JOURNAL OF CRITICAL THOUGHT AND PRAXIS
IOWA STATE UNIVERSITY DIGITAL PRESS & SCHOOL OF EDUCATION

Volume 7
Issue 2 Engaging *in the Struggle: Health Justice* Article 7

Health Justice and Kinesiology Research: An Interview with Dr. Scherezade K. Mama

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Journal of Critical Thought and Praxis
2018, Vol. 7, No. 2, 71-75

An Interview with Dr. Scherezade K. Mama

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The Journal of Critical Thought and Praxis has traditionally published interviews with individuals who have strong connections to our special issue topics. We believe that interviews are important ways to contribute to the conversation surrounding critical issues in social justice. This interview features Dr. Scherezade K. Mama, an Assistant Professor of Kinesiology and Public Health Sciences. She has over 10 years of research experience and a broad background in public health, with specific training and expertise in behavioral science and mixed-method research.

Her current research focuses on designing and disseminating evidence-based physical activity interventions to increase physical activity and improve health and well-being in underserved adults, including racial and ethnic minorities, women, rural residents, and cancer survivors. Dr. Mama is specifically interested in mind-body strategies to increase physical activity, reduce sedentary time, and improve psychosocial health and well-being in an effort to prevent and control cancer, reduce cancer health disparities, and promote health equity.

Q: If you can tell us who you are and what your research centers on.

First and foremost I'm a public health researcher. I think that's where I differ a lot from traditional Kinesiologist's. I have a very [broad] public health and community-based approach [to research]. My goal is not to give a prescription and improve the life of one person, I want to know what we can do on a population- or community-level.

My training is in public health, and my research background started in obesity prevention and control. I later made a switch to cancer prevention and survivorship with a focus on health disparities research. I would say my work primarily focuses on physical activity promotion to reduce health disparities along the cancer control continuum from prevention all the way through survivorship.

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When we think of health disparities and underserved populations, I've done work in multiple populations. I started off working with low-income, racial/ethnic minorities, and mostly women, where we saw greater disparities in physical activity. I have expanded my work to rural communities, working with rural residents and rural cancer survivors, where we see very similar disparities, so it's worked out nicely.

Q: What drives you to do this type of work in health disparities/health promotion in historically marginalized communities? Where did it start for you? Why is this work important to you?

That's a great question. I grew up in Houston, Texas, a minority majority city, so I was exposed to a lot of [health disparities] much sooner than most people. I could see what was going on. I didn't know the name for it was "health disparity," but it was some sort of systemic problem, a problem with our system, and the historical injustices that have occurred over time and how they have contributed to that.

As a master's student, I had a life-changing interaction with a participant. There was this woman who was coming from one of these wards in Houston, a low-income community. We were doing a lot to get her to participate in our study. We were busing her in and had to order Metro Lift for her. She was very low-income, and was coming mostly for the money, the incentive that was involved with this study. I could appreciate that, whatever it took to get you to come to our study. I remember she participated in the walking program for one year. During the active intervention, we talked about social injustices in the program. We asked people to map their neighborhoods to bring awareness to the fact that not all communities are built the same. I remember her telling me at the end of the first six months that she saw improvements, but not substantial improvements.

When I saw her one year at the one year mark, she was a changed woman. She had lost so much weight, she had taken to heart what we had done, and she goes, "Scher, this program's changed my life." She's like, "I'm no longer taking cholesterol medication or blood pressure medication that I couldn't afford. I'm no longer pre-diabetic. I've transformed myself." She just looked amazing and she felt free and in control, and I think that's when I was finally like, "I can really make a difference." That's what pushed me to enroll into my doctoral program, actually.

Q: Your research focuses on the social environment and psycho-social factors that influence health risk behaviors. What have you learned about the policies and laws that contribute to a person becoming more active, or having agency in their health actions and behaviors?

[I have learned a lot about] community empowerment and the role it plays [in health]. Again, I'm a public health researcher, and I follow this social-ecologic perspective. We have this health problem or behavior at the center of this ecologic model, let's say its physical activity or obesity, or whatever it may be. Then, there are these multiple levels of influence, and I'm a firm believer when you want to have impact, or disrupt the system, we

have to act at multiple levels, which includes health policy. In fact, what I've seen is that health policy is what actually has the greatest effect on [health] outcomes.

I am not a health policy researcher, and so what I would say is, I do the research, and I figure out ways to get it into policymakers' hands. I do the work that I hope somebody can then translate for the policymaker that ultimately helps inform health policy.

