Advances in Nursing Science
Vol. 32, No. 2, pp. E68–E80

Collective Knowledge Sharing as a Social Justice Strategy

The Difference It Made in a Service Project About Preterm Birth Disparity

Doris M. Boutain, PhD, RN

Knowledge about how health disparities are created and sustained from those affected is needed. Collective knowledge sharing is one way to redefine and revalue dialogue and critique processes with the aim of promoting just relationships of knowledge production. This article describes how a community service project focused on using collective knowledge sharing as a social justice strategy with health ministry volunteers produced insights about preterm birth disparity issues. Project insights related to (1) the connection between faith and health, (2) the significance of family and congregational stories, and (3) the importance of praising assets in the context of disparity recognition. **Key words:** *collective knowledge sharing*, *preterm birth disparity*, *service project*, *social justice*

Much time and energy has already been devoted to identifying the nature and extent of health disparities among racial and ethnic groups in the United States; however, still there remains a paucity of solutions and actions.

Gambescia et al[1(p534)]

THE above quote represents one of the most consistent assertions by health disparity scholars—more solutions and actions are needed to promote health equity. Particularly, in areas like preterm birth disparity, documentation has existed for decades about disparities in birth outcomes based on racial, income, and regional background.[2] Nonetheless, there remains more research documenting preterm birth disparity outcomes, antecedents, and correlates than focused on promoting birth equity as a social justice strategy. That is, descriptive research comprises the bulk of the extant literature on preterm birth.

A lens of social justice would encourage researchers to act while researching versus documenting health disparities as the primary research mode of action. Health disparities are differences in health status among socially underrepresented groups that remain unexplained even when known risk factors are taken into account.[3] Social justice, a focus on developing, implementing, and sustaining equity strategies in balancing burdens and benefits in society for the most vulnerable,[4] inspires research praxis that is relevant and novel. One way to anchor social justice in research praxis is to focus on collective knowledge sharing as a social justice strategy.

Collective knowledge sharing is different from the traditional understanding of research

Author Affiliation: *University of Washington School of Nursing, Department of Psychosocial & Community Health, Seattle, Washington.*

Funds from a 2006 March of Dimes Community Award supported project development, implementation, and evaluation. Research discussed during the project was based on a grant from the National Institute of Child Health and Human Development (HD41682). Appreciation is extended to the health ministry volunteers and congregations who participated in the project. Recognition is also given to Monvelia Blair, Joycelyn Thomas, Jenny Tsai, and Joseph Fletcher III. The project described here was originally presented at the 18th International Research Congress of the Honor Society of Nursing, Sigma Theta Tau International in Vienna, Austria.

Corresponding Author: *Doris M. Boutain, PhD, RN, University of Washington School of Nursing, Department of Psychosocial and Community Health, Box 357263, Seattle, WA 98195 (dboutain@u.washington.edu).*

dissemination in that it is dynamic. Many researchers, for example, disseminate results after research completion. The strategies of sending research reports, outlines, and briefs are the most common ways to share results with community members and policy makers.[5] These ways are viewed as needed, appropriate, and necessary because those approaches fit in the current paradigm of how to share knowledge. However, sending research reports rarely engages community members in a thoughtful discussion of how to frame scholarly issues, results, and subsequent actions. Gaining insights about health disparities, from the viewpoint of community members, may take us as researchers closer to translating knowledge into equity strategies,[5] and interrogating the mainstream scripts about health disparities that anchor research agendas that have not reduced or eliminated disparities thus far.

Often knowledge sharing is thought of as information giving or dissemination. Knowledge sharing is not typically viewed as information dialogue and critique (D&C) with community members experiencing or affected by health disparities. Using the work of Paulo Freire[6] anchors knowledge sharing contextually in relationships of power. This view is critical as we researchers attempt to counter disparity agendas by those in power who support and further ideologies of inequality.

Friere's work is known in Brazil as popular education, the education to the masses.[7] The uptake of that work in nursing, however, uses terminology like social change pedagogy, critical pedagogy, or social justice pedagogy. Unfortunately, Friere's original warning to problematize the use of his own theory out of context has not been done in nursing or the disciplines.[7] Promoting ways of sharing knowledge, therefore, that is not anchored in the everyday processes of how health disparities are created and sustained from those affected will do little to advance a health equity agenda. New models of gaining knowledge are needed.

