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Using Cross-Cultural Collaboration to Establish a Working Coalition for An Equitable COVID-19 Vaccine Program

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Abstract

Coalitions and collaborations with African Americans in the United States are often between people with equal humanity but unequal power. Endeavors between historically harmed communities and representatives of systems that continue to harm them frequently lead to intentional and unintentional miscommunication, mistrust, and distrust. The causes for health inequity are complex and should include consideration of systemic racism. In most standard public health models, departments typically take the lead and invite select members of the community to help. This article describes a collaboration that took place in Marin City, California, between

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African American churches, the department of public health, and community-based organizations during the COVID-19 pandemic. This example focuses on the value of African American history and cosmology as a foundation for respectful cross-cultural collaboration in implementing a COVID-19 vaccination effort. A cross-cultural collaborative model was developed for use by this coalition to guide the development and implementation of community response teams. Unique and shared responsibilities provided by the coalition partners are examined. Humanistic principles, including empathy, positive regard, trust, and grace, are held as central to the model when planning, implementing, and evaluating activities undertaken by cross-cultural coalitions. Sustainability issues are considered concerning staffing, funding, and public policy.

Keywords
cross-cultural collaboration, African American cosmology, public health, COVID-19, health equity, trust, grace

Health and economic disparities have been documented among marginalized groups worldwide, including the United States. In the United States, the African American community has consistently and historically been identified as having pronounced disparities on many health indices (Centers for Disease Control and Prevention [CDC], 2017) and underutilization of health resources (Suite et al., 2007). These discrepancies have also been evident and documented in COVID-19 prevention and treatment endeavors. To elucidate these findings, this article describes the development of a cross-cultural collaborative COVID-19 coalition in the African American Community of Marin City in Marin County, California. This cross-cultural collaboration, referred to as "Community Response Teams (CRT)," included the county public health department and a wide range of community and faith community organizations in Marin City. Marin City has historically served as a haven for African Americans in Marin County. An existing consensus among the leadership of the public health department and community leaders was that Marin City needed additional economic and public health assistance.

It is well established that the African American community is deeply religious (Lacy et al., 2021). This is a tradition that will likely be carried on for the foreseeable future (Saghal & Smith, 2009), as the African American community has historically turned to their faith as a source of support and comfort (DeSouza et al., 2021; Lacy et al., 2021). This level of religiosity and

spirituality found among African Americans is not typically paralleled in communities of empowered people (Sullivan et al., 2014). The socioeconomic indicators of disadvantaged Marin City relative to the surrounding high status of the rest of the county have led to a great degree of misunderstanding and mutual suspicion resulting in mistrust, distrust, and frustration (Lacy et al., 2021; Suite et al., 2007; Sullivan et al., 2014).

It was evident that effective processes needed to be developed and implemented to engender trust and reduce distrust to ensure equitable treatment of disease. In particular, this work was needed to promote COVID-19 vaccine access and to quell misinformation, conspiracy theories, and lingering doubts about the safety and utility of immunizations. It was recognized that to effect sustainable community-wide progress, a shift needed to occur that moved from narrowly focusing on a few specific health outcomes to a collaborative model that included the support of enduring community partnerships.

This article provides a case example of a collaborative approach established in Marin County. The aim of this example is to describe the challenges and successes in forming a working community partnership, referred to as the Southern Marin Community Response Team (Southern Marin CRT or SM CRT) to promote health and reduce disease (in this case, COVID-19) through the implementation of a vaccination education and outreach program in an underserved community. The benefits and barriers to maintaining newly established collaborative partnerships are examined. Although the goal of increasing COVID-19 vaccination rates in Marin City was shared by the three collaborative partners (i.e., the public health department, local churches, and the Southern Marin CRT), how best to accomplish this goal was uniquely defined by each collaborator's own perspectives. In the standard public health model, the department typically takes the lead and invites select members of the community to help with an initiative (O'Mara-Eves et al., 2015). In this case, a more collaborative model was used with churches and the community response team partnering with the public health department on many facets of the COVID-19 response.

Descriptive information pertaining to health needs, barriers, and services of Marin City presented in this article was obtained from interviews and discussions with key collaborators in the SM CRT and are depicted in italics. Mirroring the cross-cultural nature of the collaboration, the community and public health collaborators also served as members of the writing team. Where possible, authors wrote sections relevant to their participation using data and materials generated by the Southern Marin CRT. Each section was reviewed by the entire writing team and appropriate organizational leaders. Although not an intervention study per se, this organically generated case example may serve as a catalyst for future development and enhancements of

cross-cultural collaborations between public health departments and community organizations.

What Is Cross-Cultural Collaboration?

While collaboration is a well-established public health intervention (Minnesota Department of Health, 2019) the actual mechanics, challenges, and rewards of cross-cultural collaboration have been less frequently discussed in the public health literature (O'Mara-Eves et al., 2015). A formal definition of collaboration includes "the formation of a working relationship with a mutual goal" (Prybil et al., 2016). While this definition offers clarity, cross-cultural collaborations that include individuals and groups from different cultural backgrounds, including culturally specific community groups, adds richness, complexity, and potential areas for conflict. Building awareness, adjusting communication strategies, and practicing active listening can boost cross-cultural collaboration efforts at the individual, team, and organizational levels.

In an article entitled "Reflections of Cross-Cultural Collaboration," Salazar and Salas (2013) defined cross-cultural collaboration and presented some of the inherent challenges of working with groups comprised of individuals from different cultural backgrounds and diverse community groups. For example, some cross-cultural temporal differences may include the idea that "individuals across cultures vary in their perception of time, deadlines, and their preferences for how time should be utilized" (Salazar & Salas, 2013, p. 912). In an age where people are overworked, making time for collaboration may feel like an unaffordable luxury. Collaborations that include professionals who work on the clock may be challenged to find time in their contracted work obligations. Unless cross-cultural collaboration efforts are supported by their organizations and time is allotted in their contracts, pressure on well-meaning staff to participate in extra activities might engender resistance.

