GEORGIA Rural Health INNOVATION CENTER AT MERCER UNIVERSITY SCHOOL OF MEDICINE

MERCER UNIVERSITY SCHOOL OF MEDICINE

Faith in Rural Health: A Collaborative Initiative for Holistic Community Health

MERCER UNIVERSITY SCHOOL OF THEOLOGY

MERCER UNIVERSITY COLLEGE OF HEALTH PROFESSIONS

Chris Scoggins, M.P.H.[1,3,4], Paul Byrd, M.Div., BCC[2] Brian Childs, M.Div., Ph.D., HEC-C[3], Gregory DeLoach, M.Div., D.Min.[2]

[1]Georgia Rural Health Innovation Center [2]Mercer University School of Theology [3]Mercer University School of Medicine [4]Mercer University College of Health Professions

INTRODUCTION

In rural communities, the success of health promotion programs depends heavily on trust and community buy-in. Strategies to increase program success in these environments vary in scope, approach, and effectiveness. One common approach is to engage influential and trusted community leaders. Typically, local clergy and health professionals are the most recognized members of this group. Nonetheless, coordination and cooperation between clergy and health professionals, and within the clergy, can be limited.

Collaborations between faith and health have a long and varied history (Levin, 2016). Research indicates that faith leaders have a good understanding of their congregation's needs and a great amount of influence with congregants (Baruth et. Al., 2015). This makes faith leaders a key component of generating strong community buy-in for health promotion activities. Researchers have also suggested that the faith community plays a crucial public health role in challenging times, bringing resources to bear in times of need (Gunderson & Cutts, 2021). Gunderson and Cutts (2021) have outlined the many assets faith communities have that are relevant in a health context. This frame of reference is important, viewing the faith community and its leaders as not simply an avenue for intervention but as a holistic community and societal resource.

Nationally, several programs have worked to strengthen relationships between faith leaders and health professionals. Most have been local or only focused on a single health challenge. The Faith in Rural Health program seeks to establish a network of local collaboratives that respond to community needs and priorities.

METHODS

The Georgia Rural Health Innovation Center, with Mercer University's School of Theology and School of Medicine have partnered to build a series of faith and health collaboratives in rural communities across the state. Over the course of the first year, 5 potential implementation sites will be selected in rural counties of south and central Georgia. Those communities will be thoroughly evaluated for assets and challenges with the intent to move forward with developing collaboratives in at least three counties. Through guided dialogue, health professionals and faith leaders will build trust, collectively decide on priorities, and commit to mutual action. These will materialize in community driven programs starting at the end of year one and into year two. Outcome measures for each individual program will be assessed as well as overall program outcomes. With several functioning collaboratives, an overarching "community of practice" can be established where information, strategies, and skills can be shared between groups state-wide.

Figure 2: "Faith in Rural Health" logic model.

CURRENT WORK

In March of 2022, the Faith in Rural Health program officially launched with the installation of a new program director. Work began on a concentrated planning and assessment period in which a strategic plan will be designed, communities will be identified, and key community stakeholders will be engaged. The initial target areas are shown in Figure 1. Following initial stakeholder meetings, community asset mapping and assessment will take place to determine the most appropriate areas to start with. Once completed, the program will then move into an implementation phase where collaboratives will meet and begin guided discussion. The involvement of medical and theology students is currently being explored as a way to expose students to rural inter-professional collaborations. The working logic model is presented in Figure 2.

DISCUSSION

Although in its initial stages, the potential of a statewide network of faith and health collaborative groups is great. As the program develops, it is important that the focus remain on community driven approaches, asset-based development, and shared decision making among partners. Careful consideration must be given to thorough and robust evaluation as the program is designed to be highly adaptive.

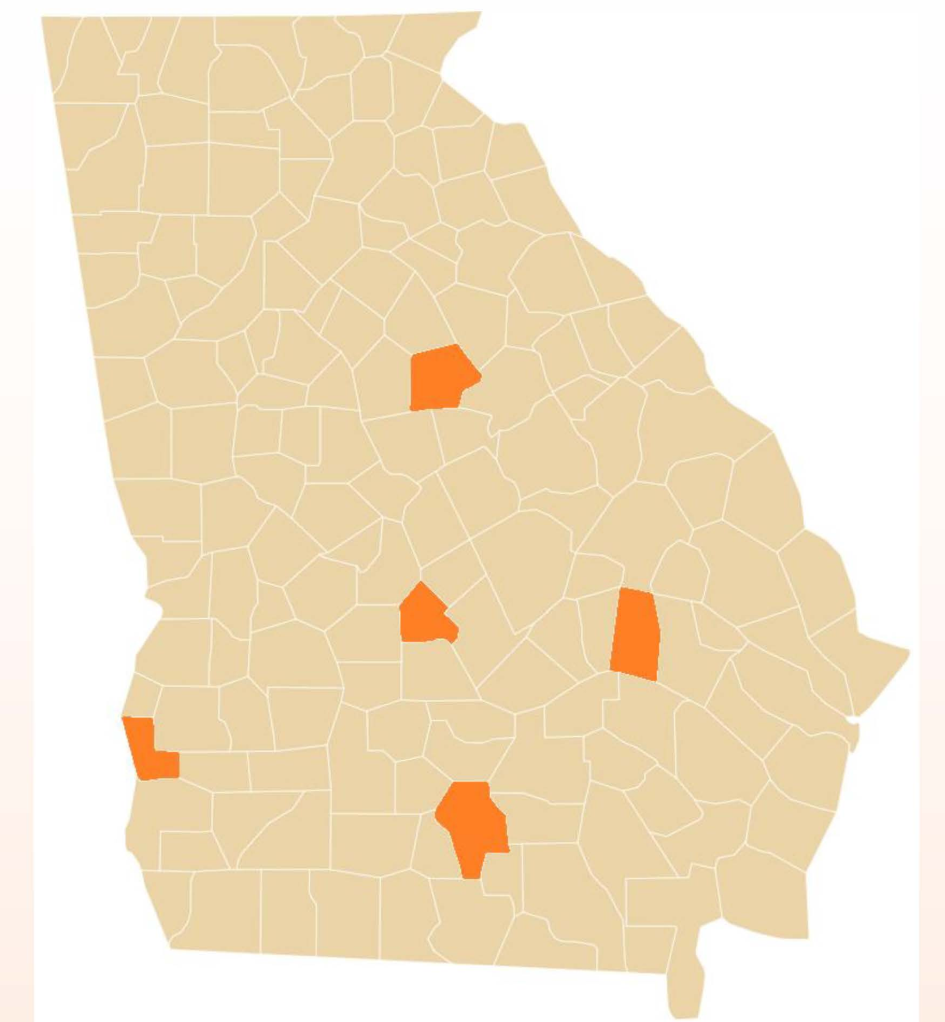

Figure 1: Current communities for assessment.

REFERENCES

1. Levin, J. (2016). Partnerships between the faith-based and medical sectors: Implications for preventive medicine and public health. Preventive medicine reports, 4, 344-350. DOI: http://dx.doi.org/10.1016/j.pmedr.2016.07.009
2. Baruth, M., Bopp, M., Webb, B.L. et al. (2015) The role and influence of faith leaders on health-related issues and programs in their congregation. J Relig Health 54, 1747–1759. https://doi.org/10.1007/s10943-014-9924-1
3. Gunderson, G., & Cutts, T. (2021). Faith Communities as a Social Immune System: Recommendations for COVID-19 Response and Recovery. Journal of Creative Communications, 16(2), 153–167. https://doi.org/10.1177/0973258620983352