Thus, in this article, the words *collective knowledge sharing* are used to highlight the purposive focus on promoting group dialogue, critique, and planned action. The purpose of this article is to describe how a community service project using collective knowledge sharing as a social justice strategy produced insights about preterm birth disparity issues. The article is about the process of using a collective knowledge sharing strategy versus the testing of a knowledge sharing intervention. This article describes how a project entitled "Health Ministry Volunteers Promote a Better Chance (ABC) for Healthy Babies, Healthy Families" was created with the input of 6 urban, faith-based congregations. This article describes the processes and outcomes of a collective knowledge sharing service project with a group of health ministry volunteers. The first section of the article describes the extant nursing literature on knowledge sharing. The second portion of the article summarizes the literature on health disparity work involving faith-based organizations. In the third section of the article, the community service project is described. After project insights are summarized, the article is concluded with implications and a summary.

COLLECTIVE KNOWLEDGE SHARING AND HEALTH DISPARITY RESEARCH

In health disparity research, most knowledge sharing activities occur in the context of funded sessions, conferences, forums, and summits.[1] This approach to knowledge sharing can be thought of as information exchanges to codify, formalize, and legitimate health disparity knowledge—and, in turn, promote the producers of that knowledge. These venues do much to further the dialogue of health disparities among researchers and academicians but little to advance collective knowledge sharing among community residents most likely to have or be affected by health disparities firsthand.

There is a role for collective knowledge sharing with community members. *Collective knowledge sharing* can be defined as the process to interrupt, redefine, and revalue the process of D&C with the aim of promoting just relationships of knowledge production.

For example, primacy is not given solely to obtaining content. The process and context of knowledge development is also a focus. Consonant with Freire's[6,7] approach, collective knowledge sharing focuses on group versus individual knowing and critique. It attempts to link knowledge with social change actions. It is assumed that actions will occur in popular sectors of society—beyond academia.[6,7]

However, this view of collective knowledge sharing is rarely described as such in the discourses on health disparity in the nursing literature. For example, a 2008 database search in the Cumulative Index to Nursing and Allied Health Literature (CINAHL) using the words *health disparity* and *knowledge sharing*, and *health disparity* and *dissemination,* as major subject search terms revealed only 3 published articles.[1,8,9] Two articles described ways of involving community members in knowledge generation and dissemination about health disparities,[1,8] while the other article recommended dissemination as a needed strategy.[9]

After changing the major subject search terms to *health disparity* and *education*, 20 articles were retrieved, with only 1 duplicate article from the other search.[1] There was only 1 article out of the 20 that focused on knowledge sharing as a health disparity intervention strategy, and this work was conducted outside of the United States in Canada.[10] The foci of the other articles varied.

Most research articles focused on studying correlates of education with health disparities,[11–16] and measuring disparity.[17,18] The next largest group of articles discussed individual patient education,[19–21] or advocating for patient and community action.[22] Other articles described the need for professional education, with a focus on nursing education,[23] providing recommendations for public health education,[24–26] and promoting researcher and practitioner education.[27] Only 1 article promoted educational mobility as a way to reduce disparities in health.[28] A review of the extant literature in CINAHL reveals that knowledge sharing is more akin to information distribution (as in patient education) or teaching (as in professional education) than it is to D&C. The next section describes how health ministry volunteers were involved in health disparity work; the specific focus is on how knowledge sharing was conceived in faith-based projects.

HEALTH MINISTRY VOLUNTEERS, HEALTH DISPARITY RESEARCH, AND KNOWLEDGE SHARING

In the late 1990s, the United States faith-based movement encouraged faith organizations to promote health disparity awareness, especially among populations most at risk for those disparities.[29] Although definitions of faith-based organizations vary depending upon governmental regulations,[30] faith-based organizations "engage in spiritual and/or social intervention activities based on religious beliefs and values of a faith and spiritual tradition for transformative purposes."[31(p484)] The word transformation represents the quality of the spiritual and/or social well-being change, which results from faith-based organizational participation.[31] However, the implied transformative quality of participation is nearly absent in most faith-focused approaches to health dialogue and intervention.

Health ministry volunteers are often enlisted in research because of their role focus on health within their faith-based organizations, or their instrumental role in offering social support.[32] Health ministry volunteers are persons formally assigned to promote congregational health. The term health ministry volunteer is thought to be a more inclusive term than parish nurse because parish nurses are often nurses who are health volunteers within the Catholic Church. Health ministry volunteers may not have any formal training or professional background in a health-related field.