Another area that may cause tension within a cross-cultural collaborative project is "goal definition and prioritization" (Salazar & Salas, 2013, p. 913). While at least *one common goal* is key to all collaborations, differences about how to best achieve that goal may exist among collaborators with different cultural values and priorities (O'Mara-Eves et al., 2015). For example, some members may hold cultural values that prioritize interpersonal relationships, whereas others may focus on obtaining quantitative measurable objectives. Cross-cultural collaboration management of culture-based conflict may require additional in-service training and facilitation. However, the potential offset in program effectiveness and team morale should be taken into consideration

The Central Role of Trust in Cross-Cultural Collaboration

> The road between access and utilization is paved by trust. Here, MCCT has paved that road in both directions—for the County and the Marin City community. (Staff from the Marin County Cooperation Team (MCCT), the lead agency for the Southern Marin CRT)

An article entitled *African American Faith Communities and Public Health: Working at the Intersections of COVID-19* describes major barriers to effective collaboration as mistrust and distrust (Goldblum et al., 2021).[1] The current article applies these ideas to an existing collaboration. According to Byron Bland (Thompkins et al., 2020), mistrust arises when one does not know enough about someone to trust them. Distrust arises when one expects harm to occur from an encounter. Distrust may be caused by negative personal experiences or from stories told by trusted others. To build trust where there is mistrust is difficult, but to build trust where there is active distrust is even more difficult because of the need to counteract one's experiences that work against trust. The authors suggest that the corrective action to combat distrust and mistrust—on an individual or community level—centers on being "trustworthy." In Bland's words, "Trustworthiness requires truthfulness and consistency in words and deeds" (Thompkins et al., 2020, p. 7). Working cross-culturally requires placing relationships at the core of the endeavor. We suggest that the humanistic traits of empathy, honestly, and positive regard are useful in measuring relationships.

Guided by the project trust model, Goldblum et al. (2021) recommended three strategies to expedite public health partnerships that included the African American community. Health care organizations need to (a) recognize and acknowledge that faith community leaders possess unique and useful knowledge of their communities; (b) include faith community leaders as full partners when planning and strategizing, making decisions, solving problems, and developing policies that affect community well-being; and (c) use an intersecting approach that recognizes the multifactorial realities of COVID-19 and uses remedies that effectively address existing and new problems in a comprehensive, long-term manner.

> In an interview, Jahmeer Reynolds, Executive Director of the Marin County Cooperation Team, reflected that: *Trust is a definite benefit of collaboration between public health and faith communities. Faith community leaders possess a unique knowledge of their communities and should be seen as full partners when collaborating with public health sectors. These leaders should be included in the planning, decision-making, and problem-solving.*

Two Cultures at Work

To understand the pressures within collaborative partnerships requires an appreciation of the historical context of these relationships. Each partner—whether from public health or the community—has a history of interaction and holds beliefs and biases related to cooperation with the other. If left unchecked, these biases can become a barrier to working together. Shirin Vakharia, a staff member of the Marin Community Foundation that is funding aspects of the current partnership, noted:

> What brings people to the field oftentimes is wrapped up in issues around religion and the role of religion in public life and the role of religion in how it shapes and influences how we think about health and public health strategies. Similarly, members of faith communities may also have biases, blind spots, harms, hurts, and bring people into the work and get in the way of collaboration with health workers.

African American Culture and Cosmology

The establishment of cross-cultural collaborative relationships between health authorities and marginalized communities requires both parties to acknowledge the existence of historical harms, mutual suspicion, and the benefits of effective processes to engender trust and reduce suspicion. Desmond Tutu described the idea of collaboration in line with the concept Ubuntu: "My humanity is bound up in yours, for we can only be human together," (Robb, 2017). Not since the AIDS crisis has the African American Church experienced such a theological and cultural challenge (Pillay, 2011; Sutton & Parks, 2013). In the dissection of the African American Church's response to the COVID-19 pandemic, it is essential to understand that the African American Church is not monolithic. The seven historically African American Church denominations include the African Methodist Episcopal Church (AME), the African Methodist Episcopal Zion Church (AMEZ), the Christian Methodist Episcopal Church (CME), the Church of God in Christ (COGIC), the National Baptist Convention of America (NBCA), the National Baptist Convention, USA, Inc. (NBC), and the Progressive National Baptist Convention (PNBC).

African Americans are descendants of enslaved African people who arrived in the Americas hundreds of years ago. At times, their oppressors utilized the power of religion and faith as an instrument of enslavement. It is not clear whether this was an intentional act or an accident of history. This brand of Christian expression emphasized the values of personal salvation, respect for authority (usually the preacher and civil authority), and the acceptance

and excuse of present suffering as a precursor to heaven (redemptive suffering). All these elements were toxic to human existence and those who were enslaved. It justified the status quo of their oppression and enslavement.

Perhaps because of the resilience of the human spirit, the enslaved people infused into their religious cosmology a bold and strong spirituality that was born in the days of their freedom and was an enshrinement in a social order in which they were fully human. The enslaved people adapted the role and function of the preacher. To this already exalted position in Christian evangelical faith, they poured into this role the leadership authority and responsibilities of their traditional society. The local communities selected their own preachers, who had to pass the leadership test of understanding scripture through the lens of oppression, clear and demonstrated political dexterity at negotiating the white power structure, and authenticity in representing African American people with a view toward historical, emotional, and psychological reparation.

Over the years, the descendants of the enslaved learned to leverage the elevated role of the preacher in both Black and White communities as a way to foster safety and promote a subversive agenda to obtain as much freedom as possible for their congregations. They did so by utilizing the story-telling tradition of enslaved people in reinterpreting the Bible as a book of liberation, promise, and reliance. This literally turned the function of the faith they were given inside out. Through the years, these religious leaders have come to be seen as people who are at the center of conflict and confrontation with outside communities and as keepers of realistic skepticism of those who come in "sheep's clothing" to interact with the Black community.

