included due to space and resource limitations. However, Health Ministry recruitment efforts and the "kick-off" event produced only a total of 53 participants across the four churches. Each VOW minister announced the program "from the pulpit" and individually approached those congregants who might benefit from attending the diabetes education program. The Health Ministry chairpersons conducted follow-up phone calls to inquiries from the kick-off and from minister referrals. In addition, they recruited congregants from non-participating VOW churches. Recruitment efforts included letters and phone calls to Ministers of all community churches and community organizations, placing announcements in local newspapers, and flyers posted in churches and community businesses.

A number of non-sponsoring, smaller churches who were expected to refer members to the program failed to do so, despite the recruitment letters and follow-up calls. Small churches have a limited number of volunteers to manage the request of external phone inquires and correspondence, and the minister must prioritize the demands on his time. Successful health programs tend to be in medium sized churches with 200 or more members, with paid staff

and educated ministers (Thomas, Quinn, Billingsley, & Caldwell, 1994). It is also conceivable that some of the church ministers were not prepared to integrate a health program into the overall mission of their ministry.

The greatest challenge for the Health Ministries was recruiting participants beyond their own church congregants. Although the “kick-off” successfully attracted approximately 90 community-wide residents, Health Ministry chairpersons stated, during the focus group, that they were less successful in attracting participants outside their own congregants. During the planning phase, the ministries knowledgeable about neighboring churches identified strategies to conduct outreach to broaden recruitment at among the churches. It was agreed that ministers of sponsoring programs were best positioned to actively engage ACCUE ministers in understanding and promoting Health Ministry programs, yet it was difficult to engage non-participating ministers. It is probable there was deferential awareness among the ministers about the benefit of diabetes self management and could have been a factor non participation.

IMPLICATIONS FOR PRACTICE

Several elements converged to make the Faith Wellness Collaboration and its diabetes self-management program a success. Utilizing Community Based Participatory Research enabled the Health Ministry members to be in control of the Health Ministries development and the diabetes self-care program. The collaboration chose Type II Diabetes as the first program because it was a salient issue for its members and many reported that they, a family member, or a close friend was diagnosed with this chronic illness. They believed that it was pervasive among community residents and one that would ensure community-wide participation.

The commitment of ACCUE to sponsor this VOW project was essential. The chairperson of VOW, a minister who developed a Health Ministry within his church, was able to articulate his vision of the project and demonstrate the important role churches can have in improving the health of African Americans. He also realized and communicated the project’s ability to stimulate capacity building for establishing Health Ministries in ACCUE churches. The sustained support of the VOW chairperson is congruent with findings that emphasize the significance of gaining the minister support to ensure the success of health education programs (National Institute of Health, Heart, Lung and Blood Institutes, 1997; Saunders, 1997; Thomas et al., 1994). The program coordinator position was also essential in facilitating the project across sites, allowing for standardizing the program content. A recommendation for future community-wide programs was to include the task of coordinating with other churches and perform the follow-up communications in this position. The Health Ministry chair, a volunteer, was instrumental in fostering engagement of the Health Ministry volunteer members and church cooks, ensuring that the health program was considered viable, recruiting workshop attendees, and coordinating the diabetes program.

The collaboration purposefully created a social climate that supported all members in enlivening the vision, being solution-focused during organizational and cultural challenges, while simultaneously structuring Health Ministries and program coordination. A major organizational challenge was obtaining recognition for Health Ministry development and the health education program as priorities within active church programs. Church calendars are densely scheduled, which required the Health Ministries to allow at least a 6-month lead time and enlist the active support of the church minister to make the program a priority.

Central to establishing health promotion programs in Black Churches is respecting the spiritual culture infused in all activities. Collaboration meetings and program workshops

opened and closed with prayer, grace was said before meals, and diabetes self-management programs included spiritual discussion related to dealing with diabetes issues. The collaboration was cognizant of their approach that spiritual life and self-care are both important in maintaining health and coping with chronic illness. This message was pervasive in all programming. The selection of a physician minister to present at the "kick-off" event was decisive in setting this tone. The speaker challenged attendees to examine African Americans' over representation in chronic illnesses as being linked to traditional African-American meals at home and at church functions. He also promoted that spirituality includes a commitment to wellness by adopting health enhancing behaviors. His message was considered culturally appropriate and was effective in recruiting participants for the workshops.

The social work researchers in this study (one African American and one Caucasian) experienced culture as a dynamic learning process throughout the collaboration. The Caucasian researcher gained awareness of the economic diversity within the Black Churches, the intrinsic value of volunteerism operating in the churches, and differences in seemingly simple social structures. One such example was the collaboration meeting in the early evenings and the church hosting the meeting was expected to provide dinner. This was an unusual event for the Caucasian social worker who suggested easing the burden for the church by the meal being a "potluck." The African-American social worker explained that these churches preferred food prepared by the church volunteer cook, especially if the group was newly formed.

Both researchers' cultural awareness was expanded in their understanding of church hierarchy between the church leadership and the members. Effectively navigating and performing the appropriate protocol with each church were essential for assisting Health Ministry capacity development. The Health Ministries were generous in assisting the social workers to learn operating procedures that advanced the collaboration's agenda. These concerns were particularly evident in program planning and participant recruiting discussions causing us to respect the varying issues and processes that each church faced for disseminating information and making the education program attractive to their congregants.