A review of published reports from 1990 to 2000 indicated that about 43% of faith and health programs were developed by health professionals and focused on the secular aspects of health in terms of health screenings, interventions, and disease education.[33] Projects that utilized faith organizations with a primary focus on enrollment such as in

participant recruitment in research projects were not viewed as faith and health projects.[33] Few health projects overall integrated the dual faith- and health-focused missions of a health ministry to support congregational health dialogues and actions.[33,34] Much needed are projects that engage faith congregations and facilitate health disparity dialogue, critique, and action based on their congregational strengths. Below is a description of one community service project with the aim of promoting D&C projects developed by health ministry volunteers.

HEALTH MINISTRY VOLUNTEERS PROMOTE A BETTER CHANCE FOR HEALTHY BABIES, HEALTHY FAMILIES: A BRIEF PROJECT DESCRIPTION

Project context

The regional presence of preterm birth disproportionately among African American families anchored the project focus on that population group. The project intent was to reach congregations (1) serving 70% to 100% of African American families and (2) located in a county region with a high incidence of preterm birth (infant mortality rate of 6.69 per 1000 births in the county health planning area compared with 4.79 per 1000 births in the entire county). The state is known as one of the least churched places in the nation and by popular survey only 42% say someone in their household is affiliated with a place of religion.[35] Nonetheless, church attendance at least once a month was reported by ministry volunteers to be near 70% for African Americans as a population group, which is consistent with one study.[36] Given that church is known to be a social and religious institution for African Americans,[36] church attendance itself did not represent project reach given that programs can, and did, occur on other days.

Twenty-five faith organizations were queried as to (1) their interest in having preterm birth disparity D&C sessions, (2) their congregational service area and population, (3) the current presence of a health ministry, and (4) their availability to work together for a 1-year period. Before funding, 6 churches committed to the project and offered advice for grant application development. The purpose of the community service project was to promote preterm birth disparity D&C sessions with a group of health ministry volunteers and then equip those volunteers to develop activities for D&C within their congregations.

Project coleaders

Twelve persons, referred hereafter as health ministry volunteers, were viewed as coleaders of the process and outcomes. Two health ministry volunteers participated from 6 different congregations. Health ministry volunteers were from Baptist ($n = 2$), Missionary Baptist ($n = 2$), Catholic ($n = 1$), and Methodist ($n = 1$) faith denominations. Health ministry volunteers were not paid monetarily for their involvement in their ministry. All 12 persons were invited for dialogue in a series of sessions about preterm birth. Having 2 volunteers from each congregation facilitated team building for project sustainability and ensured that more than 1 person could share knowledge within their larger health ministry or congregation.

All health ministry volunteers were women and had 2 to 20 years of membership in their congregations. Most health ministry volunteers were current chairs ($n = 4$) or past chairs ($n = 1$) of a nurse's guild or health ministry. These women were asked to join their health ministries because of their interest in health, willingness to serve, or background in healthcare. Most (8 of the 12) health ministry volunteers were recruited into health ministry work because of their willingness to serve. The notion that some persons were willing to serve relates to the research concept of natural helpers as observed in other community projects.[32]

Project funding

Funding was provided on multiple levels. Individual health ministry volunteers received a $100 incentive for each D&C session attended. This amount was suggested as

Table 1. Potential health ministry dialogue and critique projects

Health ministry project	General information distribution ($100)	Targeted information distribution ($300)	Targeted information dialogue and critique ($500)
Audience	General Focused on the entire congregation	Targeted Focused only on those interested in the topic of healthy babies and healthy families	Targeted Focused on women and families who had a baby in the last 2 y, are pregnant now, or wish to have a baby Couples contemplating pregnancy
Format examples	Creative poster display Engaging congregational announcement Informational mailing to the general congregation	Health hour 30 min–1 h Coffee/health break session	Small group discussion for more than 1 h Ask women and families what will promote them to have a healthy baby and family now or in the future Inquire about what members would like from the health ministry
Message content	Distribute appropriate ready-made materials Inform the congregation about resources available from the health ministry for promoting healthy babies and families	Show appropriate ready-made materials Discuss how to promote a healthy pregnancy, risk factors for prematurity, and community resources for healthy babies and families	Ask the members about their questions and concerns Discuss the educational and referral resources available from the health ministry Discuss appropriate ready-made materials

appropriate by 2 potential participants during grant application development. The amount was needed to reimburse volunteers for transportation and childcare expenses. In addition, the incentives allowed for the purchase of learning materials useful in furthering their knowledge about preterm birth disparity, or faith and health project work. Outside facilitators were reimbursed at agreed-upon rates congruent with their level of participation, ranging from $150 to $400 per session.