The function of worship, faith, and spirituality have been handed down to the descendants of enslaved people as largely as a subversive, engaged, and reliance-producing element of their lives, regardless of their formal adherence to the "tenets for their faith." This assertion is an application of suspicion, not affirmation. Moving these communities from a stance of suspiciousness requires an ongoing demonstration of trustworthiness–both from those within their community and certainly from those outside. The establishment of cross-cultural collaborative relationships between marginalized communities and health authorities requires acknowledgment of the existence of historical harms, mutual suspicion, and structural racism along with the development of effective processes to engender trust and reduce suspicion.

Understanding the value of healing practices used by the African American community requires an awareness of the community-oriented view held by many members. If the objective of an intervention is only to fix a specific problem in a specific person within the community, failure is probably inevitable; this is because the intervention does not take into consideration an

understanding of the historical roots of the problem, nor does it weigh how this change affects the community and family.

An essential part of African American Cosmology relevant to this enterprise of coalition and cross-cultural collaboration is the importance and employment of grace. The coalition and cooperation between a historically harmed community and those who represented a system that continues to do harm will inevitably lead to intentional and unintentional incidences of miscommunication, mistrust, and many opportunities for policies and practices which threaten to destroy their efforts. The coalitions and collaborations with African Americans in the U.S. context are usually between people with equal humanity but unequal power. It is a relationship between people with different lived experiences. So, in the spirit of Dr Martin Luther King (1954) Jr's sermon, "Man's Sin and God's Grace," the notion of grace is an essential ingredient in making these relationships transformative.

However, grace is not the simple popular notion of forgiveness for past or present harms. Grace has three dimensions: the experience of grace, the granting of grace, and grace as justice.

> **The experience of grace** is simply the idea of an unmerited pardon for wrongdoing. From this experience, one gets the gift of humility, gratitude, and recognition that human beings exist in broken relationships for which we all have taken responsibility and for which we have all had to be forgiven for our intentional and non-intentional wrongdoing.
>
> **The granting of grace** is a decision (based upon the experience of grace) to grant others a chance to change after they have harmed as a part of the process of reconciling, repairing, and reconfiguring the broken relationships of harm. It is an act of trust and faith in others that they will use this lack of application of consequences to grow, learn and make real changes.
>
> **Corporate grace** is the implementation of justice. This is the implementation of consequences and punishment without denial of the human potential for change. Cornell West (2011) famously said, "Justice is what love looks like in public. Tenderness is what love looks like in private."

Social justice and grace are two sides of a coin. Social justice is the striving for fairness in community relationships, while grace provides forgiveness to those who have harmed others.

An additional area of sensitivity to many African Americans is the harm from being an object of a transaction. This strong negative reaction may have long historical roots. What was most destructive to the enslaved people was being treated as chattel; in other words, an object of a transaction. Taking care not to objectify each other nor seek easy explanations and judgments related

to community behavior will open the possibility of honest relationships and understanding. Understanding African American history and cosmology provides a foundation for respectful cross-cultural collaboration.

Public Health Culture and Cosmology

Public health organizations have a mandate to prevent illness and injury in populations. Public health professionals have much to be proud of given a long history of public health successes (e.g., improved sanitation, eradication of infectious diseases, and campaigns to reduce dangerous and unhealthy behaviors). However, like the African American community, public health communities are not monolithic. People come to public health for a variety of reasons and from a variety of backgrounds. At the same time, a shared approach and shared history provide a thread of commonality.

In his commencement address to the Yale University School of Epidemiology, Arthur Viseltear (1987), a public health historian, suggested that the Public Health Ethos is "to do good, be useful, to be civically constructive." The emphasis of this ethos is on taking positive action. A hallmark of the public health approach is the use of scientific methods and data to understand and respond to problems of health. While this "evidence-based" mantra may collide at times with some community traditions and aesthetics, public health practitioners must find ways to communicate their findings in an acceptable and useful way. An example of a culturally sensitive approach to the application of data is interpreting epidemiological results to community partners, in an understandable manner, to define public health problems, set appropriate common goals and strategies, and monitor success.

Another core value that has been identified within the field of public health is "Equity" (Gebreyes et al., 2021). Health equity is the fair and just opportunity for every individual to achieve their full potential in all aspects of health and wellbeing. The causes for the current lack of equity are complex yet must include an analysis of systemic racism. According to Deloitte, "achieving health equity requires leaders to intentionally and deliberately design and build systems that advance health equity as an outcome." At the same time, equity is best understood as aspirational (Gebreyes et al., 2021).

A current debate in public health circles related to equity is the definition of population targets for interventions. While existing evidence supports the importance of taking a population-wide approach to prevention efforts (Rose, 2001), equity requires identifying subpopulations that may have unique levels of risk and require more culturally specific approaches (Thompkins et al., 2020). Developing community prevention efforts that include both population-wide and high-risk group strategies requires careful data analysis and community collaboration.

The term cosmology, while typically applied to religion, refers to commonly held worldviews and their transmission over time. Understanding the role and ethics of public health requires considering public health knowledge, practice, and authorities. At times, conflict between public health organizations and some segments of the community may arise when public officials are called upon to use their legal authorities to intervene in behaviors that certain individuals or groups may hold strongly. Debates regarding COVID-19 masking, vaccination, and social distancing are examples. Cross-cultural collaboration presents unique challenges, but if done right, it can generate creative approaches and improve effectiveness. Building awareness, adjusting communication strategies, and practicing active listening can boost individual, team, and organizational collaborative efforts. Public health specialists can also provide expert insights that can be leveraged for working within those communities. While collaboration requires a commitment to a mutual outcome, collaborators may also hold allegiances to specific community organizations.

Marin City Response to COVID-19

While a history of collaborative efforts between the community of Marin City and public health existed before the development of the Southern Marin CRT with its share of successes and disappointments, this case example begins with community funding granted in response to a request for proposals issued by Marin County Health and Human Services (HHS). CRTs were funded in four zones or regions of the county selected to ensure an equity-based approach and build upon existing infrastructure to "optimize coordination, cooperation, collaboration, and communication" (Marin Community Response Teams RFP-HHS-2021-15. Page 6. 2021).