I think empowerment is the key, and empowering communities to speak up for their own health and advocate for themselves, I do feel like that is my job, and I do that through mostly outreach and education.

Q: You've been in academia for some time now so, from your perspective, how are researchers, scholars, and faculty preparing students, whether in kinesiology or health, how are they preparing students or pre-health professionals, both graduate and undergraduates to address health disparities?

You know, to be honest with you, we're not doing enough. I feel, unfortunately, it still seems to be an individually championed initiative. You have to have a health disparities researcher who's a champion and moves it forward.

In public health, we generally do that pretty well, so if you're in public health training programs and stuff, we see a lot of education around health disparities and things like that, but at that undergraduate level, for example, in kinesiology, we need to do better.
[At Penn State] we have courses dedicated to teaching students about health disparities. If they're not in kinesiology I've seen them in education, in the college of education, I've seen them in social work, I've seen them in, of course, gender and African-American studies programs and things like that. I've seen them within my own college in biobehavioral health and other departments, as well. However, collectively, we are not doing enough at an undergraduate level. I think the goal is to train students before they go to their professional programs, so that they are aware as physical therapists or physician assistants that these are the people you're going to be seeing, and they are going to present differently. You need to be aware of those differences.

Q: On a similar note, have you ever been discouraged by your colleagues from doing health equity related work?

Yeah. I think I've been discouraged generally from doing community-based work. It's hard. The tenure track does not reward community partnerships, it does not reward fostering those community collaborations, or getting that community input and insight, and all the groundwork that goes into developing that partnership.

I think because of these reasons people have told me, "Maybe you should also pursue another line of research that has immediate payoff, in terms of publications, money, and things like that." None of that is why I got into this field. That's not where my passion is.
I wouldn't say I've been deterred. I've been told that this does not have the payoff and it won't be rewarded, and I still find it personally rewarding, and I continue to go that route.

In terms of doing work in racial/ethnic communities and working in health disparities, I wouldn't say I've been deterred from doing health disparities [research] ever. I think I attribute that to great mentors, and choosing the right environment, so I haven't gone to a place where somebody would say that to me, and I'm glad to say that.

Q: Discuss the differences in your research for rural and urban communities. The differences in need, and the lived experiences of those in these communities surrounding health promotion and access.

I think that there are some differences, but what I've actually seen is a lot of similarities between my racial and ethnic minorities and my rural communities. The church as a pillar in the community and having a strong religious affiliation is a similarity. It [the church] is not only there for the religious or spiritual reasons. It serves a social function within the community. People get together and have a good time. It's a time to connect with people. I think that's a similarity between the two groups.

I think where we failed is, as researchers, we have automatically come up with what the barriers are in rural communities, and the number one barrier that's cited is distance. We're geographically sprawled out, so geographic location is a barrier, and transportation or distance is the barrier for people engaging. Then, what we do as researchers is, "I'm going to develop a home-based program, so that they can do physical activity at home." In reality, transportation is not the barrier. I've talked to rural residents. They're willing to drive, and they already drive up to 35 to 50 miles to go to the grocery store or their church. They're willing to go to places, or they're willing to stay later if they're at church to hang out, socialize.

The real barrier is the isolation. That's a real barrier to being physically active, so I give you a home-based program and I'm like, "Hey, stay even more isolated out here." No, that's not fostering the social connections that they really want to see from programs like this.
I think that's one of the big, big issues. We are trying to solve a problem that they [rural residents] don't necessarily see as a problem. In my urban communities, I think they were less likely to travel those distances and in traffic, rightfully so, but you don't see those same barriers in rural communities.

They're so used to driving long distances for everything, that they're willing to do it, so I think that's one of the stark differences between the two communities. Actually, I found that people in urban communities are more likely to use transportation as a barrier than those in these rural communities.

Author Notes

Dr. Scherezade K. Mama is an Assistant Professor of Kinesiology and Public Health Sciences. She joined Penn State in 2015 after completing a two-year postdoctoral fellowship in cancer prevention and health disparities research at The University of Texas MD Anderson Cancer Center in Houston, Texas. She has over 10 years of research experience and a broad background in public health, with specific training and expertise in

behavioral science and mixed-method research. Her current research focuses on designing and disseminating evidence-based physical activity interventions to increase physical activity and improve health and well-being in underserved adults, including racial and ethnic minorities, women, rural residents, and cancer survivors. Dr. Mama is specifically interested in mind-body strategies to increase physical activity, reduce sedentary time, and improve psychosocial health and well-being in an effort to prevent and control cancer, reduce cancer health disparities, and promote health equity.