The health ministries in which the volunteers were members accrued $100, $300, or $500 for the implementation and evaluation of 1 health D&C project tailored to their congregation. Different project types were developed to allow for a diversity of participation and the different capacities of health ministries to complete a project (see Table 1 for examples). The project amounts depended on the project focus and type. A distinction was made between providing information (general information distribution) and engaging in targeted D&C about preterm birth disparity (targeted information D&C).

The project focus and type was determined by the health ministry pairs in consultation with project facilitators, and their congregational members, health ministry group, and pastors.

Table 2. Overview of sessions

Session	Topics	Formats
1	Project introduction	Facilitators' presentation
	Introduction of health ministry volunteers	Group dialogue and critique
	Preterm birth disparity: Trends and issues	
	The social determinants of preterm birth	
2	Health ministry work: Strengths, purposes, activities, sustainability issues	Facilitators' presentation Audiotape listening
	Secular and sacred approaches to health	Group dialogue and critique
3	Congregational strengths and action steps	Health ministry presentations Group dialogue and critique
4	Project discussion: Insights and challenges	Health ministry presentations Group dialogue and critique

D&C format

Knowledge sharing for this community service project focused on dialogue, critique, and planned action. Sessions are called D&C sessions for the remainder of this article. Four 2-hour D&C sessions, spaced 1 to 2 months apart, were held within a 1-year period. An overview of each session is outlined in Table 2.

Sessions were 2 hours in length and occurred at a location central to the participating congregations. All D&C sessions were held on Friday evenings as a group preference. At least 2 facilitators were in attendance at all sessions. One facilitator arranged the meetings, developed the agendas, and ensured a balance between dialogue and critique of information discussed. The other facilitator developed the first overview session focused on preterm birth disparity, promoted D&C discussions, and wrote meeting notes. Both facilitators handled meeting logistics, such as setup and cleanup. One to 2 team or telephone conference meetings also occurred with each health ministry volunteer pair.

D&C session 1introduced the project, health ministry volunteers, and the topic of preterm birth disparity. A brief survey was given to inquire about the stage of readiness for change related to a ministry focus on healthy babies and families. Using the Stages of Change Model[37] of precontemplation, contemplation, preparation, action, and maintenance, the health ministry pairs were polled. Then an overview of preterm birth trends, preterm birth disparity, and social determinants of preterm birth was given. The group members had an opportunity to discuss and critique the knowledge shared as well as offer their own insights about the issue of preterm birth.

D&C session 2 focused on each health ministry's strength, purpose and possible D&C activities to be done within their congregations. The goal of session 2 was to assess the health and spiritual focus of each health ministry. It was important to discuss how D&C activities would fit each congregation's strengths and missions. The framework of congregational strengths developed by Chase-Ziolek[38] was shared in the session, adopted by health ministry volunteers, and used by volunteers to guide the process (Table 3). The related ideas were developed by the author.

D&C session 3 was requested by 1 health ministry volunteer and agreed upon by the majority of the group. Session 3 applied the lessons learned from session 2 with a focus on additional D&C. For example, each health ministry pair discussed their congregational strengths, possible related activities, and a sustainability plan. The information presented in prior D&C sessions was critiqued in terms of its applicability and appropriateness

Table 3. Using congregational strengths to design projects

Congregational strengths[38]	Strength description[38]	Where or how dialogue and critique sessions can occur
Strength to accompany	To be in relationship with others	Sharing can occur with • support groups • visitation groups
Strength to connect	To link others to assets, power, and knowledge	Resources can be made available at a • life and health resource area or station
Strength to tell stories	To communicate images, values, and culture through communal stories	Sharing can occur with • listening groups • telephone discussion groups
Strength to give sanctuary	To have a physical space to gather	Sharing can occur in • designated spaces/places
Strength to bless	To use words of love, acts of welcome, and walk with those who are hurting	Sharing can occur by • being present and giving supportive information or notes
Strength to pray	To regularly share concerns and burdens while drawing upon God's resources	Sharing can occur in • groups for spiritual and physical health
Strength to endure	To last the test of time by engaging members across generations.	Sharing can occur in • intergenerational health sharing groups

to the different congregations. Handouts were shared as the group members problem solved concerns and applauded each other's efforts.