> This project will involve building a public health infrastructure to respond to and recover from countywide public health threats and emergencies by adopting strategies that improve coordination across Marin County. Threats that affect public health include, but are not limited to pandemics, wildfire, smoke, public safety power shutoffs, and infectious diseases (e.g., Hepatitis C, tuberculosis, influenza, coronavirus, etc.).
>
> The priority populations may differ across each zone depending on the public health threat. However, an equity-based approach will be taken whereby the focus of the coordination is on residents of the zones who are most vulnerable to community-wide public health disasters, and who would benefit the greatest from the provision and coordination of services and resources.

The funding awarded for the Southern Marin CRT was US$150,000 for a 2-year period (September 2021 to June 2023). While serving Southern Marin,

the Southern Marin CRT focused much of its efforts on Marin City to form a Community Response Team.

The need for expanded community partnership in COVID-19 management and prevention in Marin City was recognized by a broad coalition of community leaders and public health officials.

Both Public Health Officials and African American Faith Leaders of Marin County recognized the need for expanded community partnership in COVID-19 management and prevention.

COVID-related health disparities were identified in several marginalized groups, especially among residents of Marin City (County of Marin: Department of Health and Human Services, Division of Public Health [HHS], 2022). Low-income communities and communities of color in Marin County have been disproportionately impacted by the COVID-19 pandemic, experiencing higher rates of COVID-related morbidity as well as negative effects on residents' mental and financial well-being. Community partners reported that community members encountered barriers during the initial COVID-19 response efforts in accessing vaccinations (i.e., access to vaccine sites, transportation issues, competing demands, such as work and child care, limited health proficiency and English literacy, and a digital divide). Between January-July 2021, Marin City residents had lower rates of first vaccine dose uptake compared to the county overall at each age of eligibility (Figure 1). The one exception was in March 2021 when Marin City residents aged 65 and older surpassed the first dose uptake for age-matched residents in the county overall (Figure 1.) In addition, higher levels of vaccine hesitancy existed in these communities compared with Marin County overall. Community partners learned that residents in their communities had concerns about safety, efficacy, side effects, rapid vaccine development, misinformation, and distrust of medical expertise and the government. Vaccine hesitancy in communities of color is also rooted in historical and contemporary experiences of systemic racism and marginalization.

> In August 2021, the peak of the Delta surge in Marin County, the 30-day cumulative COVID case rate was 549 per 100,000 residents for Marin County and 749 per 100,000 for Marin City, nearly 1.4 times that of the County overall (HHS, 2022). Marin City falls within the lowest California Healthy Places Index (HPI) in Marin County (HHS, 2022). HPI is a scale describing how community factors predict life expectancy and health outcomes, with lower scores predicting lower life expectancy and poorer health outcomes compared to higher scores [1]. County data on COVID vaccine surveillance in Marin City revealed gaps in vaccine uptake, with Marin City having one of the lowest vaccination rates in the County. Data from the California Immunization Registry (HHS, 2022) reveals that between January to July 2021, Marin City residents had lower rates of first vaccine dose uptake compared to the county overall at each age of eligibility.

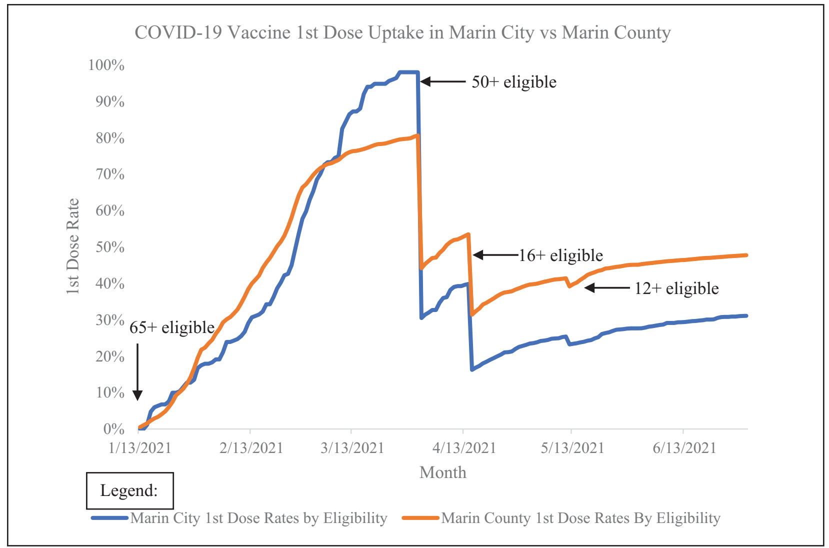

Figure 1. COVID-19 1st Dose Uptake in Marin City vs Marin County by age of eligibility.

On a positive note, data collected from vaccination sites indicate that when sites are located within the community they are well utilized.

> Data from the California COVID-19 Vaccine Scheduling Registry (California Healthy Places Index, 2022). reveals that nearly 50% of eligible Marin City residents were vaccinated in Marin City itself, either at the St. Andrew Presbyterian Church or the Marin City Health & Wellness site that preceded it. Further examination of vaccine administration at the Church reveals that Marin City residents made up the second highest group of residents to receive vaccinations at the site. These data reveal that Marin City residents choose to get vaccinated in Marin City (California Healthy Places Index, 2022).

The History of the Marin City Coalition

From the Public Health Perspective

In November 2020, the Marin County Department of HHS began engaging with community representatives to assess needs related to COVID-19 in four areas of the county and pulled together a plan for support and coordination.

Each team had a community lead and a county lead that were intended to function using a shared leadership model. Prior to this time, each team worked pretty much in isolation from the others and brought in partners only as needed to address community needs. Minimal funding (US$20,000 per team initially and then an additional approximately US$58,000) was provided over the course of approximately 1 year.