We also came to realize the extensive social network operating beyond the collaboration members' individual church affiliation to members in other churches. This broad social support network enabled the Health Ministries to extend the health education program as a community-wide event that allowed participants to feel welcome to attend a missed session in any church.

We learned that communication was also culturally different than expected. Communication styles and information was often imparted as a reflection of participants' opinions rather than direct statements. For instance, a member did not state that there would be considerable resistance from participants in giving up many traditional foods when expressing his concern about the healthy eating component of the health education program. Instead he jokingly stated "It's going to be hard for me to give up my ribs!" Also, discussions at collaboration meetings and the health education program were especially interactive and often lengthy. The Caucasian social worker noted that the informed consent process was an interactive process where participants frequently conversed with each other and the researcher about each section rather than silently listening until all information was imparted. Consequently, the social workers learned to moderate their professional roles, interpret communications, and respect the collaboration members' knowledge and processes.

Social work practitioners can be successful when engaging communities with an openness to learn the values and norms of the individuals in which they are involved. In this situation,

the Black Church was an environment with established cultural norms and values that required culturally competent collaboration. One of the social work researchers was a member of the church and acted as a mentor to the social work researcher who was neither African American nor a church member. However, both social workers realized a need to be flexible in how they initially envisioned the delivery of the diabetes education program and the process for establishing the Health Ministries. Our commitment to community empowerment provided a foundation for listening, following the collaboration's natural process, and providing information on areas of expertise only when necessary. Social work expertise included identifying the contributions available from the ADA, the REACH model, identifying specific issues for capacity building, and conducting the case study. As social work researchers, we were also supported and educated by the collaboration members as we progressed through the stages of cultural sensitivity, cultural awareness to beginning understanding of what it requires to be involved in a culturally competent collaboration.

Cultural challenges for the collaboration included understanding how some ingrained traditions for preparing foods negatively impacted health. Researchers report that food and meal preparation, the selection of some food may reflect a group's conscious or unconscious endeavor to uphold traditions, or maintain group affiliation (Perkins & McCann, 1984). Among African Americans, the history of slavery and racial discrimination that contributed to poverty influenced limited access to quality foods. As a result African Americans are known to prepare "soul food"; which traditionally are fried foods and foods prepared with salt pork, which tends to be high in sodium and high in fat (Whitehead, 1992). Researchers are examining how cultural adaptation may be required to influence the African American tradition of consuming "soul food," which is known to contribute to chronic diseases (i.e., cardiovascular diseases, diabetes, and cancer) (Airhihenbuwa et al., 1996).

A number of factors advanced open discussion among collaboration members in planning the three healthy diet workshops. The presence of Health Ministry members who were health professionals influenced the collaboration in adopting the healthy eating curriculum, as did the inclusion of well-known community diet experts who engaged the church cooks. The donation of ADA Project Power program, African-American cookbooks and exercise books provided material resources.

One area that required more time than expected by the social work researchers was the collaboration's study of the curriculum, discussion of healthy eating, review and deciding specific workshop exercises, and delegating content within the workshop session to specific presenters. Coordinating guest expert speakers across all the workshops in the four churches proved to be more demanding than expected, specifically the number of calls required to successfully contact a health professional and follow-up reminder calls. Developing partnerships with healthcare and professional organizations was acknowledged as an area for improvement.

The limited referral from many of the non-participating church ministers indicated that the group had not identified the most effective recruitment plan. However, consistent workshop attendance was supported by several factors. Weekly reminder phone calls to participants were conducted by Health Ministry members, participants generally being church members or a close friend resulted in early group cohesion and also contributed to regular attendance.

It was an ambitious endeavor to create Health Ministries while also mounting a health education program in churches that did not have a history of doing either. The combination of collaboration with supportive leadership, Health Ministry chairpersons with health backgrounds, organizational expertise from the social work researchers, and ADA appropriate materials significantly advanced the establishment of Health Ministries and

provided successful diabetes self-care programs. However; the demands placed on the individual church Health Ministries was not inconsiderable. Their accomplishments were admirable. In summary, the Faith Wellness Collaboration demonstrated the successful partnership between an African-American faith-based community, university social work researchers and a regional ADA office to promote evidenced-based practices among a group experiencing a disproportionate incident of diabetes.

This study has several limitations that should be noted. First, it is a case study of four churches within one African-American community. It is unknown to what extent the practices employed would reflect community-based health program success in other community settings. Although we perceived openness and frankness in the focus group participants' responses, the study did not control for social desirability effects.

ACCUE is committed to sustaining the collaboration's efforts by further developing the Health Ministries' organizational infrastructure. ACCUE disseminated the program results to the ACCUE minister members, offering mentoring to establish a Health Ministry in additional churches. The VOW chairman is also actively consulting with ministers to establish a permanent annual budget in their church for sustaining Health Ministry programs. In addition, the VOW Committee conducted their strategic planning process, which included a goal for establishing Health Ministry programs, building on the collaboration's development, across ACCUE churches.

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