D&C session 4 celebrated the preterm birth disparity projects that the health ministry volunteers created with their congregations during the year. Four health ministries selected to do a general information distribution project (Table 4). Two health ministries decided to do a targeted information D&C project (Table 5). All projects are summarized below. During session 4, 5 health ministry pairs presented what they had done to promote preterm birth awareness, dialogue, or critique in their respective congregations. One project was presented by the facilitator because the ministry volunteers were no longer available to speak about the project (Table 4, project 2). The insights and challenges were also noted.

A preterm birth disparity display was developed by the author to help the group members consider how simple displays could work or be tailored to their own congregations in the future. Displays were discussed in a prior D&C session as an effective way to get the attention of congregation members who congregated in the hallways or gathering rooms.

In addition to the 4 D&C sessions, small group meetings occurred with health ministry pairs ($n = 3$) or telephone consultations were offered ($n = 26$) to help brainstorm ideas throughout the year. Small group meetings occurred at restaurants near the volunteers' homes or congregations. Telephone consultations occurred primarily at night because some participants had regular daytime employment or commitments.

Project summary and outcomes

Health ministry volunteers devised preterm birth D&C projects on the basis of their congregational strengths and resources. Table 1 shows the different project types possible. Health ministry volunteers were asked to focus on preterm birth disparity

Table 4. Summary of general distribution projects

Project	Strengths shown	Project description	Project context and insights
1	Strength to connect Strength to bless	Welcome! New Births Focused on assisting 2 families who had an early birth and were in need of financial assistance as identified by the pastor. All funds were given to those families. A congregational bulletin board and public announcement to ~80 people was also made about preterm birth	As a missionary church, a focus was to provide tangible resources to the needy as a blessing from God. This congregation was anchored in the belief that God's love is shown through love for each other. The health ministry was composed of 2 retired women who completed the project in the midst of personal health and family concerns. Diverse project types offered the opportunity to envision a tangible, manageable, and needed project
2	Strength to connect	Preterm Birth Information Available A fact card insert about preterm birth as a national crisis was in the Sunday program. Other brochures and informational resources were on a table for viewing by the general congregation. A Sunday announcement was also made to the congregation (N =~150) about preterm birth	Although the health ministry attendance was from 6 to 8 members monthly, 2 members agreed to champion the project. One member stopped attending ministry meetings and the other relocated to another state. The ability to do different project types allowed the other ministry volunteers to complete the project. The church theme of the year when the project occurred was to "serve well with authority." Information from authoritative sources was valued. The church welcomed predeveloped handouts and resources from reputable healthcare or volunteer agencies
3	Strength to tell stories Strength to bless	Presentation about Preterm Birth A speaker described preterm birth trends and a personal account of having a baby born too soon to ~80 people. Gift certificates were provided to new parents	The information about preterm birth was given by a mother who had a recent preterm birth. The presentation was given on a Saturday during an in-house workshop sponsored by the church for the entire congregation. Nesting the presentation within an existing structure ensured that key church leaders would hear the information
4	Strength to tell stories	Preterm Awareness Announcement A congregational announcement to ~200 people was made about preterm birth. An information table was also created for congregational review	"While tremendous advances have been made in caring for babies born too small or too soon, we need to find out how to prevent these tragedies from happening in the first place." The preceeding sentence was the opening to the preterm birth awareness month announcement to the general congregation. It was thought that because preterm birth influences so many people in the immediate and extended families, this message needed to be heard by each person in the congregation

Table 5. Summary of targeted information dialogue and critique projects

Project	Strengths shown	Project description	Project context and insights
4	Strength to connect Strength to tell stories Strength to give sanctuary	Promoting the Health of Babies and Families Held a Saturday lunchtime session (10 AM–1 PM) in the church hall to focus on the health of babies and families. Invited parents and grandparents. Approximately 20 persons were in attendance	The health ministry ($N = 5$–8) had free access to a large gathering hall and was known to have engaging speakers Preterm birth knowledge sharing was nested in discussions about family health and the challenges of parenting. Parents were defined as biological or adopted parents and grandparents. Grandparents were included as it was learned that they were the most likely group to provide tangible support to families with a preterm infant There was a section entitled "Testimony" whereby parents or former preterm birth children could share their story. A postsession questionnaire about preterm birth facts was also created to engage the group. On one of the returned questionnaires, someone wrote: "It takes a whole community to raise a child/help with premature births."
5	Strength to connect Strength to tell stories Strength to give sanctuary	Healthy Mothers and Healthy Babies Developed a Saturday session (10 AM–2 PM) focused on healthy mothers and healthy babies. Twenty adults and 6 children were in attendance	The health ministry ($n = 5$–8) had several healthcare providers as members and had free access to a large gathering hall Saturday was selected as a day to attract parents, friends of parents, and children. Knowledge sharing was described as a workshop. The first workshop topic was parenting and practical solutions for positive discipline. Preterm birth discussions were weaved into the second workshop segment on How To's for a Healthy Pregnancy. Parents and friends of parents were invited. The workshop term helped the audience know that they would gain useful information. Children were welcomed to play in the gathering hall while the discussion occurred