On April 20, 2021 Marin County Board of Supervisors approved a 2-year initiative to provide more substantial grant funding for community work through the formation of Community Response Teams and to hire a Senior Program Coordinator (SPC) to provide backbone support to the CRTs. The organizational structure included each CRT lead selecting key, strategic community partners for their CRTs, facilitating meetings, setting agendas, keeping centered on community needs, regularly communicating key messages to their partners, and assuring follow-up on action items. In addition, CRTs provided essential input to inform the County's COVID-19 response, including: planning of vaccine and testing sites, antigen test distribution, message development, and identifying other strategies critical to reach and meet their community member's needs. HHS provided data and technical assistance to the CRTs.

According to the current SPC, Randi Lachter, MPH, Marin County is committed to racial equity in vaccine distribution.

> Our success in pandemic response was grounded in partnerships with trusted community-based organizations. The county hoped that by investing in concentrated, continuous, community-led efforts that reduced barriers to access and build vaccine confidence, would markedly increase vaccination rates within Marin County's most vulnerable neighborhoods and communities.

The impact of community involvement has been notable. For example, the content in public health status updates, flyers/handouts, and vaccine clinic locations and logistics were often informed by the questions that came from CRTs. This partnership has been a key factor in identifying and addressing information gaps. The public health leaders came to rely on the CRT's input and were generally open and responsive to the feedback.

Community Partners

Marin County Cooperation Team

Marin County Cooperation Team (MCCT) was created in 2020 as an emergency response to the COVID-19 pandemic to ensure the continuation of comprehensive support services in Marin City. In September 2021, MCCT became the lead agency for the Southern Marin CRT. MCCT began as a

volunteer network of over 200 community volunteers whose activities were focused on Marin City, a historically African American community, and were aligned with the goals and values of the MCCT. The Southern Marin CRT's success was centered upon MCCT being a conduit of trust between the County and the approximately 20 community partners that were a part of the Southern Marin CRT, with Marin City's churches being *critical* partners.

According to Mira Guidi, MCCT's Director of Development and Operations,

> MCCT's trust was established with the County through MCCT's clear vision and established partnerships; its grounding in systems, visionary thinking, and infrastructure; and MCCT's willingness to be true partners with the County in the work while simultaneously having the difficult yet necessary racial equity conversations. MCCT's demonstrated success in serving the community by providing a comprehensive outreach plan and by using outreach mechanisms specifically tailored to the needs of the African American community in Marin City (i.e., affirmative fair marketing). Our deep commitment to the Southern Marin County African American Community allowed us to facilitate information sharing among hard-to-reach individuals, including older adults, those who are immune-compromised, people with disabilities, first-time mothers/single mothers, those without phone/computer/internet access, and unhoused communities.

MCCT strives to center and keep the needs and voices of the Marin City community top of mind, is unapologetically African American focused, and does not compromise its vision for any dollar amount or relationship. This integrity transfers into MCCT's role as the Southern Marin CRT lead agency. Seen as the boots on the ground response for Marin City when the COVID-19 pandemic struck, MCCT demonstrated its trustworthiness by responding to clients' needs within a 30- to 45-min turnaround and by seeing requests through to completion. From January 1, 2022 to June 30, 2022,[2] MCCT and the Southern Marin CRT have (a) distributed over 12,000 COVID-19 rapid home testing kits and masks to the community and (b) made over 63,000 contacts regarding COVID-19 resources, testing, and vaccination clinics via in-person outreach (i.e., door-to-door canvassing, tabling at community events, bulletin boards, church announcements, etc.), digitally (i.e., social media, videos encouraging vaccinations, emails), print (i.e., flyering, door hangers), and other methods (i.e., phone calls).

In addition, Mira Guidi, stated:

> MCCT prides itself on its integrity, directness, transparency, and openness. MCCT is skilled at building relationships that break down silos, enhancing

each partner's business and service model, as well as deconstructing the scarcity mindset that can exist among nonprofits in Marin City, and in turn, providing an expanded yet collective perspective on local issues.

MCCT has also centered its community outreach and messaging related to COVID-19 vaccinations and testing on resource sharing, agency and empowerment, the concept that knowledge is power, and body autonomy. Consistent with humanistic principles, their support of body autonomy means that they do not force utilization of any resource on any community members. Their over-arching charge is, "we trust you to make the right decision for yourself."

Working in cross-cultural collaboration requires patience in communication. Courage of one's convictions in confronting bias that is tempered with grace is required to sustain working relationships. Jahmeer Reynolds, the executive director of the MCCT, described some of his frustrations working collaboratively in one of our interviews:

> . . . there are some biases that exist from public health agencies around faith—based organizations of color—especially around geography. And I could speak to working in Marin County and, in particular, working in Marin City. It's viewed as a place of high crime and so many other negative stereotypes just based on word of mouth. And so, public health agencies—they may help, but it won't be at full capacity. It'll be just enough to say, "Hey, at least we're doing something."

As a result of MCCT's effective work and established trust in the Marin City community, and after applying through the extensive RFP process, the county selected MCCT as the lead agency and partner for Southern Marin. However, this request for partnership was originally rejected in part because MCCT wanted assurances that they would be able to maintain the central values of empowerment, education, and compassionate collaboration of equal partners working for a common good. Eventually, MCCT obtained those assurances and agreed to act as the lead agency for the Southern Marin CRT.

> I am proud of the opportunity to break down barriers and myths around the African American community, faith-based organizations, and public health agencies. I was disappointed by the amount of persuasion it took to convince the public health agency to provide support in the African American community, even though the same logistical offerings were identical to the services provided

in a predominately white community (Jahmeer Reynolds, Executive Director of MCCT).

While still unapologetically focusing on service to the African American community, MCCT has now evolved into a staffed, county-wide, umbrella service coordination agency that also provides its own safety net services and youth empowerment programming. Successful programs like the Southern Marin CRT have also resulted in MCCT collaborating with Marin County on other community convening projects for the benefit of the Marin City community.