issues and tailor awareness activities to their congregational strengths. Refer to Table 3 for a list of congregational strengths and ideas and to Tables 4 and 5 for a summary of the completed projects. Allowing for congregational tailoring and flexibility is known to promote health dialogue and project success.[32] The opportunity to share, dialogue about, and critique knowledge to further the thinking of the entire group was seen as the major benefit of this project because it advanced collective thought.

Each congregation adapted a project framework that was consistent with its mission , and health ministry capacity. Health ministry projects promoted collective storytelling, visual awareness of the challenges of a preterm infant, and health information dissemination. Prior to this project, all participating health ministries had never developed a congregational ministry project focused on the health of babies and families. Ministry volunteers described their health ministry at the precontemplation stage of readiness in session 1.[37] This means, they did not have any data about prematurity, had not systematically assessed their congregational needs in that area, and had not developed a project focused on this topic area in the last 2 years. Prior projects focused on health screenings (eg, for high blood pressure, cholesterol) and information distribution (such as in health fairs via booths or pamphlet distribution during meetings). Several health ministry groups wanted more local ministry social support ($n = 5$), technical computer support ($n = 3$), and funding ($n = 5$).

The newest of this project was also evident with the funding agency. This was the first time the granting agency funded an application involving health ministry volunteers as active participants in developing projects focused on preterm birth disparity. Prior funded community projects involved healthcare agencies or institutions as project leaders and coleaders. Several project insights were gleaned during the course of this knowledge sharing experience.

PROJECT INSIGHTS

The connectedness of faith works and health works

Health ministry volunteers readily made the connection between faith and health. Most noted that it was balancing the connection between faith and health that inspired them to be of service in their congregation. For example, without health, the work of faith cannot go forth as desired, and without faith, health cannot be fully obtained. That is because health was viewed holistically as spiritual, physical, mental, and communal in nature. Faith could not be separated in discussions about health ministry work as it was integral to the mission of the congregation—to promote faith. At the same time, health ensures that health ministry workers and congregations are able to participate in doing faith works fully.

The connection between family and congregational stories

Several of the projects developed by health ministry volunteers showed the significance and connectedness between the family and congregational story of preterm birth (Table 5). Similar to not knowing about the high rates of preterm birth in their region, health ministry volunteers did not readily know how many persons in their congregation were affected by preterm birth. It was through their devised projects that they met congregational members who had preterm births and learned how that disparity impacted marriages, families, and grandparents. At the same time, the disparity also affected health ministry groups as vacant volunteer seats highlighted the "missing persons" among them but not the rationale. For example, there was low attendance at meetings and events. Low attendance results in a diminished capacity to do faith works. Preterm birth stories, which were not a focus of the health ministries until this project, tended to be told by mothers, fathers, and grandparents who remained at home or in the hospital to care for babies.

This revelation is particularly important as it indicates that population disparities can be hidden from congregations affected by them (through the absence of human resources, for example) if there is not focused attention on surveying the issue.

The importance of praising assets while ruefully accepting disparity

Health ministry volunteers were artful with praising parents and families for their faith while caring for preterm babies. At one session, for example, a mother of a preterm baby spoke to a segment of the congregation on a Saturday morning describing her preterm birth experiences and what it meant for her that the health ministry promoted knowledge sharing about preterm birth (Table 4, project 3). The speaker had the ability to acknowledge her faith and accept the work of preterm motherhood while simultaneously speaking for full infant development. The audience applauded her loudly and some wept with her as she spoke about the need for all babies to have 9 months of intrauterine development. The balance between positive praise and disparity recognition helped keep the tone of announcement focused on actions for change.

Project implications

Highlighted below are the major implications of the knowledge-sharing project using D&C sessions with health ministry volunteers:

- There is a need for a hybrid focus on faith and health when researchers engage with health ministry volunteers. For example, health ministry volunteers wanted information about health conditions as well as methods to promote holistic health, spiritual growth, and health ministry development.
- The human capacity of the health ministry may itself be diminished by health disparities as the ministry works to promote health disparity knowledge and prevention. Volunteers may become overtaxed as promoters of health equity, for example, as they care for themselves, their families, or their kin affected by health disparities. Also, even with 2 volunteers, both may become unavailable to complete the project for other reasons as well (Table 4, project 2).
- The acceptance of D&C sessions among health ministry volunteers will depend on the willingness of all parties to respect different faith and health traditions. During project development, the author was questioned about her own viewpoints on faith, on healing, and on health before several health ministry volunteers agreed to be involved. Several Christian groups did not wish to participate in a project that involved other faith traditions.
- Prior research suggests that the religion and health connection may be stronger for avoiding negative health behaviors than for promoting positive health behaviors.[36] This may be related to how researchers approach congregational health, with a disease or deficit model focus. This project focused on the close connection between faith and health as a preventive approach and a way to critique the information available on preterm birth disparity.

SUMMARY

Research and educational institutions continue to be puzzled about how best to dialogue and critique disparity topics with people who are affected significantly by those disparities. Focused approaches to health disparity discussions are needed if the researchers are to complexly understand the processes of how health disparities occur and repattern themselves despite intervention. New approaches are needed that can conjoint research efforts. Promoting collective knowledge development is critical to understanding context relevant concerns about health disparities as research is being

developed. Health ministries can engage in dialogue and critique of disparities knowledge and share those insights with others.

Collective knowledge sharing projects can be effectively developed and received if they are based on the missionary values of a congregation. Health ministry volunteers utilized their personal strengths in the context of the strengths of their health ministry and congregation. Knowledge sharing involved dialogue, critique, and actions because the projects were tailored to congregational strengths and missionary values. This article provides one example of how collective knowledge sharing can occur with health ministry volunteers using a model. Insights from this community service project can be useful to other health disparity researchers.

REFERENCES

1. Gambescia S, Woodhouse L, Auld M, Green B, Quinn S, Airhihenbuwa C. Framing a transdisciplinary research agenda in health education to address health disparities and social inequalities: a road map for SOPHE action. *Health Educ Behav*. 2006;33:531–537.
2. Krieger N, Rowley D, Herman A, Avery B, Phillips M. Racism, sexism, and social class: implications for studies of health, disease, and well-being. *Am J Prev Med*. 1993;9(suppl 6):82–122.
3. Braveman P. Health disparities and health equity: concepts and measurement. *Ann Rev Public Health*. 2006;27:167–194.
4. Boutain D. Social justice in nursing: a review of the literature. In: de Chesnay M, ed. *Caring for the Vulnerable*. 2nd ed. Sudbury, MA: Jones and Bartlett; 2008:39–52.
5. Fullilove MT, Green L, Hernandez-Cordero LJ, Fullilove R. Obvious and not-so-obvious strategies to disseminate research. *Health Promot Pract*. 2006;7(3):306–311.
6. Freire P. *Pedagogy of the Oppressed*. New York: Continuum; 1987.
7. Choules K. Social change education: context matters. *Adult Educ Q*. 2007;57(2):159–176.
8. Jackson F. Rural health and women of color. Considerations for community-based research with African American women. *J Public Health*. 2002;92(4):561–564.
9. Zucker D. A case of health disparity: treatment issues with women with hepatitis C. *Gastroenterol Nurs*. 2006;29(2):137–141.
10. Lemstra M, Neudorf C, Beaudin G. Health disparity knowledge and support for intervention in Saskatoon. *Can J Public Health*. 2007;98(6):484–488.
11. Hart J. Improved health correlated with ratio of chiropractors in Mississippi River states. *J Vertebral Subluxation Res*. 2007;5:1–10.
12. Harder VS, Chilcoat HD. Cocaine use and educational achievement: understanding a changing association over the past 2 decades. *Am J Public Health*. 2007;97(10):1790–1793.
13. Kennedy BM, Paeratakul S, Ryan DH, Bray GA. Socioeconomic status and health disparity in the United States. *J Hum Behav Soc Environ*. 2007;15(2/3):13–23.
14. Kim S, Symons M, Popkin BM. Contrasting socioeconomic profiles related to healthier lifestyles in China and the United States. *Am J Epidemiol*. 2004;159(2):184–191.
15. Walsemann K, Geronimus A, Gee G. Accumulating disadvantage over the life course: evidence from a longitudinal study investigating the relationship between educational advantage in youth and health in middle age. *Res Aging*. 2008;30(2):169–199.
16. Roth R, Barsi E. The community need index: a new tool pinpoints health care disparities in communities throughout the nation. *Health Prog*. 2005;86(4):32–38.
17. Dye BA, Hayes KL, Vargas CM. Oral health status of rural adults in the United States. *J Am Dent Assoc*. 2002;133(12):1672–1681.
18. Pearcy JN, Keppel KG. A summary measure of health disparity. *Public Health Rep*. 2002;117(3):273–280.
19. Carol R. Taking the initiative: by breaking down cultural barriers to health care and providing preventive education, nurses of color are helping to close minority health disparity gaps one patient at a time. *Minor Nurse*. 2001:24–27.
20. Peek ME, Cargill A, Huang ES. Diabetes health disparities: a systematic review of health care interventions. *Med Care Res Rev*. 2007;64(5)(suppl):101S–156S.
21. Treaster C, Hawley SR, Paschal AM, Molgaard CA, St Romain T. Addressing health disparities in highly specialized minority populations: case study of Mexican Mennonite farmworkers. *J Community Health*. 2006;31(2):113–122.
22. Neighbors HW, Braithwaite RL, Thompson E. Health promotion and African-Americans: from personal empowerment to community action. *Am J Health Promot*. 1995;9(4):281–287.
23. Boutain D. Social justice as a framework for professional nursing. *J Nurs Educ*. 2005;44(9):404–408.
24. Airhihenbuwa CO. Message from the immediate past president of SOPHE. Inaugural SOPHE Summit on