The Marin Ministerial Alliance

The Marin Ministerial Alliance (Alliance), as part of the Southern Marin CRT, lobbied the Health Department to provide a vaccination clinic at a local church as a way to support equity by improving logistics (i.e., time of day, staffing levels; Marin County Cooperation Team [MCCT], 2022). Since its founding in 1942, the Alliance has been operating within Marin City and is comprised of all the African American churches that cooperate with one another and provide moral and political advocacy for the community. Historically, the pastors of the churches have provided leadership to civic and governmental organizations in the areas of mental health equality, policing, public housing, and other such efforts. Typically, the Alliance wants to lend its access to people and resources to the community. The pastors see themselves as primarily a spiritual support system that empowers the community to do the right things for themselves and others. The membership of the four African American churches in the Alliance constitutes the largest regular gathering of Black, Indigenous, and people of color (BIPOC) in Marin City and provides a trusted venue for messaging and discussions centered on health promotion (MCCT, 2022).

Because of its historic role in the development of the city, the Alliance has been perceived by the community as the first stop in addressing health issues in Marin City. At the beginning of the pandemic the community response regarding COVID-19 prevention was combined with already existing health promotional activities. For example, the First Missionary Baptist Church made its parking lot available for COVID-19 testing and added this event to their advertising fliers that were designed for promoting their local food pantry serving several hundred people a week. This all changed in the Fall of 2021 when the Alliance held a COVID-19 remembrance service in a Marin City public park only to find that many families could not attend due to being unvaccinated. Immediately after the event, the pastors met and identified the need for more concentrated community outreach. It was around this time that HHS reengaged with the community and the MCCT assumed a central role in leading the Southern Marin CRT in addressing the crisis. The ministers

recommended the use of Saint Andrew Church because of its central location and its history of community engagement. To promote COVID-19 vaccination, four commercials with African American ministers were created and distributed through various websites and agencies (MCCT, 2022; St. Andrew Presbyterian Church, 2020).

Resources from the Alliance continue to support the Southern Marin CRT, including the use of St Andrew Church as the community-based site for COVID-19 vaccinations. In 2022, there have been 16 vaccination clinics held at St Andrew Church with a total of 360 vaccinations administered (not necessarily all Marin City community members). Even with the success of the coalition's endeavors, the cross-cultural collaboration between HHS, the Alliance, and other community organizations has not functioned without its share of problems. It is not unusual for coalitions to experience communication challenges and operate at decreased efficiency because decisions are made collaboratively and not unilaterally. For example, pastors and MCCT identified a lack of lead time to advertise new vaccination schedules that interfered with the distribution of needed information to the community. To address this problem, the Alliance has suggested continued work within the coalition to increase timely notification of scheduled events.

Through this work, it has become clear that the Ministerial Alliance of Black Churches in Marin City could do three things that the Southern Marin CRT could not do without the Alliance:

1. They were not only responding to the COVID-19 crisis. The "pandemic crisis" or the "health care crisis" was simply a part of the ongoing struggle of existence and respect that many in the African American community experiences daily. The Black Church has always worked on a number of social and health issues that various agencies have identified. So, not casting the vaccination as a crisis and weaving it into the pre-existing message of community enhancement proved effective.
2. The outreach efforts were performed in the spaces that the community owned. Working within trusted venues of the church provided a stamp of legitimacy to the program. As a result, the vaccination clinics were successful in the churches because tithes, offerings, and many countless hours of volunteer work created and maintained these spaces.
3. The African American churches already had pre-existing mechanisms of persuasion. Churches are houses of spiritual and social advocacy. Those who attend the churches accept the invitation to carry the message of the church and creating an impact on those around them. So, the church's campaigns were not simply about getting people vaccinated, but about motivating people to convince their loved ones that

they need to be vaccinated. This is reflected in a church media campaign to get family opinion-makers, matriarchs, and community trust agents to encourage those in their sphere of influence to get vaccinated. Bishop Logan, Pastor of Cornerstone Community Church of God and Christ, began his video commercial[3] with the words "I just got through doing a funeral"; he said he was tired of doing funerals. He encouraged relatives to take up the mission of getting their loved ones vaccinated using whatever means they normally employ to get the stubborn or the foolish in their family to do things. The aim of the work of the ministerial alliance was relationship, and not just education. In combating misinformation, their experience and loyalty to loved ones are what overcame fear and hesitancy.

Evaluation of the Marin City Cross-Cultural Collaboration

Most participants in the program agreed that this initial phase of the Southern Marin CRT was highly successful. The greatest gains were consistent with the language of the original request for proposal funding for the CRT that was focused on building infrastructure. As mentioned earlier, this is no small task in cross-cultural collaborations. Each individual, from each cultural background, had to be willing to provide grace to others who may have inadvertently stepped on their toes. HHS, MCCT, and faith community leaders were able to build trusting relationships and set the tone for the coalition.

In reviewing the work of the Southern Marin CRT, Rev. Floyd Thompkins, Jr, pastor of St Andrew Church, pointed out that by combining resources, HHS and the CRT with critical faith leader support were able to provide services that neither could effectively offer alone. HHS provided clinical expertise and needed prevention services in the form of vaccinations and medical information. Having an adequate infrastructure that provided appropriate vaccine administration was only possible within medically supervised operations.

Marin County Collaborative Successes

1. Rapid creation of a strong coalition that openly invited an array of community organizations to participate. As a result, a new Marin City vaccination site at St Andrew Church was created.
2. After a rigorous application process, MCCT was selected to be the Southern Marin CRT's lead agency. Having a lead organization with deep and historic roots within the Marin African American community has helped create greater trust within the community. Having a

close working relationship with the SPC of HHS facilitates shared leadership functions and transfer of information.

3. The SPC provides support and technical assistance to the Southern Marin CRT as a single point of contact. The SPC and MCCT were both intimately involved in planning, coordination, and problem-solving and provided a much-needed touchstone for the community. Having an advocate from HHS within the CRT allows for a flow of information to and from HHS. Having MCCT, a community-based organization, as a lead provides an important vantage point and improves access to members of their community.
4. During COVID-19 response, the county has been able to provide a great deal of technical assistance and support because of the funding received from the CARES III federal funding. This support came in the form of funding for the CRT initiative, printing, graphic design, logistics planning, vaccination and testing, and a liaison to advocate for the community's needs in county strategies.

Areas for Improvement

1. At times, when communication between HHS and the Southern Marin CRT broke down, lead-time for activities was not adequate to conduct outreach and promote events. This problem is now being addressed by the CRT.
2. Frequent staff turnover or shifts in HHS staffing created uncertainties in clinic staffing, outreach, and testing. This issue is directly influenced by funding and sustainability issues.
3. At times, underfunding and uncertainty about future funding have affected morale, delayed hiring, and made it more difficult to meet contractual obligations. Funding allocations were based on zone populations and not public health needs, which at times disadvantaged smaller locations like Southern Marin and Marin City.
4. At times shared leadership has been difficult. Given the challenges of cross-cultural collaboration that are described in this article, this difficulty is not surprising. One aspect that challenges collaboration is the existence of split loyalty that each participant has to their own constituents and their colleagues in the coalition.

A Cross-Cultural Collaboration Model

Our proposed cross-cultural collaboration model (CCCM) synthesizes aspects of standard public health practices with community-based cultural sensitivity and expertise. Through coalition-building, alliances among organizations or constituencies are developed and fostered to address a common

purpose (Janosky et al., 2013; Minnesota Department of Health, 2019). In the CCCM for Marin City, CA the three collaborators each appear in separate bubbles along with a description of their unique contributions to the coalition. Planning, implementation, and evaluation are shared activities that are collectively undertaken by the three collaborators as part of the coalition's mission. In the CCCM, both unique and shared contributions appear within the coalition circle along with the desired attributes of trust and grace. It is within the coalition circle that cross-cultural collaboration takes place.

Although all coalitions will be unique and comprised a different mix of community-based and public health organizations to address the problem at hand, the CCCM may be a useful tool for new cross-cultural collaborations to use to start discussions concerning shared and unique contributions and the importance of trust and grace. The success of each coalition will depend on the effectiveness of cross-cultural collaborative efforts, including the respectful treatment of colleagues, clients, and the community (O'Mara-Eves et al., 2015; Thompkins et al., 2020) (Figure 2). A humanistic context for the work of cross-cultural collaboration includes being trustworthy and extending grace (Thompkins et al., 2020).

Conclusion

Coalition is as much about the spirit of individuals as it is about the development and implementation of programs and organizations to address a common need. A dual approach is needed that is mindful of individual needs, while focusing on the greater good. Using their own sources of information, whether quantitative or qualitative "the word on the street" data, a picture of the community needs must be created. Clear articulation of common goals and the role that each collaborator has in meeting that goal is needed to develop agreements related to roles and articulation of shared leadership and conflict resolution. Having designated positions in both the health department and the community to provide shared leadership and to represent the program to their constituents appears to be essential for success. Given that most of the members are also affiliated or employed by other institutions and communities, each are required at times to exist in a space of split loyalties.

An existential task for the coalition is to be able to continue to enhance their systems for data collection and effectively conduct program implementation and evaluation without losing the human connection. A big question moving forward is whether this coalition is sustainable. Too often, community members have established trusting relationships with their counterparts in the public health bureaucracy only to have them vanish once the initiative is complete. Our hope is that this collaborative program model receives continued funding to sustain core functions and retain staff members who could

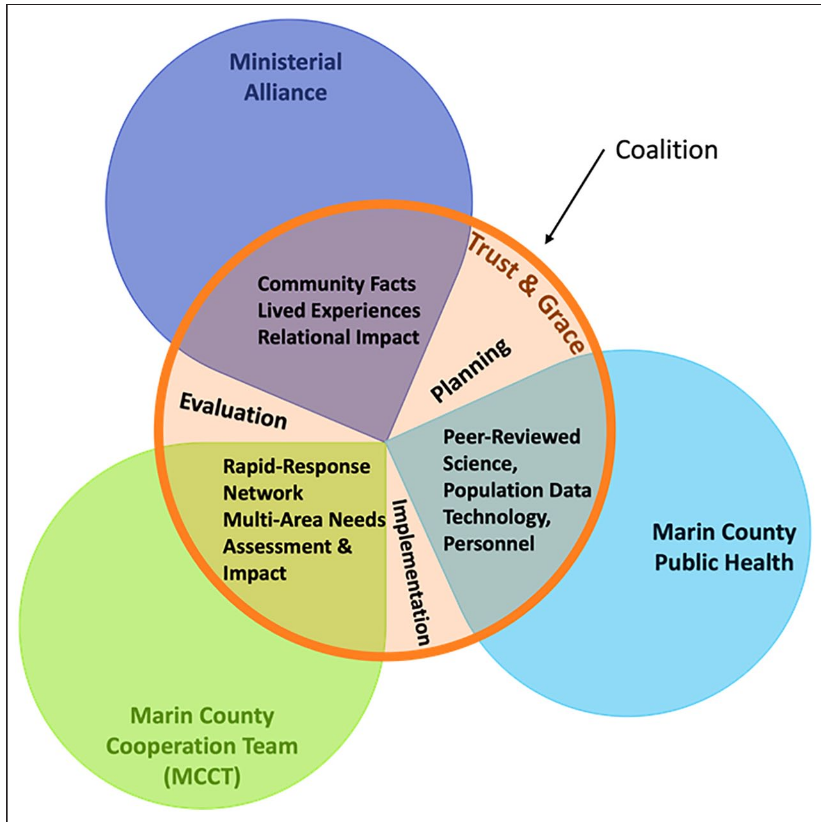

Figure 2. Cross-Cultural Collaboration Model.

meet current and future needs. While sustainability is essentially a public policy question that requires federal, state, and local government commitment to support public health, the under-funding of public health has been decried by many experts (Vinluan & de Guia, 2022). From the experience in Marin City, we strongly recommend that public funding be made available to support the development and continuation of cross-cultural collaborative community coalitions.