eliminating health disparity. *Health Educ Behav*. 2006;33(4):433–436.
25. Ai AL, Carrigan LT. Social-strata-related cardiovascular health disparity and comorbidity in an aging society: implications for professional care. *Health Soc Work*. 2007;32(2):97–105.
26. Thomas SB, Benjamin GC, Almario D, Lathan MJ. Historical and current policy efforts to eliminate racial and ethnic health disparities in the United States: future opportunities for public health education research. *Health Promot Pract*. 2006;7(3):324–330.
27. Woodhouse LD. Thematic analysis of documents from the SOPHE Health Disparity Elimination Research Agenda Summit: illuminating competencies for future researchers and practitioners. *Health Promot Pract*. 2006;7(3):346–353.
28. Oscos-Sanchez M, Oscos-Flores L, Burge S. The Teen Medical Academy: using academic enhancement and instructional enrichment to address ethnic disparities in the American healthcare workforce. *J Adolesc Health*. 2008;42(3):284–293.
29. Centers for Disease Control and Prevention. *Engaging Faith Communities as Partners in Improving Community Health*. Altanta, GA: Centers for Disease Control and Prevention; 1999.
30. Blazak J. *Tax Planning and Compliance for Tax-exempt Organizations: Forms, Checklists, Procedures.* 3rd ed. New York: Wiley; 1999.
31. Harden M. Towards a faith-based program theory: a reconceptualization of program theory. *Eval Rev*. 2006;30(4):481–504.
32. Lisovicz N, Johnson R, Higginbotham J, et al. The deep south network for cancer control: building a community infrastructure to reduce cancer health disparities. *Am Cancer Society*. 2006;107(8)(suppl):1971–1979.
33. DeHaven M, Hunter I, Wilder L, Walton J, Berry J. Health programs in faith-based organizations: are they effective? *Am J Public Health*. 2004;94(6):1030–1036.
34. Briscoe V, Pichert J. Promoting utilization of health care services through the African American church. *ABNF J*. 1996;7(5):129–132.
35. Grossman C. "Amen" to a church-free lifestyle. *USA Today*. 2002. http://www.usatoday.com/life/2002/2002-03-07-church-free.htm. Accessed January 28, 2009.
36. Gonnerman M, Lutz G, Yehieli M, Meisinger B. Religion and health connection: a study of African American, Protestant Christians. *J Health Care Poor Underserved*. 2008;19(1):193–199.
37. Prochaska J, Clemente C. Stages and processes of self-change in smoking: towards an integrative model of change. *J Consult Clin Psychol*. 1983;5:390–395.
38. Chase-Ziolek M. *Health, Healing and Wholeness: Engaging Congregations in Ministries of Health*. Cleveland: The Pilgrim Press; 2005.