Cross-cultural collaborations that include partners who have experienced racism and historical harms, can only be effective when they are grounded in humanistic values, including trust and grace. Confronting these power differences is an enterprise of truthfully addressing the past, learning to work together to create trusting relationships for problem-solving, and creating a shared vision of the future. While managing relationships within coalitions

may be at times challenging, using the humanistic principles of listening, empathy, trustworthiness, and grace increases the likelihood of success.

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Matthew Willis, M.D., M.P.H., Public Health Officer, County of Marin Department of Health and Human Services, lead the County through the pandemic and envisions and equitable response.

The Marin County COVID-19 Vaccine and Testing Teams, mobilized vaccine and testing sites throughout the community to meet both demand and equity goals.

Southern Marin Community Response Team partner organizations, provided guidance, insights, advocacy and endless amounts of grace.

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Notes

1. Several authors on this article (Thompkins, Goldblum, Lai, and Brown) worked with Project Trust to improve trust between African American churchgoers and health professionals. Two previous publications (i.e., Goldblum et al., 2021, and Thompkins et al., 2020) describe that work. The current work extends the Project Trust model by highlighting the benefits of using a cross-cultural collaborative

model to build coalitions that focus on equitable health care.

2. MCCT was not required to collect metrics until January 2022 for reporting to County, therefore, the reported timeframe starts in January 2022.
3. To find videotapes, see https://www.youtube.com/playlist?list=PLVqnt8Dt0wFymahMo9ywAJuefS2Jd2Qt9

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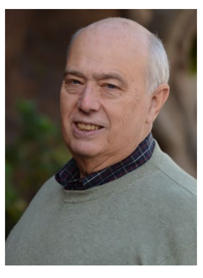
Author Biographies

Floyd Thompkins is the pastor of Saint Andrew Presbyterian Church in Marin City, California. In addition, he is the CEO of the Justice and Peace Foundation—an organization that has received several grants for "Project Trust" to engage in participatory research to explore the connection between mental health and spirituality. He is also the former Assistant and Associate Dean of the Chapel of Princeton University and Stanford University and the former Vice President of the Center for Innovation in Ministry, San Francisco Theological Seminary.



Peter Goldblum, PhD, MPH, professor emeritus at Palo Alto University, was the founder and first director of LGBTQ Program and the Sexual and Gender Identities Clinic at PAU. He has served as the behavioral health and training consultant to Project Trust since its inception and has co-authored two journal articles describing this program. A graduate of UC Berkeley School of Public Health and Palo Alto University, he was one of six original AIDS and Behavioral Health consultants to the San Francisco Health Department and one of the founders and the first deputy director of the UCSF AIDS Health Project.

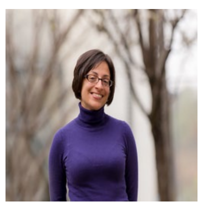
Tammy Lai, GMBA is the Chief Operating Officer of the Justice and Peace Foundation. As such, they oversee several national and local participatory research projects and programs concerning equity and inclusion. They are also the Director of Education for Alonzo King LINES Ballet. Prior to these positions, they were the Joy and Richard Dorf Director of online education, course development, and project management at the San Francisco Theological Seminary. Much of their work focuses on social entrepreneurship, community engagement, and innovation in Education.

Jahmeer Reynolds, M. Ed. is the Founder and Executive Director of Marin County Cooperation Team (MCCT). MCCT was an emergency response to the COVID-19 pandemic to ensure the continuation of comprehensive support services in Marin City. Working in California's second most racially disparate county during the pandemic further exposed its inequities. For his work as MCCT's Executive Director, he received a Certificate of Special Congressional Recognition for

Outstanding Innovation from the U.S. Congress. He was selected as the 2021 Global Fellow Echoing Green award and joined a community that includes former First Lady Michelle Obama and CNN commentator Van Jones.

Randi Lachter, MPH is a Senior Program Coordinator, Marin County Public Health. She served as a liaison between community-based organizations and the County's COVID response teams. She then shifted to managing the Community Response Team initiative focused on building and strengthening the public health infrastructure in collaboration with community organizations to address public health threats and emergencies. Prior to joining the county, she spent 19 years working to reduce commercial tobacco use as the Director of Tobacco Treatment programs for ClearWay Minnesota. She also contributed to program evaluation and policy initiatives.

Pooja Mhatre, MPH, is an epidemiologist in COVID-19 response for Marin County, CA. Her work has focused on COVID-19 disease surveillance county-wide as well as by subgroup populations, outbreak investigation, contact investigation, vaccine and health equity, and evaluating the collaboration between Marin County and community partners in addressing public health emergencies. Prior to her work with Marin County, she was an evaluator for the Trauma Informed Systems Initiative at the San Francisco Department of Public Health. Her epidemiology research focus is on infectious disease and health equity and employs evaluation and systems thinking in her work.



Shirin Vakharia serves as a program director for Health and Aging at the Marin Community Foundation. To this role, she brings 20 years of experience in human services and public health in both community-based settings and the public sector. Prior to joining the foundation, she worked for Napa County Health and Human Services Agency as the Prevention Coordinator. In this role, she planned and oversaw substance abuse prevention, tobacco control, HIV, and mental health programs. She has a Masters of Arts in Community Counseling and a Bachelor of Arts in Psychology from the University of Cincinnati.

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Lisa M. Brown, PhD, ABPP is a Professor, Director of the Trauma Program at Palo Alto University, and an Adjunct Clinical Professor at Stanford University School of Medicine. Her clinical and research focus is on trauma, resilience, and aging. She has considerable experience collaborating with state, national, and international organizations. She is actively involved in developing and evaluating programs used nationally and internationally, drafting recommendations aimed at protecting vulnerable individuals and communities, and improving access to resources and services.